

utility: (1) Adjusted risk estimates (*e.g.*, odds ratio, relative risk, hazards ratio); (2) discrimination (*e.g.*, area under the receiver operating characteristic curve [AUROC]); and (3) measures of diagnostic accuracy (*e.g.*, sensitivity, specificity, positive predictive values, and negative predictive values).

The predictive utility is defined in terms of the physiologic measure's ability to identify patients who have severe injury. Defining and operationalizing what "severe injury" means is challenging for several reasons. Whether a patient had a serious injury at the time of field triage cannot be determined conclusively and we expect that clinical outcomes (*e.g.*, death or disability) are affected by out-of-hospital and in-hospital treatment (*i.e.*, a person can have a serious injury and recover). For this reason, we accept several indicators that a patient was seriously injured. These include outcomes, such as death, whether the patient required treatments and interventions used for serious injury, or whether the injury is rated as severe using accepted rating scales. It is possible the review will identify additional indicators that a patient had a severe injury; however the following list includes those that have been used in prior research.

Indicators of Serious Injury

I. In-hospital mortality.
 II. Resource use/intervention standards or lists.
 a. Published Consensus-Based Criterion Standard—This list defines need for trauma center care as any one of the following 10 specific indicators: Major surgery, advanced airway, blood products, admission for spinal cord injury, thoracotomy, pericardiocentesis, cesarean delivery, intracranial pressure monitoring, interventional radiology, and in-hospital death.

b. Need For Life-Saving Interventions—Lists used by the U.S. military that include angioembolization, blood transfusion, cardiopulmonary resuscitation, chest tube, intubation, needle decompression, surgical cricothyrotomy or thoracotomy, pericardiocentesis, angiography with embolization, angiography without and surgical intervention.

c. Major Surgery—Not including orthopedic surgery.

d. Ratings of Injury Severity—Injury Severity Score (ISS) >15, as this is a commonly used threshold for high risk patients, but other cut-offs will be considered if used in included studies. The ISS score is based on an assessment that divides the body into nine regions, classifies the level of injury in each of the three most severely injured regions

on a scale of 1 to 6, squares these values, and adds them together.

Timing

Physiological measures upon the arrival of EMS personnel to the scene of injury, during treatment in the field, and during transport (referred to as out-of-hospital or in the field). Studies with measures taken upon arrival at an emergency department will be considered. Details about timing of measurement will be recorded in data abstraction if they are reported.

Settings

Include:

- I. Studies measuring physiologic compromise in the field/out of hospital
- II. Studies of initial ED measurement as indirect evidence only if out of hospital evidence is not available and the measure is deemed clinically relevant
- III. Studies conducted in civilian or military settings

Exclude:

- I. Inpatient, clinic, or emergency department (ED)
- II. Studies conducted in developing countries with out-of-hospital care systems that differ from those in the United States

Study Designs

Include:

- I. Any study that assesses the predictive utility of included measures either individually or that compares two or more measures. Designs may include trials and prospective and retrospective observational studies
 - a. Systematic reviews

Exclude:

- I. Nonsystematic reviews, commentaries, and letters
- II. Descriptions of the properties or performance of measures that do not include predictive utility

Sharon B. Arnold,

Acting Director.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[CDC-2017-0028, Docket Number NIOSH-290]

Draft Current Intelligence Bulletin: The Occupational Exposure Banding Process: Guidance for the Evaluation of Chemical Hazards; Notice of Public Meeting; Request for Comments

Correction

In notice document 2017-5115, beginning on page 13809, in the issue of Wednesday, March 15, 2017, make the following correction:

On page 13809, in the third column, in the second line of the **DATES** paragraph, "Tuesday, May 23, 2016" should read, "Tuesday, May 23, 2017."

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Eunice Kennedy Shriver National Institute of Child Health & Human Development; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Child Health and Human Development Special Emphasis Panel.

Date: April 24, 2017.

Time: 10:00 a.m. to 12:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6710 B Rockledge Drive, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Kimberly Lynette Houston, Scientific Review Officer, Division of Scientific Review, OD, Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, DHHS, 6710B Rockledge Drive, Bethesda, Maryland