*A. Federal Reserve Bank of Minneapolis* (Mark A. Rauzi, Vice President) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. *Todd Tyrell Ellestad, Andover, Minnesota;* to acquire voting shares of Equity Bank Holding Company, Inc., Minnetonka, Minnesota, and thereby indirectly acquire shares of Equity Bank, Minnetonka, Minnesota.

Board of Governors of the Federal Reserve System, February 21, 2018.

**Ann E. Misback,**

*Secretary of the Board.*

[FR Doc. 2018–03815 Filed 2–23–18; 8:45 am]

**BILLING CODE 6210–01–P**

## GENERAL SERVICES ADMINISTRATION

**[Notice–WWICC–2018–01; Docket No. 2018–0003; Sequence No. 1]**

### World War One Centennial Commission; Notification of Upcoming Public Advisory Meeting

**AGENCY:** World War One Centennial Commission, GSA.

**ACTION:** Meeting notice.

**SUMMARY:** Notice of this meeting is being provided according to the requirements of the Federal Advisory Committee Act. This notice provides the schedule and agenda for the March 20, 2018 meeting of the World War One Centennial Commission (the Commission). The meeting is open to the public.

**DATES:** *Meeting date:* The meeting will be held on Tuesday, March 20, 2018, starting at 9:00 a.m. Eastern Standard Time (EST), and ending no later than 12:00 p.m., EST. Written Comments may be submitted to the Commission and will be made part of the permanent record of the Commission.

Registered speakers/organizations will be allowed five minutes, and will need to provide written copies of their presentations. Requests to comment, together with presentations for the meeting, must be received by Friday, March 9, 2018, by 5:00 p.m., EST, and may be provided by email to *daniel.dayton@worldwar1centennial.gov.*

**ADDRESSES:** The meeting will be held telephonically. The call will be convened at the Offices of the World War One Centennial Commission at 1800 G Street NW, Washington, DC 20006. This location is handicapped accessible. Persons attending in person are requested to refrain from using perfume, cologne, and other fragrances.

Contact Daniel S. Dayton at *daniel.dayton@worldwar1centennial.gov* to register to comment during the meeting's 30-minute public comment Please contact Mr. Dayton at the email address above to obtain meeting materials.

**FOR FURTHER INFORMATION CONTACT:** Daniel S. Dayton, Designated Federal Officer, World War One Centennial Commission, 701 Pennsylvania Avenue NW, Ste. 123, Washington, DC 20004, telephone 202–380–0725 (*note:* this is not a toll-free number).

**SUPPLEMENTARY INFORMATION:**

#### Background

The World War One Centennial Commission was established by Public Law 112–272 (as amended), as a commission to ensure a suitable observance of the centennial of World War I, to provide for the designation of memorials to the service of members of the United States Armed Forces in World War I, and for other purposes. Under this authority, the Commission will plan, develop, and execute programs, projects, and activities to commemorate the centennial of World War I, encourage private organizations and State and local governments to organize and participate in activities commemorating the centennial of World War I, facilitate and coordinate activities throughout the United States relating to the centennial of World War I, serve as a clearinghouse for the collection and dissemination of information about events and plans for the centennial of World War I, and develop recommendations for Congress and the President for commemorating the centennial of World War I. The Commission does not have an appropriation and operates on donated funds.

#### Agenda: Tuesday, March 20, 2018

Old Business:

- Acceptance of minutes of last meeting
- Public Comment Period

New Business:

- Executive Director's Report—Executive Director Dayton
- Executive Committee Report—Commissioner Hamby
- Financial Committee Report—Vice Chair Fountain
- Memorial Report—Vice Chair Fountain
- Fundraising Report—Commissioner Sedgwick
- Education Report—Dr. O'Connell
- Endorsements—(RFS)—Dr. Seefried
- International Report—Dr. Seefried
- Armistice Centennial Events Committee (ACE) Report—Commissioner Monahan
- Other Business
- Chairman's Report
- Set Next Meeting
- Motion to Adjourn

Dated: February 21, 2018.

**Daniel S. Dayton,**

*Designated Federal Official, World War I Centennial Commission.*

[FR Doc. 2018–03830 Filed 2–23–18; 8:45 am]

**BILLING CODE 6820–95–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.*''

This proposed information collection was previously published in the **Federal Register** on December 22, 2017 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 March 28, 2018.

**ADDRESSES:** Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by email at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk officer).

**FOR FURTHER INFORMATION CONTACT:** Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by email at *doris.lefkowitz@AHRQ.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

#### Proposed Project

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

In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection. 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 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/herself and for other family members.

The only change to the MEPS–HC from the previous OMB clearance is an update to the existing Adult Self-Administered Questionnaire (SAQ).

The MEPS–HC has the following goal:

▪ To provide nationally representative estimates for the U.S. civilian noninstitutionalized population for:

- Health care use, expenditures, sources of payment
- 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.

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 occurred during the reference period
- 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, such as 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 on which a prescription was filled
- National drug code 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.

There are no changes to the MEPS–MPC from the previous OMB clearance.

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, which is typically a family, only one person normally provides this information. All sections of the current core instrument are available on the AHRQ website at *http://meps.ahrq.gov/mepsweb/survey_comp/survey_questionnaires.jsp.*

2. *Adult Self-Administered Questionnaire.* A brief self-administered questionnaire (SAQ) 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. The health status items are from the Veterans Rand 12-item health survey (VR–12). Additionally there are questions addressing adult preventive care for both males and females. This questionnaire has changed from the previous OMB clearance.

3. *Diabetes Care SAQ.* A brief self-administered, paper-and-pencil questionnaire on the quality of diabetes care is administered once a year (during rounds 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. 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, AHRQ 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 or 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 his or her 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 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 using a unique screening instrument 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, for example, cleaning or yard work, transportation, shopping, or child care, provided in the home by non-health care workers to household respondents who can't complete them because of a medical condition. 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 staff model 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 during the Hospital Event data collection by hospitals 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. *Institutions Event Questionnaire.* This questionnaire is used to collect information about vents in institutions other than hospitals, 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, the questionnaire does 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 its 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 are linked to MEPS sample respondents to enable analyses at the person-level using characteristics of provider practices.

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.

**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 response 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 $1,618,328; the annual cost burden for the MEPS–MPC is estimated to be $316,532. The total annual cost burden for the MEPS–HC and MPC is estimated to be $1,934,860.

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 | *23.86 | 1,380,468 |
| Adult SAQ | 28,254 | 3,296 | *23.86 | 78,643 |
| Diabetes care SAQ | 2,345 | 117 | *23.86 | 2,792 |
| Authorization forms for the MEPS–MPC Provider Survey | 14,489 | 3,912 | *23.86 | 93,340 |
| Authorization form for the MEPS–MPC Pharmacy Survey | 14,489 | 2,246 | *23.86 | 53,590 |
| MEPS–HC Validation Interview | 4,781 | 398 | *23.86 | 9,496 |
| Subtotal for the MEPS–HC | 79,451 | 67,826 | na | 1,618,328 |
| MEPS–MPC/MOS: | | | | |
| MPC Contact Guide/Screening Call | 35,222 | 1,174 | **16.85 | 19,782 |
| Home care for health care providers questionnaire | 532 | 119 | **16.85 | $2,005 |
| Home care for non-health care providers questionnaire | 25 | 5 | **16.85 | 84 |
| Office-based providers questionnaire | 11,785 | 2,828 | **16.85 | 47,652 |
| Separately billing doctors questionnaire | 12,693 | 9,433 | **16.85 | 158,946 |
| Hospitals questionnaire | 5,077 | 2,673 | **16.85 | 45,040 |
| Institutions (non-hospital) questionnaire | 117 | 36 | **16.85 | 607 |
| Pharmacies questionnaire | 4,993 | 1,108 | ***15.47 | 17,141 |
| Medical Organizations Survey questionnaire | 6,000 | 1,500 | **16.85 | 25,275 |
| Subtotal for the MEPS–MPC | 76,444 | 18,876 | na | 316,532 |

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN—Continued

| Form name | Number of respondents | Total burden hours | Average hourly wage rate ($) | Total cost burden ($) |
|---|---|---|---|---|
| Grand Total | 155,895 | 86,073 | na | 1,934,860 |

* 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 2016 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.

**Karen J. Migdail,**

*Chief of Staff.*

[FR Doc. 2018–03855 Filed 2–23–18; 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 ''*Patient Safety Organization Certification for Initial Listing and Related Forms, Patient Safety Confidentiality Complaint Form, and Common Formats.*''

**DATES:** Comments on this notice must be received by April 27, 2018.

**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 emails at *doris.lefkowitz@AHRQ.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

**Proposed Project**

''*Patient Safety Organization Certification for Initial Listing and Related Forms, Patient Safety Confidentiality Complaint Form, and Common Formats.*''

In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection. The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act), signed into law on July 29, 2005, was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System.* The goal of the statute is to create a national learning system. By providing incentives of nation-wide confidentiality and legal privilege, the PSO learning system improves patient safety and quality by providing an incentive for health care providers to work voluntarily with experts in patient safety to reduce risks and hazards to the safety and quality of patient care. The Patient Safety Act signifies the Federal Government's commitment to fostering a culture of patient safety among health care providers; it offers a mechanism for creating an environment in which the causes of risks and hazards to patient safety can be thoroughly and honestly examined and discussed without fear of penalties and liabilities. It provides for the voluntary formation of Patient Safety Organizations (PSOs) that can collect, aggregate, and analyze confidential information reported voluntarily by health care providers. By analyzing substantial amounts of patient safety event information across multiple institutions, PSOs are able to identify patterns of failures and propose measures to eliminate or reduce risks and hazards.

In order to implement the Patient Safety Act, the Department of Health and Human Services (HHS) issued the Patient Safety and Quality Improvement Final Rule (Patient Safety Rule, see Attachment B) which became effective on January 19, 2009. The Patient Safety Rule establishes a framework by which hospitals, doctors, and other health care providers may voluntarily report information to PSOs, on a privileged and confidential basis, for the aggregation and analysis of patient safety events. In addition, the Patient Safety Rule outlines the requirements that entities must meet to become and remain listed as PSOs and the process by which the Secretary of HHS (Secretary) will accept certifications and list PSOs.

When specific statutory requirements are met, the information collected and the analyses and deliberations regarding the information receive confidentiality and privilege protections under this legislation. The Secretary delegated authority to the Director of the Office for Civil Rights (OCR) to enforce the confidentiality protections of the Patient Safety Act (**Federal Register**, Vol. 71, No. 95, May 17, 2006, p. 28701–2). OCR is responsible for enforcing confidentiality protections regarding patient safety work product (PSWP), which may include: Patient-, provider-, and reporter-identifying information that is collected, created, or used for or by PSOs for patient safety