- Create and maintain an integrated national plan to overcome Alzheimer's disease.
- Coordinate Alzheimer's disease research and services across all federal agencies.
- Accelerate the development of treatments that would prevent, halt, or reverse the course of Alzheimer's disease.
- Improve early diagnosis and coordination of care and treatment of Alzheimer's disease.
- Improve outcomes for ethnic and racial minority populations that are at higher risk for Alzheimer's disease.
- Coordinate with international bodies to fight Alzheimer's globally.

The law also establishes the Advisory Council on Alzheimer's Research, Care, and Services and requires the Secretary of HHS, in collaboration with the Advisory Council, to create and maintain a national plan to overcome Alzheimer's disease (AD).

On February 22, 2012, HHS released a draft National Plan to Address Alzheimer's Disease. The draft National Plan has five goals:

1. Prevent and Effectively Treat Alzheimer's Disease by 2025.
2. Optimize Care Quality and Efficiency.
3. Expand Supports for People with Alzheimer's Disease and Their Families.
4. Enhance Public Awareness and Engagement.
5. Track Progress and Drive Improvement.

The draft National Plan includes strategies to achieve each goal and specific actions that HHS or its federal partners will take to drive progress towards achieving the goal.

Sherry Glied,

Assistant Secretary for Planning and Evaluation.

[FR Doc. 2012–4278 Filed 2–23–12; 8:45 am]

BILLING CODE 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: ''System Redesign for Value in Safety Net Hospitals and Delivery Systems.'' 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 April 24, 2012.

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.lefkowitzAAHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

System Redesign for Value in Safety Net Hospitals and Delivery Systems

This proposed project is a case study of 8 safety net (SN) hospitals. The goals of the project are to:

(1) Identify the tools and resources needed to facilitate system redesign in SN hospitals; and

(2) Identify any barriers to adoption of these in SN environments, or any gaps that exist in the available resources.

These goals are consistent with The National Strategy for Quality Improvement in Health Care, published by the U.S. Department of Health and Human Services in March 2011, which articulated a need for progress toward three goals: (1) Better Care; (2) Healthy People/Healthy Communities; and (3) Affordable Care. SN hospitals and systems are critical to achieving all three. SN hospitals are hospitals and health systems which provide a significant portion of their services to vulnerable, uninsured and Medicare patients. While all hospitals face challenges in improving both quality and operating efficiency, safety net (SN) hospitals face even greater challenges due to growing demand for their services and decreasing funding opportunities.

Despite these challenging environmental factors, some SN hospitals and health systems have achieved financial stability and implemented broad-ranging efforts to improve the quality of care they deliver. However, while there have been successful quality improvement initiatives for SN providers, most initiatives aim at specific units within large organizations. The improvements introduced into these units have not often been spread throughout the organization. Additionally, these improvements often are hard to sustain. ''System redesign'' refers to aligned and synergistic quality improvement efforts across a hospital or health system leading to multidimensional changes in the management or delivery of care or strategic alignment of system changes with an organization's business strategy. System redesign, if done successfully, will allow SN providers to improve their operations, remain afloat financially, and provide better quality healthcare to vulnerable and underserved populations. Resources, as defined here, may include learning materials and environments developed to support, advance, and facilitate quality improvement efforts (e.g., tools, guides, webinars, learning collaboratives, training programs). The term ''resources'' should not be interpreted here to imply financial support for routine staffing or operations of Safety Net systems, but may include quality improvement grants, fellowships, collaboratives and trainings.

Many tools, guides, and other learning environments have been developed to support the implementation of individual quality improvement initiatives.

However, the development of resources to support alignment across multiple domains of a health system has been limited. Furthermore, the applicability of existing resources to SN environments is unknown.

This study is being conducted by AHRQ through its contractor, Boston 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 activities and data collections will be implemented:

(1) In-person interviews will be conducted during a 2-day site visit with senior medical center leaders, clinical managers and staff involved in system redesign from each of the 8 participating SN hospitals. These interviews may be conducted one-on-one or in small groups, depending upon the participants' availability. The purpose

of these interviews is to learn directly from hospital leadership and staff about the resources they have used to support and guide their system redesign efforts and what, if any, gaps there are in the resources available to them.

(2) Collection of documentation from each SN hospital. The documentation to be collected includes annual reports, performance dashboards, reports on specific system redesign and quality improvement projects and hospital newsletters. The purpose of this task is to provide supplementary information about the hospitals and their quality improvement and system redesign efforts. Collection of documentation from participating hospitals will allow the research team to collect additional information that is readily available in hospital documents, but may not be known or readily accessible to interview subjects during their interviews.

The findings and recommendations developed from this project will be disseminated through AHRQ networks and through our partnership with the National Association of Public Hospitals and its membership group to ensure that findings are reaching administrators at public and SN hospitals directly. In addition, findings will be published in peer-reviewed and trade literatures so that they will be available to a wide range of SN delivery system managers and clinicians for use in hospitals and healthcare systems. Findings will be presented as illustrative of the issues facing SN hospitals engaging in system redesign—rather than as representing the quantity or distribution of conditions and practices within SN hospitals. All presentations and publications will state the limitations of our case-study methodology.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in this data collection. In-person interviews will be conducted with a total of 160 hospital staff members (20 from each of the 8 participating SN hospitals) and will last about 1 hour. The collection of documentation will require 2 hours work from 1 staff member at each hospital. The total burden is estimated to be 176 hours.

EXHIBIT 1—ANNUALIZED BURDEN HOURS

Data Collection	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
In-person interviews	160	1	1	160
Collection of documentation	8	1	2	16
Total	168	n/a	n/a	176

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to provide the requested data. The total cost burden is estimated to be $9,242 annually.

EXHIBIT 2—ESTIMATED ANNUALIZED BURDEN COST

Data Collection	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
In-person interviews	160	160	$56.23	$8,997
Collection of documentation	8	16	$15.30	$245
Total	168	176	na	$9,242

* The hourly rate of 56.23 is an average of the clinical personnel hourly wage of $91.10 for physicians and $32.56 for registered nurses, and the administrative personnel hourly wage of $45.03 for medical and health services managers. The hourly rate of $15.30 is median hourly rate for medical administrative support staff. All hourly rates are based on median salary data provided by the U.S. Bureau of Labor Statistics.

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the estimated total and annualized cost to the government for this 3 year project. The total cost is $499,877 and includes the cost of data collection, data analysis, reporting, and government oversight of the contract. The costs associated with data collection activities are not all for the primary data collection of the case studies but include the review of existing literature and other available data sources.

TABLE 3—COST TO THE FEDERAL GOVERNMENT

Cost component	Total cost	Annualized cost
Project Development	$49,161	$16,377
Data Collection Activities	123,478	41,159
Data Processing and Analysis	109,433	36,478
Publication of Results	81,836	27,279
Project Management	18,438	6,146
Overhead	117,531	39,177
Government Oversight	13,710	4,570
Total	499,877	166,626

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 healthcare research and healthcare 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: February 15, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–4254 Filed 2–23–12; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Request for Nominations of Children's Healthcare Quality Measures for Potential Inclusion in the CHIPRA 2013 Improved Core Set of Health Care Quality Measures for Medicaid/CHIP

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

ACTION: Notice of Request for measures.

SUMMARY: Section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111–3, amended the Social Security Act to enact section 1139A (42 U.S.C.1320b–9a). Section 1139A(b) charged the Department of Health and Human Services (HHS) with improving pediatric health care quality measures. The Agency for Healthcare Research and Quality (AHRQ) is soliciting the submission of measures of children's healthcare quality for potential inclusion in the CHIPRA 2013 Improved Core Set of Health Care Quality Measures (the ''Improved Core Set'') for potential voluntary use by Medicaid and the Children's Health Insurance Program. In addition, CHIPRA established the Pediatric Quality Measures Program to increase the portfolio of measures available to public and private purchasers of children's health care services, providers, and consumers. HHS anticipates that measures ultimately included in the Improved Core Set will also be used by public and private purchasers to measure pediatric healthcare quality. AHRQ is interested in information about the importance, scientific validity, and feasibility of the measures. If a measure is selected for inclusion, more information, including a copyright release (if applicable) and full measure specifications would be needed.

DATES: Please submit materials within 60 days of publication of this notice.

ADDRESSES: Electronic submissions are encouraged, preferably as an email with one or more electronic files in a standard word processing format as an email attachment. Submissions may also be in the form of a letter to: Denise Dougherty, Ph.D., Senior Advisor, Child Health and Quality Improvement, Agency for Healthcare Research and Quality, 540 Gaither Rd, Rockville, MD 20850, *Phone:* 301–427–1868, *Fax:* 301–427–1562, *Email: denise.DOUGHERTY@AHRQ.hhs.gov.*

It would be most helpful to the Agency if commenters would include the following information in their response: measure characteristics: measure name; measure description; denominator statement (if applicable); numerator statement (if applicable); data sources and exclusions; applicable proprietary rights (*e.g.,* patent or data rights); any confidentiality or trade secret protections; whether the measure is part of a measure hierarchy (*e.g.,* a collection of measures, a measure set, a measure subset as defined at *http://www.QUALITYMEASURES.AHRQ.gov/about/hierarchy.aspx*); detailed measure specifications; importance of the measure; settings, services, measure domains, and populations addressed by the measure; evidence for focus of the measure; scientific soundness of the measure; results of any efforts to demonstrate the capacity of the measure to produce results that stratify by race/ethnicity, socioeconomic status, special health care need, and/or rurality/urbanicity; feasibility of the measure (*e.g.,* availability of data in existing data systems); levels at which the measure can be aggregated (*e.g.,* State, health plan, provider); understandability to consumers and providers; health information technology readiness and sensitivity (*e.g.,* whether the measure has been tested in an electronic health record or other health information technology); followup contact information.

AHRQ would also be interested in a summary rationale for why the measure should be included in the 2013 Improved Core Set, taking into account a balance among desirable attributes of the measure. For example, you may be want to describe advantages that this measure has over alternative measures that were considered by the measure developer or advantages that this measure has over existing measures.

FOR FURTHER INFORMATION CONTACT: Denise Dougherty, Ph.D., Senior Advisor, Child Health and Quality Improvement, Agency for Healthcare Research and Quality, 540 Gaither Rd, Rockville, MD 20850, *Phone:* 301–427–1868, *Fax:* 301–427–1562, *Email: denise.DOUGHERTY@AHRQ.hhs.gov.*

SUPPPLEMENTARY INFORMATION: Section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111–3, amended the Social Security Act to enact section 1139A (42 U.S.C. 1320b–9a). Section 1139A(b) charged the Department of Health and Human Services (HHS) with improving pediatric health care quality measures. Since CHIPRA was passed, the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) have been working together to implement selected provisions of the legislation related to children's health care quality (*www.AHRQ.gov/CHIPRA*). An initial core measure set for voluntary use by Medicaid and Children's Health Insurance Programs was posted December 29, 2009 (*http://www.GPO.gov/fdsys/PKG/FR–2009–12–29/html/E9–30802.htm*). In February 2010, CMS released a State Health Official letter which outlined the initial core measures and how they should be reported to CMS.

Subsequently, AHRQ and CMS established the CHIPRA Pediatric Quality Measures Program (PQMP) to enhance select pediatric quality measures and develop new measures as needed (*http://www.AHRQ.gov/CHIPRA*). CHIPRA stipulates that improved core measures be identified annually, beginning January 1, 2013. Under the PQMP, measures are being developed and improved by 7 AHRQ–CMS Centers of Excellence (*http://www.AHRQ.gov/CHIPRA/PQMPFACT.htm*). In addition, this notice seeks public nominations of measures for potential inclusion in Improved Core Sets.