

innovative payment and service delivery models that reduce spending under Medicare, Medicaid, or CHIP, while preserving or enhancing the quality of care, the Innovation Center aims to achieve the following goals through implementation of the Bundled Payments for Care Improvement initiative:

- Improve care coordination, patient experience, and accountability in a patient centered manner.
- Support and encourage providers who are interested in continuously reengineering care to deliver better care, better health, at lower costs through continuous improvement.
- Create a virtuous cycle that leads to continually decreasing the cost of an acute or chronic episode of care while fostering quality improvement.
- Develop and test payment models that create extended accountability for better care, better health at lower costs for acute and chronic medical care.
- Shorten the cycle time for adoption of evidence-based care.
- Create environments that stimulate rapid development of new evidence-based knowledge.

The models to be tested based on applications to the RFA are as follows:

- *Model 1:* Retrospective payment models around the acute inpatient hospital stay only.
- *Model 2:* Retrospective bundled payment models for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care.
- *Model 3:* Retrospective bundled payment models for post-acute care where the episode does not include the acute inpatient hospital stay.
- *Model 4:* Prospectively administered bundled payment models for the acute inpatient hospital stay only, such as prospective bundled payment for hospitals and physicians for an inpatient hospital stay

Organizations are invited to submit proposals that define episodes of care in one or more of these four models. Proposals should demonstrate care improvement processes and enhancements such as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination. All models must encourage close partnerships among all of the providers caring for patients through the episode. Applicants must demonstrate robust quality monitoring and protocols to ensure beneficiary quality protection. Under all models, applicants must provide Medicare with a discount on Medicare fee-for-service expenditures.

Bundled Payments for Care Improvement agreements will include a performance period of 3 years, with the possibility of extending an additional 2 years, beginning with the respective program date. The program start date may be as early as the first quarter of CY 2012 for awardees in Model 1.

III. Collection of Information Requirements

Section 1115A(d) of the Act waives the requirements of the Paperwork Reduction Act of 1995 for the Innovation Center for purposes of testing new payment and service delivery models.

Authority: 44 U.S.C. 3101.

Dated: August 17, 2011.

Donald M. Berwick,
Administrator, Centers for Medicare & Medicaid Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

Project: National Child Traumatic Stress Initiative (NCTSI) Evaluation—(OMB No. 0930-0276)—Revision

The Substance Abuse and Mental Health Services Administration's (SAMHSA), Center for Mental Health Services (CMHS), will conduct the National Child Traumatic Stress Initiative (NCTSI) Evaluation. This evaluation serves multiple practical purposes: (1) To collect and analyze descriptive, outcome, and service experience information about the children and families served by the NCTSI centers; (2) to assess the NCTSI's impact on access to high-quality, trauma-informed care; (3) to evaluate NCTSI centers' training and consultation activity designed to promote evidence-based, trauma-informed services and the impact of such activity on child-serving systems; and (4) to assess the sustainability of the

grant-funded activities to improve access to and quality of care for trauma-exposed children and their families beyond the grant period.

Data will be collected from caregivers and youth served by NCTSI centers, NCTSI and non-NCTSI administrators, NCTSI trainers, service providers trained by NCTSI centers and other training participants, administrators of mental health and non-mental health professionals from state and national child-serving organizations, and administrators of affiliate centers. Data collection will take place in all Community Treatment and Services Programs (CTS) and Treatment and Service Adaptation Centers (TSA) active during the three-year approval period. Currently, there are 45 CTS centers and 17 TSA centers active (*i.e.*, 62 active centers). After the first year, in September 2011, the 15 grantees funded in 2007 will reach the end of their data collection. At that point, additional centers may be funded or funded again. Because of this variability, the estimate of 62 centers is used to calculate burden.

The NCTSI Evaluation is composed of four distinct study components, each of which involves data collection, which are described below.

Descriptive and Clinical Outcomes

In order to describe the children served, their trauma histories and their clinical and functional outcomes, nine instruments will be used to collect data from children and adolescents who are receiving services in the NCTSI, and from caregivers of all children who are receiving NCTSI services. Data will be collected when the child/youth enters services and during subsequent follow-up sessions at three-month intervals over the course of one year. This study relies upon the use of data already being collected as a part of the Core Data Set, and includes the following instruments:

- The Core Clinical Characteristics Form, which collects demographic, psychosocial and clinical information about the child being served including information about the child's domestic environment and insurance status, indicators of the severity of the child's problems, behaviors and symptoms, and use of non-Network services;
- The Trauma Information/Detail Form, which collects information on the history of trauma(s) experienced by the child served by the NCTSI center including the type of trauma experienced, the age at which the trauma was experienced, type of exposure, whether or not the trauma is chronic, and the setting and

perpetrator(s) associated with the traumatic experience;

- The Child Behavior Checklist (CBCL) 1.5–5 and 6–18, which measure symptoms in such domains such as emotionally reactive, anxious/depressed, somatic complaints, withdrawn, attention problems, aggressive behavior, sleep problems, rule-breaking behavior, social problems, thought problems, and withdrawn/depressed;

- The UCLA PTSD Short Form, which screens for exposure to traumatic events and for all DSM–IV PTSD symptoms in children who report traumatic stress experiences; and the

- The Trauma Symptoms Checklist for Children, which evaluates acute and chronic posttraumatic stress symptoms in children's responses to unspecified traumatic events across several symptom domains.

- The Trauma Symptoms Checklist for Young Children (TSCYC), which is a 90-item caretaker-report instrument developed for the assessment of trauma-related symptoms in children ages 3 to 12.

- The Parenting Stress Index Short Form (PSI–SF), which yields a total stress score from three scales: Parental distress, parent-child dysfunctional interaction, and difficult child. The PSI–SF was developed from factor analysis of the PSI–Full-Length Version.

- The Children's Depression Inventory–2 Short (CDI–2S), which is a comprehensive multi-rater assessment of depressive symptoms in youth aged 7 to 17 years. Depressive symptomatology is quantified by the CDI 2 based on reports from children/adolescents, teachers and parents.

- The Global Appraisal of Individual Needs Modified Short Screener (GAIN–MSS), which is designed primarily as a screener in general populations, ages 12 and older, to quickly and accurately identify clients who have 1 or more behavioral health disorders (e.g., internalizing or externalizing psychiatric disorders, substance use disorders, or crime/violence problems).

Approximately 6,000 youth and 9,700 caregivers will participate in the descriptive and clinical outcomes study over the clearance period.

Access to High Quality, Trauma-Informed Services

The NCTSI mission is to expand access to high quality, trauma-informed services for trauma-exposed children and adolescents and their families nationwide. This component of the evaluation is designed to assess NCTSI program progress in achieving this mission by collecting and analyzing

data from a variety of sources addressing the question of whether access to high quality, trauma-informed services has improved and for which demographic groups. Instruments used as a part of this study component include:

- Evidence-based Practice (EBP) and Trauma-informed Systems Change Survey (ETSC), which assesses the extent to which NCTSI training and other dissemination activities have enhanced the knowledge base and use of trauma-informed services (TIS) within child-serving agencies, centers and organizations that are not a part of the NCTSI but rather have received training from the NCTSI as well as to assess the extent to which such services are evidence-based. The survey branches into two versions adapted for project directors/administrators and human service providers (e.g., mental health providers, child welfare case workers, teachers, primary care health care providers and others), allowing for questions tailored to the professional orientation and activities of each group. The ETSC survey will be used to assess the extent to which NCTSI training and dissemination activities have improved access to high quality, trauma-informed services for trauma-exposed children and their families that are served through such child-serving systems.

- The National Reach Survey, which assesses the extent to which the NCTSI has impacted the knowledge and awareness, policies, planning, programs, and practices related to trauma-informed care among state and national child-serving organizations external to the NCTSI centers.

- The Online Performance Monitoring Report (OPMR), which is primarily a mechanism for SAMHSA to monitor centers' progress towards achieving stated goals and a fulfillment of SAMHSA requirements for accountability and performance monitoring. In addition, this form will also serve as an important data source informing several components of the NCTSI evaluation.

Approximately 496 service providers and 186 administrators from NCTSI centers and organizations or agencies trained by NCTSI centers will participate in the ETSC survey. Approximately 4,000 individuals will be participating in the National Reach Survey, while approximately 62 individuals will participate in the OPMR.

Training, Evidence-Based Practices (EBPs), and Family/Consumer Partnerships

A major goal of the NCTSI is to enhance the capacity of administrators and service providers from agencies, centers and organizations associated with child-serving systems (including mental health, child welfare, juvenile justice, education and primary care) to use trauma-informed services (TIS) with trauma-exposed children and their families. NCTSI centers promote the use of TIS within child-serving systems to increase public awareness and knowledge about trauma exposure, trauma impact, and the range of trauma-informed assessments and services that are available. For this component, the ETSC Survey will be used to assess whether agencies, schools, and organizations that are a part of child-serving systems trained by the NCTSI have become more evidence-based and trauma-informed. Two additional forms will be used including:

- The Training Summary Form (TSF), which will be completed by trainers and will collect information on the number of participants trained, the type of training (including the trauma types addressed in the training), and the topics emphasized in the training.

- The Training Sign-In Sheet (TSIS), which will be completed by this participants of NCTSI-sponsored trainings. Participants will provide their names; agency, organization or center for which they work; their roles; and contact information including an email addresses. In addition, they will be asked to indicate whether the evaluation may contact them for participation.

Approximately 124 trainers will complete and submit the TSF, while approximately 12,400 trainees will complete the TSIS.

Sustainability

Assessing the sustainability of the progress made by the NCTSI and its partners is a key evaluation priority identified by stakeholders advising on the redesign of the NCTSI Evaluation. Therefore, while this issue was not addressed as part of the previous evaluation design, it has been included as a new area of importance for future NCTSI evaluation. This component of the evaluation focuses on understanding the degree to which NCTSI grant activities continue after funding has ended and the factors associated with the continuation of—or lapse in—grant activities such as the implementation of evidence-based practices or approaches to strengthen trauma-informed service provision. This component collects

sustainability data as part of the OPMR in the case of funded centers and, in the case of affiliate centers (centers that no longer receive SAMHSA funding but have continued involvement with the NCTSI and are defined by SAMHSA as affiliates), the following survey will be implemented:

- Sustainability Survey for Affiliate Centers, which assesses sustainability of NCTSI grant activities by collecting data on domains including grant history, funding sources and fiscal strategies, program mission, infrastructure, service delivery and continuation of practices and programs. Approximately 45 administrators of affiliate centers are expected to participate in this survey.

The revision to the currently approved information collection activities includes the extension of NCTSI Evaluation information collection activities for an additional three years. This revision also addresses the following programmatic changes:

- The number of centers for which burden was calculated is 62, which represents the number of currently active grantees (the number of centers at the time of the previous submission was 44).

- As a result of efforts to address updated evaluation priorities, reduce redundancy and consolidate multiple data collection efforts focused on national monitoring and evaluating of the NCTSI program, the request discontinues ten surveys, forms or interviews that are currently OMB-approved.

- In place of the ten surveys, forms or interviews that are currently OMB-approved that are being discontinued, and as part of the redesigned evaluation, three new data collection efforts will be implemented, including:

- Online Performance Monitoring Report Form (OPMR)
- Evidence-based Practice and Trauma-Informed System Change Survey (ETSC)

- Sustainability Survey for affiliate centers

- This request also enhances the existing Core Data Set by revising the Core Clinical Characteristics Forms and adding new instruments to address existing gaps in knowledge including:

- Trauma Symptom Checklist for Young Children (TSCYC)
- Parenting Stress Index Short Form (PSI-SF)
- Children's Depression Inventory-2 Short (CDI-2S)
- Global Appraisal of Needs Modified Short Screener (GAIN-MSS)

- A Training Sign-in Sheet (TSIS) has been developed for use at each training event sponsored by NCTSI centers. The purpose of the form is to collect brief information about NCTSI training participants.

The average annual respondent burden is estimated below.

Instrument	Number of respondents	Average number of responses per respondent	Hours per response	Total burden hours	3-year average of annual burden hours
Caregivers Served by NCTSI Centers					
Child Behavior Checklist 1.5–5/6–18 (CBCL 1.5–5/6–18) ..	19,729	² 4	0.33	12,842	4,281
Trauma Information/Detail Form	9,729	4	0.22	8,562	2,854
Core Clinical Characteristics Form	9,729	4	0.5	19,458	6,486
UCLA-PTSD Short Form (UCLA-PTSD)	³ 7,394	4	0.17	5,028	1,676
Trauma Symptoms Checklist for Young Children (TSCYC)	⁴ 2,724	4	0.33	3,596	1,199
Parenting Stress Index Short Form (PSI-SF)	⁵ 2,919	4	0.08	934	311
Youth Served by NCTSI Centers					
Trauma Symptoms Checklist for Children-Abbreviated (TSCC-A)	⁶ 6,129	4	0.33	8,090	2,697
Children's Depression Inventory-2 Short (CDI-2S)	⁷ 2,140	4	0.08	685	228
Global Appraisal of Individual Needs Modified Shore Screener (GAIN-MSS)	⁸ 3,989	4	0.08	1,276	425
Funded NCTSI Center Project Directors of Other Administrators					
Online Performance Monitoring Report (OPMR)	62	12	0.60	446	149
Sustainability Survey for Currently—Funded Centers	62	3	0.28	52	17
NCTSI and Non-NCTSI Administrators					
Evidence-based Practice (EBP) and Trauma Informed Systems Change Survey (ETSC)—Administrator Version	⁹ 186	2	0.30	112	37
NCTSI Trainers					
Training Summary Form	¹⁰ 124	5	0.2	124	41
Service Providers Trained by NCTSI Centers					
Evidence-based Practice (EBP) and Trauma Informed Systems Change Survey (ETSC)—Provider Version	¹¹ 496	3	0.3	446	149
Training Participants					
Training Sign-In Sheet (TSIS)	¹² 12,400	1	.02	248	83

Instrument	Number of respondents	Average number of responses per respondent	Hours per response	Total burden hours	3-year average of annual burden hours
Mental Health and Non-Mental Health Professionals from State and National Child Serving Organizations					
NCTSI National Reach Survey	4,000	1	0.5	2,000	667
Affiliate Center Administrators					
Sustainability Survey— Affiliate Centers	45	3	.28	38	19
Total summary	71,857	66	63,957
Total annual summary	23,952	22	21,319

1. On average, 75 percent of centers participate in the Core Data Set (47 of 62 centers), with an average of 69 baseline visits per year.
2. On the basis of the children enrolled in the Core Data Set through September 30, 2010, the average length of time in treatment is 9 months, yielding an average of 4 assessments per child.
3. On the basis of the children enrolled in the Core Data Set through September 30, 2010, approximately 76% of the children in the Core Data Set will be ages 7 and older.
4. On the basis of the children enrolled in the Core Data Set through September 30, 2010, approximately 28% of the children in the Core Data Set will be between the ages of 3 and 7.
5. On the basis of the children enrolled in the Core Data Set through September 30, 2010, approximately 60% of the children in the Core Data Set will be aged 12 and under. We estimate that approximately 50% of centers will use this optional instrument, leading to an estimate of 30% of children in the Core Data Set.
6. On the basis of the children enrolled in the Core Data Set through September 30, 2010, approximately 63% of the children in the Core Data Set will be between the ages of 8 and 16.
7. On the basis of the children enrolled in the Core Data Set through September 30, 2010, approximately 44% of the children in the Core Data Set will be between the ages of 7 and 18, and will have depression indicated as a potential problem at baseline. We estimate that approximately 50% of centers will use this optional instrument, leading to an estimate of 22% of children in the Core Data Set.
8. On the basis of the children enrolled in the Core Data Set through September 30, 2010, approximately 41% of the children in the Core Data Set will be aged 12 and older.
9. Respondents will be administrators from 62 currently funded NCTSI centers and administrators from two child serving systems that each NCTSI center trains.
10. Respondents will be center trainers or evaluation staff. On average, 5 Training Summary Forms may be completed by 124 trainers.
11. Respondents are NCTSI center employed clinicians and center trained providers. It is estimated that on average from the 62 centers, four center-employed clinicians and four center trained providers will take the survey three times.
12. It is expected that at least two trainers per center will provide five trainings and on an average there will be twenty participants per training.

Written comments and recommendations concerning the proposed information collection should be sent by September 26, 2011 to the SAMHSA Desk Officer at the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB). To ensure timely receipt of comments, and to avoid potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, commenters are encouraged to submit their comments to OMB via e-mail to: OIRA_Submission@omb.eop.gov. Although commenters are encouraged to send their comments via e-mail, commenters may also fax their comments to: 202-395-7285. Commenters may also mail them to: Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building, Room 10102, Washington, DC 20503.

Dated: August 18, 2011.

Elaine Parry,

Director, Office of Management, Technology and Operations.

[FR Doc. 2011-21713 Filed 8-24-11; 8:45 am]

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DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA-4009-DR; Docket ID FEMA-2011-0001]

Minnesota; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Minnesota (FEMA-4009-DR), dated July 28, 2011, and related determinations.

DATES: *Effective Date:* July 28, 2011.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646-3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated July 28, 2011, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42

U.S.C. 5121 *et seq.* (the "Stafford Act"), as follows:

I have determined that the damage in certain areas of the State of Minnesota resulting from severe storms, flooding, and tornadoes during the period of July 1-11, 2011, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"). Therefore, I declare that such a major disaster exists in the State of Minnesota.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order