EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN FOR THE 2018–2019 MEPS–IC—Continued

| Form name | Number of respondents | Total burden hours | Average hourly wage rate * | Total cost burden |
|---|---|---|---|---|
| Total | 78,898 | 22,952 | na | 733,776 |

*Based upon the mean hourly wage for Compensation, Benefits, and Job Analysis Specialists occupation code 13–1141, at *https://www.bls.gov/oes/current/oes131141.htm* (U.S. Department of Labor, Bureau of Labor Statistics.)

**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 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.

**Sharon B. Arnold,**

*Deputy Director.*

[FR Doc. 2017–15884 Filed 7–27–17; 8:45 am]

**BILLING CODE 4160–90–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: ''*The AHRQ Safety Program for Improving Surgical Care and Recovery.*''

This proposed information collection was previously published in the **Federal Register** titled ''*The AHRQ Safety Program for Enhancing Surgical Care and Recovery,*'' on May 18, 2017 and allowed 60 days for public comment. AHRQ did not receive any substantive comments. The purpose of this notice is to allow an additional 30 days for public comment.

**DATES:** Comments on this notice must be received by August 28, 2017.

**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).

**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**

In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection. The AHRQ Safety Program for Improving Surgical Care and Recovery is a quality improvement project that aims to provide technical assistance to hospitals to help them implement evidence-based practices to improve outcomes and prevent complications among patients who undergo surgery. Enhanced recovery pathways are a constellation of preoperative, intraoperative, and postoperative practices that decrease complications and accelerate recovery. A number of studies and meta-analyses have demonstrated successful results. In order to facilitate broader adoption of these evidence-based practices among U.S. hospitals, this AHRQ project will adapt the Comprehensive Unit-based Safety Program (CUSP), which has been demonstrated to be an effective approach to reducing other patient harms, to enhanced recovery of surgical patients. The approach uses a combination of clinical and cultural (*i.e.,* technical and adaptive) intervention components which include promoting leadership and frontline staff engagement, close teamwork among surgeons, anesthesia providers, and nurses, as well as enhancing patient communication and engagement. Interested hospitals will voluntarily participate.

This project has the following goals:

- Improve outcomes of surgical patients by disseminating and supporting implementation of evidence-based enhanced recovery practices within the CUSP framework.
- Develop a bundle of technical and adaptive interventions and associated tools and educational materials to support implementation.
- Provide technical assistance and training to hospitals for implementing enhanced recovery practices.
- Assess the adoption, and evaluate the effectiveness of, the intervention among the participating hospitals.

This project is being conducted by AHRQ through its contractor Johns Hopkins University; with subcontractors Westat, and the American College of Surgeons. The *AHRQ Safety Program for Improving Surgical Care and Recovery* is being undertaken pursuant to AHRQ's mission to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. 42 U.S.C. 299.

**Method of Collection**

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

(1) *Safety Culture Survey.* Hospitals will assess the impact of participation in the project on perioperative safety culture by having their staff members who will be part of the enhanced recovery program complete a survey adapted from the AHRQ Surveys on Patient Safety Culture (SOPS) at the beginning and end of the program. The hospital's enhanced recovery project team will receive their survey results and then debrief their staff on their safety culture and identify opportunities for further improvement. The national

project team will provide technical assistance for this effort. Participating hospitals will promote awareness of the survey among their staff, coordinate implementation of the survey, encourage and provide staff the time to complete the survey, and organize a local debrief of the reports of their hospital's results. The national project team will assist this effort by providing an electronic portal for hospital staff to anonymously complete the survey and by analyzing the data and sending a report to the hospital. Data will also be analyzed in aggregate across all participating hospitals to evaluate the impact of the overall quality improvement effort on measured safety culture.

(2) *Patient Experience Survey.* Hospitals will also assess the impact of participation in the project on patients' experience with care. This will be done via administration of a patient experience survey to patients discharged after a qualifying surgery. Patients will receive a pre-implementation assessment of patient experience after a qualifying surgery and a post-implementation assessment of patient experience will be administered to patients who were treated the enhanced recovery program at participating hospitals. The survey will be administered by the national project team. Hospitals will provide patient contact information to the project team after execution of a data use agreement. This information will be provided to the national project team to send the survey to patients on behalf of the hospital. The national project team will provide a summative report to each hospital with the hospital's results to promote additional local quality improvement work. Data will also be analyzed in aggregate across all participating hospitals to evaluate the impact of the overall quality improvement effort on patient experience of care.

(3) *Readiness and Implementation Assessments: Semi-structured qualitative interviews.* Semi-structured qualitative interviews will be conducted with key stakeholders at participating hospitals (*e.g.,* project leads, physician project champions, etc.). These include a readiness assessment conducted after a hospital's enrollment in the project and an implementation assessment conducted after a period of implementation. The readiness assessment will help identify which, if any, technical components of the enhanced surgical care and recovery intervention already exist at the hospital, project management and resources, clinician engagement, leadership engagement and potential barriers and facilitators to implementation. The implementation assessment will evaluate what elements of the enhanced recovery practices have been adopted, resources invested, team participation, major barriers (*e.g.,* medications, equipment, trained personnel), and leadership participation. These assessments will help identify training needs of hospitals and inform the national team's approach. In addition, the results will inform the national team's understanding of local adaptations of the intervention and the degree to which intervention fidelity impacts changes in outcomes.

(4) *Site visits.* Semi-structured site visits will be conducted at a subset of participating hospitals. Findings will help inform the national project implementation strategy. Information from these visits will be critical in understanding if and how team and/or leadership issues may affect implementation of enhanced recovery practices, including how this may differ across surgical services. Interviews will help uncover and clarify misalignments in roles, needed time and resources, best practices, and potential enablers of and barriers to enhanced surgical care and recovery implementation. Site visits will be conducted at approximately 4 hospitals per year, and each will be 1 day long. The types of hospital personnel anticipated being involved in part or all of the site visit include senior leadership, perioperative leadership, and patient safety and quality staff. Participating hospitals will receive a structured debriefing and brief summary report at the end of the one-day visit.

**Estimated Annual Respondent Burden**

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

| Form name | Number of respondents | Number of responses per respondent | Hours per response | Total burden hours |
|---|---|---|---|---|
| Safety culture survey | 12,000 | 1 | 0.25 | 3,000 |
| Patient experience survey | 1,800 | 1 | 0.37 | 666 |
| Readiness and Implementation assessment | 720 | 1 | 1 | 720 |
| Site visits | 40 | 1 | 8 | 320 |
| Total | 14,560 | N/A | N/A | 4,706 |

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

| Form name | Number of respondents | Total burden hours | Average hourly wage rate * | Total cost burden |
|---|---|---|---|---|
| Safety culture survey | 6,000 | 1,500 | [a] $101.04 | $151,560 |
| Safety culture survey | 6,000 | 1,500 | [b] 34.70 | 52,050 |
| Patient experience survey | 1,800 | 666 | [d] 23.86 | 15,891 |
| Readiness and Implementation assessment | 360 | 360 | [a] 101.04 | 36,374 |
| Readiness and Implementation assessment | 360 | 360 | [c] 52.58 | 18,929 |
| Site visits | 20 | 160 | [a] 101.04 | 16,166 |
| Site Visits | 20 | 160 | [c] 52.58 | 8,413 |
| Total | 14,560 | 4,706 | N/A | 299,383 |

National Compensation Survey: Occupational wages in the United States May 2016 "U.S. Department of Labor, Bureau of Labor Statistics:" *http://www.bls.gov/oes/current/oes_stru.htm.*

[a] Based on the mean wages for *29–1060 Physicians and Surgeons.*

[b] Based on the mean wages for *29–1141 Registered Nurse*.
[c] Based on the mean wages for *11–9111 Medical and Health Services Managers*.
[d] Based on the mean wages for *00–0000 All Occupations*.

**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 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.

**Sharon B. Arnold,**

*Deputy Director.*

[FR Doc. 2017–15885 Filed 7–27–17; 8:45 am]

**BILLING CODE 4160–90–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 ''*Expanding the Comprehensive Unit-based Safety Program (CUSP) to Reduce Central Line-Associated Blood Stream Infections (CLABSI) and Catheter-Associated Urinary Tract Infections (CAUTI) in Intensive Care Units (ICU) with Persistently Elevated Infection Rates.*''

**DATES:** Comments on this notice must be received by September 26, 2017.

**ADDRESSES:** Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email 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 email at *doris.lefkowitz@AHRQ.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

**Proposed Project**

*Expanding the Comprehensive Unit-Based Safety Program (CUSP) To Reduce Central Line-Associated Blood Stream Infections (CLABSI) and Catheter-Associated Urinary Tract Infections (CAUTI) in Intensive Care Units (ICU) With Persistently Elevated Infection Rates*

In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection. Healthcare-associated infections, or HAIs, are a highly significant cause of illness and death for patients in the U.S. health care system. At any given time, HAIs affect one out of every 25 hospital inpatients. More than a million of these infections occur across our health care system every year, leading to significant patient harm and the annual loss of tens of thousands of lives, and costing billions of dollars each year. Some of the most prevalent HAIs include: Surgical site infections, catheter-associated urinary tract infections (CAUTI), central-line associated blood stream infections (CLABSI), and ventilator-associated pneumonia. It is estimated that CAUTIs affect approximately 250,000 hospital patients per year, and approximately 40,000 CLABSI cases occur annually with a mortality rate from 12 to 25 percent.

From 2008–2012, AHRQ supported the National Implementation of the Comprehensive Unit-Based Safety Program (CUSP) to Reduce Central Line-Associated Blood Stream Infections (under an ACTION contract with the Health Research and Educational Trust (HRET), in partnership with Johns Hopkins University and the Michigan Hospital Association. From 2011–2015, AHRQ expanded its CUSP efforts to include the national implementation of CUSP for CAUTI in hospitals across the United States. This effort was carried out under an ACTION II contract with HRET, in partnership with Johns Hopkins University and the Michigan Hospital Association.

As part of the Department of Health and Human Services National Action Plan to Prevent Healthcare-Associated Infections, AHRQ has supported the implementation and adoption of the CUSP for CLABSI and CUSP for CAUTI, and is applying the principles and concepts that have been learned from these HAI reduction efforts to ICUs with persistently elevated infection rates.

**Results of Implementation of CUSP for CLABSI and CAUTI**

The nationwide CUSP for CLABSI project implemented CUSP with teams at more than 1,100 adult ICUs in 44 states over a 4-year period. ICUs participating in this project reduced the rate of CLABSIs nationally from 1.915 infections per 1,000 central line days to 1.133 infections per 1,000 line days, an overall reduction of 41 percent. However, not all ICUs performed equally well.

The CUSP for CAUTI project implemented CUSP in nine cohorts, representing over 1,600 hospital units in over 1,200 hospitals located across 40 states, the District of Columbia, and Puerto Rico. Inpatient CAUTI rates in non-ICUs were decreased by 30%. However, CAUTI rates in ICUs were not reduced significantly.

In other words, while the overall results of the implementation of CUSP for CLABSI and CUSP for CAUTI have shown remarkable progress, not all ICUs in the projects have achieved the intended rate reductions, nor have all ICUs participated in the two projects. Moreover, a significant number of institutions and ICUs continue to have persistently elevated infection rates. There are institutions that have varying rates of infections within the same institution, indicating that infection control is often a unit-based issue.

In sum, despite the significant overall reductions in CLABSI and CAUTI rates that have been achieved in these two projects, there is evidence that ICUs have generally faced challenges in reducing CAUTI rates, and that many hospitals still are not where they should be in CLABSI rates. Modified approaches and strategies for the CUSP intervention need to be developed and implemented to reach ICUs with