• One or more individuals with expertise in developing algorithms using ICD–9–CM codes to construct or modify quality indicators using administrative data is desirable, but not mandatory

In addition, the workgroup is expected to include representatives from impacted provider groups and their professional organizations, other stakeholders, consumers and other users, quality alliances, business coalitions, medical or specialty societies, measure developers, accrediting organizations, and public and private payers.

Standing Workgroup

The standing workgroup is part of a structured approach to bring together individuals from multiple disciplines for the purpose of providing technical feedback on proposed updates to the AHRQ QIs. The intent is to collect feedback in a standardized fashion, and to ensure continued improvement of key measurement aspects of the QIs based on new data sources, data enhancements, and methodological advances. The standing workgroup may potentially provide guidance for the development of new indicators or the modification or retirement of existing indicators. Annual topics include: (1) Strategic areas for AHRQ QI program development for the upcoming year, (2) measure specification, software and documentation changes that have been proposed from users, the literature or other sources, (3) results from the analysis of proposed changes and review of recommendations for implementation, and (4) general methodological developments in quality measurement.

The standing workgroup will consist of 8–12 members to form a diverse group of clinicians and other individuals from a variety of disciplines and settings with expertise and interest in quality measurement and improvement. Members of the standing workgroup may include:

• One or more currently practicing clinicians specialized in various disciplines

• One or more individuals with inpatient nursing and/or nursing management experience

• One or more individuals with experience using AHRQ 01 measures for assessing hospital performance and/or public reporting

• One of more individuals with expertise in developing algorithms for relevant quality indicators using administrative data

• One or more individuals with expertise in validating ICD–9–CM codes using chart abstraction (to assess criterion validity), or assessing their accuracy in identifying individuals at risk for specific adverse outcomes (predictive validity)

• One or more individuals with experience using HCUP or similar data for the purpose of quality measurement

• One or more individuals with knowledge of ICD–9–CM and ICD–10–CM coding guidelines and practices

Submission Criteria

To be considered for membership on either workgroup, please send the following information for each nominee:

1. A brief nomination letter highlighting experience and knowledge in the use of the AHRQ QIs, including any experience with the National Quality Forum (NQF) Consensus Development Process, and the workgroup of interest. The nominee's profession and specialty, and the spectrum of his or her experience related to the QIs should be described. Please include full contact information of nominee: name, title, organization, mailing address, telephone and fax numbers, and email address.

2. Curriculum vita (with citations to any pertinent publications related to quality measure development or use).

3. Description of any financial interest, recent conduct, or current or planned commercial, non-commercial, institutional, intellectual, public service, or other activities pertinent to the potential scope of the workgroup, which could be perceived as influencing the workgroup's process or recommendations. The objective is not to prevent nominees with potential conflicts of interest from serving on the workgroups, but to obtain such information so as to best inform the selection of workgroup members, and to help minimize such conflicts.

Nominee Selection Criteria

Selection of standing workgroup members will be based on the following criteria:

• Knowledge of and experience with health care quality measurement using administrative data, including issues of coding, specification, and risk adjustment

• Peer-reviewed publications relevant to developing, testing, or applying health care quality measures based on ICD-coded administrative data

• Knowledge of current quality measurement methodologies published in the literature

• Clinical expertise in the use and applications of the AHRQ QIs

• Knowledge of the NQF measure submission and maintenance process

The selection process will be adapted to ensure that the standing workgroup includes a diverse group of clinicians and other individuals from a variety of disciplines and settings.

Time Commitment

Time-limited and standing workgroup participants will hold a minimum two-year term with an optional extension. The time-limited workgroup will meet by teleconference approximately three times for approximately two hours each year, with a total time commitment including preparation and follow-up time of approximately 8–12 hours. The standing workgroup will meet quarterly by teleconference for approximately two hours with an annual time commitment including preparation and follow-up time of approximately 12–16 hours.

Workgroup Activities

1. Workgroup members will receive pre-meeting material to review and to provide written feedback (1.0 hours).

2. The workgroup meeting will be convened by phone or web conference. Initial feedback and revisions will be discussed during the live meetings along with other relevant topics (2.0 hours).

3. Post meeting, members will review and comment on meeting minutes and associated documents along with any follow-up action items (1 hour).

4. There may be opportunities for workgroup members to collaboratively publish peer-reviewed journal articles or reports based on workgroup activities. However, this is not a mandatory requirement of workgroup members and is not included in the estimated time commitment.

Dated: April 5, 2013.

Carolyn M. Clancy,

Director, AHRQ.

[FR Doc. 2013–08834 Filed 4–16–13; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–13–13QQ]

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 404–639–7570 or send comments to Ron Otten, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email 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

Older Adult Safe Mobility Assessment Tool—NEW—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In 2010, there were 40 million adults aged 65 or older in the U.S., representing 13% of the U.S. population. By 2030, this segment of the population will increase to an estimated 72 million or 20%. People now aged 65 are expected to live well into their 80s with the vast majority preferring to ''age in place'' (i.e., grow old in their current homes). With most adults aging in place, rather than in retirement or nursing homes, it is absolutely critical to better prepare communities and older Americans for what is on the horizon.

There is widespread agreement that older adults in the U.S. do not adequately plan for their future mobility needs, nor are most aware of existing mobility resources in their communities. Thus, when an individual's mobility becomes impaired they are ill prepared to adapt their lifestyle to their changing needs. A process of mobility assessment would begin to address this situation and aid older adults in meeting their changing mobility needs.

At present there are numerous mobility-related assessments actively used throughout the U.S. Most are designed to collect information from just one particular mobility silo, such as assessments that focus on fall prevention. None of these existing tools cut across mobility silos while focusing on older adults. None create a national picture of older adult safe mobility that captures an individual's physical and emotional health, their social network, or the ease of mobility in their home, transportation, their neighborhood, their city, and beyond. And no existing older adult tools are both mobility holistic and empowerment driven self-administered assessments. The data collected in this project will allow CDC to develop a tool that can help older adults both assess and improve their complete mobility.

This project involves developing, refining and validating a Safe Mobility Assessment Tool that allows older adults to assess their current mobility situation, learn about mobility challenges that may affect them in the future, and receive actionable feedback on how to improve and protect their mobility. The information collected in this project will be used to refine and improve the tool, as well as to conduct feasibility and audience acceptability analysis of the tool. This information will allow CDC to create the most useful Safe Mobility Assessment Tool possible for U.S. older adults.

CDC requests OMB approval to collect both qualitative and quantitative data. Qualitative data collection will include key informant interviews, focus groups, and intercepts in urban and rural communities. In brief, these methods will include key informant interviews of community stakeholders (three stakeholder interviews in two states for a total of six key informant interviews); older adult consumer focus groups (two focus groups in two states with seven people each for a total of fourteen participants); and older adult consumer intercepts (thirty intercepts in two rural locations and ten intercepts in two urban locations for a total of forty intercepts). The qualitative data collection will be used to help inform a quantitative stage of work to include a national sample of geographically and socio-demographically diverse older adults (N = 1,000) who will be recruited and interviewed by telephone. The key informant interviews, focus groups, intercepts and telephone survey data collection will allow us to gain information about the feasibility and usefulness of the Older Adult Safe Mobility Tool; about what impacts the tool may have on older adults (e.g., motivation to change/behavior intent, and changes in knowledge, attitudes, and awareness); about which mobility domains are most valuable to include in the tool (e.g., which are of greatest interest and can be improved by older adults); and about what other areas of the tool could be refined and improved. This information will allow us to create a final version of the Safe Mobility Assessment Tool that can be used by older adults across the U.S. to protect and enhance their mobility.

CDC anticipates that data collection will begin in December 2013 and that all data collection will be completed by July 2014. CDC estimates the following burden for one-time respondents: Key informant interviews will take approximately 30 minutes to complete, focus groups will each take up to 120 minutes, intercept interviews will take up to 20 minutes each, and the telephone survey will involve an on-your-own review of materials (approximately 15 minutes) and a pre-scheduled telephone survey (approximately 12 minutes). CDC plans for 6 individuals to complete the key informant interviews, 14 older adults to participate in the focus groups, and 40 older adults to participate in the intercepts. Additionally, CDC plans to collect information from 1,000 older adults for the telephone survey. Each respondent will only provide information once. Key informant interviews and the quantitative survey will be conducted by telephone. As telephone survey participants are recruited, they may elect to receive stimulus material (i.e., a draft version of the Tool) prior to the survey either by mail or electronically via email, whichever they prefer. In addition, focus group participants may receive communications (confirmation and reminder notices) via email or mail. Email communication will be used with key informant, focus group and telephone survey respondents, however each will be given the option of mail rather than email as their preferred communication method. Email will be provided not only as a courtesy to respondents, for those respondents that prefer email rather than mail, but also, it will allow more open and swift communication between the data collectors and study participants. Additionally, recruitment/screening for the focus groups and telephone surveys, as well as administration of the telephone surveys will use Computer Assisted Telephone Interview (CATI) systems for data collection, which are designed to reduce the burden to respondents.

There are no costs to respondents other than their time.

ESTIMATE ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Key informant interview respondents	Interview guide	6	1	30/60	3
Focus group respondents	Moderator guide	14	1	2	28
Intercept respondents	Intercept script	40	1	30/60	20
Telephone survey respondents	Survey	1,000	1	27/60	450
Total					501

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–08911 Filed 4–16–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day–13–0469]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project

National Program of Cancer Registries Cancer Surveillance System—(0920–0469 Reinstatement Exp. 11/30/2012)—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In 1992, Congress passed the Cancer Registries Amendment Act, which established the National Program of Cancer Registries (NPCR). The NPCR provides support for central cancer registries (CCR) that collect, manage and analyze data about cancer cases. The NPCR-funded CCR, which are located in states, the District of Columbia, and U.S. territories, report information to CDC annually through the National Program of Cancer Registries Cancer Surveillance System (NPCR CSS)(OMB No. 0920–0469, exp. 1/31/2010). Many registries maintain additional data items that are not part of the standard NPCR CSS report to CDC.

The NPCR CSS has allowed CDC to collect, aggregate, evaluate and disseminate cancer incidence data at the national and state level, and is the primary source of information for *United States Cancer Statistics* (*USCS*), which CDC has published annually since 2002. The NPCR CSS also allows CDC to monitor cancer trends over time, describe geographic variation in cancer incidence throughout the country, and provide incidence data on minority populations and rare cancers. These activities and analyses further support CDC's planning and evaluation efforts for state and national cancer control and prevention. Finally, datasets compiled through the NPCR CSS have been made available to investigators for secondary analysis.

CDC plans to request OMB approval to reinstate the NPCR CSS information collection, with changes. First, the frequency of reporting to CDC will be changed from an annual to a semi-annual schedule. The additional report will allow CDC to compile preliminary cancer incidence estimates in advance of the lengthy process of data validation required for each registry's final annual report. Second, data definitions for each report will be updated to reflect changes in national standards for cancer diagnosis, treatment, and coding. These changes will affect the standard reports for all NPCR-funded central cancer registries.

The third set of changes applies to a subset of 10 cancer registries. These CCR received ARRA funding to develop common standards and reporting mechanisms for enhanced description of cases of breast cancer, colorectal cancer, and chronic myelogenous leukemia. The enhanced data items will support more in-depth analysis of treatment strategies and patient outcomes than is currently possible with the standard NPCR CSS information collection. The 10 registries that participated in the enhancement process will begin reporting the additional data items to CDC in 2013 as part of their routine submission. CDC plans to make de-identified data available for comparative effectiveness research.

OMB approval will be requested for three years. Respondents will be 48 NPCR-supported central cancer registries in the U.S. (45 states, the District of Columbia, Puerto Rico, and the Pacific Islands jurisdictions). Information will be reported electronically to CDC twice per year. The first report will consist of a single-year file for data that includes diagnosis 12 months past the close of the diagnosis year. The second report will consist of a cumulative file containing incidence data from the first diagnosis year for which the cancer registry collected data with the assistance of NPCR funds (e.g., 1995) through 24 months past the close of the diagnosis year (e.g., 2010 data submitted in 2012). The estimated burden per response is two hours. Because cancer incidence data are already collected, aggregated and used for analyses at the state level, the additional burden of reporting the information to CDC is modest and the number of data items in the report does not affect the estimated burden per response.

There are no costs to respondents except their time. The total estimated annualized burden hours are 192.