EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Data entry into GRS	500	4	10/60	333
Total	500	na	na	333

EXHIBIT 2. ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Data entry into GRS	500	333	$35.35	$11,772
Total	500	333	na	$11,772

* Based upon the average wages for Healthcare Practitioner and Technical Occupations (29–0000), ''National Compensation Survey: Occupational Wages in the United States, May 2012,'' U.S. Department of Labor, Bureau of Labor Statistics.

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: February 6, 2014.

Richard Kronick,

AHRQ Director.

[FR Doc. 2014–03487 Filed 2–14–14; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Health care Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Health care 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: *''Assessing the Impact of the National Implementation of TeamSTEPPS Master Training Program.''* 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 August 27th, 2013 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 March 20, 2014.

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@AHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Assessing the Impact of the National Implementation of TeamSTEPPS Master Training Program

As part of their effort to fulfill their mission goals, AHRQ, in collaboration with the Department of Defense's (DoD) Tricare Management Activity (TMA), developed TeamSTEPPS® (aka Team Strategies and Tools for Enhancing Performance and Patient Safety) to provide an evidence-based suite of tools and strategies for training teamwork-based patient safety to health care professionals. In 2007, AHRQ and DoD coordinated the national implementation of the TeamSTEPPS program. The main objective of this program is to improve patient safety by training a select group of stakeholders such as Quality Improvement Organization (QIO) personnel, High Reliability Organization (HRO) staff, and health care system staff in various teamwork, communication, and patient safety concepts, tools, and techniques and ultimately helping to build national capacity for supporting teamwork-based patient safety efforts in health care organizations and at the state level. The implementation includes the availability of voluntary training of Master Trainers in various health care systems capable of stimulating the utilization and adoption of TeamSTEPPS in their health care delivery systems, providing technical assistance and consultation on

implementing TeamSTEPPS, and developing various channels of learning (e.g., user networks, various educational venues) for continuation support and improvement of teamwork in health care. During this effort, AHRQ has trained more than 2400 participants to serve as the Master Trainer infrastructure supporting national adoption of TeamSTEPPS. Participants in training become Master Trainers in TeamSTEPPS and are afforded the opportunity to observe the tools and strategies provided in the program in action. In addition to developing Master Trainers, AHRQ has also developed a series of support mechanisms for this effort including a data collection Web tool, a TeamSTEPPS call support center, and a monthly consortium to address any challenges encountered by implementers of TeamSTEPPS.

To understand the extent to which this expanded patient safety knowledge and skills have been created, AHRQ will conduct an evaluation of the National Implementation of TeamSTEPPS Master Training program. The goals of this evaluation are to examine the extent to which training participants have been able to:

(1) Implement the TeamSTEPPS products, concepts, tools, and techniques in their home organizations and,

(2) spread that training, knowledge, and skills to their organizations, local areas, regions, and states.

This study is being conducted by AHRQ through its contractor, Health Research & Educational Trust (HRET), pursuant to AHRQ's statutory authority to conduct and support research on health care and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of health care 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 assessment the following two data collections will be implemented:

(1) Web-based questionnaire to examine post-training activities and teamwork outcomes as a result of training from multiple perspectives. The questionnaire is directed to all master training participants. Items will cover post-training activities, implementation experiences, facilitators and barriers to implementation encountered, and perceived outcomes as a result of these activities.

(2) Semi-structured interviews will be conducted with members from organizations who participated in the TeamSTEPPS Master Training program. Information gathered from these interviews will be analyzed and used to draft a ''lessons learned'' document that will capture additional detail on the issues related to participants' and organizations' abilities to implement and disseminate the TeamSTEPPS post-training. The organizations will vary in terms of type of organization (e.g., QIO or hospital associations versus health care systems) and region (i.e., Northeast, Midwest, Southwest, Southeast, Mid-Atlantic, and West Coast). In addition, we will strive to ensure representativeness of the sites by ensuring that the distribution of organizations mirrors the distribution of organizations in the master training population. For example, if the distribution of organizations is such that only one out of every five organizations is a QIO, we will ensure that a maximum of two organizations in the sample are QIOs. The interviews will more accurately reveal the degree of training spread for the organizations included. Interviewees will be drawn from qualified individuals serving in one of two roles (i.e., implementers or facilitators). The interview protocol will be adapted for each role based on the respondent group and to some degree, for each individual, based on their training and patient safety experience.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondent's time to participate in the study. Semi-structured interviews will be conducted with a maximum of 9 individuals from each of 9 participating organizations and will last about one hour each. The training participant questionnaire will be completed by approximately 10 individuals from each of about 240 organizations and is estimated to require 20 minutes to complete. The total annualized burden is estimated to be 881 hours.

Exhibit 2 shows the estimated annualized cost burden based on the respondents' time to participate in the study. The total cost burden is estimated to be $38,923.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Semi-structured interview	9	9	60/60	81
Training participant questionnaire	240	10	20/60	800
Total	249	NA	NA	881

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Semi-structured interview	9	81	$44.18	$3,579
Training participant questionnaire	240	800	44.18	35,344
Total	249	881	NA	38,923

*Based upon the mean of the average wages for all health professionals (29–0000) for the training participant questionnaire and for executives, administrators, and managers for the organizational leader questionnaire presented in the National Compensation Survey: Occupational Wages in the United States, May, 2012, U.S. Department of Labor, Bureau of Labor Statistics. *http://www.bls.gov/oes/current/oes_nat.htm#37–0000.*

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 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 record.

Dated: January 29, 2014.

Richard Kronick,

AHRQ Director.

[FR Doc. 2014–03482 Filed 2–14–14; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Common Formats for Patient Safety Data Collection and Event Reporting

AGENCY: Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (HHS).

ACTION: Notice of Availability—New Common Formats

SUMMARY: As authorized by the Secretary of HHS, AHRQ coordinates the development of common definitions and reporting formats (Common Formats) for reporting patient safety events to Patient Safety Organizations (PSOs) and other entities. The purpose of this notice is to announce the availability of a new type of Common Formats for public review and comment—*Common Formats for Surveillance—Hospital.*

DATES: Ongoing public input.

ADDRESSES: The newly released *Common Formats for Surveillance—Hospital*—which includes modules entitled Generic Adverse Event Information, Blood or Blood Product, Delivery-Maternal, Delivery-Neonatal, Device or Medical/Surgical Supply Including Health Information Technology (HIT), Fall, Medications, Pressure Ulcer, Readmissions, Surgery or Anesthesia, Venous Thromboembolism, and Other Outcomes of Interest—can be accessed electronically at the following HHS Web site: *http://www.PSO.AHRQ.gov/index.html*

FOR FURTHER INFORMATION CONTACT: Glenn Egelman, M.D., Center for Quality Improvement and Patient Safety, AHRQ, 540 Gaither Road, Rockville, MD 20850; Telephone (toll free): (866) 403–3697; Telephone (local): (301) 427–1111; TTY (toll free): (866) 438–7231; TTY (local): (301) 427–1130; Email: *PSO@AHRQ.HHS.GOV.*

SUPPLEMENTARY INFORMATION:

Background

The Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. 299b-21 to b-26, (Patient Safety Act) and the related Patient Safety and Quality Improvement Final Rule, 42 CFR Part 3 (Patient Safety Rule), published in the **Federal Register** on November 21, 2008: 73 FR 70731–70814, provide for the formation of PSOs, which collect, aggregate, and analyze confidential information regarding the quality and safety of healthcare delivery. The Patient Safety Act (at 42 U.S.C. 299b-24(b)(1)(F)) requires PSOs to collect information from providers in a standardized manner that permits valid comparisons of similar cases among similar providers, to the extent practical and appropriate. As explained in 42 CFR 3.102(b)(1)(iii)(A)(1), one option for a PSO to satisfy this requirement is by certifying that it is using the Secretary's published guidance for common formats and definitions in its collection of information from healthcare providers.

The Patient Safety Act and Patient Safety Rule establish a framework by which doctors, hospitals, skilled nursing facilities, and other healthcare providers may assemble information regarding patient safety events and quality of care. Information that is assembled and developed by providers for reporting to PSOs and the information received and analyzed by PSOs—called patient safety work product—is privileged and confidential. Patient safety work product is used to conduct patient safety activities, which may include identifying events, patterns of care, and unsafe conditions that increase risks and hazards to patients. Definitions and other details about PSOs and patient safety work product are included in the Patient Safety Act and Patient Safety Rule which can be accessed electronically at: *http://www.PSO.AHRQ.gov/REGULATIONS/REGULATIONS.htm.*

Definition of Common Formats

The term Common Formats refers to the common definitions and reporting formats, specified by AHRQ, that allow healthcare providers to collect and submit standardized information regarding patient safety events. The Common Formats are not intended to replace any current mandatory reporting system, collaborative/voluntary reporting system, research-related reporting system, or other reporting/recording system; rather the formats are intended to enhance the ability of healthcare providers to report information that is standardized both clinically and electronically.

In collaboration with the interagency Federal Patient Safety Workgroup (PSWG), the National Quality Forum (NQF) and the public, AHRQ has developed Common Formats for two settings of care—acute care hospitals and skilled nursing facilities—in order to facilitate standardized data collection. The scope of Common Formats applies to all patient safety concerns including: Incidents—patient safety events that reached the patient, whether or not there was harm; near misses or close calls—patient safety events that did not reach the patient; and unsafe conditions—circumstances that increase the probability of a patient safety event.

Until now, Common Formats have been designed to support only traditional event reporting. *Common Formats for Surveillance—Hospital* are designed to provide, through retrospective review of medical records, information that is complementary to that derived from event reporting systems. These formats will facilitate improved detection of events and calculation of adverse event rates in populations reviewed.

Common Formats Development

In anticipation of the need for Common Formats, AHRQ began their development by creating an inventory of functioning private and public sector patient safety reporting systems. This inventory provides an evidence base that informed construction of the Common Formats. The inventory includes many systems from the private sector, including academic settings, hospital systems, and international reporting systems (e.g., from the United Kingdom and the Commonwealth of