disseminate toxicological and safety testing information. ICCVAM conducts technical evaluations of new, revised, and alternative safety testing methods and strategies with regulatory applicability and promotes the scientific validation and regulatory acceptance of toxicological and safety testing methods that more accurately assess the safety and hazards of chemicals and products. ICCVAM evaluations include test methods and strategies that will reduce or replace animal use, or refine animal use by enhancing animal welfare and avoiding or lessening pain and distress.

The ICCVAM Authorization Act of 2000 (42 U.S.C. 285*l*–3) established ICCVAM as a permanent interagency committee of the NIEHS under NICEATM. NICEATM administers ICCVAM, provides scientific and operational support for ICCVAM-related activities, and conducts independent validation studies to assess the usefulness and limitations of new, revised, and alternative test methods and strategies. NICEATM and ICCVAM work collaboratively to evaluate new and improved test methods and strategies applicable to the needs of U.S. Federal agencies.

NICEATM and ICCVAM welcome the public nomination of new, revised, and alternative test methods and strategies for validation studies and technical evaluations. Additional information about NICEATM and ICCVAM can be found on the NICEATM–ICCVAM Web site (*http://iccvam.niehs.nih.gov*).

References

ICCVAM. 2008. The NICEATM–ICCVAM Five-Year Plan (2008–2012). A plan to advance alternative test methods of high scientific quality to protect and advance the health of people, animals, and the environment. NIH Publication No. 08–6410. Research Triangle Park, NC: NIEHS.

Available: http://iccvam.niehs.nih.gov/docs/5yearplan.htm.

Dated: June 4, 2012.

John R. Bucher,

Associate Director, National Toxicology Program.

[FR Doc. 2012–14435 Filed 6–12–12; 8:45 am]

BILLING CODE 4140–01–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: ''Adapting Best Practices for Medicaid Readmissions.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on March 28th, 2012 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 July 13, 2012.

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 email 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 email at *doris.lefkowitz@AHRO.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Adapting Best Practices for Medicaid Readmissions

One particular mission of AHRQ is to improve the efficiency of health care through reducing unnecessary health care costs while maintaining or improving quality. The proposed data collection supports this goal through developing strategies to assist safety net hospitals in reducing readmissions for Medicaid patients. Previous research has shown that a focus on transitional care, including needs assessment, discharge planning, post-discharge intervention, and care coordination can reduce avoidable readmissions. Based on this evidence, there have been a number of strategies and resources developed for hospitals to reduce avoidable readmissions, including:

- The Aging & Disability Resource Centers Evidence-Based Care Transitions program by the Administration on Aging & CMS to support state efforts in implementing evidence-based care transition models for older adults and individuals with disabilities.
- The State Action on Avoidable Rehospitalizations (STAAR) initiative by the Institute for Healthcare Improvement to improve care transitions and care coordination through state-based multi-stakeholder collaborative efforts.
- The Hospital-to-Home (H2H) initiative by the American College of Cardiology to reduce readmissions for patients with cardiovascular conditions.
- Project Re-Engineered Discharge (RED), funded by AHRQ and the National Institutes of Health (NIH) National Heart, Lung, and Blood Institute, to reduce re-hospitalizations by improving hospital discharge processes.

However, the majority of these strategies and resources focuses on general patient populations or specifically targets the elderly and/or disabled, primarily Medicare populations. Recent research finds that rates of readmission among Medicaid-insured non-elderly adults equals that of the elderly, Medicare-insured population and is 60 percent higher than a privately-insured population. It is not known whether existing resources and strategies to reduce readmissions address the circumstances and characteristics of Medicaid-insured patients. Particular socio-demographic characteristics more prevalent in populations insured through Medicaid, such as low-income, racial and ethnic minority, low literacy, housing instability, mental illness, substance abuse disorders, chronic and disabling conditions, language barriers, and discontinuous insurance coverage may mean that strategies for reducing readmissions need to be tailored specifically to the unique needs of this population.

Additionally, safety net hospitals, which serve large populations of the most vulnerable in society and where Medicaid is often a major payer, face unique conditions. Not only do they serve more vulnerable populations, they are often constrained by their financing and governance structures. Safety net hospitals generally operate on lower

financial margins than other hospitals because they are often underpaid for many services provided to Medicaid recipients and the uninsured. Faced with declining contributions from state and local governments and payment reduction from both public and private payers, many are struggling to meet the growing demand for their services with stagnant or declining revenues. Resources addressing hospital readmissions may also have to be tailored to meet the unique circumstances of safety net settings.

This project will recruit six safety net hospitals to assess the existing resources and strategies and suggest and test modifications to address the particular circumstances related to Medicaid readmissions and safety net hospital settings. The goals of this project are to:

- Identify factors at the patient, provider, and community levels that especially contribute to hospital readmissions for Medicaid patients;
- Assess and test existing strategies to reduce avoidable readmissions for their adequacy and applicability to Medicaid-insured populations and safety net hospital settings;
- Modify and test modifications of existing strategies as necessary for applicability to Medicaid-insured populations and safety net hospital settings; and
- Develop a package of revised strategies for reducing avoidable readmissions that are specific to the factors contributing to Medicaid-insured patient readmissions in safety net settings.

Four cycles of testing will be conducted to collect data on samples of patient readmissions in each of the participating hospitals. The data will be collected and analyzed by the hospital staff after each cycle. The first cycle will identify factors related to Medicaid readmissions, as well as establishing baseline measures, while the next 3 cycles will be a quality improvement effort to test the existing strategies, or modifications to existing strategies, to address the factors identified in the first cycle. Each cycle will use a different sample of Medicaid readmission patients.

This study is being conducted by AHRQ through its contractor, John Snow, Inc. (JSI), 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

To achieve the goals of this project the following data collections will be implemented:

(1) Medical records review—The medical records review will gather background information about a patient's index admission and readmission. Data to be abstracted from the medical record includes patient demographic information, living arrangements, dates and timing of index and readmissions, lengths of stay, diagnoses on admission, source of admission, discharge disposition, and other transition factors, as well as the name and setting of the patient's primary care provider (PCP), and whether an appointment was made with the PCP before discharge.

(2) Patient/family/caregiver interview—After completion of the patient's medical record review, interviews will be conducted with the patient and a family member or caretaker (using the same tool for all) who has permission to discuss the patient's case. The purpose of the patient/family/caregiver interviews is to obtain the patient/family perspective, in their own words, of their index admission, their transition period, and their readmission. Data to be collected includes perspectives on reasons for readmission, discharge experience, extent to which they were able to follow any discharge instructions provided, setting to which they were discharged, and any other assistance needed.

(3) Provider interview—Provider interviews will complete the patient readmission data. Two providers involved in each readmission case will be interviewed. Providers are likely to be from the hospital setting (e.g., hospitalists, admitting physicians, emergency room physicians) but also may be from the larger care community (e.g., primary care, skilled nursing facility, home health). Providers selected will change from case to case, although any particular provider may be asked about more than one readmission over the course of the project. Providers will be asked why they believe the patient was readmitted and what they think could have been done to avoid the readmission.

The purpose of the primary data collections is to add insight and direct patient/family and provider input and experience into all phases of the project. The first data collection will provide patient/family and provider insight into the process of identifying factors related to Medicaid readmissions. Based on these factors, existing readmissions strategies will be assessed for their suitability in addressing these factors. Participating hospitals will then select existing or modified strategies to test in their settings using a rapid cycle QI process. Primary data collection will occur during each of the three testing cycles for purposes of gathering patient and provider insight into the factors associated with readmissions of Medicaid patients and gauging the extent to which the modified strategies would be able to address those factors.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden for the respondent's time to participate in the project. The medical records review will be performed by one QI nurse at each of the 6 participating hospitals for 80 readmission cases (20 from each of 4 cycles) and will take about 20 minutes per case. In that the primary data collections are intended to inform the factors related to Medicaid readmissions and inform the testing of existing or modified strategies, there is no set number of readmissions cases required during each of the four data collection cycles. Participating hospitals will be instructed that it is a process that should continue until patterns of response converge and little new information is being learned, with 20 cases as the maximum during any one of the four cycles of data collection.

For each readmission case interviews will be conducted by the QI nurse with a total of 120 patients and family member or care giver (20 of each from each of the 6 hospitals) during each of the 4 cycles of data collection. The interviews are estimated to require 10 minutes each. The QI nurse will also conduct interviews with 2 providers associated with each readmission case (a total of 240 providers across the 6 hospitals) during each of the 4 cycles and will take about 5 minutes. The total burden is estimated to be 640 hours annually.

Exhibit 2 shows the estimated cost burden associated with the respondent's time to participate in this project. The total cost burden is estimated to be $23,398 annually.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Medical records review	6	80	20/60	160
Patient/family/caregiver interviews	120	4	10/60	80
Patient interview	120	4	10/60	80
Family/caregiver interview QI Nurse to conduct interviews	6	160	10/60	160
Provider interviews:				
Provider interviews	240	4	5/60	80
QI Nurse to conduct interviews	6	160	5/60	80
Total	498	na	na	640

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Medical records review	120	160	$32.56	$5,210
Patient/family/caregiver interviews:				
Patient interview	120	80	$21.35	$1,708
Family/caregiver interview	120	80	$21.35	$1,708
QI Nurse to conduct interviews	6	160	$32.56	$5,210
Provider interviews:				
Provider interviews	240	80	$86.96	$6,957
QI Nurse to conduct interviews	6	80	$32.56	$2,605
Total	498	640	na	$23,398

*Based upon the mean of the average wages, National Compensation Survey: Occupational wages in the United States May 2010, ''U.S. Department of Labor, Bureau of Labor Statistics;'' 29–1111 (Registered Nurse, $32.56/hr); 00–0000 (All Occupations, $21.35/hr); 29–1069 (Physicians and Surgeons, All Other, $86.96/hr).

Estimated Annual Costs to the Federal Government

The total cost to the government is estimated to be $253,033, which includes costs for project development, data collection, data analysis, publication, project management, and overhead as shown in Exhibit 3. The data collection occurs throughout the 2.5 year project term (30 months); thus, it has an estimated annual cost of $101,212.

EXHIBIT 3—ESTIMATED ANNUAL AND TOTAL COSTS TO THE FEDERAL GOVERNMENT

Task/activity	Estimated annual cost	Estimated total cost
Project Development	$7,438	$18,596
Data collection	30,866	77,165
Data analysis	9,470	23,676
Publication	5,606	14,016
Project Management	15,086	37,716
Overhead	32,746	81,864
Total	101,212	253,033

Request for Comments

In accordance with the Paperwork Reduction Act, 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 1, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–14206 Filed 6–12–12; 8:45 am]

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