

Strategic Communication, headed by the Division Director, is responsible for professional and public outreach, communications channel technical support, and regional liaison. The division develops and executes programs to educate the public and health professionals and conducts regional liaison activities; develops evidence-based approaches in the development and evaluation of educational materials and implements clinical professional and adult educational practices and methodologies; acts as the liaison with the OASH communications office; is the gatekeeper for all materials; and manages the clearance process for OWH communications. The division provides communications channel technical support by implementing a wide range of communications media (including listservs, print, radio, TV, and social media) and tools; oversees web design, content development, and management; acts as the OWH technical liaison and APSA web council representative; and maintains a social media presence. As the RHC liaison, it supports the RHC in their mission to coordinate and implement public health initiatives to promote women's health issues at the regional, state, and local levels.

D. Under Section AC.20, Functions, "B. Office on Women's Health (ACB)" following Section 3 Division of Strategic Communication (ACB3) insert:

4. Division of Program Innovation (ACB4). The Division of Program Innovation, headed by the Division Director, is responsible for program development, management and support, and program development research. The division identifies evidence based strategies and develops model programs for targeted issues; designs, develops and implements interventions to improve women's health; incorporates gender specific issues into model programs; provides oversight for model program development and all related activities, including budget development and management; identifies future direction of women's health and associated strategies and gaps in current coverage; and reviews promising strategies to identify and promote innovative ideas for future program development.

II. Delegations of Authority. Directives or orders made by the Secretary, Assistant Secretary for Health, or Director, Office on Women's Health, all delegations and re-delegations of authority made to officials and employees of the affected organizational component will continue in force pending further redelegations, provided

they are consistent with this reorganization.

III. Funds, Personnel, and Equipment. Transfer of organizations and functions affected by this reorganization shall be accompanied by direct and support funds, positions, personnel, records, equipment, supplies, and other resources.

Dated: August 15, 2013.

E.J. Holland, Jr.,

Assistant Secretary for Administration.

[FR Doc. 2013-20524 Filed 8-26-13; 8:45 am]

BILLING CODE 4150-33-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection

Activities: Proposed Collection; Comment Request.

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: "Pilot Test of an Emergency Department Discharge Tool." In accordance with the Paperwork Reduction Act of 1995, 44 U.S.C. 3506(c)(2)(A), AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by October 28, 2013.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email at doris.lefkowitz@ahrq.hhs.gov.

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT:

Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427-1477, or by email at doris.lefkowitz@ahrq.hhs.gov.

SUPPLEMENTARY INFORMATION:

Proposed Project

Pilot Test of an Emergency Department Discharge Tool

The research study "Pilot Test of an Emergency Discharge Tool" fully supports AHRQ's mission. The ultimate aim of this study is to pilot test a discharge tool which has the potential to reduce unnecessary visits to the

Emergency Department (ED), reduce healthcare expenditure in the ED, as well as streamline and enhance the quality of care delivered to ED patients.

The ED is an important and frequently used setting of care for a large part of the U.S. population. In 2006, there were nearly 120 million ED visits in the U.S., of which only 15.5 million (14.7%) resulted in admission to the hospital or transfer to another hospital. Thus the majority ED visits result in discharge to home. Patients discharged from the ED face significant risk for adverse outcomes, with between 3-5 patients per 100,000 visits experiencing an unexpected death following discharge from the ED. Additionally, a sizable minority of patients return to the ED frequently. Published studies estimate that 4.5% to 8% of patients revisit the ED 4 or more times per year, accounting for 21% to 28% of all ED visits. Internal data from John Hopkins Hospital, AHRQ's contractor for this pilot test, supports these findings with 7% of their patients accounting for 26% of visits to the Johns Hopkins Hospital ED in 2011.

Patients who revisit the ED contribute to overcrowding, unnecessary delays in care, dissatisfaction, and avoidable patient harm. ED revisits are also an important contributor to rising health care costs, as ED care is estimated to cost two to five times as much as the same treatment delivered by a primary care physician. Thus it is estimated that eliminating revisits and inappropriate use of EDs could reduce health care spending as much as \$32 billion each year. Overall, an effective and efficient ED discharge process would improve the quality of patient care in the ED as well as reduce healthcare costs.

To respond to the challenges faced by our nation's EDs and the patients they serve, AHRQ will develop and pilot test a tool to improve the ED discharge process. More specifically, this project has the following goals:

(1) Develop and Pilot Test a Prototype ED Discharge Tool in a limited number of settings to assess:

(A) The feasibility for use with patients;

(B) The methodological and resource requirements associated with tool use;

(C) The feasibility of measuring outcomes;

(D) The costs of implementation and; (E) Preliminary outcomes or impacts of tool use.

(2) Revise the Tool based on the results from the Pilot Test

This study is being conducted by AHRQ through its contractor, John Hopkins Hospital, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on

systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

Method of Collection

To achieve these goals the following data collections will be implemented:

(1) Emergency Department Discharge Tool (EDT)—The EDT will be pilot tested in the three John Hopkins EDs in Baltimore. The purpose of the EDT is to assist hospitals in identifying patients who excessively use the ED and can be categorized as “frequent ED users,” and to target interventions to these patients to reduce the risk of further avoidable revisits. A designated ED personnel will screen the medical record of all adult patients for the presence of frequent ED use, the key risk factor for ED discharge failure. Frequent ED use is defined as: (1) 1 or more previous ED visit within the last 72-hours, or (2) 2 or more previous ED visits within the last 3 months, or (3) 3 or more ED visits within the last 12 months. This definition can be modified to align with the resources of the individual ED.

For those flagged as frequent ED users this tool uses data collected from the patient’s record and from the patient himself to identify individuals with risk factors that have been shown in the literature to predict sub-optimal ED discharges and resulting revisits. These risk factors include patients who are uninsured, lack a primary care physician, have psychiatric diseases, are substance users, have difficulty caring for themselves, or have trouble comprehending ED discharge instructions.

A user’s manual (EDT User’s Manual) is also provided to assist EDs in developing resources to provide interventions recommended by the EDT. No data collection activities will be made from this manual.

(2) One Month Patient Follow-up—After the ED visit, a project research assistant (RA) will have a follow-up telephone interview with all enrolled patients. During the interview, the RA will inquire about the patient’s remembrance of the instructions that were given for the patient.

(3) Three Month Patient Follow-up—Patients who are uninsured will receive an additional phone call 3 months after

the ED visit to assess whether or not they were able to acquire insurance.

(4) Post Pilot Test Focus Groups—AHRQ will conduct three sets of focus groups to collect qualitative data about the usability and usefulness of the EDT from three stakeholder groups: EDT implementers, patients, and post-ED care providers. Questions for each of the focus groups will vary based on their differing objectives:

(A) EDT Implementers Focus Group—For implementers of the EDT (RNs, case managers, social workers, research assistants), the objectives will include: (1) How well it does or does not meet implementer goals of discharge; (2) resources required for implementation; and (3) unintended consequences or impacts on other ED operations.

(B) Patient Focus Group—For the patients, the objective will be: (1) What was their general impression of the EDT; (2) did the EDT improve the ED discharge process for them; and (3) do they foresee any potential unintended problems of the EDT.

(C) Post-ED Care Providers Focus Group—For the post-ED care providers, the objectives are to determine: (1) How well the EDT has met the needs of these providers in caring for these patients; (2) how feasible it has been to properly care for patients for whom the EDT had been implemented; (3) if there are any unintended consequences of using the EDT. Post-ED care provider focus group members will be drawn from Johns Hopkins Community Physicians, East-Baltimore Medical Center (a primary referral site for patients without primary care), and Healthcare for the Homeless, a not-for-profit organization in Baltimore, Maryland that provides health services, education and advocacy to people affected by homelessness.

(5) Post Pilot Test In-depth Interviews—AHRQ will conduct semi-structured interviews with approximately eight individuals from each of the 3 stakeholder groups: EDT implementers, patients, and post-ED care providers. These individuals will provide feedback on issues surfaced during the focus groups. This will provide an opportunity to delve more deeply into specific topics of interest.

(6) Administrative and Observational Data—Quantitative outcome measures will come from an extraction of medical record data and direct observations performed by project RAs. Data will be extracted from hospital billing records

and Electronic Medical Records (EMRs) and will include frequency of revisits, cost of 72-hour returns, cost of ED visits per 3 months and the cost of implementing the EDT. To calculate costs of program implementation, RAs will observe the time required by social work, case management, and nursing staff to implement the interventions prescribed in the tool. They will also keep a log of the materials given to the patients as part of the intervention. To evaluate the percentage of patients evaluated for assistance or placement, RAs will observe case managers/social workers during their interaction with the patients. To evaluate the percentage of follow-up phone calls, the RAs will keep a log of attempts and actual contacts. Since these data collections involve RA observations, or extractions from existing medical records performed by the RA, they pose no burden to the hospital or public and therefore are not included in the burden estimates in Exhibit 1.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden for the respondents’ time to participate in this pilot test. The EDT will be pilot tested with a total of 1,200 patients (50 per week * 8 weeks * 3 sites = 1,200) and takes about 20 minutes per patient to complete. The one-month patient follow-up will be conducted with all 1,200 patients and will take 10 minutes to complete. The 3-month patient follow-up will be conducted with those patients identified as being uninsured and is estimated to take 5 minutes to complete.

Focus groups will be conducted with all three of the stakeholder groups (EDT implementers, patients, and post-ED care providers). There will be two groups held for the EDT implementers consisting of 8 persons each (16 total), and one group of 8 for both the patients and the post-ED care providers. Each focus group will last for 2 hours.

As a follow-up to the focus groups in-depth interviews will be conducted with eight members from each of the three stakeholder groups. The interviews will require one hour to complete. The total annualized burden is estimated to be 708 hours.

Exhibit 2 shows the annualized cost burden associated with the respondents’ time to participate in the pilot test. The total annualized cost burden is estimated to be \$16,359.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

| Form name | Number of respondents | Number of responses per respondent | Hours per response | Total burden hours |
|--|-----------------------|------------------------------------|--------------------|--------------------|
| Pilot Test of the Emergency Department Discharge Tool (EDT) | | | | |
| EDT | 1,200 | 1 | 20/60 | 400 |
| One Month Patient Follow-up | 1,200 | 1 | 10/60 | 200 |
| Three Month Patient Follow-up | 240 | 1 | 5/60 | 20 |
| Post Pilot Test Focus Groups and Interviews | | | | |
| EDT Implementers Focus Group | 16 | 1 | 2 | 32 |
| Patient Focus Group | 8 | 1 | 2 | 16 |
| Post-ED Care Providers Focus Group | 8 | 1 | 2 | 16 |
| EDT Implementer Interview | 8 | 1 | 1 | 8 |
| Patient Interview | 8 | 1 | 1 | 8 |
| Post-ED Care Providers Interview | 8 | 1 | 1 | 8 |
| Total | 2,696 | na | na | 708 |

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

| Form name | Number of respondents | Total burden hours | Average hourly wage rate* | Total cost burden hours |
|--|-----------------------|--------------------|---------------------------|-------------------------|
| Pilot Test of the Emergency Department Discharge Tool (EDT) | | | | |
| EDT | 1,200 | 400 | \$22.01 ^a | \$8,804 |
| One Month Patient Follow-up | 1,200 | 200 | 22.01 ^a | 4,402 |
| Three Month Patient Follow-up | 240 | 20 | 22.01 ^a | 440 |
| Post Pilot Test Focus Groups and Interviews | | | | |
| EDT Implementers Focus Group | 16 | 32 | 27.42 ^b | 877 |
| Patient Focus Group | 8 | 16 | 22.01 ^a | 352 |
| Post-ED Care Providers Focus Group | 8 | 16 | 45.36 ^c | 726 |
| EDT Implementer Interview | 8 | 8 | 27.42 ^b | 219 |
| Patient Interview | 8 | 8 | 22.01 ^a | 176 |
| Post-ED Care Providers Interview | 8 | 8 | 45.36 ^c | 363 |
| Total | 2,696 | 708 | na | 16,359 |

*National Compensation Survey: Occupational wages in the United States May 2012, "U.S. Department of Labor, Bureau of Labor Statistics."

^a—based on the mean wages for All Occupations (00–0000)

^b—salary based upon average of: 2 nurses (29–1141), 2 case managers (29–1141), 2 social workers (21–1022), and 2 research assistants (19–4061)

^c—salary based upon average of: 2 physicians (29–1060), 2 nurses (29–1141), 2 case managers (29–1141), 2 social workers (21–1022).

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ health care research, quality improvement and information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the

respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: August 8, 2013.

Carolyn M. Clancy,

Director.

[FR Doc. 2013–20825 Filed 8–26–13; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Agency for Healthcare Research and Quality****Agency Information Collection Activities: Proposed Collection; Comment Request**

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: "Assessing the Impact of the National