

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Patient Safety Organizations: Voluntary Relinquishment From the Coalition for Quality and Patient Safety of Chicagoland (CQPS PSO)

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

ACTION: Notice of Delisting.

SUMMARY: The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act), Public Law 109–41, 42 U.S.C. 299b–21–b–26, provides for the formation of Patient Safety Organizations (PSOs), which collect, aggregate, and analyze confidential information regarding the quality and safety of health care delivery. The Patient Safety and Quality Improvement Final Rule (Patient Safety Rule), 42 CFR Part 3, authorizes AHRQ, on behalf of the Secretary of HHS, to list as a PSO an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be “delisted” by the Secretary if it is found no longer to meet the requirements of the Patient Safety Act and Patient Safety Rule, or when a PSO chooses to voluntarily relinquish its status as a PSO for any reason. AHRQ has accepted a notification of voluntary relinquishment from the Coalition for Quality and Patient Safety of Chicagoland (CQPS PSO) of its status as a PSO, and has delisted the PSO accordingly.

DATES: The directories for both listed and delisted PSOs are ongoing and, reviewed weekly by AHRQ. The delisting was effective at 12:00 Midnight ET (2400) on May 24, 2012.

ADDRESSES: Both directories can be accessed electronically at the following HHS Web site: <http://www.pso.AHRQ.gov/index.html>.

FOR FURTHER INFORMATION CONTACT: Eileen Hogan, Center for Quality Improvement and Patient Safety, AHRQ, 540 Gaither Road, Rockville, MD 20850; Telephone (toll free): (866) 403–3697; Telephone (local): (301) 427–1111; TTY (toll free): (866) 438–7231; TTY (local): (301) 427–1130; Email: psa@AHRQ.hhs.gov.

SUPPLEMENTARY INFORMATION:

Background

The Patient Safety Act authorizes the listing of PSOs, which are entities or component organizations whose mission and primary activity is to conduct activities to improve patient safety and the quality of health care

delivery. HHS issued the Patient Safety Rule to implement the Patient Safety Act. AHRQ administers the provisions of the Patient Safety Act and Patient Safety Rule (PDF file, 450 KB. PDF Help) relating to the listing and operation of PSOs. The Patient Safety Rule authorizes AHRQ to list as a PSO an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be “delisted” if it is found no longer to meet the requirements of the Patient Safety Act and Patient Safety Rule, or when a PSO chooses to voluntarily relinquish its status as a PSO for any reason. Section 3.108(d) of the Patient Safety Rule requires AHRQ to provide public notice when it removes an organization from the list of federally approved PSOs. AHRQ has accepted a notification from Coalition for Quality and Patient Safety of Chicagoland (CQPS PSO), PSO number P0090, which is a component entity of Project Patient Care, Inc., to voluntarily relinquish its status as a PSO. Accordingly, the Coalition for Quality and Patient Safety of Chicagoland (CQPS PSO) was delisted effective at 12:00 Midnight ET (2400) on May 24, 2012.

More information on PSOs can be obtained through AHRQ's PSO Web site at <http://www.pso.AHRQ.gov/index.html>.

Dated: July 13, 2012.

Carolyn M. Clancy,
Director.

[FR Doc. 2012–17531 Filed 7–19–12; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Request for Information on Quality Measurement Enabled by Health IT

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

ACTION: Notice of Request for Information (RFI).

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) requests information from the Public, including diversified stakeholders (health information technology (IT) system developers, including vendors; payers, quality measure developers, end-users, clinicians, health care consumers) regarding current successful strategies and challenges regarding quality measurement enabled by health IT. Quality measurement—the assessment

of the timeliness, completeness and appropriateness of preventive services, diagnostic services, and treatment provided in health care—has been most generally conducted via paper chart information capture, manual chart abstraction, and the analysis of administrative claims data.

DATES: Submit comments on or before August 20, 2012.

ADDRESSES: Electronic responses are preferred and should be addressed to HIT-PTQ@AHRQ.hhs.gov. Non-electronic responses will also be accepted. Please send by mail to: Rebecca Roper, Agency for Healthcare Research and Quality, Attention: HIT-Enabled QM RFI Responses, 540 Gaither Road, Room 6000, Rockville, MD 20850, Phone: 301–427–1535.

FOR FURTHER INFORMATION CONTACT:

Please identify in the subject line of emails that you are inquiring about the “Question about HIT-enabled QM RFI”. Contact Angela Nunley, email: Armela.Nunley@AHRQ.hhs.gov, Phone: 301–427–1505, or, Rebecca Roper, email: Rebecca.ROPER@AHRQ.hhs.gov, Phone: 301–427–1535.

SUPPLEMENTARY INFORMATION:

Background

Health information technology (IT), such as, electronic health records (EHR) which may include clinical decision support and health information exchange, has seen a tremendous increase in adoption in recent years. Some institutions have successfully used health IT to generate health IT-enabled quality measures which may be retooled versions of established paper-based or administrative data-driven quality measures or (preferably) they are “de novo” quality measures that were developed with the capabilities of health IT in mind. These new health IT-enabled quality measures seek to leverage the use of electronic clinical data capture, analysis and reporting to measure and report electronically enabled quality measures in order to facilitate improvements in the quality of care provided. AHRQ supports research to improve health care quality through enhancements in the safety, efficiency, and effectiveness of health care available to all Americans. Through this RFI, AHRQ is seeking information related to successful strategies and/or remaining challenges encountered regarding the development of health IT-enabled quality measure development and reporting.

Health IT has the potential to advance quality measurement and reporting through the use of efficient automated data collection, analysis, processing,

and its ability to facilitate information exchange among and across care settings, providers, and patients. Quality measurement enabled by health IT, referred to as health IT-enabled quality measurement, is an emerging field. There are numerous perspectives on how to achieve the future state of quality measurement. These varied perspectives sometimes include competing choices and challenges: (1) Underdeveloped or unavailable infrastructure (e.g., whether the measure set should be extensive or parsimonious); (2) incompleteness of the measure set (e.g., developing measures that matter to consumers, how to measure value); and (3) technology challenges (e.g., how might unstructured data be captured in the EHR to be used for measurement, if and how to integrate patient-generated and clinician-generated data).

In preparation for the development of this RFI, AHRQ generated a high-level overview of the current state of quality measurement through health IT, challenges facing the advancement of quality measurement enabled by health IT, a partial catalog of current efforts seeking to address those challenges, and, possibilities for the next generation of health IT-enabled quality measurement. This report, "An environmental snapshot—Quality Measurement Enabled by Health IT: Overview, Possibilities, and Challenges" can be found at <http://healthit.AHRQ.gov/HealthITEnabledQualityMeasurement/Snapshot.pdf>.

AHRQ is committed to garnering further insight in order to facilitate meaningful advancements in the next generation of quality measurement. Through this Request for Information AHRQ is seeking information on the building blocks of health IT-enabled quality measurement in terms of perspectives, practicalities, and priorities. Responses will be used in conjunction with deliberative activities to inform the development of a summary report to be released to the public approximately in summer 2013.

Respondents should note that this Request for Information is completely voluntary; respondents are welcome to address as many of the questions posed as they wish. AHRQ would appreciate if you clearly indicate the number of the question area to which you are providing a response. This RFI is for planning purposes only.

Responses to this are not offers, cannot be accepted by the Government to form a binding contract, and are not intended to influence regulation.

Questions Regarding Quality Measurement Enabled by Health IT

1. Briefly describe what motivates your interest in clinically-informed quality measures through health information technology. To what extent is your interest informed by a particular role (e.g., provider, payer, government, vendor, quality measure developer, quality improvement organization, standards organization, consumer advocate) in this area?

2. Whose voices are not being heard or effectively engaged at the crucial intersection of health IT and quality measurement? What non-regulatory approaches could facilitate enhanced engagement of these parties?

3. Some quality measures of interest have been more difficult to generate, such as measures of greater interest to consumers, measures to assess value, specialty-specific measures, measures across care settings (i.e., measures enabled by health information exchange), and measures that take into account variations in risk. Describe the infrastructure that would be needed to ensure development of such measures.

4. What health IT-enabled quality measures, communication channels, and/or technologies are needed to better engage consumers either as contributors of quality information or as users of quality information?

5. How do we motivate measure developers to create new health IT-enabled quality measures (which are distinct from existing measures which were retooled into electronically-produced quality measures) that leverage the unique data available through health IT? Please provide examples of where this has been successfully. What new measures are in the pipeline to leverage data available through health IT?

6. Describe how quality measurement and "real-time" reporting could inform clinical activity, and the extent to which it could be considered synonymous with clinical decision support.

7. Among health IT-enabled quality measures you are seeking to generate in a reliable fashion, including the currently proposed Meaningful Use Stage 2 measure set, what types of advances and/or strategies for e-measure generation if pursued, would support more efficient generation of quality measures?

8. Many EHR, HIE, and other health IT vendors are developing software code to support measures. Tools such as the Measure Authoring Tool (MAT) were created to improve efficiencies in the process of creating and implementing eMeasures. What additional approaches

might be used to enable consistent, accurate, and efficient quality measurement when using health IT?

9. How do you see the establishment and adoption of data standards impacting the future of health IT-enabled quality measurement? For what types of quality measures should a combination of natural language processing and structured data be considered?

10. Much support has been voiced for the need of longitudinal data in quality measurement. What are the strengths and weaknesses of different information architectures and technologies to support health IT-enabled quality measurement across time and care settings? How can data reuse (capture once, use many times) be supported in different models? What examples might you provide of successful longitudinal health IT-enabled quality measurement (across time and/or across multiples care settings)?

11. What are the most effective means by which to educate providers on the importance of health IT-enabled quality measurement and how clinical information is used to support health IT-enabled quality measurement and reporting? How can providers be better engaged in the health IT-enabled quality measurement process?

12. What is the best way to facilitate bi-directional communication between vendors and measure developers to facilitate collaboration in health IT-enabled measure development?

13. To what extent do you anticipate adopting payment models that use quality measurement informed by electronic clinical records (as opposed to exclusively using claims data)? What strategies are you pursuing to gain access to clinical data and test the reliability of health IT-enabled clinical outcome measures? How do you anticipate sharing quality measure results with consumers and other stakeholders?

14. What tools, systems, and/or strategies has your organization been using to aggregate information from various EHRs and other health IT for use in quality measurement? What strategies is your organization pursuing to move toward greater automation in quality measurement?

15. Please describe scalable programs, demonstrations, or solutions (domestic or internationally) that show material progress toward quality measurement enabled by health IT.

Reference Material

Anderson KM, Marsh CA, Isenstein H, Flemming AC, Reynolds J. An Environmental Snapshot: Health IT-

enabled Quality Measurement: Efforts, Challenges, and Possibilities (Prepared by Booz Allen Hamilton, under Contract No. HHSA2902009000241.) AHRQ Publication No. 12-0061-EF. Rockville, MD: Agency for Healthcare Research and Quality. July 2012. See: <http://healthit.ahrq.gov/HealthITEnabledQualityMeasurement/Snapshot.pdf>

Dated: July 13, 2012.

Carolyn M. Clancy,
AHRQ Director.

[FR Doc. 2012-17530 Filed 7-19-12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Statement of Organization, Functions, and Delegations of Authority

Part F of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), (last amended at **Federal Register**, Vol. 76, No. 203, pp. 65197-65199, dated October 20, 2011) is amended to change the organizational title from the Office of Clinical Standards and Quality (OCSQ) to the Center for Clinical Standards and Quality. The organizational title change reflects the increasing breadth and importance of quality, patient safety, evidence-based coverage, and value-based purchasing programs. The administrative code is not changed and remains the same.

Part F., Section FC. 10 (Organization) is revised as follows:

Office of the Administrator (FC)
Office of Equal Opportunity and Civil Rights (FCA)
Office of Legislation (FCC)
Office of the Actuary (FCE)
Office of Strategic Operations and Regulatory Affairs (FCF)
Center for Clinical Standards and Quality (FCG)
Center for Medicare (FCH)
Center for Medicaid and CHIP Services (FCJ)
Center for Strategic Planning (FCK)
Center for Program Integrity (FCL)
Chief Operating Officer (FCM)
Office of Minority Health (FCN)
Center for Medicare and Medicaid Innovation (FCP)
Federal Coordinated Health Care Office (FCQ)
Center for Consumer Information and Insurance Oversight (FCR)
Office of Public Engagement (FCS)
Office of Communications (FCT)

Authority: 44 U.S.C. 3101)

Dated: July 11, 2012.

Marilyn Tavenner,
Acting Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

[FR Doc. 2012-17782 Filed 7-19-12; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Tribal TANF Data Report, TANF Annual Report, and Reasonable Cause/

Corrective Action Documentation Process-Final.

OMB No.: 0970-0215.

Description

42 U.S.C. 612 (Section 412 of the Social Security Act as amended by Pub. L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)), mandates that federally recognized Indian Tribes with an approved Tribal TANF program collect and submit to the Secretary of the Department of Health and Human Services data on the recipients served by the Tribes' programs. This information includes both aggregated and disaggregated data on case characteristics and individual characteristics. In addition, Tribes that are subject to a penalty are allowed to provide reasonable cause justifications as to why a penalty should not be imposed or may develop and implement corrective compliance procedures to eliminate the source of the penalty. Finally, there is an annual report, which requires the Tribes to describe program characteristics. All of the above requirements are currently approved by OMB and the Administration for Children and Families is simply proposing to extend them without any changes.

Respondents

Indian Tribes

ANNUAL BURDEN ESTIMATES

| Instrument | Number of respondents | Number of responses per respondent | Average burden hours per response | Total burden hours |
|---|-----------------------|------------------------------------|-----------------------------------|--------------------|
| Final Tribal TANF Data Report | 66 | 4 | 451 | 119,064 |
| Tribal TANF Annual Report | 66 | 1 | 40 | 2,640 |
| Tribal TANF Reasonable Cause/Corrective | 66 | 1 | 60 | 3,960 |
| Estimated Total Annual Burden Hours | | | | 125,664. |

Additional Information

Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be

identified by the title of the information collection. Email address: infocollection@acf.hhs.gov.

OMB Comment

OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment

is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Fax: 202-395-7285, Email: