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: March 19, 2010.

Carolyn M. Clancy,

Director.

[FR Doc. 2010–6776 Filed 3–30–10; 8:45 am]

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, 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: "Reductions of Infection Caused by Carbapenem Resistant Enterobacteriaceae (KPC) Producing Organisms through the Application of Recently Developed CDC/HICPAC Recommendations." In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3520, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by June 1, 2010.

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

Reductions of Infection Caused by Carbapenem Resistant Enterobacteriaceae (KPC) Producing Organisms Through the Application of Recently Developed CDC/HICPAC Recommendations

Healthcare Acquired Infections (HAIs) caused almost 100,000 deaths among the 2.1 million people who acquired infections while hospitalized in 2000, and HAI rates have risen relentlessly since then. On March 20, 2009, the Centers for Disease Control (CDC) and the Healthcare Infections Control Practices Advisory Committee (HICPAC) developed infection control (IC) guidance for Klebsiella pneumonia carbapenemase-producing (KPC) isolates, as they have been rapidly emerging as a significant challenge in healthcare settings. The danger of these bacteria is that they are resistant to carbapenem (a class of beta-lactam antibiotics with a broad spectrum of antibacterial activity) and cannot be treated by the most commonly prescribed antibiotics. Limited treatment options mean that infections caused by carbapenem resistant bacteria result in substantial mortality and morbidity.

The CDC and HICPAC recommendations draw on infection control strategies which have been applied to these pathogens in other settings, and other evidence based strategies in infection control. There has been little research, however, on the implementation of control strategies to prevent the spread of these KPC infections. The goal of this project is to understand how these recommendations can best be implemented and how effective these recommendations will be in practice. This research will advance private and public efforts to improve health care quality by improving measures to control the spread of a dangerous organism. This research will also provide data for the development of an implementation toolkit that hospitals can use to prevent the spread of carbapenem resistant bacteria. The toolkit may include the following types of resources: General information about the implementation of evidenced-based clinical practices, resource materials, and tools and methods that users can adopt to conduct point prevalence surveys, protocols and tools that users can adopt to specify when active KPC surveillance is needed, and resources for approaching the problem as a team-based quality-improvement effort.

OMB clearance will be sought for this toolkit once it is developed.

This study is being conducted by AHRQ through its contractor, Boston University, 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 quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

Method of Collection

This project will include the following data collections from the intensive care unit (ICU) staff within each of three participating hospitals:

(1) Pre-intervention focus groups will be conducted separately with managers and staff. The purpose of these focus groups is to identify potential problems in the implementation that can be addressed through various means (*e.g.,* additional education, other changes in process). Another purpose is to understand the existing approach to quality improvement, the connection(s) between overall approach to quality improvement and to KPC infection control practices, current practices at the hospital of quality reporting and accountability, and constraints and obstacles to quality improvement as seen in their roles. Staff members identified for the focus groups will be those with the most first-hand knowledge of existing quality improvement efforts, and KPC infection control practices.

(2) Clinical staff survey. Factors identified in the pre-intervention focus groups will be used to inform the development of a self-administered survey of staff knowledge of and attitudes toward KPC surveillance and infection control procedures. Respondents will be health care workers on the units where these new guidelines have been implemented. Findings from the survey will be used to assess barriers perceived by the staff, potential differences across units, and potential differences by employee/occupational group.

(3) Post-intervention focus groups (6 months after implementation of new KPC IC guidelines) will be conducted separately with managers and staff. The purpose of these focus groups is to identify actual problems experienced in the initial implementation and possible measures to address, and to identify successful practices to include in a toolkit that hospitals can use to implement the CDC and HICPAC recommendations.

In addition to developing a toolkit, AHRQ plans to disseminate the lessons

learned from this project about how hospitals can best implement the CDC guidance for KPC screening and infection control, in order to inform efforts to change practice in this area.

Estimated Annual Respondent Burden

The estimated annualized burden hours for respondents to participate in this two year research project are presented in Exhibit 1. Pre-intervention focus groups with clinical staff will be conducted with 18 staff members (an average of 9 per year for 2 years) from each of the 3 participating hospitals and will take about 1 hour. Pre-intervention focus groups with also be conducted with 2 managers (an average of 1 per year for 2 years) from each hospital and will take about an hour to complete.

The clinical staff survey will be administered to 20 clinical staff (an average of 10 per year for 2 years) from each hospital and will take 15 minutes to complete.

Finally, respondents from the pre-intervention focus groups will participate in post-intervention focus groups approximately four months after the initiation of the intervention. They will not last more than an hour each. The total annualized burden hours are estimated to be 68 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this research. The total annualized cost burden is estimated to be $3,108.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Data collection	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Pre-intervention focus groups with clinical staff *	3	9	1	27
Pre-intervention focus groups with managers *	3	1	1	3
Clinical staff survey	3	10	15/60	8
Post-intervention focus groups with clinical staff *	3	9	1	27
Post-intervention focus groups with managers *	3	1	1	3
Total	15	n/a	n/a	68

* Individuals that cannot attend the focus groups will be interviewed one-on-one. Clinical staff includes IC leaders, QI team members and unit staff. Managers include the chief nursing officer and chief medical officer.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Data collection	Number of respondents	Total burden hours	Average hourly wage rate	Total cost burden
Pre-intervention focus groups with clinical staff	3	27	* $36.73	$992
Pre-intervention focus groups with managers	3	3	** 138.38	415
Clinical staff survey	3	8	* 36.73	294
Post-intervention focus groups with clinical staff	3	27	* 36.73	992
Post-intervention focus groups with managers	3	3	** 138.38	415
Total	15	68	na	3,108

* Based upon the mean hourly wage for Registered Nurses in Nassau and Suffolk County, NY as reported by the Bureau of Labor Statistics in May 2008.

** Based on report of a private survey of HR departments conducted in November 2009 in New York, NY published by *http://www.salary.com;* 3 chief nursing officers at $101.14/hr and 3 chief medical officers at $175.61/hour.

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the annualized and total cost to the federal government for this two year research project. Project development covers steps taken to revise the research plan and begin implementation. The total cost is estimated to be $500,001.

EXHIBIT 3—ANNUALIZED AND TOTAL COST TO THE FEDERAL GOVERNMENT

Cost component	Annualized cost	Total cost
Project Management	$125,526	$251,052
Project Development	54,622	109,244
Data Collection Activities	41,864	83,728
Travel	4,000	8,000
Overhead	23,754	47,507
Total	250,001	500,001

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 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: March 19, 2010.

Carolyn M. Clancy,

Director.

[FR Doc. 2010–6778 Filed 3–30–10; 8:45 am]

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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: "Collection of Information for Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey Comparative Database." In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3520, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on January 25th, 2010 and allowed 60 days for public comment. No 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 April 30, 2010.

ADDRESSES: Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by e-mail at *OIRA_submission@omb.eop.gov* (*attention:* AHRQ's desk officer).

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.letkowitz@AHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Collection of Information for Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Comparative Database

The Agency for Healthcare Research and Quality (AHRQ) requests that the Office of Management and Budget (OMB) approve, under the Paperwork Reduction Act of 1995, AHRQ's collection of information for the AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Database for Health Plans. The CAHPS Health Plan Database consists of data from the AHRQ CAHPS Health Plan Survey.

Health plans in the U.S. are asked to voluntarily submit data from the survey to AHRQ, through its contractor, Westat. The CAHPS Database was developed by AHRQ in 1998 in response to requests from health plans, purchasers, and the Centers for Medicare & Medicaid Services (CMS) to provide comparative data to support public reporting of health plan ratings, health plan accreditation and quality improvement.

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. The development of the CAHPS Health Plan Survey began in 1995, when AHRQ awarded the first set of CAHPS grants to Harvard, RTI, and RAND. In 1997 the CAHPS 1.0 survey was released by the CAHPS Consortium. The CAHPS Consortium refers to the research organizations involved in the development, dissemination, and support of CAHPS products. The current Consortium includes AHRQ, CMS, RAND, Yale School of Public Health, and Westat.

Since that time, the Consortium has clarified and updated the survey instrument to reflect field test results; feedback from industry experts; reports from health plan participants, data collection vendors, and other users; and evidence from cognitive testing and focus groups. In November 2006, the CAHPS Consortium released the latest version of the instrument: The CAHPS Health Plan Survey 4.0. The development of this update to the Health Plan Survey has been part of the "Ambulatory CAHPS (A–CAHPS) Initiative," which arose as a result of extensive research conducted with users. AHRQ released the CAHPS Health Plan Survey 4.0, along with guidance on how to customize and administer it. The National Quality Forum endorsed the 4.0 version of the Health Plan Survey in July 2007.

The CAHPS Health Plan Database uses data from AHRQ's standardized CAHPS Health plan survey to provide comparative results to health care purchasers, consumers, regulators and policy makers across the country. The Database also provides data for AHRQ's annual National Healthcare Quality and National Healthcare Disparities Reports. Voluntary participants include public and private employers, State Medicaid agencies, State Children's Health Insurance Programs (SCHIP), CMS, and individual health plans.

The collection of information for the CAHPS Database for Health Plans is being conducted pursuant to AHRQ's statutory authority to conduct and support research on health care and systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of health care services. *See* 42 U.S.C. 299a(a)(1).

Method of Collection

Information for the CAHPS Health Plan Database has been collected by AHRQ through its contractor Westat on an annual basis since 1998. Health plans are asked to voluntarily submit their data to the comparative database in June of each year. The data are cleaned with standardized programs, then aggregated and used to produce comparative results for commercial (adult and child), Medicaid (adult and child), and Medicare (adult) populations for the two most recent years. In addition, individual participant reports are produced that display the participating organizations' own results compared to appropriate comparisons derived from the National, regional and product-type distributions on a password-protected section of the online reporting system.

The CAHPS Health Plan Database receives the data from three sources. First, commercial health plan data is purchased by the CAHPS Health Plan Database directly from the National Committee for Quality Assurance (NCQA). The data is collected by NCQA from those who participate in its accreditation program. Second, Medicare data is provided by CMS through an agency data use agreement. The Medicare data is collected by CMS