

ANNUAL BURDEN ESTIMATES

Form	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Survey of Consumers	563	1	563	0.5	281.5
Survey of the Distributors of the Consumer Tools	40	1	40	0.5	20
Consumer Focus Groups	4 sites × 16 focus group participants per site = 64.	1	64	1.5	96
Total	667	3	667	2.5	397.5

E-mail comments to paperwork@hrsa.gov or mail the HRSA Reports Clearance Officer, Room 10–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: May 5, 2009.

Alexandra Huttinger,

Director, Division of Policy Review and Coordination.

[FR Doc. E9–11086 Filed 5–12–09; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–09–0607]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 or send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to omb@cdc.gov.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection 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 on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

The National Violent Death Reporting System (NVDRS) OMB# 0920–0607—Revision—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Violence is an important public health problem. In the United States, homicide and suicide are the second and third leading causes of death, respectively, in the 1–34 year old age group. Unfortunately, public health agencies do not know much more about the problem than the numbers and the sex, race, and age of the victims, all information obtainable from the standard death certificate. Death certificates, however, carry no information about key facts necessary for prevention such as the relationship of the victim and suspect and the circumstances of the deaths, thereby making it impossible to discern anything but the gross contours of the problem. Furthermore, death certificates are typically available 20 months after the completion of a single calendar year. Official publications of national violent death rates, *e.g.* those in *Morbidity and Mortality Weekly Report*, rarely use data that is less than two years old. Public health interventions aimed at a moving target last seen two years ago may well miss the mark.

Local and Federal criminal justice agencies such as the Federal Bureau of Investigation (FBI) provide slightly more information about homicides, but they do not routinely collect standardized data about suicides, which are in fact much more common than homicides. The FBI's Supplemental Homicide Report (SHRs) does collect basic information about the victim-suspect

relationship and circumstances related to the homicide. SHRs do not link violent deaths that are part of one incident such as homicide-suicides. It also is a voluntary system in which some 10–20 percent of police departments nationwide do not participate. The FBI's National Incident Based Reporting System (NIBRS) provides slightly more information than SHRs, but it covers less of the country than SHRs. NIBRS also only provides data regarding homicides. Also, the Bureau of Justice Statistics Reports does not use data that is less than two years old.

CDC therefore proposes to continue a state-based surveillance system for violent deaths that will provide more detailed and timely information. It taps into the case records held by medical examiners/coroners, police, and crime labs. Data is collected centrally by each state in the system, stripped of identifiers, and then sent to the CDC. Information is collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States use standardized data elements and software designed by CDC. Ultimately, this information will guide states in designing programs that reduce multiple forms of violence.

Neither victim families nor suspects are contacted to collect this information. It all comes from existing records and is collected by state health department staff or their subcontractors. Health departments incur an average of 2.5 hours per death in identifying the deaths from death certificates, contacting the police and medical examiners to get copies of or to view the relevant records, abstracting all the records, various data processing tasks, various administrative tasks, data utilization, training, communications, etc.

This revision is a request to allow 10 new state health departments to be added to the currently funded 17, if funding becomes available. This may bring the total to 27 by the year 2012.

Violent deaths include all homicides, suicides, legal interventions, deaths from undetermined causes, and unintentional firearm deaths. The

average state will experience approximately 1,000 such deaths each year.

There is no cost to respondents to participate other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses/respondent	Average burden/response (in hours)	Total burden (in hours)
State Health Departments	27	1,000	2.5	67,500

Dated: May 6, 2009.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E9-11128 Filed 5-12-09; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Conunent 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: "Health Literacy Item Set Supplemental to CAHPS Hospital Survey—Pretest of Proposed Questions and Methodology." In accordance with the Paperwork Reduction Act of 1995, Public Law 104-13 (44 U.S.C. 3506(c)(2)(A)), AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by July 13, 2009.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by e-mail at doris.lefkowitz@ahrq.hhs.gov.

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427-1477, or by e-mail at doris.lefkowitz@ahrq.hhs.gov.

SUPPLEMENTARY INFORMATION:

Proposed Project

"Health Literacy Item Set Supplemental to CAHPS Hospital Survey—Pretest of Proposed Questions and Methodology"

AHRQ proposes to conduct a pretest of the Consumer Assessment of Healthcare Providers and Systems (CAHPSR) Hospital Survey health literacy module. The CAHPS program is a multi-year initiative of the Agency for Healthcare Research and Quality. AHRQ first launched the program in October 1995 in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective. Numerous public and private organizations collected information on enrollee and patient satisfaction, but the surveys varied from sponsor to sponsor and often changed from year to year. The CAHPSR program was designed to make it possible to compare survey results across sponsors and over time, and to generate tools and resources that sponsors can use to produce understandable and usable comparative information for consumers.

Over time, the program has expanded beyond its original focus on health plans to address a range of health care services to meet the various needs of health care consumers, purchasers, health plans, providers, and policymakers. Based on a literature review and an assessment of currently available questionnaires, AHRQ identified the need to develop a health literacy module for the CAHPSR Hospital Survey. The intent of the planned module is to examine patients' perspectives on how well health information is communicated to them by healthcare professionals in the hospital setting. The objective of the new module is to provide information to health plans, hospitals, clinicians, group practices, and other interested parties regarding the quality of health information delivered to patients. The set of questions about health literacy will be evaluated as a supplement to the CAHPSR Hospital Survey.

This study will be conducted for AHRQ by its contactor, RAND Corporation. It is being conducted pursuant to AHRQ's statutory authority to conduct research and evaluations on health care and systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of health care services. See 42 U.S.C. 299a(a)(1).

This study is a one-time field test to be completed in the calendar years 2009 and 2010. The field test to be conducted under this request will be done for the following purposes:

a. Analysis of item wording—Assess candidate wordings for items.

b. Analysis of participation rate—Evaluate the overall response rate and the proportion of that obtained from mail versus telephone modes of data collection.

c. Case mix adjustment analysis—Evaluate variables that need to be considered for case mix adjustment of scores.

d. Psychometric Analysis—Provide information for the revision of the health literacy item set based on the assessment of the reliability and validity.

The end result will be collection of the data related to the assessment of patients' perspective on how well health information is communicated to them by health care professionals in hospital setting. The field testing will ensure that future data collections yield high quality data and minimize respondent burden, increase agency efficiency, and improve responsiveness to the public. The survey items will be added to currently available CAHPS R surveys and will enhance the ability of hospitals to assess the quality of their services.

Method of Collection

The potential respondent universe is persons who had at least one overnight stay at a hospital within the previous five months. Excluded from the study will be those who were less than 18 years old at the time of their admission, had a psychiatric diagnosis, were