ATTACHMENT 2

60-DAY Federal Register Notice

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST—Continued

Cost component	Total cost	Annualized cost
Total	5,703	5,703

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, 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, quality improvement and information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ' s estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: January 25, 2010.

Carolyn M. Clancy,

Director.

[FR Doc. 2010–1894 Filed 1–29–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–10–0745]

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 and send comments to Maryam 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

Colorectal Cancer Screening Program (OMB Number 0920–0745, exp. 7/31/2010)—Revision—Division of Cancer Prevention and Control (DCPC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Colorectal Cancer (CRC) is the second leading cause of cancer-related deaths in the United States, following lung cancer. Based on scientific evidence which indicates that regular screening is effective in reducing CRC incidence and mortality, regular CRC screening is now recommended for average-risk persons. Screening tests that are recommended by the United States Preventive Services Task Force, and that may be used alone or in combination, include fecal occult blood testing (FOBT), fecal immunochemical testing (FIT), flexible sigmoidoscopy, colonoscopy, and/or double-contrast barium enema (DCBE).

In 2005, CDC established a three-year demonstration program, subsequently extended to four years, to screen low-income individuals 50 years of age and older who have no health insurance or inadequate health insurance for CRC. The five demonstration sites report information to CDC including de-identified, patient-level demographic, screening, diagnostic, treatment, outcome and cost reimbursement data (OMB No. 0920–0745, exp. 7/31/2010). The information is being used to assess the feasibility and cost effectiveness of a publicly funded screening program and describe key outcomes, and has been critical in guiding the expansion of the program.

CDC will request OMB approval to continue the information collection for three years, with changes. First, the number of funded sites will increase from 5 to 26, and the term "Demonstration" will be deleted from the title of the program. Second, there will be a reduction in the burden per respondent associated with the collection of clinical information. Reporting forms for medical complications and medically ineligible clients will be discontinued, and reporting forms for colorectal cancer clinical data elements (CCDE) will be streamlined. Data elements that were underused in analysis of the demonstration program data, or difficult to standardize across programs, will be removed, and the level of detail collected from endoscopy and pathology reports will be reduced. As a result, the reporting burden per CCDE form will be similar regardless of primary test provided. Third, the collection of patient-level reimbursement cost data will be discontinued and will be replaced by the collection of program-level activity-based cost data. The revised information collection will utilize a Cost Assessment Tool (CAT) currently in use by another CDC-funded cancer program (OMB No. 0920–0812, exp. 6/30/2012). The information to be collected through the CAT will allow CDC to compare activity-based costs across multiple sites and programs, and will provide a more effective means of monitoring and improving the performance and cost-effectiveness of the CRC screening program.

The goals of the expanded CRC screening program are to increase population-based screening and to reduce health disparities in CRC screening, incidence and mortality. The program will continue to provide services to low-income individuals age 50 and older with inadequate or no health insurance. Each site will screen an estimated 375 patients per year (186 semiannually). The increase in the number of funded sites and the proposed changes will result in an

overall increase in burden to respondents.

CCDE information will be transmitted to CDC electronically twice per year. Information collected through the Cost Assessment Tool will be transmitted electronically to CDC once per year. Participation is required for all sites funded through the CRC screening program. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form type	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Colorectal Cancer Screening Programs.	Clinical Data Elements	26	375	15/60	2,438
	Cost Assessment Tool	26	1	22	572
Total					3,010

Dated: January 26, 2010.

Maryam I. Daneshvar,

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

[FR Doc. 2010–2059 Filed 1–29–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–10–10BG]

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 and 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

National Voluntary Environmental Assessment Information System (NVEAIS)—New—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The CDC is requesting OMB approval for a National Voluntary Environmental Assessment Information System to collect data from food- and waterborne illness outbreak environmental assessments routinely conducted by local, State, territorial, or tribal food and water safety programs during outbreak investigations. Environmental assessment data are not currently collected at the national level. The data reported through this information system will provide timely data on the causes of outbreaks, including environmental factors associated with outbreaks, and are essential to environmental public health regulators' efforts to respond more effectively to outbreaks and prevent future, similar outbreaks. This information system is specifically designed to link to CDC's existing disease outbreak surveillance system (National Outbreak Reporting System).

The information system was developed by the Environmental Health Specialists Network (EHS–Net), a collaborative project of CDC, the U.S. Food and Drug Administration (FDA), the U.S. Department of Agriculture (USDA), and nine states (California, Connecticut, Georgia, Iowa, New York, Minnesota, Oregon, Rhode Island, and Tennessee). The network consists of environmental health specialists (EHSs), epidemiologists, and laboratorians. The EHS–Net has developed a standardized protocol for identifying, reporting, and analyzing data relevant to food- and waterborne illness outbreak environmental assessments.

The information to be reported to NVEAIS will be obtained from environmental assessments routinely conducted by state, local, tribal and territorial food and water safety program officials in response to food- and waterborne illness outbreaks. While conducting environmental assessments during outbreak investigations is routine for food and water safety program officials, reporting information from the environmental assessments to CDC is not. Thus, state, local, tribal, and territorial food and water safety program officials are the respondents for this data collection. However, participation in the system is voluntary.

There are approximately 3,000 public health departments (where food and water safety programs are typically located) in the United States. Many of these departments have separate food and water safety programs. If a public health department chooses to participate in NVEAIS, there will likely be two respondents from that department—one person responsible for reporting foodborne outbreak environmental assessment data to NVEAIS and one person responsible for reporting waterborne outbreak environmental assessment data to NVEAIS. Thus, although it is not possible to determine how many departments will choose to participate, as NVEAIS is voluntary, the maximum potential number of respondents is approximately 6,000 (one for each food safety program and one for each water safety program in each public health department).

It is not possible to determine exactly how many outbreaks will occur in the future, nor where they will occur. However, we can estimate, based on existing data, that a maximum of 1,600 illness outbreaks (1,100 foodborne and 500 waterborne) will occur annually.