

Send comments to SAMHSA Reports Clearance Officer, 5600 Fisher Lane, Room 15E45, Rockville, MD 20852 OR email him a copy at samhsapra@samhsa.hhs.gov. Written comments should be received by October 15, 2024.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276-0361.

Comments are invited on: (a) whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection 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 on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: SAMHSA Certified Community Behavioral Health Clinic—Expansion (CCBHC-E) Grant Program Evaluation (OMB No. 0930-XXXX)—New Collection

In FY 2022, SAMHSA awarded two new cohorts of its CCBHC-Expansion program, one for clinics interested in becoming CCBHCs that need planning and support to come into compliance with CCBHC Certification Criteria, and another for established CCBHCs seeking to expand, improve, and advance their services. The purpose of the CCBHC-E grants is to address problems of access,

coordination, and quality of behavioral health care by establishing a standard definition and criteria for organizations certified as CCBHCs to ensure that all service recipients have access to a common set of comprehensive, coordinated services, with the ultimate goal of decreasing disparities in care and outcomes across communities.

SAMHSA is requesting clearance for eleven data collection instruments and forms related to the implementation and impact studies to be conducted as part of an evaluation of these cohorts. Data collected in this evaluation will help SAMHSA assess the degree to which activities at the clinic level and systems level affect the development, implementation, and sustainment of CCBHCs consistent with the certification criteria and the impacts of model adoption on client outcomes.

1. SAMHSA has developed a grantee web survey that will be administered twice to all 298 grant project directors, once during a first option year and again during a third option year. The survey consists of 76 questions the first time it is administered and 68 questions the second time it is administered. The survey includes mostly binary or multiple-choice response options and a limited number of open-ended questions. The survey will enable respondents to complete the data collection instrument at a location and time of their choice, and its built-in editing checks and programmed skips will reduce response errors. SAMHSA estimates the web survey will take no more than 45 minutes to complete and expects a 100 percent response rate, for a total of 298 completed grantee surveys at each time of administration. Grantees will provide valuable insights into their experience with the CCBHC model; if they are not conducted, SAMHSA will not have adequate information to evaluate the extent to which Planning, Development, and Implementation (PDI) grantees come into full compliance with the certification criteria and Improvement and Advancement (IA) grantees sustain the model in a manner that is consistent with the CCBHC certification criteria.

2. SAMHSA has developed a protocol for annual interviews with all 26 grantee Government Project Officers (GPOs) during three option years. Interviews will last approximately one hour and focus on the types of support grantees need to successfully implement the model in the future and identify specific components of the certification criteria that were challenging for grantees to implement. SAMHSA will offer to conduct individual interviews or meet

with groups of GPOs during regularly scheduled meetings. GPOs will provide valuable insights into CCBHC model implementation and factors that facilitate or impede implementation; if they are not conducted, SAMHSA will not glean essential insights into contextual factors that affect implementation of the CCBHC model, including adaptations grantees make to the model to align with their local service delivery system, grantee characteristics that might contribute to successful implementation, and the types of support grantees need to successfully implement the model in the future and the specific components of the certification criteria that were challenging for grantees to implement.

3. SAMHSA has developed a protocol for interviews with representatives from 50 organizations that support adults, youth, and family members with lived experience over the course of the first three option years. Interviews will last approximately one hour. State consumer, youth, and family member organizations will provide valuable insights into their own involvement in the planning and development of the model in respective states, and the perspectives of adults and youth who received CCBHC services and their families on various aspects of the CCBHC model; if they are not conducted, SAMHSA will not adequately understand how these organizations contributed to the planning and development of the model, how CCBHCs tailored services to the diverse needs of communities, and how people with lived experience might refine the model to fill gaps in care.

4. SAMHSA has developed a protocol for interviews with a sample of 120 grantee project directors during option years 1 and 3 (*i.e.*, approximately 60 interviews in each year). Interviews will last approximately one hour. Grantees will provide valuable insights into CCBHC model implementation nuances that cannot be captured via the grantee survey alone; if they are not conducted, SAMHSA will not adequately understand how grantees initially plan to use funding to develop or improve CCBHC program-specific activities in response to the community needs assessment, and successes and challenges expanding services and increasing access to care, and how they eventually progress toward meeting the goals of Continuous Quality Improvement (CQI) efforts and plans for sustainability.

5. SAMHSA has developed a protocol for interviews with clinic leadership from a sample of 50 strategically selected grantees for site visits during the first three option years. Positions of leadership include project directors, medical directors, and/or quality improvement directors. Interviews will last approximately one hour. Clinic leaders will provide valuable insights into understanding their experiences and perspectives as they implement the CCBHC model; if they are not conducted, SAMHSA will not adequately understand the more granular, on-the-ground impacts of model implementation.

6. SAMHSA has developed a protocol for interviews with frontline clinic staff from a sample of 50 strategically selected grantees for site visits. Clinic staff positions include mental health and substance use providers, case managers, and peer mentors/support personnel. Interviews will last approximately one hour. Clinic staff will provide valuable insights into understanding their experiences and perspectives as the site implements the CCBHC model; if they are not conducted, SAMHSA will not adequately understand the impacts of model implementation from the perspective of the clinic staff.

7. SAMHSA has developed a protocol for interviews with representatives of CCBHC partners from a sample of 50 strategically selected grantees for site visits, including designated collaborating organizations (DCOs) and

Opioid Treatment Programs (OTPs). Interviews will last approximately one hour. Clinic partner organizations will provide valuable insights into understanding their experiences and perspectives; if they are not conducted, SAMHSA will not adequately understand how partnerships with DCOs and OTPs function, how care is coordinated between entities, and how CCBHCs maintain clinical responsibility for DCO services.

8. SAMHSA has developed a protocol for focus groups with people 18 and older who receive CCBHC services from a sample of 50 strategically selected grantees for site visits. Focus groups will last approximately one hour and consist of 8–10 adult clients, who will provide valuable insights into understanding their experience of CCBHC services; if they are not conducted, SAMHSA will not be able to adequately synthesize and present similar or different perspectives among diverse stakeholders from a common clinic.

9. SAMHSA has developed a protocol for focus groups with people under 18 who receive CCBHC services. Focus groups will last approximately one hour and consist of 8–10 youth clients, who will provide valuable insights into understanding their experience of CCBHC services; if they are not conducted, SAMHSA will not be able to adequately synthesize and present similar or different perspectives among diverse stakeholders from a common clinic.

10. SAMHSA has developed a protocol for focus groups with parents and caregivers of youth who receive CCBHC services. Focus groups will last approximately one hour and consist of 8–10 parents and caregivers of youth clients, who will provide valuable insights into understanding their experience of CCBHC services; if they are not conducted, SAMHSA will not be able to adequately synthesize and present similar or different perspectives among diverse stakeholders from a common clinic.

11. SAMHSA has developed a protocol for in-person interviews with a sample of clients who receive CCBHC services. The interview consists of 33 questions and will take place on no more than three occasions at the same time as National Outcome Measures (NOMs) data collection. Interviews will last approximately 15 minutes. If they are not conducted, the evaluation team will not have adequate information to evaluate longitudinal changes in client-level outcomes pertaining to substance use, mental health symptomology and functioning, and recovery, as these dimensions are not captured in the NOMs data with sufficient sensitivity to detect change over time. It is essential to obtain information directly from the clients of CCBHC services to understand how implementation of the model affects their access to care and experiences with care.

The estimated response burden is as follows:

Type of respondent	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours	Average hourly wage	Total hour cost burden ^a
Grantee survey	298	2	0.75	447	\$59.07	\$26,404.29
GPO interviews	26	3	1	78	45.85	3,576.30
Consumer & family member organization interviews	50	1	1	50	29.14	1,457.00
Grantee phone/virtual interviews	120	1	1	120	59.07	7,088.40
Clinic leadership interviews	^b 150	1	1	150	59.07	8,860.50
Clinic staff interviews	^c 250	1	1	250	49.19	12,297.50
Clinic partner interviews	^d 150	1	1	150	61.26	9,189.00
Adult client focus groups	^e 500	1	1	500	22.26	11,130.00
Youth client focus groups	^f 400	1	1	400	N/A	N/A
Parents/caregivers of youth clients focus groups	^g 400	1	1	400	22.26	8,904.00
Client interview	45,700	3	0.25	34,275	22.26	762,961.50
Total	^h 47,999	36,820	851,868.50

^a Total respondent cost is calculated as number of respondents × number of responses per respondent × average burden per response in hours × average hourly wage.

^b 3 respondents per site × 50 site visits = 150 total respondents.

^c 5 respondents per site × 50 site visits = 250 total respondents.

^d 3 respondents per site × 50 site visits = 150 total respondents.

^e 10 respondents per site × 50 site visits = 500 total respondents.

^f 8 respondents per site × 50 site visits = 400 total respondents.

^g 8 respondents per site × 50 site visits = 400 total respondents.

^h Estimated number of total unique respondents; some respondents, such as project directors, will overlap across the data collection activities.

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Proposed Project: SAMHSA Unified Client-Level Performance Reporting Tool (SUPRT)—(OMB No. 0930-NEW)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA is seeking approval for the new SAMHSA Unified Client-level Performance Reporting Tool (SUPRT) to modify the existing Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) Client-Level Performance Instruments into a

streamlined, multi-component SAMHSA Client-Level Performance Tool. Currently, over 7,500 grantees across a range of prevention, harm reduction, treatment, and recovery support discretionary grant programs report program performance data into SAMHSA's Performance Accountability and Reporting System (SPARS) that serves as a central data repository. SPARS also functions as a performance management system that captures information on the substance use and mental health services delivered via the range of SAMHSA's discretionary grants. SAMHSA has historically required grantees to collect much of the client-level information in SPARS using a prescribed series of questions in long complex instruments. This is not the totality of data tools SAMHSA uses, however, to collect performance data on its discretionary grant programs. SAMHSA uses data collected, depending on the grant program, at the client-level, but also through aggregate program performance tools, required narrative performance progress reports, or a combination of these. This notice informs the public of SAMHSA's intent to develop and implement a new streamlined client-level performance tool that will allow SAMHSA to continue to meet Government Performance and Results Modernization Act (GPRAMA) of 2010 reporting requirements, reduce the scope and associated burden of questions requiring responses directly from clients, and limit the amount of client-level detail reported by grantees.

The proposed new client-level performance tool will involve streamlining questions from the currently used client-level performance reporting tools, as well as incorporating select new measures/questions into a multi-component client-level tool. With this change, SAMHSA will provide guidance specifying which items SAMHSA expects grantees to ask directly of clients and those for which grantees may use alternate data sources for gathering and reporting client-level data. This new, streamlined client-level performance tool will reduce client and grantee reporting burden and enhance consistency of the collected performance data. This tool also reflects diverse stakeholder feedback SAMHSA obtained through multiple listening sessions conducted with key stakeholders and will incorporate findings of cognitive testing to improve clarity of the measures. This performance tool will align with, and strengthen, SAMHSA's complementary evaluation activities of its discretionary

grant programs providing client services.

SAMHSA will use the data collected through the new streamlined client-level performance tool for both annual reporting required by GPRAMA, grantee monitoring, and continuous improvement of its discretionary grant programs. The information collected through this process will allow SAMHSA to (1) monitor and report on implementation and overall performance of the associated grant programs; (2) advance SAMHSA's proposed performance goals; and (3) assess the accountability and performance of its discretionary grant programs, focused on efforts that promote mental health, prevent substance use, and provide treatments and supports to foster recovery.

Through the proposed new, streamlined single client-level performance tool, SAMHSA seeks to (1) improve the utility of client-level performance tools while decreasing burden; (2) standardize and utilize tested questions across programs wherever possible; and, (3) elicit programmatic information that helps inform the impact of discretionary grant programs on the achievement of SAMHSA's Strategic Priority Area goals and objectives (<https://www.samhsa.gov/about-us/strategic-plan>). Furthermore, this effort is designed to align performance reporting requirements with the measurement activities of other federal agencies (e.g., the Centers for Medicare & Medicaid Services; the Centers for Disease Control and Prevention; the U.S. Census Bureau; the Office of Management and Budget; etc.) to the extent possible. To meet these goals, data from the new client-level performance tool for SAMHSA's discretionary grants can be used to delineate who is served, how they are served, what services they receive, and how the program impacts the progress of clients in terms of mental health and substance use issues. The tool reflects SAMHSA's goals to elicit pertinent program data that can be used to inform current and future programs and practices and respond to stakeholders, congressional, and other agency inquiries.

The proposed structure of the new tool will be one that is streamlined and multi-component with client-level information collected and reported at varying frequencies. The first component will be composed of standardized questions about demographic information (asked directly of clients at baseline only) and social determinants of health (asked directly of clients at baseline and