

**FEDERAL COMMUNICATIONS COMMISSION****[DA 22–844; FR ID 104382]****Announcement of Renewal of Charter of the FCC Consumer Advisory Committee****AGENCY:** Federal Communications Commission.**ACTION:** Notice of intent to renew the Charter for the FCC Consumer Advisory Committee

**SUMMARY:** In this document, the Federal Communications Commission (FCC or Commission) hereby announces that the charter of the Consumer Advisory Committee (hereinafter Committee) will be renewed for a two-year period pursuant to the Federal Advisory Committee Act (FACA) and following consultation with the Committee Management Secretariat, General Services Administration.

**ADDRESSES:** Federal Communications Commission, 45 L St. NE, Washington, DC 20554.

**FOR FURTHER INFORMATION CONTACT:** Joshua Mendelsohn, Designated Federal Officer, Federal Communications Commission, Consumer and Governmental Affairs Bureau, *CAC@fcc.gov*.

**SUPPLEMENTARY INFORMATION:** After consultation with the General Services Administration, the Commission intends to renew the charter on or before October 13, 2022, providing the Committee with authorization to operate for two years. In keeping with its advisory role, the FCC Consumer Advisory Committee will continue to provide recommendations to the Commission on consumer topics, as specified by the Commission, gather data and information, and perform analyses that are necessary to respond to the questions or matters before it. The mission of the Committee is to make recommendations to the Commission on topics specified by the Commission relating to the needs and interests of consumers. The Commission will specify topics the Committee may consider, which may include: Consumer protection and education; Implementation of statutes, Commission rules, and policies to protect consumers; Promoting consumer participation and input into Commission rulemaking proceedings and other decision-making processes; and, Impact of new and emerging communications technologies on consumers, including those in underserved populations.

**Advisory Committee**

The Committee will be organized under, and will operate in accordance with, the provisions of the Federal Advisory Committee Act (FACA) (5 U.S.C. app. 2). The Committee will be solely advisory in nature. Consistent with FACA and its requirements, each meeting of the Committee will be open to the public unless otherwise noticed. A notice of each meeting will be published in the **Federal Register** at least fifteen (15) days in advance of the meeting. Records will be maintained of each meeting and made available for public inspection. All activities of the Committee will be conducted in an open, transparent, and accessible manner. The Committee shall terminate two (2) years from the filing date of its charter, or earlier upon the completion of its work as determined by the Chair of the FCC, unless its charter is renewed prior to the termination date.

During the Committee's next term, it is anticipated that the Committee will meet in Washington, DC at the discretion of the Commission, approximately three (3) times a year. The first meeting date and agenda topics will be described in a Public Notice issued and published in the **Federal Register** at least fifteen (15) days prior to the first meeting date.

In addition, as needed, subcommittees will be established to facilitate the Committee's work between meetings of the full Committee. Meetings of the Committee will be fully accessible to individuals with disabilities.

Federal Communications Commission.

**Robert A. Garza,***Legal Advisor, Consumer and Governmental Affairs Bureau.*

[FR Doc. 2022–20110 Filed 9–15–22; 8:45 am]

**BILLING CODE 6712–01–P****FEDERAL MARITIME COMMISSION****Sunshine Act Meetings**

**TIME AND DATE:** September 21, 2022; 1:00 p.m.

**PLACE:** This meeting will be held at the Surface Transportation Board at the address below and also streamed live at *www.fmc.gov*.

Surface Transportation Board, 395 E Street SW, Room #1042 (Hearing Room), Washington, DC 20423.

**STATUS:** Part of the meeting will be open to the public: held in-person at the Surface Transportation Board for public attendants and also available to view streamed live, accessible from *www.fmc.gov*. The rest of the meeting will be closed to the public.

The hearing will be held on September 21, 2022, beginning at 1:00 p.m. in the Hearing Room of the Surface Transportation Board's headquarters (not at the Federal Maritime Commission) and will be open for public observation. If technical issues prevent the Commission from live streaming, the Commission will post a recording of the public portion of the meeting on the Commission's YouTube Channel. Any person wishing to attend the meeting in-person should report to Surface Transportation Board headquarters with enough time to clear building security procedures. Additional meeting guidance can be found on *www.fmc.gov*.

**MATTERS TO BE CONSIDERED:****Portions Open to the Public**

1. Commissioner Bentzel, Update on Maritime Transportation Data Initiative
2. Staff Briefing on Ocean Shipping Reform Act of 2022

**Portions Closed to the Public**

3. Staff Briefing on Demurrage and Detention Billing Requirements
4. Staff Briefing on Charge Complaints

**CONTACT PERSON FOR MORE INFORMATION:**

William Cody, Secretary, (202) 523–5725.

**William Cody,***Secretary.*

[FR Doc. 2022–20161 Filed 9–14–22; 11:15 am]

**BILLING CODE 6730–02–P****DEPARTMENT OF HEALTH AND HUMAN SERVICES****Agency for Healthcare Research and Quality****Request for Information on Person-Centered Care Planning for Multiple Chronic Conditions (MCC)**

**AGENCY:** Agency for Healthcare Research and Quality (AHRQ), HHS.

**ACTION:** Notice of request for information.

**SUMMARY:** The Agency for Healthcare Research and Quality (AHRQ) seeks public comment about comprehensive, longitudinal, person-centered care planning for people with Multiple Chronic Conditions (MCC). Specifically, the RFI seeks comment on the current state of comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC across settings of care (e.g., health systems, primary care, home, and other ambulatory practices), including

existing models of person-centered care planning, their current scale, and barriers and facilitators to implementation. In addition, the RFI seeks comments about innovative models of care, approaches, promising strategies and solutions in order for clinicians and practices to routinely engage in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC. This request for information will inform AHRQ's work in improving care for people at risk for or living with MCC.

**DATES:** Comments on this notice must be received by November 15, 2022. AHRQ will not respond individually to responders but will consider all comments submitted by the deadline.

**ADDRESSES:** Please submit all responses via email to: [MCC@ahrq.hhs.gov](mailto:MCC@ahrq.hhs.gov).

**FOR FURTHER INFORMATION CONTACT:** Poonam Pardasane, ScD, DPT, MS, Staff Fellow, Phone: (301) 427-1121; Email: [Poonam.Pardasane@ahrq.hhs.gov](mailto:Poonam.Pardasane@ahrq.hhs.gov).

**SUPPLEMENTARY INFORMATION:** AHRQ is seeking public comment about comprehensive, longitudinal, person-centered care planning for people at risk for or living with Multiple Chronic Conditions (MCC). Specifically, AHRQ seeks comment on the current state of comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC across settings of care (e.g., health systems, primary care, home, and other ambulatory practices) including existing models of person-centered care planning, their current scale, and barriers and facilitators to implementation. In addition, AHRQ seeks information about innovative models of care, approaches, and promising strategies and solutions, in order for clinicians and practices to routinely engage in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC. Because it may be possible to prevent or delay the onset of MCC, AHRQ is interested in care planning for those at risk for MCC in addition to those who have MCC. Evidence for effectiveness of strategies for implementation and delivery of person-centered care planning, their impact on improving health outcomes, as well as evidence on how to adapt, scale, and spread the intervention are of interest.

For the purposes of this RFI, the following working definitions apply:

*Comprehensive, Longitudinal, Person-Centered Care Planning (also known as shared care planning):* A process of collaboration among people at risk for or

living with MCC, clinicians, and healthcare teams to proactively discuss and record: (1) roles and tasks among care team members, including the individual, their family and caregivers; (2) plans for coordinating care within and across organizations and settings; (3) strategies for supporting and empowering patients to manage their own health; (4) plans for engaging in shared decision making.<sup>1</sup> The care plan should: include all conditions including biomedical and behavioral health conditions; facilitate screening for and/or diagnosing co-existing conditions that impact care management and outcomes, as well as social risks and supports; support evidence-based care; include an individual's goals and preferences; be dynamic and incorporate an approach to updating, as necessary.

*Person-Centered Care Plan:* A single record of care shared among people at risk for or living with MCC and their clinicians that: (1) is accessible to persons with MCC and their caregivers; (2) puts the person's goals at the center of decision-making; (3) is holistic, including somatic and behavioral health, clinical and nonclinical data, including the social determinants of health; (4) follows the person through both high-need episodes and periods of health improvement and maintenance; (5) allows care team coordination.<sup>2</sup>

Multiple Chronic Conditions (MCC) are defined here as the co-occurrence of two or more chronic physical or behavioral health conditions (including mental health and/or substance use disorders). Some use the term multimorbidity as synonymous with MCC, while others define MCC as including additional factors that contribute to the burden of illness, including disease severity, functional impairments and disabilities, syndromes such as frailty, and sometimes social factors such as homelessness.

### Importance of Care Planning for People at Risk for or Living With MCC

Comprehensive, longitudinal, person-centered care planning is central to models of care that deliver high quality care that meet the needs of people at risk for or living with MCC. Person-centered care planning should be designed to achieve the following objectives:

- Prioritize care that maximizes benefits and minimizes harms.

<sup>1</sup> Burt, J., et al., *Care plans and care planning in long-term conditions: a conceptual model*. Prim Health Care Res Dev, 2014. 15(4): p. 342–54.

<sup>2</sup> Baker, A., et al., *Making the Comprehensive Shared Care Plan a Reality*. NEJM Catalyst, 2016.

- Incorporate and prioritize competing demands and people's preferences (e.g., morbidity, mortality, burden of care, quality of life).

- Identify roles and tasks among care team members, including the person with MCC.

- Coordinate planning, management and treatment with the whole care network across time and setting (e.g., a multi-disciplinary team, specialty care, community and social services, people with MCC and caregivers) to create and maintain a single plan for each person.

- Elicit and reflect choices and values of people at risk for or living with MCC in the context of their lives.

- Share decision making in a manner that is preferred by people at risk for or living with MCC and caregivers, considering individual values, preferences, cultural, and social contexts.

- Support and empower people at risk for or living with MCC to manage their own health and initiate and sustain behavior change, with the support of their health care team.

- Document specific goals of both people at risk for or living with MCC and their clinicians and health care team and reconcile when necessary.

- Continuously monitor and track progress on goals and preferences through high-need episodes, as well as during periods of health improvement and maintenance, with modification as necessary.

- Is supported by evidence-based clinical guidelines that optimize care for coexisting conditions.

- Ensure equity is adequately addressed to deliver effective person-centered care to all and actively reduce health inequities including among Black, Indigenous, and people of color (BIPOC); socioeconomically disadvantaged individuals; across Sexual Orientation and Gender Identity (SOGI); for those with low levels of health literacy or limited English proficiency; and for persons with disabilities.

Implementing comprehensive, longitudinal, person-centered care planning requires fundamental changes in the way care is organized and delivered in order to ensure: the active engagement and shared learning of diverse stakeholders; the capacity for timely implementation of rapidly evolving evidence; and innovative approaches to care transformation. While person-centered care planning is practiced in some care settings, it is not routine practice and there are significant evidence gaps regarding the most effective approaches for implementation, scale, and spread.

Additionally, the use of shared electronic care plans (e-care plans) can facilitate coordination and communication among people at risk for or living with MCC and their clinicians and health care teams, and provide a shared resource for documenting goals, treatments and supports, education and self-management, along with other patient-generated health data to support care management.<sup>3</sup>

#### *Who should respond?*

AHRQ seeks information from:

- Clinicians and other health care personnel who perform some or all key components of comprehensive, longitudinal person-centered care planning for people at risk for or living with MCC, including clinicians and personnel from across all care settings (primary care, specialty care, mental and behavioral health, post-acute care, rehabilitative care, and home and community-based services).

- Researchers and implementers developing interventions to implement person-centered care planning in practice.

- Clinical decision support developers who develop tools for comprehensive, longitudinal person-centered care planning.

- Quality and other measure developers (e.g., metrics, indicators) of person-centered care planning, including process, implementation, and outcomes.

- Patient advocacy groups and organizations.

- Clinical professional societies.
- Payers.
- Healthcare delivery organizations.
- IT Directors who implement and manage health IT and other systems that may support person-centered care planning by people with MCC and their clinicians and health care teams.

- Vendors who develop health IT solutions that facilitate person-centered care planning, including traditional EHR systems, care planning platforms, consumer apps, and other products.

- Organizations that facilitate health information exchange (i.e., regional or local health information exchanges, vendor-driven networks, and others) who may support sharing of care plan information across systems.

- Device developers who incorporate comprehensive longitudinal person-centered care planning into device software.

- People at risk for or living with MCC, their families and caregivers.

- Representatives from human service agencies and/or community organizations, or people with experience in addressing the social determinants of health and reducing disparities for people at risk for or living with MCC.

- Higher education institutions that train clinicians and healthcare personnel and/or train those involved in community health and education.

Specific questions of interest to AHRQ include, but are not limited to, the following:

- What terms, strategies, and models of care are used to describe and deliver care planning for the whole person (not just for individual health conditions) that records: (1) roles and tasks among care team members, including the individual, their family and caregivers; (2) plans for coordinating care within and across organizations and settings; (3) strategies for supporting and empowering patients to manage their own health; (4) plans for engaging in shared decision making?

- What key components are necessary to fully deliver on the promise of person-centered care planning?

- How is comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC currently being done in health systems, primary care, and other ambulatory practices?

- Which organizations are successfully engaged in person-centered care planning for people at risk for or living with MCC?

- Who are the thought leaders in this area and/or where would leaders go to seek information about how to begin this work?

- What are examples of innovative models of care, approaches, promising strategies and solutions that could support clinicians and practices in routinely engaging in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC?

- How are health systems, primary care, and other ambulatory care practices using innovative approaches to implement person-centered care planning for people at risk for or living with MCC?

- What are best practices for designing, implementing, and evaluating person-centered care planning for people at risk for or living with MCC? What implementation challenges are clinicians and systems likely to face?

- What are suggested strategies for effective implementation of person-centered care planning at multiple

levels (e.g., policy, system, practice, clinical team, people with MCC)?

- What kinds of information, tools, resources, or support are most needed to address barriers and challenges to implementation?

- Which payment models might enable and sustain person-centered care planning?

- What quality of care measurements (e.g., metrics, indicators) exist or are emerging for assessing process, implementation, and outcomes associated with person-centered care planning?

- Which personnel or roles within systems or practice settings would know most about person-centered care planning efforts, challenges, and successes (e.g., IT directors, c-suite, care coordinators, etc.)?

- Within systems/practice settings, who takes the lead, or would be expected to take the lead, in coordinating efforts to implement person-centered care planning?

- What credentials and/or training of the team members, including paraprofessionals such as community health workers and/or persons with lived experience such as peer recovery specialists are necessary?

- Are there or should there be competency requirements for people engaged in facilitating person-centered planning processes, and what should those entail?

- What are suggested methods for recruiting and retaining the workforce to staff such programs?

- What are the impacts of different models of person-centered care planning on the experience of clinicians and other healthcare personnel, and are increased demands posed by some models precipitating practitioner burnout?

- How have shared electronic care plans (e-care plans) been developed, implemented, and shared with the care team? What are best practices for sharing e-care plans across sites and settings of care?

- What existing and emerging data standards are effectively supporting the interoperability of e-care plans? What key standards gaps around e-care plans should be prioritized by industry and other stakeholders?

- What policy levers should HHS use to further advance the adoption of standards-based e-care plans?

- How can technical approaches using Fast Healthcare Interoperability Resources (FHIR) standards better support sharing of e-care plans across care teams? What are major barriers to advancing these approaches?

<sup>3</sup> AHRQ. *eCare Plan Joint NIH/NIDDK AHRQ Project*. 9/22/2021; Available from: <https://ecareplan.ahrq.gov/>.

- What are best practices for using e-care plans to facilitate communication among people at risk for or living with MCC, their caregivers, clinicians, and health care teams, and provide a shared resource for documenting goals, treatments and supports, education and self-management, along with other patient-generated health data?

- What are promising approaches for systematically identifying and addressing social determinants of health?

- Are there any programmatic adaptations that would address the cultural and linguistic considerations when working with minority populations?

- How can equity be ensured in person-centered care planning?

- What are active areas of research and gaps in knowledge?

AHRQ is interested in all of the questions listed above, but respondents are welcome to address as many or as few as they choose and to address additional areas of interest regarding comprehensive longitudinal person-centered care planning not listed. It is helpful to identify the question to which a particular answer corresponds.

This RFI is for planning purposes only and should not be construed as a policy, solicitation for applications, or as an obligation on the part of the Government to provide support for any ideas in response to it. AHRQ will use the information submitted in response to this RFI at its discretion and will not provide comments to any respondent's submission. However, responses to this RFI may be reflected in future solicitation(s) or policies. The information provided will be analyzed and may appear in reports. Respondents will not be identified in any published reports. Respondents are advised that the Government is under no obligation to acknowledge receipt of the information received or provide feedback to respondents with respect to any information submitted. No proprietary, classified, confidential or sensitive information should be included in your response. The contents of all submissions will be made available to the public upon request. Submitted materials must be publicly available or able to be made public.

Dated: September 12, 2022.

**Marquita Cullom,**  
Associate Director.

[FR Doc. 2022-20027 Filed 9-15-22; 8:45 am]

BILLING CODE 4160-90-P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

[60Day-22-22IU; Docket No. CDC-2022-0110]

#### Proposed Data Collection Submitted for Public Comment and Recommendations

**AGENCY:** Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

**ACTION:** Notice with comment period.

**SUMMARY:** The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other federal agencies the opportunity to comment on a proposed information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a proposed information collection project titled Evaluation of the CDC/NIOSH Health Worker Mental Health Campaign. This project will collect data through the administration of online surveys to health workers and their employers prior to campaign launch and 12 months afterward to assess changes in relevant knowledge, attitudes, and beliefs to help inform recommendations.

**DATES:** CDC must receive written comments on or before November 15, 2022.

**ADDRESSES:** You may submit comments, identified by Docket No. CDC-2022-0110 by either of the following methods:

- **Federal eRulemaking Portal:** [www.regulations.gov](http://www.regulations.gov). Follow the instructions for submitting comments.
- **Mail:** Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30329.

**Instructions:** All submissions received must include the agency name and Docket Number. CDC will post, without change, all relevant comments to [www.regulations.gov](http://www.regulations.gov).

*Please note: Submit all comments through the Federal eRulemaking portal ([www.regulations.gov](http://www.regulations.gov)) or by U.S. mail to the address listed above.*

**FOR FURTHER INFORMATION CONTACT:** To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and

Prevention, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30329; Telephone: 404-639-7570; Email: [omb@cdc.gov](mailto:omb@cdc.gov).

**SUPPLEMENTARY INFORMATION:** Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. In addition, the PRA also requires federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
3. Enhance the quality, utility, and clarity of the information to be collected;
4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses; and
5. Assess information collection costs.

#### Proposed Project

National Education and Awareness Social Marketing Campaign: Employer Efforts to Support the Mental Health of Health Workers—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

#### Background and Brief Description

As part of the COVID-19 American Rescue Plan of 2021, in response to a congressional mandate, and on the heels of the passage of the Dr. Lorna Breen Health Care Provider Protection Act, the National Institute for Occupational Safety and Health (NIOSH), within the Centers for Disease Control and