

standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at www.ffiec.gov/nic/.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than February 25, 2010.

A. Federal Reserve Bank of Kansas City (Dennis Denney, Assistant Vice President) 1 Memorial Drive, Kansas City, Missouri 64198-0001:

1. *Sandhills Financial Services, LLC, Fremont, Nebraska*; to become a bank holding company through the acquisition of 100 percent of the voting shares of Bassett Investment Company, and thereby acquire Commercial Bank, both in Bassett, Nebraska.

Board of Governors of the Federal Reserve System, January 27, 2010.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 2010-1965 Filed 1-29-10; 8:45 am]

BILLING CODE 6210-01-S

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: "Studying the Implementation of a Chronic Care Toolkit and Practice Coaching In Practices Serving Vulnerable Populations." 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 April 2, 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

Studying the Implementation of a Chronic Care Toolkit and Practice Coaching In Practices Serving Vulnerable Populations

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. This proposed information collection supports that part of AHRQ's mission by further refining the practice coaching delivered in conjunction with a previously developed toolkit, Implementing Integrating Chronic Care and Business Strategies in the Safety Net: A Toolkit for Primary Care Practices and Clinics. AHRQ requests that the Office of Management and Budget approve, under the Paperwork Reduction Act of 1995, AHRQ's intention to collect information needed to determine whether practice coaching is effective in facilitating adoption of the Chronic Care Model (CCM) for improving treatment and management of chronic medical conditions by primary care physicians, especially those who care for underserved populations. This project is being conducted 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 quality measurement and improvement and with respect to clinical practice, including primary care and practice-oriented research. 42 U.S.C. 299a(a)(2) and (4). This project will be conducted by AHRQ through a contract with the University of Minnesota.

Although 1500 physician practices in the U.S. and internationally have been involved in CCM quality improvement efforts, most patients still do not receive their chronic care in accordance with CCM. One factor affecting CCM implementation has been that having teams attend collaborative meetings (three two-day meetings over a nine-month period) is burdensome, especially for under-resourced providers. An attempt to use the Internet as a virtual collaborative met with disappointing results. Another barrier to adoption of the CCM in settings that serve vulnerable

populations is the scarcity of resources to implement and sustain the CCM. In 2006 AHRQ contracted with the RAND Corporation, Group Health's MacColl Institute, and the California Health Care Safety Net Institute (SNI) to develop a toolkit that informs safety net providers on how to redesign their systems of care along the lines of the Chronic Care Model while attending to their financial realities. The result was Implementing Integrating Chronic Care and Business Strategies in the Safety Net. A Toolkit for Primary Care Practices and Clinics. The Toolkit was piloted in two California safety net clinics. Recognizing that merely distributing the Toolkit was unlikely to foster adoption of CCM, the intervention included six months of practice coaching delivered by the MacColl Institute. Practice Coaches (PC) are health care or related professionals who help primary care practices in a variety of quality improvement and research activities. PCs made two site visits to each site and participated in weekly team meetings by phone. They also interacted with the sites through e-mail and phone contact.

The lack of documentation available on coaching led to the development of a practice coaching manual, which was funded by AHRQ through a contract with the RAND Corporation. Development of the Coaching Manual entailed conducting a literature review, interviewing practice coaching experts, and incorporating evaluation results from the coaching provided in conjunction with the Toolkit. The Coaching Manual was published in the winter of 2009. The literature review and interviews revealed that there are a number of different models of practice coaching. However, knowledge is scant about how practice coaching is best performed, under what conditions practice coaching is most successful, and the costs of coaching and being coached. Pilot testing the Toolkit with a low-intensity practice coaching strategy proved insufficient to encourage practices to use the Toolkit independently. The Toolkit was subsequently streamlined based on pilot sites' reports that the initial Toolkit was not easy to use. This project will explore the implementation of the revised Toolkit along with a more intensive practice coaching strategy, providing lessons on methods to improve chronic care in clinical practices that serve vulnerable populations.

Method of Collection

This project will include the following data collections:

(1) *Key Informant Interviews* with providers, staff and practice coaches

from 20 safety net practices that participate in the practice coaching intervention. These will be used to describe the process and content of practice coaching, perceived changes from the coaching intervention at the practice, provider and patient levels, factors that impeded or facilitated the coaching intervention and implementation of practice changes through the coaching process, overall satisfaction with practice coaching, and recommendations for improvement.

(2) *Primary Care Practice Profile (PCPP)*. This questionnaire will be completed by a single individual at each site, either the medical director or chief administrator, and will provide an overview of each replication site that will help place intervention activities and outcomes in context for each site. It covers demographics of patients served, patient flow, disease health outcomes, most frequent diagnoses, most frequent referrals, number of staff by discipline, staff and patient satisfaction, processes of care, and organizational processes.

(3) *Physician Practice Connections-Readiness Survey (PPC-RS)*—This questionnaire asks about the presence of 53 practice systems in 5 of the 6 domains of the Chronic Care Model: Clinical information systems (information systems, presence of registry or organized database, and systematic monitoring of patient population); decision support (clinician reminders and alerts for lab tests, and visits or guidelines related to individual patient care), delivery system redesign (services for managing patients with chronic illness involving multiple clinicians and care between visits), health care organization (performance tracking and feedback, process of using clinical information systems to aggregate and report on key indicators, and use of data for benchmarking performance and informing QI activities), and clinical quality improvement (presence of formal processes to assess care, develop interventions, and use data to monitor the effects).

(4) *Assessment of Chronic Illness Care (ACIC)*—The ACIC is contained in the Toolkit and yields subscale scores and a total score. Subscale scores reflect CCM components and include: Community linkages, self-management support, decision support, delivery system design, information systems, and organization of care.

(5) *Change Process Capability Questionnaire (CPCQ)*—The CPCQ assesses 30 factors and strategies that experienced quality improvement leaders ranked as most important for

successful implementation. A recent validation study found good predictive validity. Items correlating with the PPC-RS were eliminated after the initial validation study so there is little to no overlap across the two measures. In addition to changes in the content of care (CCM components), these also include organizational will for change (Priority) and capacity and skill in the conduct of the actual change processes and strategies.

(6) *Patient Assessment of Chronic Illness Care (PACIC)*—The 20-item PACIC consists of five sub scales which assess components of the CCM: Patient activation, delivery system design/ decision support, goal setting, problem-solving/contextual counseling, and followup and coordination.

(7) *Consumer Assessment of Healthcare Providers and Systems—Primary Care Adult*—This questionnaire assesses patient experiences in three areas: Getting appointments and healthcare when needed; how well doctors communicate, and courteous and helpful office staff.

(8) *Primary Care Staff Satisfaction Survey*—This questionnaire assesses staff satisfaction with their work environment. It consists of 8 4-point likert scale items and 2 open-ended questions, and was developed by the Institute for Healthcare Improvement.

(9) *Chart Audits*—Chart audits will be conducted at baseline, the end of the 10 month coaching intervention, and at 3-month follow-up to assess changes in patient care quality over the course of the intervention. A chart abstraction form will be developed to collect these data. This data collection will be performed by the project staff and will not impose a burden on the participating sites. Therefore, OMB clearance is not required for this data collection.

Clinic staff will be provided with a paper version of the surveys as well as the option to complete the surveys on line using a secure on-line survey program. With the exception of the staff surveys, no special information technology will be used to collect information, since many of the data collection forms are standardized instruments available in hard-copy form, and special permission from the developers would be required to create electronic versions of these forms. The information collection is a one-time only project; thus, there would be little benefit in reduced burden from automated information collection tools for the other instruments.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in this two year study. Key informant interviews will be conducted with practice coaches at midpoint in the intervention and again at the end of the intervention. Key informant interviews will also be conducted with up to 3 primary care providers and 2 other staff members from each of the 20 practices (10 per year) prior to start of the intervention, and again at 3-month follow-up after the intervention is completed. Each interview takes about 1 hour.

The Primary Care Practice Profile will be administered once and will be completed by one staff person from each practice and takes 30 minutes to complete. The Physician Practice Connections-Readiness Survey (PPC-RS) will be completed pre, post and at 3-month follow-up by three individuals from each of the 20 practices (individuals with the appropriate knowledge to complete the survey will be identified by the medical director of each site). It takes 90 minutes to complete. The Assessment of Chronic Illness Care (ACIC) will be completed by 4 staff and 4 primary care providers per practice at pre, post and 3-month follow-up and takes 30 minutes to complete. The Change Process Capability Questionnaire (CPCQ) will be completed by 4 staff and 4 primary care providers per practice at pre, post and 3-month follow-up and takes 15 minutes to complete. The Primary Care Staff Satisfaction Survey (PCSSS) will be completed by 4 staff and 4 primary care providers per practice at pre, post and 3-month follow-up and takes 15 minutes to complete. The Patient Assessment of Chronic Illness Care (PACIC) will be completed by 3,000 adult patients (1,500 annually) with chronic illness and requires 15 minutes to complete. The Consumer Assessment of Healthcare Providers and Systems-Primary Care Adult (CAHPS) will be completed by 3,000 adult patients (1,500 annually) with chronic illness and requires 45 minutes to complete. Both patient surveys will be administered to adult patients with a chronic disease who receive care at the practices during a 2-day data collection period immediately before, immediately after, and at 3-month follow-up. The surveys will be administered during the post visit period in the wait room, by a bi-lingual Spanish-English research assistant. The total annualized burden hours are estimated to be 1,984 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondent's time to participate in this study. The total annualized cost burden is estimated to be \$60,714.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Key informant interviews with practice coaches	2	2	1	4
Key informant interviews with providers (3 per practice interviewed twice) ...	10	6	1	60
Key informant interviews with staff (2 per practice interviewed twice)	10	4	1	40
Primary Care Practice Profile (PCPP)	10	1	30/60	5
Physician Practice Connections—Readiness Survey (PPC-RS) (3 per practice × 3 times)	10	9	1.5	135
Assessment of Chronic Illness Care (ACIC) (8 per practice × 3 times)	10	24	30/60	120
Change Process Capability Questionnaire (CPCQ) (8 per practice × 3 times)	10	24	15/60	60
Primary Care Staff Satisfaction Survey (PCSSS) (8 per practice × 3 times)	10	24	15/60	60
Patient Assessment of Chronic Illness Care (PACIC)	1,500	1	15/60	375
Consumer Assessment of Healthcare Providers and Systems—Primary Care Adult (CAHPS)	1,500	1	15/60	1,125
Total	3,072	1,984

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Key informant interviews with practice coaches	2	4	\$42.00	\$168
Key informant interviews with providers	10	60	77.64	4,658
Key informant interviews with staff	10	40	32.64	1,306
Primary Care Practice Profile (PCPP)	10	5	77.64	388
Physician Practice Connections—Readiness Survey (PPC-RS)	10	135	77.64	10,481
Assessment of Chronic Illness Care (ACIC)	10	120	**55.14	6,617
Change Process Capability Questionnaire (CPCQ)	10	60	**55.14	3,308
Primary Care Staff Satisfaction Survey	10	60	**55.14	3,308
Patient Assessment of Chronic Illness Care (PACIC)	1,500	375	20.32	7,620
Consumer Assessment of Healthcare Providers and Systems—Primary Care Adult (CAHPS)	1,500	1,125	20.32	22,860
Total	3,072	1,984	60,714

* Based upon the mean of the average wages, May 2008 National Occupational and Wage Estimates accessed on December 14, 2009 at: [http://www.bls.gov/oes/current/oesnat.htm#b290000National Compensation Survey](http://www.bls.gov/oes/current/oesnat.htm#b290000National%20Compensation%20Survey);

** Average for 4 staff (\$32.64/hr) and 4 physician clinicians. (\$77.64/hr).

Estimated Annual Costs to the Federal Government

research. The total cost over two years is estimated to be \$600,000.

Exhibit 3 shows the estimated total and annualized cost to conduct this

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annualized cost
Project Development	\$162,744	\$81,372
Data Collection Activities	92,994	46,497
Data Processing and Analysis (20%)	92,994	46,497
Publication of Results	23,248	11,624
Project Management	92,994	46,497
Overhead	135,026	67,513
Total	600,000	300,000

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, comments on AHRQs 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: January 15, 2010.

Carolyn M. Clancy,
Director.

[FR Doc. 2010-1953 Filed 1-29-10; 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: "Evaluation of the GuideLines Into Decision Support (GLIDES)." In accordance with the Paperwork Reduction Act of 1995, 44 U.S.C. 3506(c)(2)(A), AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on November 27th, 2009 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 3, 2010.

ADDRESSES: Written comments should be submitted to: AHRQs 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.lefkowitz@AHRQ.hhs.gov.

SUPPLEMENTARY INFORMATION:

Proposed Project

Evaluation of the GuideLines Into Decision Support (GLIDES)

With this project AHRQ proposes to evaluate how the translation of clinical knowledge into clinical decision support can be routinized in practice and taken to scale in ways that improve the quality of healthcare delivery for children in the U.S. Previously in the GLIDES project, AHRQ designed and implemented decision support tools based on guidelines for the prevention of pediatric overweight and obesity and the management of chronic asthma in the pediatric population (publication forthcoming). In this phase of the project, conducted for AHRQ through a contract with Yale University and Nemours, physicians will be surveyed about their experiences with the decision support tools developed in the previous phase. The participating study institutions (Yale University and Nemours) are geographically and organizationally diverse, and include a wide range of patients from a variety of social, economic and ethnic backgrounds. This project directly addresses AHRQ's mission of improving health systems practices, in particular for priority populations, including low-income groups, minority groups, women, children, and individuals with chronic diseases. See 42 USC 299(c)(1)(B).

The evaluation plan includes a physician survey component and an extraction of electronic medical record data. Participating physicians will be surveyed about their experiences with the decision support tools developed for this project. This will allow AHRQ to evaluate the fulfillment of knowledge transformation goals and the

effectiveness of the decision support tools in improving the quality of health care at the chosen sites. Without such an evaluation, it would be difficult to determine whether this project has met AHRQ's goals of enhancing the "quality, appropriateness and effectiveness of health services." See 42 USC 299(b); 42 USC 299a(a)(1). Consequently, it is necessary to collect this information to fulfill AHRQ's mission.

Method of Collection

Self-administered questionnaires will be used to elicit physicians' general opinions of guideline-based care and clinical decision support tools on a five point Likert-type scale. Results from low-utilizing physicians will be compared to high-utilizing physicians to determine whether general opinions of guidelines and technology correlate with actual practice. Results will also be analyzed by demographic characteristics included in the survey questionnaire to determine whether opinions vary by age, degree of computer experience and skill, level of training and professional degree. These analyses will be important to future studies and decision support designers because they will help us understand whether interventions need to be targeted differently to different audiences. For example, senior level specialists may have less desire or need for clinical decision support tools than novice generalists have. In-person qualitative interviews lasting approximately 30 minutes will be conducted with key personnel at each site (including physicians, nurse practitioners, and respiratory therapists). Participants will remain anonymous in the transcribed interviews. The interviews will be analyzed using standard qualitative techniques to explore barriers and facilitators to using the clinical decision support tool. The Human Investigation Committee (HIC) at Yale University has reviewed this protocol. The HIC found the survey study to be exempt from review under 45 CFR 46.101(b)(2). The HIC approved the interview study and required signed informed consent from participants.

Electronic medical record data will be extracted into an electronic spreadsheet for analysis. This extraction will occur at regular intervals to ensure continued maintenance and uptake of the tool. Utilization of the decision support tools at the provider and site level will be assessed based on the rate of electronic chart documentation. This is important to determine the rate of uptake of the intervention, as well as to determine whether there are any flaws in the design of the tool. Congruence of actual