

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST—Continued

Cost component	Total cost	Annualized cost
Project Management	164,552	41,138
Total Costs	439,552	109,888

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: July 13, 2011.

Carolyn M. Clancy,
Director.

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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: "Evaluation of ARRA Comparative Effectiveness Research Dissemination Contractor Efforts." 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 September 26, 2011.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by e-mail 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 e-mail at doris.lefkowitz@AHRQ.hhs.gov.

SUPPLEMENTARY INFORMATION:

Proposed Project

Evaluation of ARRA Comparative Effectiveness Research Dissemination Contractor Efforts

Today, both patients and their health care providers have many options when deciding on a treatment plan. Information available to patients and their health care providers offers great opportunities for informed decision making. However, the volume of information that needs to be reviewed and synthesized can be daunting. To complicate matters, studies may offer conflicting information or have a conflict of interest (e.g., research sponsored by pharmaceutical companies that make drugs). Sorting through conflicting information requires a background in research that most patients do not have, and physicians have limited time to conduct these reviews. Having a neutral third party review research, draw conclusions, and disseminate findings is necessary to ensure effective health care delivery and consumption of quality care.

AHRQ recognizes the need to fill this gap and has taken a lead role in developing mechanisms for reviewing and disseminating Comparative Effectiveness Research (CER) and findings to clinicians, health care decision makers, purchasers/business decision makers, and consumers through its Effective Healthcare Program

(EHCP). CER directly compares the benefits, potential risks, and costs of two or more health care interventions. These direct comparisons allow assessments of how well a health care treatment or intervention works under real-world conditions. AHRQ has paid careful attention not only to how studies are conducted but also to how results are communicated to its audiences.

To augment AHRQ's existing CER dissemination efforts performed by the Eisenberg Center and other initiatives, AHRQ is conducting four one-time projects to test other ways to disseminate CER results. These four related projects will test new approaches to CER dissemination and promote awareness of the EHCP. Collectively, dissemination efforts will reach AHRQ's priority audiences of: clinical decision makers, health care system decision makers, purchasers/business decision makers, public policy decision makers, and consumers/patients.

Through these four projects AHRQ aims to: (1) Educate professional and consumer audiences about CER; (2) inform professional and consumer audiences about AHRQ's EHCP; (3) and inform a wide range of audiences about new EHCP research findings.

This project will evaluate the effectiveness of these four new dissemination efforts. The evaluation has four main goals:

1. Assess the effectiveness of the four dissemination strategies in creating awareness of CER, specific CER topics, and the EHCP.

2. Assess the effectiveness of the four dissemination strategies in fostering knowledge and understanding of CER finding, specific CER topics, and the EHCP.

3. Assess the effectiveness of the four dissemination strategies in promoting utilization, including use of the EHCP materials by consumers and by clinicians in patient care and if usage by clinicians is increasing across time.

4. Assess the effectiveness of the four dissemination strategies in supporting the benefits of using CER, and specific CER topics, for both patients and health care providers.

This study is being conducted by AHRQ through its contractor, IMPAQ

International, LLC and its subcontractor, Battelle Memorial Institute, 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 clinical practice, including primary care and practice-oriented research. 42 U.S.C. 299a(a)(1) and (4).

Method of Collection

To achieve project goals the following data collections will be implemented, each of which apply to all of the above-stated goals:

1. **Clinician Survey**—Conduct three cross-sectional mail surveys with clinicians to measure awareness, understanding, use of the EHCP materials, and benefits of CER. Collecting survey data at multiple time points is critical to assess trends in the outcomes of interest among clinicians and the impact of ongoing and increased dissemination contractor activities. Three data points for the survey will allow us to test if the proportion of clinicians aware of CER and the Effective Healthcare Program is changing over time and if the rate of change is changing. The Survey will be administered at the end of years 1, 3 and 4; the burden for the year 4 data collection is not included in the estimates in Exhibits 1 and 2 since it will be included in a second OMB clearance package to be submitted after year 3.

2. **Consumer/Patient Survey**—Conduct two cross-sectional telephone surveys with consumers/patients to measure awareness, understanding, use of the EHCP materials, and benefits of CER. Collecting survey data at multiple time points is critical to assess trends in the outcomes of interest among consumers/patients and the impact of ongoing and increased dissemination contractor activities. Two data points for the survey will allow us to test if the proportion of consumers/patients aware of CER and the Effective Healthcare Program is changing over time. The Survey will be administered at the end of years 1 and 3. A short screener questionnaire will be used to identify eligible respondents.

3. **Health System Decision Maker Survey**—Conduct one cross-sectional telephone survey with health care system decision makers to measure awareness, understanding, use of the EHCP materials, and benefits of CER. The questionnaire and respondent materials for this data collection are not included in this submission since it

occurs in year 4 of the project and have not yet been developed. These materials will be submitted in another OMB clearance package in year 3 of this project. This data collection is mentioned here in order to provide an overview of the entire 5 years of the project; it is not included in the burden estimates in Exhibits 1 and 2.

4. **Clinician Focus Groups**—Conduct six follow-up focus groups with clinicians after the first and third cross-sectional surveys of this audience. The focus groups will be conducted with three clinician segments: (1) Those who report awareness of CER and have self-reported use of CER in their clinical practice; (2) those who report awareness of CER and have self-reported non-use of CER in their clinical practice; and (3) those who report no awareness of CER. One moderator guide will be used for each focus group. By asking the same questions to each clinician segment, who will have been targeted by all four dissemination contractors, differences among answers are more likely to be attributed to the segmentation criteria and eliminate bias through different questions. Two focus groups will be conducted for each of the three segments. The clinician focus groups will be conducted by telephone. The focus groups will be administered at the end of year 2 and during year 5; the burden for the year 5 data collection is not included in the estimates in Exhibits 1 and 2 since it will be included in a second OMB clearance package to be submitted after year 3.

5. **Consumer/Patients Focus Groups**—Conduct twelve follow-up focus groups with consumers/patients after the first cross-sectional survey of this audience, at the end of year 2 of the project. The focus groups will be conducted with three consumer/patient segments: (1) Those who report awareness of CER and have self-reported use of CER in medical decision making; (2) those who report awareness of CER and have self-reported non-use of CER in medical decision making; and (3) those who report no awareness of CER. Four focus groups will be conducted for each of the three segments. A single screening questionnaire will be used to recruit participants. The consumer/patient focus groups will be conducted by telephone.

6. **Health System Decision Maker Focus Groups**—Conduct twelve follow-up focus groups with health care system decision makers, after the cross-sectional survey of this audience. The focus groups will be conducted with three decision maker segments: (1) Those who reported awareness of CER and have self-reported use of CER in

business decision making; (2) those who reported awareness of CER and have self-reported non-use of CER in business decision making; and (3) those who report no awareness of CER. Four focus groups will be conducted for each of the three segments. The focus groups will be conducted by telephone. The screener, moderator guides, and respondent materials for this data collection are not included in this submission since it occurs in year 5 of the project and have not yet been developed. These materials will be submitted in another OMB clearance package in year 3 of this project. This data collection is mentioned here in order to provide an overview of the entire 5 years of the project; it is not included in the burden estimates in Exhibits 1 and 2.

7. **Semi-structured Interviews**—Conduct semi-structured interviews, in year 3 of the project, with 20 individuals in each of the following groups: health care system decision makers, purchasers, and policymakers for a total of 60 interviews. In-depth interviews will be used to determine how people receive and interpret CER-related materials and verbal information, and adopt new behaviors based on information they receive.

AHRQ will use the survey, focus group, and in-depth interview data to assess trends and the effectiveness of the four complementary and different dissemination methods to inform current and future dissemination of the EHCP. Specific attention will be given to changes in audience awareness, understanding, behavior change/use, and benefits of CER. Collecting data at multiple times will enable AHRQ to determine whether increased dissemination contractors' activities over time is associated with any change in CER awareness, knowledge, use, or benefit. Finally, collecting data from five audiences (*i.e.*, clinicians, consumers/patients, health system decision makers, purchasers, and policy makers) will enable AHRQ to assess the effectiveness of its CER-related dissemination efforts among its target populations.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondent's time to participate in this evaluation. The total burden hours are estimated to be 3,760.

Clinician Surveys: The design for the clinician survey consists of three cross sectional waves (only 2 of which are included in the estimates here, as explained in section 1), each wave having 1,926 respondents for a total of

3,852 across the two waves included in this information collection request. The survey will take no longer than 20 minutes to complete.

Consumer/Patient Surveys: The design for the consumer/patient survey consists of two cross-sectional waves, each wave having 1,000 respondents for a total of 2,000 across both waves. The screener will take no longer than 5 minutes to complete. The survey will take no longer than 20 minutes to complete.

Clinician Focus Groups: Six follow-up focus groups with clinicians will be conducted by telephone twice; once after the first and again after the third cross-sectional surveys of this audience (only one of which is included in the estimates here, as explained in section 1). Focus group participants will have

completed the survey and will have expressed interest in participating in a telephone focus group. For each of the two rounds of focus groups, twelve clinicians will be recruited for each of six focus groups.

Focus groups will last one hour.

Consumer/Patient Focus Groups: Twelve follow-up focus groups with consumer/patients will be conducted by telephone after the first cross-sectional survey of this audience. Focus group participants will have completed the survey and will have expressed interest in participating in a telephone focus group. Eight people will be in each focus group. The screener will take no longer than 5 minutes to complete. Focus group will last approximately 90 minutes.

In-Depth Interviews with Other Key Audiences: In-depth interviews will be conducted with up to 20 representatives in each of three key audiences: (1) Health care system decision makers, (2) purchasers, and (3) policy makers. Respondents located in the metropolitan Washington, DC/Baltimore area will be interviewed in person, and respondents located outside the local area will be interviewed by telephone. Participant recruitment should take no longer than five minutes. The interviews will last one hour.

The estimated annualized cost burden associated with the respondent's time to participate in this evaluation is shown in Exhibit 2. The total cost burden is estimated to be \$144,266.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Data Collection Activity	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Clinician Survey	3,852	1	20/60	1,284
Consumer/Patient Survey Screener	2560	1	5/60	214
Survey	2000	1	20/60	667
Clinician Focus Groups	72	1	60/60	72
Consumer/Patient Focus Groups Screener	120	1	5/60	10
Focus Group	96	1	90/60	144
Semi-structured Interviews with Health System Decision Makers	20	1	60/60	20
Semi-structured Interviews with Purchasers	20	1	60/60	20
Semi-structured Interviews with Policymakers	20	1	60/60	20
Total	8,760	n/a	n/a	2,451

EXHIBIT 2: ESTIMATED ANNUALIZED COST BURDEN

Data Collection Activity	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Clinician Survey	3,852	1,284	\$88.46	\$113,583
Consumer/Patient Survey Screener	2560	214	20.90	4,473
Survey	2000	667	20.90	13,940
Clinician Focus Groups	72	72	88.46	6,369
Consumer/Patient Focus Groups Screener	120	10	20.90	209
Focus Groups	96	144	20.90	3,010
Semi-structured Interviews with Health System Decision Makers	20	20	43.74	875
Semi-structured Interviews with Purchasers	20	20	46.59	932
Semi-structured Interviews with Policymakers	20	20	43.74	875
Total	8,760	2,451	n/a	144,266

* Based upon the mean of the average wages, National Compensation Survey: Occupational wages in the United States May 2009, "U.S. Department of Labor, Bureau of Labor Statistics." Hourly wage rates for clinicians were estimated using the mean wage for internists (occupation code 29-1063). Hourly wage rates for consumers/patients were estimated using the mean wage for all occupations (occupation code 00-0000) since participants in the consumer groups may have a wide range of jobs and occupations. Hourly wage rates for health system decision makers and policymakers were estimated using the mean wage for medical and health services managers (occupation code 11-9111). Hourly wage rates for purchasers were estimated using the mean wage for purchasing managers (occupation code 11-3061). These rates were obtained in January 2011 at the following Web site: http://www.bls.gov/oes/current/oes_nat.htm#b29-0000.

Estimated Annual Costs to the Federal Government

The total cost to the Government for this information collection is \$2,719,272

over the five years of the project. Exhibit 3 provides a breakdown of these costs.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost Component	Total cost	Annualized cost
Project Development	\$420,055	\$84,011
Data Collection Activities	1,452,290	290,458
Data Processing and Analysis, and Reports to AHRQ	141,637	28,327
Project Management	291,706	58,341
Overhead	413,584	82,717
Total	2,719,272	543,854

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: July 6, 2011.

Carolyn M. Clancy,
Director.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Meeting of the National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults

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

ACTION: Notice of public meeting.

SUMMARY: This notice announces a meeting of a Subcommittee of the National Advisory Council for Healthcare Research and Quality.

DATES: The meeting will be held on Tuesday, August 9th from 10 a.m. to 6 p.m., and Wednesday, August 10th from 9 a.m. to 3 p.m.

ADDRESSES: The meeting will be held at the Westin Washington, DC City Center, 1400 M Street, NW., Washington DC.

FOR FURTHER INFORMATION CONTACT: Nancy Wilson, MD MPH, Coordinator of the National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults at the Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland, 20850, (301) 427-1310. For press-related information, please contact Karen Migdail at (301) 427-1855.

If sign language interpretation or other reasonable accommodation for a disability is needed, please contact the Food and Drug Administration (FDA) Office of Equal Employment Opportunity and Diversity Management on (301) 827-4840, no later than August 1, 2011. The agenda, roster, and meeting report will be available from Dr. Wilson.

SUPPLEMENTARY INFORMATION:

I. Purpose of the National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults

The purpose of the National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults is to develop consensus on a core set of health quality measures for Medicaid-eligible adults. While a number of current efforts to assess, publicly report, and improve quality of care include Medicaid eligible adults, this core set of measures will reflect aspects of care particularly important to Medicaid recipients that are not currently assessed consistently and routinely.

Section 2701 of the Affordable Care Act (ACA), which added Section 1139B to Title XI of the Social Security Act, requires the Secretary of Health and Human Services to identify and publish a recommended core set of health quality measures for Medicaid eligible adults. AHRQ and the Centers for

Medicare and Medicaid Services (CMS) have entered into an interagency agreement to collaboratively identify these measures. Section 2701 also requires the Secretary, in consultation with States, to develop a standardized format for reporting information and to develop procedures that encourage voluntary reporting based on the initial core set of measures. The Secretary is also required to establish a Medicaid Quality Measurement Program that will fund the development, testing, and validation of emerging and innovative evidence-based measures and to subsequently publish recommended changes to the initial core measure set. Not later than September 30, 2014 and annually thereafter the Secretary is required to collect, analyze, and make publically available the information reported by the States.

The National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults met on October 18th and 19th 2010, and identified an initial core set of measures. These measures were subsequently posted in the **Federal Register** for a two month public comment period. This initial core set of measures must be finalized by January 1, 2012.

The purpose of the National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults is to: (a) Review the public comment analysis, (b) determine and apply criteria by which the initial list is further refined, and (c) make recommendations to the National Advisory Council regarding finalizing the initial core set of measures. The National Advisory Council Subcommittee Identifying Quality Measures for Medicaid Eligible Adults membership will reflect expertise in healthcare quality measurement, healthcare disparities, and in the populations eligible for Medicaid. Elizabeth McGlynn, PhD, Director, Kaiser Permanente Center for Effectiveness & Safety Research, and Foster Gesten, M.D., Medical Director of