c. Is there evidence that the data is used by consumers?

d. Is the data relevant to consumers making healthcare decisions?

e. Is the data easily accessible and presented in a consumer friendly way?

3. What are the intended and unintended consequences of consumers' use of public-reported cost data?

a. Do consumers find the public reporting of cost measures relevant and are consumers satisfied with the experience?

b. Does the public reporting of cost measures impact (or have the potential to impact) consumers' decisions or behaviors?

c. What are the potential unintended consequences of public reporting of cost measures?

d. Are there key research gaps and needs for future research?

Dated: January 24, 2014.

Richard Kronick,

AHRQ Director.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–14–13AGH]

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 (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 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Examining Traumatic Brain Injury in Youth—New—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Traumatic brain injury (TBI) is one of the highest priorities in public health because of its magnitude, economic and human impact, and preventability. The Centers for Disease Control and Prevention (CDC) estimates that approximately 1.7 million TBIs are sustained in the United States annually, either alone or in conjunction with another injury or condition. These figures may be an underestimation as they do not include people who are treated in physicians' offices or outpatient facilities, those who did not seek medical care, military personnel, or Americans living abroad. Moreover, the number of sports and recreation-related TBIs treated in U.S. emergency departments is increasing and has increased steadily since the early 2000s. Children ages 0 to 4 years and adolescents ages 15–19 are at the greatest risk of sustaining a TBI.

A TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. The severity of a TBI may range from ''mild'' (a brief change in mental status or consciousness) to ''severe'' (an extended period of unconsciousness or amnesia after the injury).

In 1996, Congress passed Public Law 104–166, the Traumatic Brain Injury Act, which charged CDC with implementing projects to reduce the incidence of traumatic brain injury. The CDC definition of TBI uses selected codes of the International Classification of Diseases, 9th Clinical Modification (ICD–9 CM) to identify cases of TBI from hospital and non-hospital databases containing billing records for services rendered to patients. It is thought, however, that the ICD–9 CM codes currently used in CDC's surveillance system to capture cases of TBI are not sufficiently sensitive to capture diagnosed TBI.

CDC requests OMB approval for one year to collect de-identified medical information of a representative sample of pediatric patients, from two clinical settings, who received a confirmed diagnosis of mild to severe TBI and link these patients to their administrative medical claims forms. Collectively, the data will allow CDC to estimate the sensitivity of currently utilized ICD–9 CM codes to capture cases of diagnosed TBI, as well as ICD–9 CM codes not currently being utilized that may improve the sensitivity to capture cases of TBI. We propose to conduct a retrospective cross-sectional study of a random sample of patients with a suspected TBI within two clinical settings (Emergency Departments and Concussion Clinics).

A review of the medical coding data for additional ICD–9 CM codes that are not part of the CDC TBI definition will also take place to determine whether the addition of any of these codes improves the sensitivity of the CDC TBI definition to detect TBI.

The Emergency Department medical records of 150 patients will be abstracted in order to review ICD–9 codes and TBI diagnoses. Each record will take 60 minutes to abstract. Also, 50 patient medical records from the Concussion Clinic, located within the hospital, will be abstracted in order to review the selection criteria to confirm eligibility, which includes age of the patient, and the valid encounter with physician or nurse related to an injury consistent with a TBI. Each record will take 60 minutes to abstract. The same Research Assistant will be abstracting the data within the Emergency Department and the Concussion Clinic.

There are no costs to respondents other than their time. The total estimated annual burden hours are 200.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)
Emergency Department Research Assistant	TBI Records Data Tool	1	150	1
Concussion Clinic Research Assistant	TBI Records Data Tool	1	50	1

Leroy A. Richardson,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–14–13PR]

Proposed Data Collections Submitted for Public Comment and Recommendations

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 (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) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Evaluating the Implementation and Outcomes of Policy and Environmental Cancer Control Interventions—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The National Comprehensive Cancer Control Program (NCCCP) is administered by the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control. Through the NCCCP, 65 awardees receive support through cooperative agreements (CDC–RFA–DP12–1205). The current cooperative agreements maintain core comprehensive cancer control (CCC) activities and build on policy, system, and environmental (PSE) change strategies that many NCCCP programs have begun to incorporate into their program plans and initiatives. Awardees provide routine progress reports to CDC which describe their overall objectives and activities (Management Information System for Comprehensive Cancer Control Programs, OMB No. 0920–0841, exp. 3/31/2016).

In 2010, additional pilot funding was provided under CDC–RFA–D10–1017 to 13 of the 65 NCCCP awardees (''1017 awardees''). The additional funds are intended to increase awardees' focus on PSE change strategies relating to cancer control, and to strengthen collaboration with both traditional and nontraditional partners. With additional resources and structure, CDC hopes that 1017 awardees will achieve greater health impact through increased skills and capacity and enhanced interactions with partners. CDC plans to conduct a new information collection to assess whether the 1017 pilot is meeting its goals and to compare the experiences of NCCCP programs funded at both levels of support. The study design includes a Web-based survey of all 65 CCC funded programs, administered at two points in time; a longitudinal case study of 6 of the 1017 programs involving interviews with key awardee staff and NCCCP partners; focus groups with staff who provide technical assistance related to the 1017 program; and a one-time survey of coalition members and strategic partners who are collaborating with 1017 awardees.

Information collection activities are designed to address specific evaluation questions,such as: Did 1017 cooperative agreement funding, training and technical assistance enhance the ability of grantees to inform PSE change as part of comprehensive cancer control?; Did the 1017 cooperative agreement facilitate a shift towards primary prevention?; How did 1017 programs build infrastructure required to develop an environmental scan, policy agenda, evaluation plan, and media plans?; What methods were used by 1017 programs to develop the policy agenda and media plan?; What key outcomes were achieved by 1017 programs?; How did the PSE Workgroups facilitate implementation and achievement of PSE change?; and What lessons have been learned that could inform the expansion of the 1017 program to the other NCCCP-funded programs? Findings will be used to improve program guidance and direct future investments in the NCCCP.

OMB approval is requested for three years. Participation is voluntary and there are no costs to the respondents other than their time. The total estimated annualized burden hours are 161.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)
CCC Program Directors	Program Director Web Survey Questionnaire	43	1	.5
CCC Staff	Key Informant Selection	2	1	8
	Key Informant Recruitment/Scheduling	12	1	5/60
	Key Informant Interview Guide	12	1	1.5
CCC Partners	Key Informant Recruitment/Scheduling	48	1	5/60
	Key Informant Interview Guide	48	1	1
	Coalition Survey	87	1	20/60
	TA Provider Focus Group Guide	15	1	1.5