Attachment 2a

60-Day Federal Register Notice

time per response for screening and recruitment is 12 minutes, for a total annualized burden of 204 hours.

This request is submitted to extend OMB clearance for one year. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours
Parents of adolescents (aged 15–17) living with SCD. Young adults (aged 18–25) living with SCD Adults (aged 26–35) living with SCD Older adults (aged 36+) living with SCD	Participant Screener and Recruitment Script.	120	1	12/60	24
Parents of adolescents (aged 15–17) living with SCD. Young adults (aged 18–25) living with SCD Adults (aged 26–35) living with SCD Older adults (aged 36+) living with SCD.	Focus Group Moderator's Guide	90	1	2	180
Total	.....	.....	.....	.....	204

Dated: January 8, 2013.

Ron A. Otten,

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

[FR Doc. 2013–00806 Filed 1–15–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–13–0745]

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 404–639–7570 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

Colorectal Cancer Screening Program (OMB No. 0920–0745, exp. 6/30/2013)—Extension—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Of cancers affecting both men and women, Colorectal Cancer (CRC) is the second leading cause of cancer-related deaths in the United States. Based on scientific evidence which indicates that regular screening is effective in reducing CRC incidence and mortality, regular CRC screening is now recommended for adults starting at age 50 and continuing until age 75 years. 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, and colonoscopy.

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 reported information to CDC including de-identified, patient-level demographic, screening, diagnostic, treatment, outcome and cost reimbursement data (Colorectal Cancer Screening Demonstration Program, OMB No. 0920–0745, exp. 7/31/2010). The information was used to assess the feasibility and cost effectiveness of a publicly funded screening program, describe key outcomes, and guide program expansion.

In 2009, CDC received additional funding from Congress and established the expanded Colorectal Cancer Control Program (CRCCP) to increase screening rates in the general population through evidence-based screening provision and screening promotion activities. All funded sites provide CRC screening and follow-up services to low-income men and women who are underinsured or uninsured for CRC screening. Funded sites also plan and implement program activities that promote CRC screening in the general population through policy, systems, community and individual level interventions. With expanded CRCCP support, the number of sites funded to provide CRC screening services increased from five to 26 and the original information collection was revised. Changes incorporated through the revision process included an increase in the number of respondents; simplification of the clinical data collection based on experience with the five demonstration program sites;

discontinuation of the cost reimbursement data collection; addition of an activity-based economic data collection; and deletion of the term "Demonstration" from the title. Information currently reported to CDC includes program-level activity cost data, and de-identified patient-level demographic, screening, diagnostic, treatment and outcome data (Colorectal Cancer Screening Program, OMB No. 0920–0745, exp. 6/30/2013).

CDC plans to request a three-year extension of the current approval. No changes are proposed to the content of the information collection, reporting procedures for awardees, or the estimated burden per respondent. However, the number of funded CRC screening sites will increase from 26 to 29.

Program awardees will continue to implement evidence-based interventions to increase population-level screening rates and to address disparities in access to CRC screening services.

Through this program, funded awardees will provide CRC screening services to low-income individuals 50 years of age and older who have no health insurance or inadequate health insurance for CRC. On average, each program awardee is expected to provide services to 375 individuals per year. De-identified clinical data elements will be reported to CDC electronically. In addition, each awardee will collect and report program-level activity-based cost data to CDC through an electronic Cost Assessment Tool (CAT). The activity-based cost information allows CDC to monitor individual awardees and compare activity-based costs across multiple sites and programs. A similar approach has been employed for a number of CDC-funded cancer programs (see Economic Analysis of the National Breast and Cervical Cancer Early Detection Program, OMB No. 0920–0776, exp. 3/31/2011, and Economic Analysis of the National Program of Cancer Registries, OMB No. 0920–0812, exp. 6/30/2012).

CDC will use the information collected from Colorectal Cancer Screening Program awardees to monitor and evaluate the CRC screening program and funded sites; improve the quality of screening and diagnostic services for underserved individuals; develop outreach strategies to increase screening; and report program results to Congress and other legislative authorities. Participation is required for all CRCCP awardees. 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 Control Program Awardees.	Clinical Data Elements	29	375	15/60	2,719
	Cost Assessment Tool	29	1	22	638
Total					3,357

Dated: January 8, 2013.

Ron A. Otten,

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

[FR Doc. 2013–00755 Filed 1–15–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: School Readiness Goals and Head Start Program Functioning.

OMB No.: New Collection.

Description: The Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS) is proposing a data collection as part of the "School Readiness Goals and Head Start Program Functioning" research project. The purpose of this study is to improve understanding of how local Head Start and Early Head Start programs define, measure, and communicate school readiness goals, and how they use these goals in program planning to improve program functioning. ACF is proposing to use a semi-structured telephone interview protocol to collect information from program directors and other key staff from approximately 60 local grantees and site visit protocols to collect further qualitative information through interviews and/or focus groups with program staff, oversight boards, key stakeholders, and parents in a subset of 12 of these grantees. ACF has contracted with the Urban Institute to collect and analyze the data gathered in the telephone interviews and site visits.

Topics to be covered in the telephone interview and site visit protocols include: A description of school readiness goals set by local grantee; the process used to set school readiness goals; contextual factors informing choices made about school readiness goals (e.g., needs of local children and families, program and staff characteristics, and community characteristics); how programs use and analyze data about school readiness goals; how programs report progress on goals; and how school readiness goals and data form program planning and improvement efforts.

Respondents: Head Start and Early Head Start program directors and managers closely involved with school readiness goal setting (e.g. education services coordinators); others in leadership positions (e.g. agency directors, center directors, home-based services coordinators or assistant program directors); front-line staff (e.g. Head Start teachers, Early Head Start teachers, home visitors, family service workers, and program specialists); members of Head Start governing bodies and local policy councils; liaisons from local education agencies; and parents with children in Head Start and Early Head Start programs.