Dated: October 25, 2012.

Karen V. Gregory,

Secretary.

[FR Doc. 2012–26701 Filed 10–30–12; 8:45 am]

BILLING CODE 6730–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than November 15, 2012.

A. Federal Reserve Bank of Minneapolis (Jacqueline G. King, Community Affairs Officer) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. *The Philip G. Amundson 2012 Irrevocable Grantor Trust, Sioux Falls, South Dakota; Matt Amundson, Trustee, Hendricks, Minnesota; Angie Mixner, Trustee, Sioux Falls, South Dakota; and Blair Folkens, Trustee, Brandson, South Dakota;* all to join the Amundson Family Group, and thereby acquire voting shares of Beulah Bancorporation, Inc., Sioux Falls, South Dakota, and indirectly acquire voting shares of First Security Bank—West, Beulah, North Dakota, and Valley Bank and Trust, Mapleton, Iowa.

Board of Governors of the Federal Reserve System, October 26, 2012.

Robert deV. Frierson,

Secretary of the Board.

[FR Doc. 2012–26777 Filed 10–30–12; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the 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.

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 November 26, 2012.

A. Federal Reserve Bank of St. Louis (Glenda Wilson, Community Affairs Officer) P.O. Box 442, St. Louis, Missouri 63166–2034:

1. *Bank of the Ozarks, Inc.,* Little Rock, Arkansas; to acquire 100 percent of the voting shares of Genala Banc, Inc., and thereby indirectly acquire voting shares of Citizens Bank, both in Geneva, Alabama.

Board of Governors of the Federal Reserve System, October 26, 2012

Robert deV. Frierson,

Secretary of the Board.

[FR Doc. 2012–26776 Filed 10–30–12; 8:45 am]

BILLING CODE 6210–01–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: ''Using Health Information Technology in Practice Redesign: Impact of Health Information Technology on Workflow.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by December 31, 2012.

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@AHRO.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Proposed Project

Using Health Information Technology in Practice Redesign: Impact of Health Information Technology on Workflow

The Agency for Healthcare Research and Quality (AHRQ) is a lead Federal agency in developing and disseminating evidence and evidence-based tools on how health information technology (IT) can improve health care quality, safety, efficiency, and effectiveness.

Health IT has the potential to improve the quality, safety, efficiency, and effectiveness of care. In particular, health IT can aid health care professionals in improving care delivery by redesigning care processes to be more effective and efficient (*e.g.,* engaging care settings in practice redesign). The use of health IT to support practice redesign requires a deep understanding of the interaction between health IT and workflow, ideally through a human factors and socio-technical framework. Unfortunately, these health IT-workflow interactions are poorly understood and the research to date has largely focused on large academic medical centers and large health maintenance organizations, while the impact of health IT on workflow in smaller, ambulatory care practices is not well studied.

To that end, AHRQ conducted an in-depth study of existing research and evidence in the area of the impact of health IT on workflow, its linkage to clinician adoption, and its links to the safety, quality, efficiency, and effectiveness of care delivery. However, most of the articles found were not

focused directly on workflow, so the quality of evidence related to workflow change varied substantially. The majority of studies described research completed in large clinics affiliated with academic medical centers, health maintenance organizations or national health systems outside the U.S., limiting applicability to other settings, particularly small and medium-sized primary care and other ambulatory care settings. Also, most of the studies did not use a scientifically rigorous design. Finally, most of the literature did not include descriptions of the socio-technical context of health IT implementations and use, making it difficult to understand the role of potentially conflating or mediating factors such as training, technical support, and organizational culture.

These gaps and limitations of existing research study designs and findings related to health IT and workflow limit the relevance and quality of the available evidence for health care organizations wishing to effectively implement health IT systems to support current work without negatively affecting existing workflow processes. The existing evidence is of equally limited utility to those organizations seeking to use health IT systems to support redesign of their ambulatory care settings.

The goal of the project is to understand the impact of implementing health IT-enabled care coordination on workflow within small community-based primary care clinics in various stages of practice redesign. The focus of this study is the interaction of health IT and care coordination workflow in the context of practice redesign. This study will focus on clinic staff caring for patients with diabetes within small primary care clinics to understand enablers and barriers to care coordination workflow through the use of health IT.

The study will be conducted over a 14-month period in six Vanderbilt University Medical Center (VUMC) affiliated-clinics that each have an electronic health record (EHR) but are in different phases of introducing the health IT component of a care coordination redesign program called My Health Team (MHT). MHT was launched at Vanderbilt University Medical Center to redesign ambulatory care delivery for patients with three chronic conditions (diabetes, hypertension, and congestive heart failure) through intensified patient engagement, dedicated care coordinators, and specific health IT tools to facilitate scalable chronic disease management. The health IT component of MHT, layered on a mature EHR, enables (1) diabetes, hypertension and congestive heart failure registries, (2) a shared view of the care plan for the patient among clinical staff, (3) alerts and reminders to track patients' acute care episodes, (4) closed-loop feedback of patient self-management through at-home physiological monitoring and two-way electronic clinical messaging (via the patient portal), and (5) frequent patient contact with coordinators in between physician visits by telephone and using a secure patient portal.

This study is intended to address existing gaps and generate findings of particular relevance to health IT and workflow by employing a mixed-methods, theoretically-grounded research design that focuses on the socio-technical factors in smaller, ambulatory care settings.

Combining this formal approach with iterative observations and analysis across six clinics for 14 months will generate a detailed understanding of changes in health IT workflow interaction for each clinic over time, and across clinics in various implementation phases (pre-MHT, early-MHT, or mature-MHT). Each clinic will be observed at two time points: the first (time = 0 months) to capture baseline interactions, and the second (time = 12 months) to capture interactions later in adoption. Although each clinic will be observed over a period of 12 months, the total study period will span 14 months to allow for staggered observation windows for the clinics. All clinics are anticipated to exhibit changes to health IT-workflow interactions over time given that learning and efforts to streamline workflow at each practice are ongoing. The early-MHT clinics, engaged actively in practice redesign, will be observed at a third time point—midway between the first and second observation period—since more changes, and possibly more rapid changes in workflow and the use of health IT could occur. The 6-month interval between observation periods was chosen based on prior experience with MHT implementation in which many adoption changes occur during a 3–5 month period during practice redesign. Thus, in clinics anticipated to experience slower change, an observation period of one year is anticipated to allow capture of workflow patterns that have occurred; in fast-changing clinics, a 6-month observation interval will improve capture of key interactions.

This study is being conducted by AHRQ through its contractor, RTI International, 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 project the following activities will be carried out:

(1) Project orientation meeting—Researchers will hold an orientation meeting for clinic staff to introduce them to the study. Up to ten staff members at each clinic will be asked to participate in the orientation meetings. During the orientation meeting, research staff will explain the purpose of the study, provide an overview of the study schedule, explain processes for recruiting individual clinic staff to participate, and answer any questions that clinic staff might have.

(2) Direct observation by researchers of clinic staff performing care coordination activities with patients, caregivers, and providers to capture their workflow, health IT usage, and work processes. A total of 14 observation periods will take place across the six clinics. Each site will have an initial observation period that occurs over several weeks, with an estimated 60 hours of observation time per site. The two sites in the early MHT phase of implementation will also have a middle observation period (at 6 months), and all six sites will have a final observation period (at 12 months). The middle and final observation periods, which build on data gathered during the initial observation period, are shorter—approximately 30 hours of observation per site, because observations will be more targeted as a result of the previously collected contextual data. Observations will be recorded on the Direct Observation Field Notes Form. This data collection will not burden the clinic staff and is not included in the burden estimates in Exhibit 1.

(3) Artifact and spatial data collection—Artifacts such as paper notes or forms, or reminder postcards identified by researchers during direct observations as relevant to understanding workflow and health IT, will be collected.

Spatial data, such as still photographs of the workplace and/or objects in the workplace, will be collected to augment observation data. These will enable the researcher to capture spatial relationships and other dimensions, such as the proximity of work stations, exam rooms, and technology. For

example, a health IT tool may include the functionality to print information to give to the patient, but if the printer is not conveniently located for the user, busy clinic staff may choose not to use this function. An image or drawing of this spatial relationship can be included in the data and will be coded in the data analysis phase. The choice of using a photograph or a drawing will be dependent upon the type of information that is needed to better understand the context of the workflow. For example, to capture the overall configuration of the workspace, photographs will be taken. When other information such as process flows are being captured, the observer will draw a sketch of that process. This may include the steps that a nurse takes to retrieve a patient chart, call the patient from the waiting room, escort the patient to a station where vital signs are measured, and escort them to an exam room.

Artifacts and spatial data will be used to enrich the understanding of the environment in which care coordination activities and health IT interact and will add information that is important for modeling workflow. This data collection will not burden the clinic staff and is not included in the burden estimates in Exhibit 1.

(4) Semi-structured individual interviews and surveys with clinic staff to further understand their use of health information technology and work routines. During each observation period, up to six staff members at each clinic will be asked to participate in semi-structured interviews and to complete the Technology Assessment Model (TAM) survey. The interview will address up to five key topic areas: Demographics; general experience with technology; work routines; interactions with computers in the work context; and strategies for dealing with unanticipated health IT or workflow challenges. The survey will be used to consistently assess the staff attitudes that may impact their experience of using health IT and adapting workflow to their needs.

(5) Semi-structured interviews and surveys with patients with diabetes to gather information from patients as participant-observers of clinical workflow and health IT, to understand the impact of work processes on their experience of care, and to identify enablers and barriers in clinic work processes from their perspective. During the initial observation period in each clinic, and during the final observation period in two of the clinics (early-MHT), eight patients with diabetes will be invited to participate in semi-structured interviews and to complete the Patient Activation Measure and Summary of Diabetes Self-Care Activities surveys (64 patients total). Since fewer changes are anticipated in the pre-MHT and mature-MHT clinics, patients will be interviewed at baseline only in these four clinics. Since the pre-MHT and mature-MHT clinics will not undergo changes in technology during the study period, it is anticipated that saturation of patient experiences and observations of workflow, technology use and interactions will occur during the initial observation period. Greater changes are anticipated at the early-MHT clinics as they adopt MHT, therefore, patient interviews will be conducted at these two clinics twice. The purpose of the patient interviews is to gather information from patients as participant-observers of clinical workflow and health IT, to understand the impact on their experience of care, and to identify enablers and barriers in work processes from their perspective. The interviews will address six key areas related to care coordination, including (1) general care experience; (2) patient workflow; (3) information needs; (4) barriers; (5) strategies; (6) evaluation. The Patient Activation Measure (PAM) and Summary of Diabetes Self-Care Activities (SDSCA) surveys will be used to understand patient motivation for self-care and the potential impact on care processes and workflows.

The focus of this research is anticipated to be relevant to many other settings in which health IT is used to support care coordination activities for diabetes and other chronic conditions. This focus is especially important given the cost and illness burden of diabetes. Information collected by the study will help researchers and practitioners better understand the impact of workflow and health IT in ambulatory care practices.

The lessons learned from this research may be used in a variety of ways: 1) to identify additional workflow components that ambulatory practices should consider when implementing health IT systems; 2) to identify issues to address in best practice guidelines health IT implementation; and 3) to identify issues for consideration in the design and evaluation of other health IT tools.

The study findings will be widely disseminated to health IT researchers and implementers via AHRQ's National Resource Center for Health IT Web site, email alerts, and conference presentations.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annual burden hours for each respondent's time to participate in this study.

A total of up to 60 persons will participate in the project orientation meeting across the six clinics (up to 10 per clinic), which will last up to 30 minutes.

The staff semi-structured interviews will be completed by a total of up to 36 persons across the six clinics (up to 6 per clinic) and requires one hour. Those same individuals will also be asked to complete Technology Acceptance Model surveys; each survey response is estimated to take 30 minutes. Clinic staff interviews and administration of surveys will take place at the clinics either two or three times. Staff interviews will be conducted twice at each of the pre-MHT and mature-MHT clinics, at the initial and final observation periods (eight total sets of interviews), for a total of up to 48 staff interviews. Staff interviews will be conducted three times at the two early-MHT clinics, during the initial, middle, and final observation periods, for up to 36 staff interviews across the two early-MHT clinics for all observation periods. In total, up to 84 interviews of clinic staff will be conducted with up to 36 individual staff for an average of 2.33 responses per staff member, as shown in Exhibit 1.

Up to 64 patients will be asked to participate in the patient-semi structured interview, which should take no longer than 1 hour. Those same patients will be asked to complete the Patient Activation Measures survey, which is estimated to take 12 minutes, and the Summary of Diabetes Self Care Activities survey, which should take no longer than 18 minutes. Patient interviews and surveys will take place at the clinics either once or twice. Up to eight patients will be interviewed during the initial observation period at each of the clinics for a total of 48 patient interviews across all six clinics. Up to 8 patients will be interviewed during the final observation period at each of the two early-MHT clinics, for a total of 16 patient interviews during the final observation period across the two early-MHT clinics. In total, up to 64 patient interviews and surveys will be conducted. The total annual burden is estimated to be 252 hours.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this research. The total annual burden is estimated to be $6,670.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form Name	Maximum number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Project orientation meeting	60	1	30/60	30
Staff Semi-Structured Interviews	36	[a] 2.33	1	84
Technology Acceptance Model Survey	36	[a] 2.33	30/60	42
Patient Semi-Structured Interviews	64	1	1	64
Patient Activation Measures Survey	64	1	12/60	13
Summary of Diabetes Self Care Activities Survey	64	1	18/60	19
Total	324	na	na	252

[a] This is an average based on the study design and the number of interviews that respondents will complete. Two thirds of respondents will participate in two interviews. One third will participate in three interviews.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form Name	Maximum number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Project orientation meeting	60	30	$34.80	$1,044
Staff Semi-Structured Interviews	36	84	32.03	2,691
Technology Acceptance Model Survey	36	42	32.03	1,345
Patient Semi-Structured Interviews	64	64	16.57	1,060
Patient Activation Measures Survey	64	13	16.57	215
Summary of Diabetes Self Care Activities Survey	64	19	16.57	315
	324	252	na	6,670

* Based upon the mean of the average wages, a National Compensation Survey: Occupational wages in the United States May 2011, ''U.S. Department of Labor, Bureau of Labor Statistics.'' For the project orientation meeting, the hourly rate is a weighted average of two physicians or surgeons, all other ($88.78), two registered nurses ($33.32), two licensed practical nurses ($19.79), two medical assistants ($13.99), one health care support worker other ($14.80), and one health care practitioners and technician other ($21.61). For the interviews and surveys with clinic staff, hourly wage is an average including one physician or surgeon, all other ($88.78), one registered nurse ($33.32), one licensed practical nurse ($19.79), one medical assistant ($13.99), one health care support worker other ($14.80), and one health care practitioners and technician other ($21.61). For patient interviews and surveys, median U.S. hourly wage was used.

Estimated Annual Costs to the Federal Government

The total cost of this study is $799,929 over a 36-month time period for an annualized cost of $266,643. Exhibit 3 provides a breakdown of the estimated total and average annual costs by category.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST*

Cost component	Total cost	Annualized cost
Development of Research Plan	$32,520	$10,840
Development of Analysis Plan	24,028	8,009
Compliance with PRA Requirements	21,252	7,084
Conduct Research Study	271,916	90,639
Conduct Data Analysis	279,009	93,003
Develop Final Report of Findings	62,237	20,746
Develop Presentation of Findings	28,670	9,557
Project Administration	58,976	19,659
Coordination with Other AHRQ Offices and Contractors	15,195	5,065
Ensure High Quality 508 Compliant Deliverables	6,125	2,042
Total	799,929	266,643

* Costs are fully loaded including overhead and G&A.

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.

Dated: October 12, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–26596 Filed 10–30–12; 8:45 am]

BILLING CODE M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Notice of Meeting

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: In accordance with section 10 (a)(2) of the Federal Advisory Committee Act (5 U.S.C. App. 2), announcement is made of an Agency for Healthcare Research and Quality (AHRQ) Special Emphasis Panel (SEP) meeting on ''AHRQ NATIONAL RESEARCH SERVICE AWARDS (NRSA) INSTITUTIONAL RESEARCH TRAINING GRANTS (T32)''.

DATES: November 14–15, 2012 (Open on November 14 from 8:00 a.m. to 8:30 a.m. and closed for the remainder of the meeting).

ADDRESSES: Gaithersburg Marriott, RIO, 9751 Washingtonian Boulevard, Gaithersburg, MD 20878.

FOR FURTHER INFORMATION CONTACT: Anyone wishing to obtain a roster of members, agenda or minutes of the non-confidential portions of this meeting should contact: Mrs. Bonnie Campbell, Committee Management Officer, Office of Extramural Research, Education and Priority Populations, AHRQ, 540 Gaither Road, Room 2038, Rockville, Maryland 20850, Telephone: (301) 427–1554.

Agenda items for this meeting are subject to change as priorities dictate.

SUPPLEMENTARY INFORMATION: A Special Emphasis Panel is a group of experts in fields related to health care research who are invited by the Agency for Healthcare Research and Quality (AHRQ), and agree to be available, to conduct on an as needed basis, scientific reviews of applications for AHRQ support.

Individual members of the Panel do not attend regularly-scheduled meetings and do not serve for fixed terms or a long period of time. Rather, they are asked to participate in particular review meetings which require their type of expertise.

Substantial segments of the SEP meeting referenced above will be closed to the public in accordance with the provisions set forth in 5 U.S.C. App. 2, section 10(d), 5 U.S.C. 552b(c)(4), and 5 U.S.C. 552b(c)(6). Grant applications for ''AHRQ NATIONAL RESEARCH SERVICE AWARDS (NRSA) INSTITUTIONAL RESEARCH TRAINING GRANTS (T32)'' are to be reviewed and discussed at this meeting. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Dated: October 12, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–26597 Filed 10–30–12; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Patient Safety Organizations: Voluntary Relinquishment From PDR Secure, LLC

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Notice of Delisting.

SUMMARY: The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act), Public Law 109–41, 42 U.S.C. 299b–21–b–26, provides for the formation of Patient Safety Organizations (PSOs), which collect, aggregate, and analyze confidential information regarding the quality and safety of health care delivery. The Patient Safety and Quality Improvement Final Rule (Patient Safety Rule), 42 CFR Part 3, authorizes AHRQ, on behalf of the Secretary of HHS, to list as a PSO an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be ''delisted'' by the Secretary if it is found no longer to meet the requirements of the Patient Safety Act and Patient Safety Rule, or when a PSO chooses to voluntarily relinquish its status as a PSO for any reason. AHRQ has accepted a notification of voluntary relinquishment from PDR Secure, LLC of its status as a PSO, and has delisted the PSO accordingly.

DATES: The directories for both listed and delisted PSOs are ongoing and reviewed weekly by AHRQ. The delisting was effective at 12:00 Midnight ET (2400) on August 31, 2012.

ADDRESSES: Both directories can be accessed electronically at the following HHS Web site: *http://www.pso.AHRQ.gov/index.html*.

FOR FURTHER INFORMATION CONTACT: Eileen Hogan, 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 Act authorizes the listing of PSOs, which are entities or component organizations whose mission and primary activity is to conduct activities to improve patient safety and the quality of health care delivery.

HHS issued the Patient Safety Rule to implement the Patient Safety Act. AHRQ administers the provisions of the Patient Safety Act and Patient Safety Rule (PDF file, 450 KB. PDF Help) relating to the listing and operation of PSOs. The Patient Safety Rule authorizes AHRQ to list as a PSO an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be ''delisted'' if it is found no longer to meet the requirements of the Patient Safety Act and Patient Safety Rule, or when a PSO chooses to voluntarily relinquish its status as a PSO for any reason. Section 3.108(d) of the Patient Safety Rule requires AHRQ to provide public notice when it removes an organization from the list of federally approved PSOs.

AHRQ has accepted a notification from PDR Secure, LLC, PSO number P0098, which is a component entity of PDR Network, LLC, to voluntarily relinquish its status as a PSO. Accordingly, PDR Secure, LLC was delisted effective at 12:00 Midnight ET (2400) on August 31, 2012. PDR Network, LLC represents that it has patient safety work product (PSWP) in its possession. The PSO is obligated to meet the requirements of section 3.108(c)(2)(i) of the Patient Safety Rule to notify the sources from which it received PSWP of the PSO's intention to cease PSO operations and activities, to relinquish voluntarily its status as a PSO, to request that these other entities