desk officer for the agencies by mail to the Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 10235, 725 17th Street NW., Washington, DC 20503; by fax to (202) 395–6974; or by email to *oira_submission@omb.eop.gov.*

FOR FURTHER INFORMATION CONTACT: Additional information or a copy of the collections may be requested from Nuha Elmaghrabi, Federal Reserve Board Clearance Officer, (202) 452–3829, Office of the Chief Data Officer, Board of Governors of the Federal Reserve System, 20th and C Streets NW., Washington, DC 20551. Telecommunications Device for the Deaf (TDD) users may call (202) 263–4869.

SUPPLEMENTARY INFORMATION: Proposal to request approval from OMB of the extension for three years, without revision, of the following reports:

1. Report titles: Report of Assets and Liabilities of U.S. Branches and Agencies of Foreign Banks; Report of Assets and Liabilities of a Non-U.S. Branch that is Managed or Controlled by a U.S. Branch or Agency of a Foreign (Non-U.S.) Bank.

Agency form numbers: FFIEC 002; FFIEC 002S.

OMB control number: 7100–0032.

Frequency of response: Quarterly.

Affected public: U.S. branches and agencies of foreign banks.

Number of respondents: FFIEC 002—223; FFIEC 002S—49.

Estimated average time per response: FFIEC 002—25.43 hours; FFIEC 002S—6.0 hours.

Estimated total annual burden: FFIEC 002—22,684 hours; FFIEC 002S—1,176 hours.

General description of reports: These information collections are mandatory (12 U.S.C. 3105(c)(2), 1817(a)(1) and (3), and 3102(b)). Except for select sensitive items, the FFIEC 002 is not given confidential treatment; the FFIEC 002S is given confidential treatment (5 U.S.C. 552(b)(4) and (8)).

Abstract: On a quarterly basis, all U.S. branches and agencies of foreign banks are required to file the FFIEC 002, which is a detailed report of condition with a variety of supporting schedules. This information is used to fulfill the supervisory and regulatory requirements of the International Banking Act of 1978. The data are also used to augment the bank credit, loan, and deposit information needed for monetary policy and other public policy purposes. The FFIEC 002S is a supplement to the FFIEC 002 that collects information on assets and liabilities of any non-U.S. branch that is managed or controlled by a U.S. branch or agency of the foreign bank. Managed or controlled means that a majority of the responsibility for business decisions, including but not limited to decisions with regard to lending or asset management or funding or liability management, or the responsibility for recordkeeping in respect of assets or liabilities for that foreign branch, resides at the U.S. branch or agency. A separate FFIEC 002S must be completed for each managed or controlled non-U.S. branch. The FFIEC 002S must be filed quarterly along with the U.S. branch or agency's FFIEC 002. The data from both reports are used for (1) monitoring deposit and credit transactions of U.S. residents; (2) monitoring the impact of policy changes; (3) analyzing structural issues concerning foreign bank activity in U.S. markets; (4) understanding flows of banking funds and indebtedness of developing countries in connection with data collected by the International Monetary Fund and the Bank for International Settlements that are used in economic analysis; and (5) assisting in the supervision of U.S. offices of foreign banks. The Federal Reserve System collects and processes these reports on behalf of all three agencies. No changes were proposed to the FFIEC 002 and FFIEC 002S reporting forms or instructions.

2. Report title: Country Exposure Report for U.S. Branches and Agencies of Foreign Banks.

Agency form number: FFIEC 019.

OMB control number: 7100–0213.

Frequency of response: Quarterly.

Affected public: U.S. branches and agencies of foreign banks.

Number of respondents: 167.

Estimated average time per response: 10 hours.

Estimated total annual burden: 6,680 hours.

General description of reports: This information collection is mandatory (12 U.S.C. 3906 for all agencies); 12 U.S.C. 3105 and 3108 for the Board; 12 U.S.C. 1817 and 1820 for the FDIC; and 12 U.S.C. 161 for the OCC. This information collection is given confidential treatment under the Freedom of Information Act (5 U.S.C. 552(b)(8)).

Abstract: All individual U.S. branches and agencies of foreign banks that have more than $30 million in direct claims on residents of foreign countries must file the FFIEC 019 report quarterly. Currently, all respondents report adjusted exposure amounts to the five largest countries having at least $20 million in total adjusted exposure. The agencies collect this data to monitor the extent to which such branches and agencies are pursuing prudent country risk diversification policies and limiting potential liquidity pressures. No changes were proposed to the FFIEC 019 reporting form or instructions.

Board of Governors of the Federal Reserve System, August 12, 2015.

Robert deV. Frierson,

Secretary of the Board.

[FR Doc. 2015–20275 Filed 8–17–15; 8:45 am]

BILLING CODE 6210–01–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 September 2, 2015.

A. Federal Reserve Bank of Richmond (Adam M. Drimer, Assistant Vice President) 701 East Byrd Street, Richmond, Virginia 23261–4528:

1. *Robert G. Lowe,* Fort Myers, Florida; to acquire voting shares of Palmetto Heritage Bancshares, Inc., and thereby indirectly acquire voting shares of Palmetto Heritage Bank & Trust, both in Pawleys Island, South Carolina.

Board of Governors of the Federal Reserve System, August 13, 2015.

Margaret McCloskey Shanks,

Deputy Secretary of the Board.

[FR Doc. 2015–20321 Filed 8–17–15; 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 changes to the currently approved information collection project: ''*Medical Expenditure Panel Survey (MEPS) Household Component and the MEPS Medical Provider Component.*'' 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 September 20, 2015 and allowed 60 days for public comment. AHRQ received no 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 September 17, 2015.

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.*

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

Medical Expenditure Panel Survey (MEPS) Household Component (HC)

For over thirty years, results from the MEPS and its predecessor surveys (the 1977 National Medical Care Expenditure Survey, the 1980 National Medical Care Utilization and Expenditure Survey and the 1987 National Medical Expenditure Survey) have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses and health policy.

Major changes continue to take place in the health care delivery system. The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment, income, health insurance and health status over two years. The use of the National Health Interview Survey (NHIS) as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

Households selected for participation in the MEPS–HC are interviewed five times in person. These rounds of interviewing are spaced about 5 months apart. The interview will take place with a family respondent who will report for him or herself and for other family members.

The goal of MEPS–HC is to provide nationally representative estimates for the U.S. civilian noninstitutionalized population for health care use, expenditures, sources of payment and health insurance coverage.

Medical Expenditure Panel Survey (MEPS) Medical Provider Component (MPC)

The MEPS–MPC will contact medical providers (hospitals, physicians, home health agencies and institutions) identified by household respondents in the MEPS–HC as sources of medical care for the time period covered by the interview, and all pharmacies providing prescription drugs to household members during the covered time period. The MEPS–MPC is not designed to yield national estimates as a stand-alone survey. The sample is designed to target the types of individuals and providers for whom household reported expenditure data was expected to be insufficient. For example, Medicaid enrollees are targeted for inclusion in the MEPS–MPC because this group is expected to have limited information about payments for their medical care.

There is one addition to the MEPS–MPC being implemented in this renewal request, the MEPS MPC Medical Organizations Survey (MOS). The MEPS MOS will expand current MPC data collection activities to include information on the organization of the practices of office-based care providers identified as a usual source of care in the MEPS MPC. This additional data collection will be for a subset of office-based care providers already included in the MEPS MPC sample. In the MEPS MPC sample, for a nationally representative sample of adults, primary location for individual's office-based usual sources of care will be identified. The MEPS MPC will contact these places where medical care is provided, determine the appropriate respondent and administer a MEPS MOS. The design of the survey will be multimodal including some telephone contact. Additional data collection methods may include phone, fax, mail, self administration, electronic transmission, and the Web. The data collection method chosen for a provider shall be the method that results in the most complete and accurate data with least burden to the provider.

The MEPS–MPC collects event level data about medical care received by sampled persons during the relevant time period. The data collected from medical providers include:

- Dates on which medical encounters during the reference period occurred.
- Data on the medical content of each encounter, including ICD–9 (or ICD–10) and CPT–4 codes.
- Data on the charges associated with each encounter, the sources paying for the medical care, including the patient/family, public sources, and private insurance, and amounts paid by each source.

Data collected from pharmacies include:

- Date of prescription fill
- National drug code (NDC) or prescription name, strength and form
- Quantity
- Payments, by source

The MEPS–MPC has the following goal:

- To serve as an imputation source for and to supplement/replace household reported expenditure and source of payment information. This data will supplement, replace and verify information provided by household respondents about the charges, payments, and sources of payment associated with specific health care encounters.

This study is being conducted by AHRQ through its contractors, Westat and 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 cost and use of health care services and with respect to health statistics and surveys. 42 U.S.C. 299a(a)(3) and (8); 42 U.S.C. 299b–2.

Method of Collection

To achieve the goals of the MEPS–HC the following data collections are implemented:

1. Household Component Core Instrument. The core instrument collects data about persons in sample households. Topical areas asked in each round of interviewing include condition enumeration, health status, health care utilization including prescribed medicines, expense and payment, employment, and health insurance. Other topical areas that are asked only once a year

include access to care, income, assets, satisfaction with health plans and providers, children's health, and adult preventive care. While many of the questions are asked about the entire reporting unit (RU), which is typically a family, only one person normally provides this information. All sections of the current core instrument are available on the AHRQ Web site at *http://meps.ahrq.gov/mepsweb/survey_comp/survey_questionnaires.jsp.*

2. Adult Self-Administered Questionnaire. A brief self-administered questionnaire will be used to collect self-reported (rather than through household proxy) information on health status, health opinions and satisfaction with health care for adults 18 and older (see *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#supplemental*). The satisfaction with health care items are a subset of items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The health status items are from the Short Form 12 Version 2 (SF–12 version 2), which has been widely used as a measure of self-reported health status in the United States, the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ–2). This questionnaire is unchanged from the previous OMB clearance.

3. Diabetes Care Self-Administered Questionnaire. A brief self-administered paper-and-pencil questionnaire on the quality of diabetes care is administered once a year (during round 3 and 5) to persons identified as having diabetes. Included are questions about the number of times the respondent reported having a hemoglobin A1c blood test, whether the respondent reported having his or her feet checked for sores or irritations, whether the respondent reported having an eye exam in which the pupils were dilated, the last time the respondent had his or her blood cholesterol checked and whether the diabetes has caused kidney or eye problems. Respondents are also asked if their diabetes is being treated with diet, oral medications or insulin. This questionnaire is unchanged from the previous OMB clearance. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#supplemental.*

4. Authorization forms for the MEPS–MPC Provider and Pharmacy Survey. As in previous panels of the MEPS, we will ask respondents for authorization to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC_AF* for the pharmacy and provider authorization forms.

5. MEPS Validation Interview. Each interviewer is required to have at least 15 percent of his/her caseload validated to insure that computer-assisted personal interview (CAPI) questionnaire content was asked appropriately and procedures followed, for example the use of show cards. Validation flags are set programmatically for cases pre-selected by data processing staff before each round of interviewing. Home office and field management may also request that other cases be validated throughout the field period. When an interviewer fails a validation all their work is subject to 100 percent validation. Additionally, any case completed in less than 30 minutes is validated. A validation abstract form containing selected data collected in the CAPI interview is generated and used by the validator to guide the validation interview.

To achieve the goal of the MEPS–MPC the following data collections are implemented:

1. MPC Contact Guide/Screening Call. An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS–MPC, the appropriate MEPS–MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of these seven provider types in the MEPS–MPC, except for the two home care provider types which use the same screening form; see *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC_CG.*

2. Home Care Provider Questionnaire for Health Care Providers. This questionnaire is used to collect data from home health care agencies which provide medical care services to household respondents. Information collected includes type of personnel providing care, hours or visits provided per month, and the charges and payments for services received. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

3. Home Care Provider Questionnaire for Non-Health Care Providers. This questionnaire is used to collect information about services provided in the home by non-health care workers to household respondents because of a medical condition; for example, cleaning or yard work, transportation, shopping, or child care. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

4. Medical Event Questionnaire for Office-Based Providers. This questionnaire is for office-based physicians, including doctors of medicine (MDs) and osteopathy (DOs), as well as providers practicing under the direction or supervision of an MD or DO (*e.g.,* physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as HMOs are included. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

5. Medical Event Questionnaire for Separately Billing Doctors. This questionnaire collects information from physicians identified by hospitals (during the Hospital Event data collection) as providing care to sampled persons during the course of inpatient, outpatient department or emergency room care, but who bill separately from the hospital. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

6. Hospital Event Questionnaire. This questionnaire is used to collect information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the hospital itself; the doctors that do bill separately from the hospital will be contacted as part of the Medical Event Questionnaire for Separately Billing Doctors. HMOs are included in this provider type. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

7. Institution Event Questionnaire. This questionnaire is used to collect information about institution events, including nursing homes, rehabilitation facilities and skilled nursing facilities. Institution data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay. In many cases, the institution administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the institution itself. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC*).

8. Pharmacy Data Collection Questionnaire. This questionnaire requests the national drug code (NDC) and when that is not available the prescription name, date prescription was filled, payments by source, prescription strength and form (when the NDC is not available), quantity, and person for whom the prescription was filled. When the NDC is available, we do not ask for prescription name, strength or form because that information is embedded in the NDC; this reduces burden on the respondent. Most pharmacies have the requested information available in electronic format and respond by providing a computer-generated printout of the patient's prescription information. If the computerized form is unavailable, the pharmacy can report their data to a telephone interviewer. Pharmacies are also able to provide a CD–ROM with the requested information if that is preferred. HMOs are included in this provider type. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

9. Medical Organizations Survey Questionnaire. This questionnaire will collect essential information on important features of the staffing, organization, policies, and financing for identified usual source of office based care providers. This additional data collection will be a subset of office based care providers already included in the MEPS MPC sample and will be a nationally representative sample of adults' primary location for individuals office based usual sources of care.

Dentists, optometrists, psychologists, podiatrists, chiropractors, and others not providing care under the supervision of a MD or DO are considered out of scope for the MEPS–MPC.

The MEPS is a multi-purpose survey. In addition to collecting data to yield annual estimates for a variety of

measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, consumer assessment of health care, health insurance coverage, demographic characteristics, employment and access to health care indicators. Estimates can be provided for individuals, families and population subgroups of interest. Data obtained in this study are used to provide, among others, the following national estimates:

- Annual estimates of health care use and expenditures for persons and families
- Annual estimates of sources of payment for health care utilizations, including public programs such as Medicare and Medicaid, private insurance, and out of pocket payments
- Annual estimates of health care use, expenditures and sources of payment of persons and families by type of utilization including inpatient stay, ambulatory care, home health, dental care and prescribed medications
- The number and characteristics of the population eligible for public programs including the use of services and expenditures of the population(s) eligible for benefits under Medicare and Medicaid
- The number, characteristics, and use of services and expenditures of persons and families with various forms of insurance
- Annual estimates of consumer satisfaction with health care, and indicators of health care quality for key conditions
- Annual estimates to track disparities in health care use and access

In addition to national estimates, data collected in this ongoing, longitudinal study are used to study the determinants of the use of services and expenditures, and changes in the access to and the provision of health care in relation to:

- Socio-economic and demographic factors such as employment or income
- The health status and satisfaction with health care of individuals and families
- The health needs and circumstances of specific subpopulation groups such as the elderly and children

To meet the need for national data on health care use, access, cost and quality, MEPS–HC collects information on:

- Access to care and barriers to receiving needed care
- Satisfaction with usual providers
- Health status and limitations in activities
- Medical conditions for which health care was used
- Use, expense and payment (as well as insurance status of person receiving care) for health services

Given the twin problems of the lack of response and response error of some household reported data, information is collected directly from medical providers in the MEPS–MPC to improve the accuracy of expenditure estimates derived from the MEPS–HC. Because of their greater level of precision and detail, we also use MEPS–MPC data as the main source of imputations of missing expenditure data. Thus, the MEPS–MPC is designed to satisfy the following analytical objectives:

- Serve as source data for household reported events with missing expenditure information
- Serve as an imputation source to reduce the level of bias in survey estimates of medical expenditures due to item nonresponse and less complete and less accurate household data
- Serve as the primary data source for expenditure estimates of medical care provided by separately billing doctors in hospitals, emergency rooms, and outpatient departments, Medicaid recipients and expenditure estimates for pharmacies
- Allow for an examination of the level of agreement in reported expenditures from household respondents and medical providers

Data from the MEPS, both the HC and MPC components, are intended for a number of annual reports produced by AHRQ, including the National Healthcare Quality and Disparities Report.

The MEPS MPC MOS data will be used to create a database that will be unique in providing an internally consistent source of information both on individuals' characteristics and health care utilization and expenditures, and on the characteristics of the providers they use. The following areas will be addressed in the MOS as they potentially affect individuals' access to, use of and affordability of health care services:

- Organizational characteristics, *e.g.,* size, specialties covered, practice rules and procedures, patient mix and scope of care provided, membership in an ACO, certification as a primary care medical home
- Use of health information technology
- Policies and practices related to the Affordable Care Act
- Financial arrangements, *e.g.,* reimbursement methods, number and types of insurance contracts, compensation arrangements within the practice

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in the MEPS–HC and the MEPS–MPC. The MEPS–HC Core Interview will be completed by 15,093* (see note below Exhibit 1) ''family level'' respondents, also referred to as RU respondents. Since the MEPS–HC consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS–HC core requires an average time of 92 minutes to administer. The Adult SAQ will be completed once a year by each person in the RU that is 18 years old and older, an estimated 28,254 persons. The Adult SAQ requires an average of 7 minutes to complete. The Diabetes care SAQ will be completed once a year by each person in the RU identified as having diabetes, an estimated 2,345 persons, and takes about 3 minutes to complete. The authorization form for the MEPS–MPC Provider Survey will be completed once for each medical provider seen by any RU member. The 14,489 RUs in the MEPS–HC will complete an average of 5.4 forms, which require about 3 minutes each to complete. The authorization form for the MEPS–MPC Pharmacy Survey will be completed once for each pharmacy for any RU member who has obtained a prescription medication. RUs will complete an average of 3.1 forms, which take about 3 minutes to complete. About one third of all interviewed RUs will complete a validation interview as part of the MEPS–HC quality control, which takes an average of 5 minutes to complete. The total annual burden hours for the MEPS–HC are estimated to be 67,826 hours.

All medical providers and pharmacies included in the MEPS–MPC will receive a screening call and the MEPS–MPC uses 7 different questionnaires; 6 for medical providers and 1 for pharmacies. Each questionnaire is relatively short and requires 2 to 15 minutes to complete. The total annual burden hours for the MEPS–MPC are estimated to be 18,876 hours. The total annual burden for the MEPS–HC and MPC is estimated to be 86,702 hours.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection. The annual cost burden for the MEPS–HC is estimated to be $1,540,328; the annual cost burden for the MEPS–MPC is estimated to be $302,985. The total annual cost burden for the MEPS–HC and MPC is estimated to be $1,843,313.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
MEPS–HC				
MEPS–HC Core Interview	*15,093	2.5	92/60	57,857
Adult SAQ	28,254	1	7/60	3,296
Diabetes care SAQ	2,345	1	3/60	117
Authorization form for the MEPS–MPC Provider Survey	14,489	5.4	3/60	3,912
Authorization form for the MEPS–MPC Pharmacy Survey	14,489	3.1	3/60	2,246
MEPS–HC Validation Interview	4,781	1	5/60	398
Subtotal for the MEPS–HC	79,451	na	na	67,826
MEPS–MPC/MOS				
MPC Contact Guide/Screening Call**	35,222	1	2/60	1,174
Home care for health care providers questionnaire	532	1.49	9/60	119
Home care for non–health care providers questionnaire	25	1	11/60	5
Office-based providers questionnaire	11,785	1.44	10/60	2,828
Separately billing doctors questionnaire	12,693	3.43	13/60	9,433
Hospitals questionnaire	5,077	3.51	9/60	2,673
Institutions (non-hospital) questionnaire	117	2.03	9/60	36
Pharmacies questionnaire	4,993	4.44	3/60	1,108
Medical Organizations Survey questionnaire	6,000	1	15/60	1,500
Subtotal for the MEPS–MPC	76,444	na	na	18,876
Grand Total	155,895	na	na	86,702

*While the expected number of responding units for the annual estimates is 14,489, it is necessary to adjust for survey attrition of initial respondents by a factor of 0.96 (15,093 = 14,489/0.96).

**There are 6 different contact guides; one for office based, separately billing doctor, hospital, institution, and pharmacy provider types, and the two home care provider types use the same contact guide.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate	Total cost burden
MEPS–HC				
MEPS–HC Core Interview	15,093	57,857	*$22.71	$1,313,932
Adult SAQ	28,254	3,296	*22.71	74,852
Diabetes care SAQ	2,345	117	*22.71	2,657
Authorization forms for the MEPS–MPC Provider Survey	14,489	3,912	*22.71	88,842
Authorization form for the MEPS–MPC Pharmacy Survey	14,489	2,246	*22.71	51,007
MEPS–HC Validation Interview	4,781	398	*22.71	9,039
Subtotal for the MEPS–HC	79,451	67,826	na	1,540,328
MEPS–MPC/MOS				
MPC Contact Guide/Screening Call	35,222	1,174	**16.12	18,925
Home care for health care providers questionnaire	532	119	**16.12	1,918
Home care for non–health care providers questionnaire	25	5	**16.12	81
Office–based providers questionnaire	11,785	2,828	**16.12	45,587
Separately billing doctors questionnaire	12,693	9,433	**16.12	152,060
Hospitals questionnaire	5,077	2,673	**16.12	43,089
Institutions (non-hospital) questionnaire	117	36	**16.12	580
Pharmacies questionnaire	4,993	1,108	***14.95	16,565
Medical Organizations Survey questionnaire	6,000	1,500	**16.12	24,180
Subtotal for the MEPS–MPC	76,444	18,876	na	302,985
Grand Total	155,895	86,073	na	1,843,313

*Mean hourly wage for All Occupations (00–0000).

**Mean hourly wage for Medical Secretaries (43–6013).

***Mean hourly wage for Pharmacy Technicians (29–2052).

Occupational Employment Statistics, May 2014 National Occupational Employment and Wage Estimates United States, U.S. Department of Labor, Bureau of Labor Statistics. *http://www.bls.gov/oes/current/oes_nat.htm#b29-0000*.

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. 2015–20358 Filed 8–17–15; 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: ''*Pilot Test of the Proposed Hospital Survey on Patient Safety Culture Version 2.0.*'' 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 May 7, 2015 and allowed 60 days for public comment. AHRQ received one comment of substance. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by September 17, 2015.

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:

Pilot Test of the Proposed Hospital Survey on Patient Safety Culture Version 2.0

Proposed Project

In 2004, AHRQ developed and published a measurement tool to assess the culture of patient safety in hospitals (OMB control no. 0935–0115). The *Hospital Survey on Patient Safety Culture* (HSOPS) is a survey of providers and staff that can be implemented by hospitals to identify strengths and areas for patient safety culture improvement as well as raise awareness about patient safety. When conducted routinely, the survey can be used to examine trends in patient safety culture over time and evaluate the cultural impact of patient safety initiatives and interventions. The data can also be used to make comparisons across hospital units. AHRQ also produced a survey user's guide to assist hospitals in conducting the survey successfully. The guide addresses issues such as which providers and staff should complete the survey, how to select a sample of hospital providers and staff, how to administer the questionnaire, and how to analyze and report on the resulting data.

Since 2004, thousands of hospitals within the U.S. and internationally have implemented the survey. In response to requests for comparative data from other hospitals, AHRQ funded the development of a comparative database on the survey in 2006 (OMB control no. 0935–0162). The database is currently compiled every two years, using the latest data provided by participating hospitals (and retaining submitted data for no more than 2 years). Reports describing the findings from analysis of the database are made available on the AHRQ Web site to assist hospitals in comparing their results. The 2014 database contains data from 405,281 hospital provider and staff respondents within 653 participating hospitals. The 2014 User Comparative Database Report presents results by hospital characteristics (*e.g.,* number of beds, teaching status, geographic location) and respondent characteristics (*e.g.,* position type, work area/unit).

The survey constructed in 2004 remains in use today, more than 10 years after its initial launch. Since the launch of HSOPS, AHRQ has funded development of patient safety culture surveys for other settings. In 2008, surveys were published for outpatient medical offices (OMB control no. 0935–0131) and nursing homes (OMB control no. 0935–0132). In 2012, a survey for community pharmacies (OMB control no. 0935–0183) was released. Surveys for each setting built upon the strengths of HSOPS but improved and updated items where appropriate.

Users of HSOPS have provided feedback over the years suggesting that changes to the instrument would be valuable and welcomed. The comparative database registrants provided feedback about potential changes in 2013, and telephone interviews were conducted with 8 current survey users and vendors to gain an in-depth understanding of their thoughts on the current survey and possible changes. As a result of this feedback, the *Hospital Survey on Patient Safety Culture Version 2.0* (HSOPS 2.0) is being constructed with the following 8 objectives in mind.

(1) Shift to a Just Culture framework for understanding responses to errors. In the original HSOPS, questions around responses to errors were negatively worded to detect a ''culture of blame'' in organizations. For example, respondents evaluated the extent to which errors were held against them and whether it felt as though the person was being written up rather than the problem. In contrast, a Just Culture framework emphasizes learning from mistakes, providing a safe environment for reporting errors, and utilizing a balanced approach to errors that considers both system and individual behavioral reasons as causes for errors. New items will be constructed in HSOPS 2.0 to capture the extent to which positive responses to error consistent with a Just Culture framework are present in an organization. For example, respondents will be asked to evaluate the extent to which the organization tries to understand the factors that lead to patient safety errors.

(2) Reduce the number of negatively worded items. The original HSOPS had negatively worded items. For example, respondents are asked whether there are ''patient safety problems in this unit'' (negatively worded). Using some negatively worded items was intended