December 6, 2013, the IRS announced that as of January 1, 2014, the relocation mileage rate would decrease to $0.235 per mile for the 12-month period ending on December 31, 2014. Thus, the reimbursement rate for POVs used in conjunction with official relocation will also be $0.235 for the same period. FTR Bulletin 14–04 is attached. FTR Bulletin 14–04 and all other FTR bulletins may be found at *www.gsa.gov/federaltravelregulation.*

DATES: This notice is effective January 29, 2014 and applies to relocations performed on or after January 1, 2014, through December 31, 2014.

FOR FURTHER INFORMATION CONTACT: Mr. Ed Davis, GSA, Office of Government-wide Policy (M), Office of Asset and Transportation Management (MA), at 202–208–7638 or via email at *ed.davis@gsa.gov*. Please cite FTR Bulletin 14–04.

Dated: January 17, 2014.

Anne E. Rung,

Associate Administrator, Office of Government-wide Policy.

[FR Doc. 2014–01705 Filed 1–28–14; 8:45 am]

BILLING CODE 6820–14–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary for Financial Resources (ASFR); Statement of Organization, Functions, and Delegations of Authority

Part A, Office of the Secretary, Statement of Organization, Functions and Delegations of Authority for the Department of Health and Human Services (HHS) is being amended at Chapter AM, Office of the Assistant Secretary for Financial Resources, as last amended at 77 FR 19666–67, dated April 2, 2012. This reorganization will eliminate the Office of Executive Program Information (AMW) within ASFR through the following changes:

A. Under Section AM.10 Organization, delete the last sentence of the section in its entirety and replace with the following:

The office consists of the following components:

- Immediate Office of the Assistant Secretary (AM).
- Office of Budget (AML).
- Office of Finance (AMS).
- Office of Grants and Acquisition Policy and Accountability (AMT).

B. Under Section AM.20 Functions, delete Chapter AMW, Office of Executive Program Information (OEPI), in its entirety.

Dated: November 13, 2013.

E.J. Holland, Jr.,

Assistant Secretary for Administration.

[FR Doc. 2014–01712 Filed 1–28–14; 8:45 am]

BILLING CODE 4150–24–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.

This proposed information collection was previously published in the **Federal Register** on August 27th, 2013 and allowed 60 days for public comment. One comment was received. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by February 28, 2014.

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) Pilot Test of the 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,'' as well as to target interventions to these patients to reduce the risk of further avoidable revisits. A research assistant 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) 3 or more previous ED visits within the last 3 months, or (3) 4 or more ED visits within the last 12 months. This definition can be modified to align with the resources of the individual ED.

This tool uses data collected from the record of patients that are flagged as frequent ED users. By asking patients a series of questions about their medical history, the tool also helps 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 being uninsured, lack of a primary care physician, having psychiatric diseases, abusing substances, difficulty caring for oneself, or having trouble comprehending ED discharge instructions.

A User's Guide (EDT User's Guide) is also provided to assist EDs in developing resources to provide interventions recommended by the EDT. No data collection activities will occur from this manual.

(2) One Month Patient Follow-up Telephone Interview—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 success of the interventions that were given for the patient.

(3) Three Month Patient Follow-up Telephone Interview—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) Implementer Focus Groups—AHRQ will conduct four sets of focus groups to collect qualitative data about the usability and usefulness of the EDT from four stakeholder groups: Three groups of EDT implementers and one group of research assistants. Questions for each of the focus groups will vary based on their differing objectives:

(a) EDT Implementers Focus Group (non-RA)—For *non-RA implementers* of the EDT (RNs, case managers, social workers,), the objectives will include exploring: (1) How well it does or does not meet implementer goals of discharge; (2) experiences with rollout and implementation, including resources required for implementation; (3) impressions of the value, strengths and weaknesses of the EDT; and (4) unintended consequences or impacts on other ED operations. The focus groups will consist of 8 implementers. Three focus groups will be conducted, one for each pilot site.

(b) Research Assistant Focus Group—The three research assistants who will be implementing the EDT will participate in one focus group in which they discuss: (1) Experiences with implementation (including comparisons in their experiences across the three test sites; (2) possible areas for improvement; (3) unintended consequences or impacts on other ED operations.

(5) Key Informant Interviews—AHRQ will conduct semi-structured interviews with no more than twenty-four individuals that can be classified as either ED Directors, patients, or community 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. The interview guides are included as for patients, for community care providers, and for ED Directors.

(a) Patient Interviews—For the patients, the objective will be to explore: (1) The barriers they face in obtaining health care; (2) their experiences in the ED in visits prior to, and after, implementation of the EDT (3) their satisfaction with the care they received in the ED and their remaining unmet needs. Fifteen patients will be interviewed individually.

(b) Community Care Providers Interviews—For the post-ED care providers, the objectives are to explore challenges in communication and coordination for patients referred to them by the ED and the degree to which the EDT can address those challenges. 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. Six community care providers will be interviewed for this section.

(c) ED Directors Interviews—Interviews from ED Directors will occur to get their opinions of the EDT from their perspectives as the ultimate orchestrators of processes in the emergency room and decision-makers regarding operations (resources use, staffing). Three ED directors will be interviewed separately for this portion.

(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, they pose no burden to the hospital or public and therefore are not included in the burden estimates in Exhibits 1 and 2 below.

No pre-intervention measures will be collected because this is a feasibility study to evaluate the methodology and feasibility of collection of this data.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this pilot test. A research assistant will use the EMR to screen patients for past frequent ED use. This step does not represent a participant burden. Based upon historical data at our three participating sites, we expect approximately 200 patients per week to qualify as ''frequent users'' at these sites. Based upon available resources and recruitment, we expect to enroll and use the EDT with approximately 50 of these patients per week at each site to identify their specific risk factors and tailor

interventions to their needs. Thus we will have a total of 900 patient participants (50 patients/per week * 6 weeks * 3 sites = 900 patients total). It will take about 20 minutes per patient to collect the data associated with the EDT. The one-month patient follow-up will be conducted with all 900 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.

Four focus groups will take place among RAs and non-RA EDT implementers. The first focus group will consist of three RAs who implemented the discharge tool. The other three separate focus groups will exclude RAs and include eight other ED personnel that implemented the discharge tool. The total annualized burden for these focus groups is estimated to be 54 hours.

As a follow-up to the focus groups, in-depth interviews will also be conducted with members from different stakeholder groups. Between 12 and 16 patients will be interviewed as well as three ED directors and six community healthcare providers. The interviews will be conducted in person and require one hour to complete. The total annualized burden for these interviews is estimated to be 30 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 $13,262.

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	900	1	20/60	300
One Month Patient Follow-up	900	1	10/60	150
Three Month Patient Follow-up	180	1	5/60	15
Implementer Focus Groups				
RA Focus Group	3	1	2	6
EDT Implementer (non-RA) #1 Focus Group	8	1	2	16
EDT Implementer (non-RA) #2 Focus Group	8	1	2	16
EDT Implementer (non-RA) #3 Focus Group	8	1	2	16
Key Informant Interviews				
Community Healthcare Provider Interview	6	1	2	12
Patient Interview	15	1	1	15
ED Director Interview	3	1	1	3
Total	2,031	NA	NA	549

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Pilot Test of the Emergency Department Discharge Tool (EDT)				
EDT	900	300	[a] $22.01	$6,603
One Month Patient Follow-up	900	150	[a] 22.01	3,302
Three Month Patient Follow-up	180	15	[a] 22.01	330
Implementer Focus Groups				
RA Focus Group	3	6	[d] 17.86	107
EDT Implementer (non-RA) #1 Focus Group	8	16	[b] 27.42	439
EDT Implementer (non-RA) #2 Focus Group	8	16	[b] 27.4	439
EDT Implementer (non-RA) #3 Focus Group	8	16	[b] 27.42	439
Key Informant Interviews				
Community Healthcare Provider Focus Group	6	12	[c] 45.36	544
Patient Interview	15	15	[a] 22.01	330
ED Director Interview	3	3	[e] 97.30	292
Total	2,031	549	NA	12,825

* 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).
[d] based on mean hourly wage of: Social Science Research Assistants (19–4061).
[e] based on mean annual wage of: Physicians and Surgeons (29–1060).

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: January 16, 2014.

Richard Kronick,

AHRQ Director.

[FR Doc. 2014–01709 Filed 1–28–14; 8:45 am]

BILLING CODE 4160–90–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: ''SelectMD 2.0 Clinician Choice Experiment.'' 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 March 31, 2014.

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

SelectMD 2.0 Clinician Choice Experiment

This study builds on previous research conducted as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program to explore new ways of integrating patient comments with other performance metrics in web-based quality reports for consumers to support their choice of physicians. Our previous consumer choice study, referred to as SelectMD 1.0 (approved by OMB on 3/8/10 under OMB Control Number 0935–0161), revealed important risks and opportunities of using patient comments that require additional research in order to develop effective guidance for report sponsors. Sponsors of performance reports in both the public and private sectors, including Federal agencies such as the Centers for Medicare & Medicaid Services (CMS), have indicated strong interest in receiving such guidance on strategies for effectively incorporating patient comments to increase consumers' use of public reports and to enhance their ability to interpret CAHPS and other performance measures.

This follow-on study (referred to as SelectMD 2.0) will use an experimental design to test different methods of incorporating patient comments along with CAHPS survey results, the Healthcare Effectiveness Data and Information Set (HEDIS)-like measures of effective clinical treatments, and indicators of patient safety in web-based physician quality reports. The study will help AHRQ understand how people choose a doctor as their regular source of medical care and advice.

The study has three stages. In the first stage, respondents will be asked some questions about their health care experiences and how they go about choosing a doctor. In the second stage the respondents will log onto an experimental Web site that has information about a fictitious set of doctors from which to choose. Respondents will be asked to use the information on the Web site to select a doctor who they think would be the best for their health care needs. Although they will not really be selecting a doctor, they will be asked to consider the choice as carefully as if they were making it for themselves. In the third stage, following their selection of a doctor, respondents will answer a set of questions about how they made their choice of doctor, how useful they found the Web site, and how confident they were in the choice they made.

This research has the following goals:

(1) To expand on the findings from AHRQ's previous choice experiment regarding how including narrative patient comments in web-based physician quality reports influences the ways in which consumers learn about and select among clinicians, and

(2) to assess whether and how patient comments can be presented in a way that promotes learning about physician quality and complements rather than detracts from standardized measures of quality.

This study is being conducted by AHRQ through its contractors, RAND and Yale University, 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 the goals of this project the following data collections will be implemented over the three stages of the experiment:

(1) Pre-Choice Survey—The purpose of this survey is to measure the respondents' previous exposure to information on health care provider performance and how they go about choosing a physician.

(2) Experimental Web site—The purpose of this site is to present different combinations and displays of performance information that respondents will use to select a doctor. Respondents will be randomly assigned to one of eight different versions of the experimental SelectMD Web site that will vary according to the level of detail presented, how patient comments are grouped and labeled, whether respondents can choose which and how much information to review, and whether respondents have access to live telephone assistance when making their choices.

(3) Post-Choice Survey—The purpose of the post-choice survey is to assess how respondents made their doctor selection, how useful the Web site version assigned to them was in helping