- Change in dietary or nutrient intake (i.e., energy intake, saturated fat consumption)
- Adherence to treatment, including self-monitoring and medication

- Clinical outcomes
  - Glycemic control (Hemoglobin Alt)
  - Change in body composition (i.e., weight, Body Mass Index, waist circumference, % body fat)
  - Episodes of severe hypoglycemia
  - Treatment for hyperglycemia (ketoacidosis)
  - Control of blood pressure and lipids
  - Development or control of depression or anxiety
- Health outcomes
  - Quality of life (e.g., validated tools for health-related quality of life, life satisfaction, psychosocial adaptation to illness, patient satisfaction)
  - Development of micro- and macrovascular complications (i.e., retinopathy, nephropathy, neuropathy, cardiovascular outcomes)
  - Mortality (all-cause)
- Diabetes-related health care utilization
  - Hospital admissions
  - Length of stay in hospital
  - Emergency department admissions
  - Visits to specialist clinics
- Program acceptability as measured by participant attrition rates
- Harms from program as reported for studies
- Activity-related injury

Timing

Any length of followup

Study Design

Prospective comparative studies using a best evidence approach based on hierarchy of evidence: randomized controlled trials, nonrandomized controlled trials, prospective cohort studies, controlled before-after studies

Settings

- Community health setting (i.e., ambulatory care clinics, outpatient clinics, primary care clinics, family physician clinics, Community Health Centers, Rural Health Centers)
- United States or other high-income countries with a very high Human Development Index

Key Questions 5–6

Population

Adults (≥18 years) with T2DM who have undergone primary diabetes education

Interventions

- Multicomponent behavioral programs that include at least one of:
  - Diabetes self-management education; OR
  - Structured dietary intervention (related to any of weight loss, glycemic control, or reducing risk for complications) together with one or more additional components; OR
  - Structured exercise/physical activity intervention together with one or more additional components.
  - Additional components may include interventions related to: diet or physical activity, behavioral change (including but not limited to: Goal setting, problem solving, motivational interviewing, coping skills training, cognitive behavioral therapy strategies), relaxation or stress reduction, blood glucose awareness, medication adherence, or self-monitoring for diabetic complications (foot, eye, and renal tests).
- Repeated provision by one or more trained individuals
- Duration of intervention: Minimum 4 weeks

Comparators

- Usual or standard care or an active comparator (e.g., behavioral program or intervention) as reported for studies
- Delivery methods (personnel, intensity, communication methods etc.) as reported for studies

Outcomes

- Behavioral outcomes
  - Change in physical activity (e.g., volume of activity per week) or fitness (e.g., cardiorespiratory fitness, strength)
  - Change in dietary or nutrient intake (i.e., energy intake, saturated fat consumption)
  - Adherence to medication
- Clinical outcomes
  - Glycemic control (Hemoglobin Mc)
  - Change in body composition (i.e., weight, Body Mass Index, waist circumference, % body fat)
  - Control of blood pressure and lipids
  - Sleep apnea or sleep quality
  - Development or control of depression or anxiety
- Health outcomes
  - Quality of life (e.g., validated tools for health-related quality of life, life satisfaction, psychosocial adaptation to illness, patient satisfaction)
  - Development of micro- and macrovascular complications (i.e., retinopathy, nephropathy, neuropathy, cardiovascular outcomes)
  - Mortality (all-cause)
- Diabetes-related health care utilization
  - Hospital admissions
  - Length of stay in hospital
  - Emergency department admissions
  - Visits to specialist clinics
- Program acceptability as measured by participant attrition rates

Timing

Any length of followup

Study design

Randomized controlled trials

Settings

- Community health setting (i.e., ambulatory care clinics, outpatient clinics, primary care clinics, family physician clinics, Community Health Centers, Rural Health Centers)
- United States or other high-income country with a very high Human Development Index

Language

English

Dated: July 3, 2014.

Richard Kronick,

AHRQ Director.

[FR Doc. 2014–16669 Filed 7–18–14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Statement of Organization, Functions, and Delegations of Authority

Part E, Chapter E (Agency for Healthcare Research and Quality), of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services (61 FR 15955–58, April 10, 1996, most recently amended at 78 FR 38981, on June 28, 2013) is amended to reflect recent organizational changes. The specific amendments are as follows:

I. Under Section E–10, Organization, delete all components and replace with the following:

A. Office of the Director.

B. Center for Delivery, Organization, and Markets.

C. Center for Financing, Access, and Cost Trends.

D. Center for Evidence and Practice Improvement.

E. Center for Quality Improvement and Patient Safety.

F. Office of Communications and Knowledge Transfer.

G. Office of Extramural Research, Education, and Priority Populations.

H. Office of Management Services.

II. Under Section E–20, Functions, delete Center for Outcomes and Evidence (EJ) and Center for Primary Care, Prevention, and Clinical Partnerships (EK) in its entirety and replace with the following:

Center for Evidence and Practice Improvement (EK). Generates new knowledge, synthesizes evidence, translates science for multiple stakeholders, and catalyzes practice improvement. Specifically: (1) Conducts and supports evidence synthesis and research on health care delivery and improvement that is informed by the needs of patients, clinicians, and policy makers, including providing scientific, administrative and dissemination support for the U.S. Preventive Services Task Force; (2) advances decision and communication sciences and implementation research to facilitate informed treatment and health care decision making by patients and their health care providers and serving as a trusted source for evidence-based tools, decision aids, and other products about what works in health care and practice improvement; (3) explores how health information technology can improve clinical decision making and health care quality and helping Federal partners and health care stakeholders use this evidence; (4) catalyzes and sustains ongoing improvements in clinical practice across health care settings through research, demonstration projects, and partnership development; (5) operates the National Center for Excellence in Primary Care Research.

Division of the Evidence-Based Practice Center Program (EKB). Produces evidence syntheses by conducting systematic evidence reviews using robust and rigorous methodologies to advance the methods of evidence synthesis to ensure scientific rigor and unbiased reviews of evidence.

Division of U.S. Preventive Services Task Force Support (EKC). Provides scientific, administrative, and dissemination support for the independent U.S. Preventive Services Task Force, enabling the Task Force to make evidence-based recommendations on clinical preventive services.

Division of Decision Science and Patient Engagement (EKD). Provides evidence-based tools, decision aids, and other products that address what works in health care and practice improvement. Specifically: (1) Translates complex scientific evidence into tools and products targeted to diverse stakeholders that facilitate informed health care decision making and (2) engages with stakeholders to advance the field of evidence-based decision making to improve methods for engagement of all communities in health care decision making.

Division of Health Information Technology (EKE). Develops and disseminates evidence and evidence-based tools to inform policy and practice on how health information technology can improve the quality of health care.

Division of Practice Improvement Science and Implementation (EKF). Engages stakeholders and communities of learning for practice improvement, serves as a trusted resource of evidence and tools for methods, measures, and evaluation of practice improvement. Specifically: (1) Explores how to facilitate practice transformation and improvement in diverse settings and (2) pilots innovative models of practice improvement.

All delegations and redelegations of authority to officers and employees of the Agency for Healthcare Research and Quality that were in effect immediately prior to the effective date of this reorganization shall continue in effect pending further redelegation provided they are consistent with this reorganization.

These changes are effective upon date of signature.

Dated: July 9, 2014.

Richard Kronick,

AHRQ Director.

[FR Doc. 2014–17126 Filed 7–18–14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–14–14YK]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) has submitted the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The notice for the proposed information collection is published to obtain comments from the public and affected agencies.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address any of the following: (a) 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; (b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) Enhance the quality, utility, and clarity of the information to be collected; (d) 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 submission of responses; and (e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Written comments and/or suggestions regarding the items contained in this notice should be directed to the Attention: CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Information Collection on Cause-Specific Absenteeism in Schools—New—National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Global Migration and Quarantine (DGMQ), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Global Migration and Quarantine (DGMQ), requests approval of a new information collection to better understand the triggers, timing and duration of the use of school related measures for preventing and controlling the spread of influenza during the next pandemic.

The information collection for which approval is sought is in accordance with DGMQ/CDC's mission to reduce morbidity and mortality in mobile populations, and to prevent the introduction, transmission, or spread of communicable diseases within the United States. Insights gained from this information collection will assist in the