formulating, monitoring, and evaluating ASPR budgets and financial plans that support program activities and ensures the effective and efficient execution of ASPR financial resources. OFPA has administrative oversight of the Administration & Finance section of the emergency management group that is activated under ESF 8 of the NRF during a public health emergency. On behalf of the ASPR, OFPA serves as the primary point of contact with the Office of the Assistant Secretary for Financial Resources, the Office of Management and Budget (OMB) and Congressional Appropriation Committees. In compliance with OMB Circular A–123, FPA ensures accountability and effectiveness of ASPR's financial programs and operations by establishing, assessing, correcting, and reporting on internal controls.

The Office of Financial Planning and Analysis is headed by a Director and includes the following components:

- Division of Budget Formulation and Execution (ANF1)
- Division of Requisition Services (ANF2)
- Division of Management Assurance (ANF3)
- Division of Administration and Finance (ANF4)

II. Delegations of Authority. All delegations and redelegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further redelegation, provided they are consistent with this reorganization.

Dated: June 14, 2010.

E.J. Holland, Jr.,

Assistant Secretary for Administration.

[FR Doc. 2010–14997 Filed 6–18–10; 8:45 am]

BILLING CODE 4150–37–P

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: "Avoiding Readmissions in Hospitals Serving Diverse Patients." 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 August 20, 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

Avoiding Readmissions in Hospitals Serving Diverse Patients

An important part of AHRQ's mission is to disseminate information and tools that can support improvement in quality and safety in the U.S. health care community. The transition process from the hospital to the outpatient setting is nonstandardized and frequently inadequate in quality. One in five hospital discharges is complicated by an adverse event (AE) within 30 days, often leading to an emergency department visit and/or rehospitalization. Many readmissions stem from errors that can be directly attributed to the discontinuity and fragmentation of care at discharge. High rates of low health literacy, lack of coordination in the "hand-off' from the hospital to community care, gaps in social supports, and other limitations also contribute to the risk of rehospitalization.

Boston University Medical Center (BUMC), through a grant from AHRQ, previously defined the discharge process and determined what improvements could be made to improve this care transition for patients. This new process was called the "re-engineered discharge" (RED). The RED consists of 11 elements, including educating the patient throughout the hospital stay, making follow-up appointments, and giving the patient a written discharge plan. The RED was tested in a randomized controlled trial in an academic safety net hospital at BUMC with English speaking, general medical patients being discharged to home or community settings. Results of this trial of 749 patients showed a reduction in rehospitalizations within 30 days and emergency department visits following hospital discharge. Participants also followed up with primary care providers more often and reported higher patient satisfaction with the discharge process. Project RED researchers created several tools to help hospitals replicate RED. After AHRQ and Project RED researchers fielded many inquiries about how to implement Project RED at hospitals nationwide, AHRQ realized that the Project RED Toolkit did not provide sufficient guidance to potential replicators. Various components of the RED were not documented, and issues regarding implementing the RED at hospitals serving linguistically and culturally diverse patient populations had not been addressed. AHRQ has therefore contracted with the RED researchers to create a revised RED Toolkit that will address these issues.

This proposed information collection supports AHRQs mission by improving upon the RED Toolkit. This project has the following 3 goals:

(1) To revise the Project RED Toolkit to comprehensively address all components of the RED, as well as the needs of culturally and linguistically diverse patients;

(2) To pre-test the revised RED Toolkit in ten varied hospital settings, evaluating how the RED Toolkit is implemented in varied hospital settings by: (a) Documenting the implementation process; (b) assessing the fidelity of implementation; and (c) identifying the factors that affect redesign fidelity, including intensity of technical assistance (TA).

(3) To modify the revised RED Toolkit based on pre-testing and to disseminate it.

BUMC will provide TA at two varying levels. Four selected hospitals will receive "train-the-trainer" TA, which includes:

(1) Telephone assistance in conducting a baseline needs assessment;

(2) Master trainer training;

(3) Access to Webinar trainings specifically designed for each user (nurse, IT professional, hospital leadership, and pharmacist);

(4) An electronic template to print an After Hospital Care Plan (AHCP) booklet; and

(5) E-mails regarding updates to the RED Web site and the opportunity to ask questions about the newly revised and enhanced RED tools and implementation via telephone and email.

Six selected hospitals will receive intensive TA, which includes:

(1) Telephone baseline needs assessment;
(2) On-site training;
(3) Monthly semi-structured interviews via phone calls with the implementation team to discuss implementation efforts and barriers;
(4) Adaptation of the revised RED Toolkit to include specific details about the hospital (such as the hospital name on the cover of the AHCP booklet and hospital-specific services provided to patients included in the AHCP booklet);
(5) An assessment and evaluation site visit by the organizational change evaluator (a member of the implementation team), at baseline and 12 months after the start of implementation efforts to interview select participating hospital staff;
6) IT support to install and support the RED Toolkit software to automatically generate the AHCP booklet; and
(7) E-mails regarding updates to the RED Web site and the opportunity to ask questions about the newly revised and enhanced RED tools and implementation via telephone and email.

A diverse group of hospitals will be selected to receive each level of TA, based upon hospital size, location, readmission rate and patient population. Implementing the revised RED Toolkit in diverse settings will provide a better understanding of whether and how RED can be best implemented in different hospital settings.

The project will be framed within a model of organizational change and transformation called the Organizational Transformation Model (OTM), which is based on the evaluation of Robert Wood Johnson Foundation's Pursuing Perfection initiative. OTM identifies key elements that drive dramatic system change and informs the implementation process and impact evaluation. Using a mixed-methods design, the evaluation tracks change over time and across the implementation period within each hospital. The evaluation therefore will encompass feedback on specific implementation processes and factors in microsystems where RED is adopted, in the larger organizational context, and interactions between the two.

This research study is being conducted by AHRQ through its contractor, BUMC, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and disseminate information 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. 299(b) and 299a(a)(1) and (2).

Method of Collection

To achieve the projects' second and third goals, the following data collections and training will be implemented for the six hospitals that will receive more TA as well as the 4 hospitals receiving train-the-trainer TA, unless otherwise noted:

(1) Baseline needs assessment to help each hospital plan and prepare for implementation of the revised RED Toolkit and to evaluate it in varied settings. The baseline needs assessment will be administered by telephone, approximately two months prior to implementation, to the key contact at each of the ten study hospitals. The purpose of the assessment is to identify the implementation team, collect some basic information about the hospital, such as the number of beds and if electronic medical records are used, and to establish the baseline readmission rate.

(2) Monthly semi-structured interviews with the key contact or other implementation team member will be conducted monthly for 12 months after implementation. These interviews will be conducted by phone with each of the six hospitals receiving intensive technical assistance (TA) (the two levels of TA are described above). The purpose of these interviews are to allow hospitals to share their experiences with implementing the revised RED Toolkit, their use of specific tools, changes resulting from using the tools and problems encountered implementing the revised RED Toolkit and how they are being addressed.

(3) Baseline semi-structured interviews will be conducted prior to the implementation of the revised RED Toolkit with 15 hospital staff from each of the six study hospitals receiving intensive TA. The purpose of this interview is to measure the staffs opinion of the current discharge process, their perceived need for a redesigned process, and the perceived barriers and facilitators to redesigning the discharge process.

(4) Post implementation semi-structured interviews will be conducted 12 months after the implementation of the revised RED Toolkit with 15 hospital staff from each of the six study hospitals receiving intensive TA. The purpose of this interview is to measure the staffs opinion of the redesigned discharge process, which tools were used and their opinion of the tools, and the observed barriers and facilitators to redesigning the discharge process.

(5) Patient surveys will be administered by telephone to a random sample of patients 30 days after being discharged from one of the six intensive TA study hospitals. The purpose of this survey is to measure patient outcomes, including satisfaction with the care they received, 30-day hospital and emergency department visits, and physician appointments, to help determine the success of the RED Toolkit implementation in diverse patient populations. The survey will be administered by a hospital staff member to patients during the pre-implementation period and again during the post-implementation period to compare patient outcomes.

(6) Medical record review of patient outcomes at all ten study hospitals. This data collection will be conducted both pre- and postimplementation of the revised RED Toolkit and will inform the success of the revised RED Toolkit implementation in diverse patient populations. Outcomes to be collected include process outcomes, such as primary care provider appointments scheduled prior to discharge, and patient outcomes, such as 30-day hospital and emergency department visits.

(7) Master trainer training will be conducted with 3 staff members from each of the 4 hospitals receiving train-the-trainer TA. These people will be trained to administer the RED Toolkit and be able to use recorded Webinar training sessions within their organization. They will be invited to travel to BUMC for a 2-day onsite orientation of the RED intervention. These people will meet with several members of the BUMC implementation team (physician leader, discharge advocate nurse) and will have the opportunity to shadow the nurse discharge advocates in conducting the RED intervention.

(8) Intensive training will be conducted with about 28 staff from each of the 6 hospitals receiving intensive TA. The training will consist of a two-day on-site orientation and training at each hospital conducted by the BUMC implementation team. The BUMC implementation team will consist of a physician researcher, a discharge advocate nurse, an organizational change champion/evaluator and the information technology expert. The BUMC team will spend two days, 8 hours per day, to train the relevant hospital staff to perform the 11 components of the RED discharge. The training will include material for senior hospital management, hospital physicians, nurses, IT staff, and pharmacists.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours associated with the respondent's time to participate in this research. The baseline needs assessment will be administered to the key contact at each of the 10 participating hospitals and takes about 2 hours to complete. Monthly semi-structured interviews with the key contact or other implementation team member will be conducted monthly for 12 months after implementation. These interviews will be conducted by phone with each of the six hospitals receiving intensive TA and will require 1 hour to complete. Both the base-line and post-implementation semi-structured interviews will be conducted with 15 staff members from each of the 6 hospitals receiving intensive TA and will last about one hour. The patient survey will be administered twice, pre and post implementation, to 3,108 patients recently discharged from one of the 6 hospitals receiving intensive TA and requires 10 minutes to complete. Medical record review will be performed at all 10 participating hospitals both pre- and post-implementation and will take about 41.6 hours. Master trainer training will be conducted with 3 staff members from each of the 4 hospitals receiving train the trainer TA and will last 16 hours. Intensive training will be conducted with about 28 staff members from each of the 6 hospitals receiving intensive TA and will also last 16 hours. The total annualized burden is estimated to be 5,020 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondent's time to participate in this research. The total annualized cost burden is estimated to be $162,157.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Baseline needs assessment	10	1	2	20
Monthly semi-structured interviews	6	12	1	72
Base-line semi-structured interview	6	15	1	90
Post implementation semi-structured interview	6	15	1	90
Patient survey	3,108	2	10/60	1,036
Medical record review	10	2	41.6	832
Master trainer training	4	3	16	192
Intensive training	6	28	16	2,688
Total	3,156	na	na	5,020

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Baseline needs assessment	10	20	[a] $41.94	$839
Monthly semi-structured interviews	6	72	[b] 40.91	2,946
Base-line semi-structured interview	6	90	[c] 38.51	3,466
Post implementation semi-structured interview	6	90	[d] 38.51	3,466
Patient survey	3,108	1,036	20.32	21,052
Medical record review	10	832	17.32	14,410
Master trainer training	4	192	[g] 31.31	6,012
Intensive training	6	2,688	[h] 40.91	109,966
Total	3,156	5,020	na	162,157

* Based upon the mean of the average wages, National Compensation Survey: Occupational wages in the United States May 2008, "U.S. Department of Labor, Bureau of Labor Statistics."

[a] 75% Nurses (29–1111, $31.31/hr), 20% Physicians (29–1069, $79.33/hr) and 5% General and Operations Managers (29–1069, $51.91/hr); [b] 80% Nurses and 20% Physicians; [c] and [d] 85% Nurses and 15% Physicians; [e] 100% General public (00–0000, $20.32/hr); [f] 100% Statistical assistants (43–9111, $17.32/hr); [g] 100% Nurses; [h] 80% Nurses and 20% Physicians.

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the total and annualized cost over the 18 months of this clearance. The total cost is $449,976.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annual cost
Project RED Toolkit Development	$97,413	$64,942
Dissemination Planning and Support	98,080	65,387
Data Collection Activities	84,563	56,375
Data Processing and Analysis	52,215	34,810
Publication of Results	3,184	2,123
Project Management	28,892	19,261

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST—Continued

Cost component	Total cost	Annual cost
Overhead	85,629	57,086
Total	449,976	299,984

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: June 8, 2010.

Carolyn M. Clancy,

Director.

[FR Doc. 2010–14864 Filed 6–18–10; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–10–10EG]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 and send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is 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. Written comments should be received within 60 days of this notice.

Proposed Project

Audience Analysis for Biomonitoring—New—National Center for Environmental Health/Agency for Toxic Substances and Disease Registry (NCEH/ATSDR), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

People's exposure to environmental chemicals can be a risk to their health. Scientists at the CDC use biomonitoring, which is the measurement of environmental chemicals in human tissues and fluids, to assess such exposure. Biomonitoring findings, however, do not typically provide information on health risks and toxicity data often lag behind new biomonitoring data. The health effects on humans are, therefore, often uncertain or unknown, particularly, for many new or "emerging" chemicals. Nevertheless, communicating biomonitoring findings for those charged with this task is necessary, especially due to the growing media coverage and public concern about chemicals found in the human body. The demand for answers and decreasing patience with uncertainty characterizes the interpretation of such results. This poses enormous challenges to those tasked to communicate such findings to both scientific and non-scientific audiences without a biomonitoring background.

The CDC is, therefore, interested in developing a framework for communicating health risk messages, particularly about emerging environmental chemicals, to the attentive public audience such as selected women who are pregnant or have very young children. The three environmental chemicals, Bisphenol A (BPA), phthalates, and mercury have been selected for this study. They are of particular interest to these selected women as the risks of exposure are higher for very young children because of their hand-to-mouth behaviors and direct oral (mouth) contact with materials containing these chemicals. Furthermore, young children eat and drink more per pound of body weight than adults.

Focus groups will be conducted in different parts of the country with selected women. During phase one, eight exploratory focus groups will be conducted to develop messaging strategies and the results will be used in the development of preliminary messages about the emerging chemicals. The second phase will include six message testing focus groups to determine which messages are most attractive and compelling in terms of communicating health risk information about emerging chemicals.

Participants will be recruited via standard focus group recruitment methods. Most will come from an existing database (or list) of potential participants maintained by the focus group facility. There is no cost to respondents.