proportionate to the national distribution of homes in each category.

All employees, contractors and agency staff in all job classes in nursing homes with up to 200 employees will be asked to respond to the survey. In nursing homes with more than 200 employees, a random sample of 200 employees will be selected. Since not all nursing home staff have access to or are familiar with e-mail or the internet, paper surveys will be administered. Standard non-response follow-up techniques such as reminder postcards and distribution of a second survey will be used. Individuals and organizations contacted will be assured of the confidentiality of their replies under Section 924(c) of the Healthcare Research and Quality Act of 1999.

Estimated Annual Respondent Burden

The survey will be distributed to approximately 5,500 nursing home employees, with a target response rate of 70%, or 3,850 returned surveys. Respondents should take approximately 15 minutes to complete the survey. Therefore, we estimate that the respondent burden for completing the survey will be 963 hours (3,850 completes multiplied by 0.25 hours per completed survey).

Type of respondent	Number of respondents	Number of responses per respondent	Estimated time per respondent (hours)	Estimated total respondent burden hours
Nursing home staff member	3,850	1	0.25	963

Estimated Annual Costs to the Federal Government

The total cost to the Government for developing this survey is approximately $319,000, and is being funded solely by AHRQ. This estimate includes the costs of a background literature review, survey development, cognitive testing, pilot data collection, data analysis, and preparation of final deliverables and reports.

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of infomation is necessary for the proper performance of AHRQ health care research and health care 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 period.

Dated: January 23, 2007.

Carolyn M. Clancy,

Director.

[FR Doc. 07–573 Filed 2–12–07; 8:45am]

BILLING CODE 4160–90–M

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, Department of Health and Human Services.

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) allow the proposed information collection project: ''Development of an Electronic System for Reporting Medication Errors and Adverse Drug Events in Primary Care Practice (MEADERS).'' In accordance with the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C., 3506(c)(2)(A)), AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on December 12th, 2006 and allowed 60 days for public comment. No public comments were received. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by March 15, 2007.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, 540 Gaither Road, Room #5036, Rockville, MD 20850, or 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 AHRQ's Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ, Reports Clearance Officer, (301) 427–1477

SUPPLEMENTARY INFORMATION:

Proposed Project

''Development of an Electronic System for Reporting Medication Errors and Adverse Drug Events in Primary Care Practice (MEADERS)''

The project is being conducted in response to an AHRQ RFP entitled ''Resource Center for Primary Care Practice-Based Research Networks (PBRNs)'' (issued under Contract 290–88–0008).

In response to a proposed modification to AHRQ contract no. 290.02.0008, the PBRN Resource Center is proposing to assist AHRQ in its continued commitment to assessing the status and capabilities of its funded PBRNs and making available to them the tools and resources necessary to improve the quality of care they provide. Through the modification of this contract, the PBRN Resource Center will develop and make available an electronic system for reporting medication errors and adverse drug events that occur in outpatient physician practices of selected PBRNs to their own practices for quality improvement purposes and to the Food and Drug Administration (FDA).

The landmark Harvard Medical Practice Study was published in 1991 and stated that 98,000 Americans die each year from medical errors.[1] Although the exact figure has been disputed, no one disputes the fact that too many Americans are injured unnecessarily by medical mistakes that could be avoided.[2–3] Another study performed by the Department of Veterans Affairs suggests that in one out of every 10,000 hospitalizations, a patient dies due directly to a medical error.[4]

In response to the growing concern over medical errors, the Agency for Healthcare Research and Quality (AHRQ) has published three important monographs outlining the problems of errors,[5] their effects on the quality of care,[6] and offering suggestions on improving patient safety.[7] The first recommendation of this third monograph was ''*capture information on patient safety—including both adverse events and near misses—as a byproduct of care, and use this information to design even safer care delivery systems.*'' One central theme to each of these monographs is that there simply is too much chaotic information flowing in the medical environment for a single provider to handle effectively. Therefore, solutions to the problem of medical errors should include some combination of health information technology and redesign of health care systems to enhance the prevalence of appropriate decisions (i.e., avoiding errors of omission) and reduce the occurrence of avoidable mistakes (i.e., avoiding errors of commission).

A recent conference sponsored by AHRQ highlighted interventions to improve medical decision-making and reduce medical errors.[8] Most of the interventions presented were based in hospitals, where the most intensive and immediately life-threatening events occur. Yet the majority of medical decisions are made in outpatient practices and offices where there has been little error-reduction research performed. Further, most outpatient studies have been performed in academic medical centers which have capabilities, providers, and patients that may not typify the average U.S. medical practice.[9]

With the recent passing of the Patient Safety and Quality Improvement Act of 2005, 42 USC 299b–21–b–26, now is an opportune time to evaluate a primary care error reporting system and PBRNs are an ideally suited place to study interventions aimed at reporting and reducing medical errors. In most primary care practices there is no mechanism in place to report medical errors as they occur. We propose to develop, implement, and study an outpatient error reporting system to better understand the ability of physicians to identify their own errors and their willingness to report them to their own practices and the FDA and AHRQ. We will focus on the most common invasive intervention invoked in outpatient practice—drug treatment of acute and chronic conditions—and will create and test a paper- and computer-based system for both capturing medication errors and reporting adverse drug events, which are also under-reported.[10]

The fundamental objective is to utilize the Resource Center's expertise in health information technology and its working relationships with PBRNs to support AHRQ's objectives in developing and evaluating systems for reporting medication errors and adverse drug events in primary care. We will accomplish this objective through (1) developing and implementing an electronic and paper-based outpatient medication error and adverse event reporting system, (2) evaluating the usefulness, ease of use, and actual use of the system in everyday clinical practices, and (3) identifying patient, provider, and practice characteristics that predict uptake and use of this system in participating primary care practices.

Methods of Collection

The value of MEADERS to practicing primary care clinicians will be illustrated by performing demonstration implementations in two PBRNs. A PBRN is a group of clinicians working together, either locally or nationally, to conduct research and implement research findings into practice settings. A total of 45 physicians and their practice staff will participate in the field test in addition to completing baseline surveys of their practice.

A request for proposals will be sent to all PBRNs that have registered with the PBRN Resource Center. A review committee consisting of a selection of four expert panel members, one or two PBRN representatives, and some members of the PBRN Resource Center will evaluate the applications. The AHRQ Project Officer will chair the review committee and, together with PBRN Resource Center staff, develop a set of review criteria. The review committee will make recommendations to the PBRN Resource Center who will make the final determination of participating PBRNs. Once the PBRNs are selected, each PBRN will chose up to three of its affiliated practices to participate in this trial. Although initial participation by a practice is voluntary, once selected the practice must provide assurances that at lease three to five clinicians will agree to use the system and that the practice will support the project.

The PBRN Resource Center will develop a series of surveys to capture data describing the practice and the patients it serves, the extent of the error reporting system's use, and an assessment of the users' overall satisfaction with the system. Practice and provider information will be collected at baseline along with characteristics that could be facilitators (such as an electronic medical record system) or barriers (such as lack of time and resources needed to report information) to implementation of the MEADER system. Data collected on the system's use will include the number of clinicians who have used MEADERS at least once, the number of times used overall, the time it takes to enter data into the electronic MEADERS, and the types of medication errors and adverse drug events that are being reported. Both the paper and electronic versions of the system will be assessed at the conclusion of the evaluation period. The follow-up assessment will include clinicians' and managers' satisfaction with the system (e.g., ease of use, usefulness of the generated reports and individual feedback) and whether they intend to continue its use after the initial study period has concluded. Finally, semi-structured interviews and conference call discussions will be used to collect additional comments and suggestions for future implementation of MEADERS.

Although any clinician in the practice will be able to use the system, physicians are likely to be the primary users of the system. The Resource Center is estimating that physicians will account for about 80% of MEADERS use and Nurse Practitioners, Physician Assistants and Medical Assistants will make up the remainder (See Exhibit 1). The time for entering an event into the system is estimated to require no more than 8 minutes of a clinician's time.

Wherever possible, existing validated measures will be used. Where validated measures do not exist, new measures will be developed and assessed. The final instruments will be field tested within selected practices in the PBRNs chosen to participate in the implementation study.

Estimated Annual Respondent Burden

EXHIBIT 1.—ESTIMATE OF COST BURDEN TO RESPONDENTS

Date collection effort	Number of responses*	Estimated time per respondent in hours	Estimated total burden hours	Average hourly wage rate** ($)	Estimated annual cost burden to respondents ($)
Office Manager baseline survey	45	0.25	11.25	$34.67	$390.04
Physician baseline survey	45	0.25	11.25	57.90	651.38
Physician opinion survey of system	45	0.25	11.25	57.90	651.38
Physician entry of medication error	216	0.134	28.94	57.90	1675.63
Nurse opinion survey of system	45	0.25	11.25	27.35	307.69
Nurse entry of medication error	18	0.134	2.4	27.35	65.64
PA/NP opinion survey of system	45	0.25	11.25	34.17	384.41
PA/NP entry of medication error	18	0.134	2.4	34.17	82.00
Medical assistant survey of system	45	0.25	11.25	12.58	141.53
Medical assistant entry of medication error	18	0.134	2.4	12.58	30.19
Office Manager opinion-survey of system	45	0.25	11.25	34.67	390.04
Total	585	.....	114.89	.....	4769.93

*Based on a six month trial period of MEADER reporting.
**Based upon the mean of the average wages, National Compensation Survey: Occupational wages in the United States 2004, ''U.S. Department of Labor, Bureau of Labor Statistics.''

This information collection will not impose a cost burden on the respondent beyond that associated with their time to provide the required data. There will be no additional costs for capital equipment, software, computer services, etc.

Estimated Costs to the Federal Government

The total cost to the government for this activity is estimated to be $1,000,000.00.

Request for Comments

In accordance with the above-cited legislation, 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 health care research and information dissemination functions of AHRQ, 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 request for OMB approval of the proposed information collection. All comments will become a matter of public record.

References

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[9] Green LA, Fryer GE, Yawn BP, Lanier D, Dovey SM: The ecology of medical care revisited. N Engl J Med 2001; 344:2021–2025.

[10] Uribe CL, Schweikhart SB, Pathak DS, Dow M, Marsh GP. Perceived barriers to medical-error reporting: an exploratory investigation. J Healthcare Management. 2002; 47(4):263–79.

Dated: January 30, 2007.

Carolyn M. Clancy,

Director.

[FR Doc. 07–574 Filed 2–12–07; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day–07–05CJ]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 371–5960 or send an e-mail to *omb@cdc.gov*. Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project

Colorectal Cancer Screening Demonstration Program—New—National Center for Chronic Disease Prevention and Health Promotion (NCDDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) is seeking a 3-year Office of Management and Budget (OMB) approval to collect individual patient-level screening, diagnostic, and treatment data in association with a new colorectal cancer screening demonstration program. CDC funded 5 cooperative agreements in fiscal year