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 the Proposed Value and Efficiency Surveys and Communicating About Value Checklist.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by March 8, 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 the Proposed Value and Efficiency Surveys and Communicating About Value Checklist

Maximizing value within the American health care system is an important priority. Value is often viewed as a combination of high quality, high efficiency care, and there is general agreement by consumers, policy makers, payers, and providers that it is lacking in the U.S. A recent report by the Institute of Medicine estimated that 20 to 30 percent ($765 billion a year) of U.S. healthcare spending was inefficient and could be reduced without lowering quality.

Multiple overlapping initiatives are currently seeking to improve value using a variety of approaches. Public reporting efforts led by the Centers for Medicare and Medicaid Services (CMS), other payers and consumer groups seek to enable consumers to make more informed choices about the quality, and in some cases, the costs of their care. A variety of demonstration projects and payment reforms initiated by CMS and private insurers are attempting to more closely link care quality with payments to incent higher value care. And national improvement initiatives led by AHRQ (comprehensive unit-based safety programs [CUSP] for central line-associated blood stream infection [CLABSI], catheter-associated urinary tract infections [CUTI], and surgical units [SUSP]) and CMS (hospital engagement networks, QI0 scopes of work) are seeking to raise care quality and reduce readmissions. Results from the CUSP–CLABSI project have demonstrated that central line infections can be reduced and unnecessary costs can be removed from the health care system by concerted, unit-based improvement efforts.

As a systems level example, Denver Health, with initial funding from AHRQ, has taken major steps towards redesigning clinical and administrative processes so as to reduce staff time, patient waiting, and unnecessary costs. These improvements occurred without harm to quality and in some instances actually improved quality.

In many cases, improving quality improves efficiency naturally. Reducing the number of hospital errors for example will reduce costs associated with longer length of stay or error-triggered readmissions. It is more cost-effective to do things right the first time. But higher value is more likely if organizations doing quality improvement link efforts to improve care quality with efforts to reduce unnecessary costs. Ignoring the financial implications of quality improvement efforts will fail in the real world where many providers face acute financial challenges and where costs are leading to consumer bankruptcies and increased insurance costs. AHRQ understands that many of the root causes of inefficiencies that drive up costs are closely linked to root causes of inefficiencies that lead to poor quality, uncoordinated care where redundancies and system failures place patients at risk. Adding value within healthcare requires understanding the contribution that organizational culture makes to value and working to foster a culture where high value is a cultural norm. AHRQ's development of the Hospital Survey on Patient Safety Culture (HSOPS) has contributed greatly to efforts to promote the important role culture plays in providing safe care. HSOPS is used extensively in national improvement campaigns and many hospitals and health systems now regularly assess their safety cultures and use culture scores on organizational dashboards and as parts of variable compensation programs.

If organizations lack cultures committed to value then discrete efforts to raise dimensions of value are likely to yield limited and unsustainable results. And if organizational leaders have no plausible way to know whether their organizational culture is committed to value, then their ability to make value a higher organizational priority will be very limited. Thus, developing value and efficiency survey instruments for hospitals and medical offices fills an important need for many ongoing and planned efforts to foster greater value within American health care.

Given the widespread impact of cost and waste in health care, AHRQ will develop the Value and Efficiency (VE) Surveys for hospitals and medical offices. These surveys will measure staff perceptions about what is important in their organization and what attitudes and behaviors related to value and efficiency are supported, rewarded, and expected. The surveys will help hospitals and medical offices to identify and discuss strengths and weaknesses within their individual organizations. They can then use that knowledge to develop appropriate action plans to improve their value and efficiency. To develop these tools AHRQ will recruit medical staff from 42 hospitals and 96 medical offices to participate in cognitive testing and pretesting.

In addition to the YE surveys, AHRQ also intends to develop a Communicating About Value Checklist (CV checklist). The objective of the CV checklist is to aid clinicians in having conversations with patients about value. Since the proper goal for any health care delivery system is to improve the value delivered to patients, such a tool will address the important aspects of health care that are of value to patients. Value in health care is typically measured in terms of the patient outcomes achieved per dollar expended. But a good outcome must be defined in terms of what is meaningful and valuable to the individual patient.

Better identification of patients' preferences is not only the right ethical thing to do but it also can reduce the cost of healthcare. Studies indicate that engaged and informed patients often choose to have less intensive care and become more careful about having lots of procedures. In addition, participatory decision making can reduce medication non-adherence which has been directly linked to increased morbidity, mortality and potentially avoidable healthcare

costs totaling $290 billion annually in the U.S.

The CV checklist will address three major topics: who should talk with patients about value issues (e.g., nurses, physicians, etc.), when should these conversations occur (e.g., when patients may incur costs, when they express financial concerns, etc.), and how can clinicians prepare for and effectively facilitate such discussions.

This research has the following goals:

(1) Develop, cognitively test and modify as necessary the VE surveys (one for hospitals and one for medical offices);

(2) Pretest the VE surveys in hospitals and medical offices and modify as necessary based on the results;

(3) Develop, cognitively test and modify as necessary the CV checklist;

(4) Pretest the CV checklist in hospitals and medical offices and modify as necessary based on the results;

(5) Make the final VE surveys and CV checklist available for use by the public.

This study is being conducted by AHRQ through its contractor, Health Research & Educational Trust (HRET), and subcontractor, Westat, 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 activities and data collections will be implemented:

(1) Cognitive interviews for the VE surveys. One round of interviews on the VE surveys will be conducted by telephone with 9 respondents from hospitals and 9 respondents from medical offices. The purpose of these interviews is to understand the cognitive processes the respondent engages in when answering a question on the VE survey and to refine the survey's items and composites. These interviews will be conducted with a mix of senior leaders and clinical staff (i.e., unit/department managers, practitioners, nurses, technicians, and medical assistants) from hospitals and medical offices throughout the U.S. with varying characteristics (e.g., size, geographic location, type of medical office practice/hospital, and possibly extent of experience with waste-reduction efforts).

(2) Pretest for the VE surveys. The surveys will be pretested with senior leaders and clinical staff from 42 hospitals and 96 medical offices. The purpose of the pretest is to collect data for an assessment of the reliability and construct validity of the surveys' items and composites, allowing for their further refinement. A site-level point-of-contact (POC) will be recruited in each medical office and hospital to manage the data collection at that organization (compiles sample information, distribute surveys, promote survey response, etc.). Exhibit 1 includes a burden estimate for the POC's time to manage the data collection.

(3) Medical office information form. This form will be completed by the medical office manager in each of the 96 medical office pretest sites to provide background characteristics, such as type of specialty(s) and majority ownership. A hospital information form will not be needed because characteristics on pretest hospitals will be obtained from the American Hospital Association's (AHA) data set based on a hospital's AHA ID number.

(4) Survey to identify items for CV checklist. In order to identify items to put on the checklist, a survey will be developed and sent to 160 representative participants (40 Physicians, 40 Registered Nurses, 20 Social Workers, 20 Health Educators, and 40 Patients). Once the survey responses have been collected, responses will be analyzed to help inform the development of the CV checklist. Checklist items will be chosen based on what is learned. For example, if clinicians strongly believe that it is inappropriate to discuss costs and value with patients, the checklist may require different items than if clinicians recognize the importance of such conversations but believe they lack required information to facilitate them.

(5) Cognitive Interviews for the CV checklist. Once checklist items have been identified, cognitive interviews will be conducted with 9 respondents in hospitals and 9 respondents in medical offices to understand the cognitive processes the respondent engages in when using the CV checklist. Cognitive interviewing will allow checklist developers to identify and classify difficulties respondents may have regarding checklist items. To get different perspectives, interviews will be conducted with a mix of physicians, nurses, social workers, health educators, and patients in hospitals and medical offices.

(6) Pretest the CV checklist. The checklist will then be pretested to solicit feedback from 50 physicians in hospitals and 50 physicians in medical offices. The pilot testing process will help identify areas where users of the checklist have trouble understanding, learning, and using the checklist. It also provides the opportunity to identify issues that can prevent successful deployment of the checklist.

(7) Dissemination activities. The final VE Surveys and CV checklist will be made available to the public through the AHRQ Web site. This activity does not impose a burden on the public and is therefore not included in the burden estimates in Section 12.

The information collected will be used to test and improve the draft survey items in the VE Surveys and CV checklist.

The final VE instruments will be made available to the public for use in hospitals and medical offices to assess value and efficiency from the perspectives of their staff. The survey can be used by hospitals and medical offices to identify areas for improvement. Researchers are also likely to use the surveys to assess the impact of hospitals' and medical offices' value and efficiency improvement initiatives.

The final CV checklist will be made available to hospital and medical office clinicians to aid in having conversations with patients about value.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in this research. Cognitive interviews for the Hospital VE survey will be conducted with 9 hospital staff (approximately 3 managers, 3 nurses, and 3 technicians) and will take about one hour and 30 minutes to complete. Cognitive interviews for the Medical Office VE survey will be conducted with 9 medical office staff (approximately 4 physicians and 5 medical assistants) and will take about one hour and 30 minutes to complete. The Hospital VE survey will be administered to about 4,032 individuals from 42 hospitals (about 96 surveys per hospital) and requires 15 minutes to complete. A site-level POC will spend approximately 16 hours administering the Hospital VE survey. The Medical Office VE survey will be administered to about 504 individuals from 96 medical offices (about 5 surveys per medical office) and requires 15 minutes to complete. A site-level POC will spend approximately 6 hours administering the Medical Office YE survey. The medical office information form survey will be completed by a medical office manager at each of the 96 medical offices participating in the pretest and takes 10 minutes to complete.

One-hundred and sixty individuals (40 physicians, 40 nurses, 20 social workers, 20 health educators, and 40 patients) will participate in the survey to identify items for the CV checklist and will take 15 minutes to complete. Cognitive interviews for the CV checklist will be conducted with 18 individuals (9 in hospitals and 9 in medical offices, consisting of approximately 4 physicians, 4 nurses, 2 social workers, 2 health educators, and 6 patients) and will take about one hour to complete. One hundred physicians will participate in the pretest of the CV checklist (50 in hospitals and 50 in medical offices). The total burden is estimated to be 2,534 hours annually.

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this research. The total cost burden is estimated to be $115,559 annually.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Cognitive interviews for the Hospital VE survey	9	1	1.5	14
Cognitive interviews for the Medical Office VE survey	9	1	1.5	14
Pretest for the Hospital VE survey	4,032	1	15/60	1,008
Pretest for the Medical Office VE survey	504	1	15/60	126
POC Administration of the Hospital VE survey	42	1	16	672
POC Administration of the Medical Office VE survey	96	1	6	576
Medical office information form	96	1	10/60	16
Survey to identify items for CV checklist	160	1	15/60	40
Cognitive interviews for the CV checklist	18	1	1	18
Pretest for the CV checklist	100	1	30/60	50
Total	5,066	na	na	2,534

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Cognitive interviews for the Hospital VE survey	9	14	[a] $36.16	$506
Cognitive interviews for the Medical Office VE survey	9	14	[b] 46.87	656
Pretest for the Hospital VE survey	4,032	1,008	[c] 36.02	36,308
Pretest for the Medical Office VE survey	504	126	[d] 27.73	3,494
Administration of the Hospital VE survey	42	672	[e] 55.80	37,498
Administration of the Medical Office VE survey	96	576	[f] 50.98	29,364
Medical office information form	96	16	[f] 50.98	816
Survey to identify items for CV checklist	160	40	[g] 45.02	1,801
Cognitive interviews for the CV checklist	18	18	[h] 39.84	717
Pretest for the CV checklist	100	50	[i] 87.98	4,399
Total	5,066	2,534	na	115,559

[a] Based on the weighted average wages for 3 Registered Nurses (29–1111, $33.56), 3 Medical and Clinical Laboratory Technicians (29–2012, $19.11), and 3 General and Operational Managers (11–1021, $55.80) in the hospital setting;

[b] Based on the weighted average wages for 4 Family and General Practitioners (29–1062; $87.18) and 5 Medical Assistants (31–9092, $14.63) in the medical office setting;

[c] Based on the weighted average wages for 1,937 Registered Nurses, 1,131 Medical and Clinical Laboratory Technicians, 526 General and Operational Managers and 446 Physicians (29–1069; $66.23) in the hospital setting;

[d] Based on the weighted average wages for 91 Family and General Practitioners and 413 Medical Assistants in the medical office setting;

[e] Based on the average wages for General and Operational Managers in the hospital setting;

[f] Based on the average wages for General and Operational Managers in the medical office setting;

[g] Based on the weighted average wages for 40 Physician and Surgeons (29–10692; $88.78), 40 Registered Nurses (29–1111; $33.23), 20 Social Workers (21–1022; $24.28), 20 Health Educators (21–1091, $25.07), and 20 Patients (00–0000; $21.74);

[h] Based on the weighted average wages for 4 Physician and Surgeons, 4 Registered Nurses, 2 Social Workers, 2 Health Educators, and 6 Patients;

[i] Based on the weighted average wages for 50 Physician and Surgeons in the hospital setting and 50 Family and General Practitioners in the medical office setting;

* National Occupational Employment and Wage Estimates in the United States, May 2011, ''U.S. Department of Labor, Bureau of Labor Statistics'' (available at *http://www.bls.gov/oes/current/naics4_621100.htm* [for medical office setting] and *http://www.bls.gov/oes/current/naics4_622100.htm* [for hospital setting]).

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the estimated total and annualized cost to the government for this data collection. Although data collection will last for less than one year, the entire project will take about 2 years. The total cost for the three surveys is approximately is $1,001,202.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annualized cost
Project Development	$273,838	$136,919
Data Collection Activities	153,119	76,560
Data Processing and Analysis	171,764	85,882
Publication of Results	14,753	7,377
Project Management	10,032	5,016
Overhead	377,696	188,848
Total	1,001,202	500,601

Request for Comments

In accordance with the Paperwork Reduction Act, 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 and health care 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: December 20, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–31592 Filed 1–4–13; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Office for State, Tribal, Local and Territorial Support (OSTLTS)

In accordance with Presidential Executive Order No. 13175, November 6, 2000, and the Presidential Memorandum of November 5, 2009 and September 23, 2004, Consultation and Coordination with Indian Tribal Governments, CDC/Agency for Toxic Substances and Disease Registry (ATSDR), announces the following meeting and Tribal Consultation Session:

Name: Tribal Advisory Committee (TAC) Meeting and 10th Biannual Tribal Consultation Session.

Times and Dates:

8:00 a.m.–9:30 a.m., February 5, 2013 (TAC Meeting).

8:00 a.m.–5:00 p.m., February 6, 2013 (10th Biannual Tribal Consultation Session).

8:00 a.m.–4:00 p.m., February 7, 2013 (TAC Meeting).

Place: The TAC Meeting and Tribal Consultation Session will be held at CDC Headquarters, 1600 Clifton Road, NE., Global Communications Center, Auditorium B3, Atlanta, Georgia.

Status: All meetings are being hosted by CDC/ATSDR. Meetings on February 5, 6, and 7, 2013, are open to the public.

Purpose: In 2011–2012, CDC began revising its existing Tribal Consultation Policy (issued in 2005) with the primary purpose of providing guidance across the agency to work effectively with American Indian/Alaska Native (AI/AN) tribes, communities, and organizations to enhance AI/AN access to CDC resources and programs. Within the CDC Consultation Policy, it is stated that CDC will conduct government-to-government consultation with elected tribal officials or their authorized representatives before taking actions and/or making decisions that affect them. Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension. CDC believes that consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. Although formal responsibility for the agency's overall government-to-government consultation activities rests within the CDC Office of the Director (OD), other CDC Center, Institute, and Office (CIO) leadership shall actively participate in TAC meetings and HHS-sponsored regional and national tribal consultation sessions as frequently as possible.

Matters To Be Discussed: The TAC will convene their advisory committee meeting with discussions and presentations from various CDC senior leaders on activities and areas identified by TAC members and other tribal leaders as priority public health issues. The following topics are scheduled for presentation and discussion during the TAC Meeting; however, discussion is not limited to these topics: substance abuse/mental health, community based participatory public health, success stories, and grant information and opportunities at CDC for Native participation.

The 10th Biannual Tribal Consultation Session will engage CDC senior leadership from the CDC OD and various CDC CIOs. Sessions that will be held during the Tribal Consultation include the following: a listening session with the director of CDC, roundtable discussions with CDC senior leadership and an opportunity for tribal testimony.

Additional opportunities will be provided during the Consultation Session for tribal testimony. Tribal Leaders are encouraged to submit written testimony by 12:00 a.m., EST on January 25, 2013, to Kimberly Cantrell, Deputy Associate Director for Tribal Support, OSTLTS, via mail to 4770 Buford Highway NE., MS E–70, Atlanta, Georgia 30341 or email to *klw6@cdc.gov.* Depending on the time available, it may be necessary to limit the time of each presenter.

The agenda is subject to change as priorities dictate.

Information about the TAC, CDC's Tribal Consultation Policy, and previous meetings may be referenced on the following web link: *http://www.cdc.gov/tribal.*

Contact Person For More Information: Kimberly Cantrell, Deputy Associate Director for Tribal Support, OSTLTS, via mail to 4770 Buford Highway NE., MS E–70, Atlanta, Georgia 30341 or email to *klw6@cdc.gov.*