the doctor responded to the parent's concerns and whether the child accessed screening, diagnostic and treatment services. We estimate each parent will return to the clinic twice during the study for activities such as WIC eligibility re-certification. This offers the opportunity to track referral outcomes over time. The Referral Outcome Tracking Form will be completed twice by the same 100 parent/guardian respondents.

In Phase 3, two measures will evaluate the WIC staff's response to the study to help determine program and message improvements, feasibility and sustainability. An online survey will assess staff perceptions of factors such as key elements, such as ease of use, time requirements and perceived impact on children and families. The WIC Developmental Milestones Staff Survey will be completed by 47 WIC staff members who work in the WIC clinics in the 9 sites where the project will be implemented. Each staff member also will be sent an email invitation to attend one 60-minute focus group meeting. This will allow for further clarification of the group's response. WIC staff members have provided feedback to refine questions, ensure accurate programming and establish the estimated time required to complete this data collection process.

The estimate for burden hours is based on the number of questions included in the questionnaires, as well as survey pre-testing to determine the typical length of time for completion. To obtain maximum potential burden estimates, we did not factor in attrition during the course of the study but rather assumed that all participants would complete all measures.

The total estimated burden is 255 hours. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Parents/guardians of children receiving WIC enrolled in Phase 1.	Pre-Intervention Survey	450	1	10/60	75
	Post-Intervention Survey	450	1	10/60	75
Parents/guardians of children enrolled in Phase 2.	Referral Outcome Tracking Form	100	2	15/60	50
WIC staff enrolled in Phase 3	WIC Developmental Milestones Staff Survey.	47	1	10/60	8
WIC staff enrolled in Phase 3	Focus Group Questions	47	1	1	47
Total					255

LeRoy 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.

[FR Doc. 2014–09768 Filed 4–29–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–14–14VS]

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 Leroy Richardson, at 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

Developmental Studies to improve the National Health Care Surveys—New—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Section 306 of the Public Health Service (PHS) Act (42 U.S.C. 242k), as amended, authorizes the Secretary of Health and Human Services (DHHS), acting through the Division of Health Care Statistics (DHCS) within NCHS, shall collect statistics on the extent and nature of illness and disability of the population of the United States.

The DHCS conducts the National Health Care Surveys, a family of nationally representative surveys of encounters and health care providers in inpatient, outpatient, and long-term care settings. This information collection request (ICR) is for a new generic to conduct developmental studies to improve this family of surveys. This three year clearance period will include studies to evaluate and improve upon existing survey design and operations, as well as to examine the feasibility of, and address challenges that may arise with, future expansions of the National Health Care Surveys.

Specifically, this request covers developmental research with the following aims: (1) To explore ways to refine and improve upon existing survey designs and procedures; and (2) to explore and evaluate proposed survey designs and alternative approaches to data collection. The goal of these research studies is to further enhance DHCS existing and future data collection protocols to increase research capacity and improve health care data quality for the purpose of monitoring public health and well-being at the

national, state and local levels, thereby informing health policy decision-making process. The information collected through this generic ICR will not be used to make generalizable statements about the population of interest or to inform public policy; however, methodological findings may be reported.

This generic ICR would include studies conducted in person, via the telephone or internet, and by postal or electronic mail. Methods covered would include qualitative (e.g., usability testing, focus groups, ethnographic studies, and respondent debriefing questionnaires) and/or quantitative (e.g., pilot tests, pre-tests and split sample experiments) research methodologies. Examples of studies to improve existing survey designs and procedures may include evaluation of incentive approaches to improve recruitment and increase participation rates; testing of new survey items to obtain additional data on providers, patients, and their encounters while minimizing misinterpretation and human error in data collection; testing data collection in panel surveys; triangulating and validating survey responses from multiple data sources; assessment of the feasibility of data retrieval; and development of protocols that will locate, identify, and collect accurate survey data in the least labor-intensive and burdensome manner at the sampled practice site.

To explore and evaluate proposed survey designs and alternative approaches to collecting data, especially with the nationwide adoption of electronic health records, studies may expand the evaluation of data extraction of electronic health records and submission via continuity of care documentation to small/mid-size/large medical providers and hospital networks, managed care health plans, prison-hospitals, and other inpatient, outpatient, and long-term care settings that are currently either in-scope or out-of-scope of the National Health Care Surveys. Research on feasibility, data quality and respondent burden also may be carried out in the context of developing new surveys of health care providers and establishments that are currently out-of-scope of the National Health Care Surveys.

Specific motivations for conducting developmental studies include: (1) Within the National Ambulatory Medical Care Survey (NAMCS), new clinical groups may be expanded to include dentists, psychologists, podiatrists, chiropractors, optometrists), mid-level providers (e.g., physician assistants, advanced practice nurses, nurse practitioners, certified nurse midwives) and allied-health professionals (e.g., certified nursing aides, medical assistants, radiology technicians, laboratory technicians, pharmacists, dieticians/nutritionists). Current sampling frames such as those from the American Medical Association may be obtained and studied, as well as frames that are not currently in use by NAMCS, such as state and organizational listings of other licensed providers. (2) Within the National Study of Long-Term Care Providers, additional new frames may be sought and evaluated and data items from home care agencies, long-term care hospitals, and facilities exclusively serving individuals with intellectual/developmental disability may be tested. Similarly, data may be obtained from lists compiled by states and other organizations. Data about the facilities as well as residents and their visits will be investigated. (3) In the inpatient and outpatient care settings, the National Hospital Care Survey (NHCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) may investigate the addition of facility and patient information especially as it relates to insurance and electronic medical records.

The National Health Care Surveys collect critical, accurate data that are used to produce reliable national estimates—and in recent years, state-level estimates—of clinical services and of the providers who delivered those services in inpatient, outpatient, ambulatory, and long-term care settings. The data from these surveys are used by providers, policy makers and researchers to address important topics of interest, including the quality and disparities of care among populations, epidemiology of medical conditions, diffusion of technologies, effects of policies and practice guidelines, and changes in health care over time. Research studies need to be conducted to improve existing and proposed survey design and procedures of the National Health Care Surveys, as well as to evaluate alternative data collection approaches particularly due to the expansion of electronic health record use, and to develop new sample frames of currently out-of-scope providers and settings of care. There is no cost to respondents other than their time to participate. Average burdens are designed to cover 15–40 minute interviews as well as 90-minute focus groups, longer on-site visits, and situations where organizations may be preparing electronic data files.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Health Care Providers and Business entities.	Interviews, surveys, focus groups, experiments (in person, phone, internet, postal/electronic mail).	18,000	1	1	18,000
Health Care Providers, State/local government agencies, and business entities.	Interviews, surveys, focus groups, experiments (in person, phone, internet, postal/electronic mail).	500	1	2.5	1,250
Total					19,250

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.

[FR Doc. 2014–09767 Filed 4–29–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–14–14VU]

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 and send comments to Leroy Richardson, 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

Promoting Adolescent Health Through School-Based HIV/STD Prevention—New—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Many young people engage in sexual behaviors that place them at risk for HIV infection, other sexually transmitted diseases (STD), and pregnancy. According to the 2011 National Youth Risk Behavior Survey (YRBS) results, 47% of U.S. high school students never had sexual intercourse; 34% had sexual intercourse with at least one person during the 3 months before the survey; and 15% had had sexual intercourse with four or more persons during their lifetime. Of those sexually active high school students, 40% reported that either they or their partner had not used a condom during last sexual intercourse, and 77% reported that either they or their partner had not used birth control pills or Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), Implanon (or any implant), or any intrauterine device (IUD) before last sexual intercourse.

Establishing healthy behaviors during childhood and adolescence is easier and more effective than trying to change unhealthy behaviors during adulthood. Since 1987, the Division of Adolescent and School Health (DASH), which is now a part of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), has been a unique source of support for HIV prevention efforts in the Nation's schools.

CDC requests Office of Management and Budget (OMB) approval to collect data over a three-year period from funded agencies under award PS13–1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance.* Funded agencies include non-governmental organizations, state education agencies, and local education agencies. The primary purpose of PS–13–1308 is to build the capacity of priority districts and priority schools to effectively contribute to the reduction of HIV infection and other STD among adolescents; the reduction of disparities in HIV infection and other STD experienced by specific adolescent sub-populations; and the conducting of school-based surveillance, a component not included in this data collection for evaluation.

CDC will be using a web-based system to collect data on the approaches that funded agencies are using to meet their goals. Approaches include helping districts and schools deliver exemplary sexual health education emphasizing HIV and other STD prevention; increasing adolescent access to key sexual health services; and establishing safe and supportive environments for students and staff.

To track funded agency progress and evaluate the effectiveness of program activities, CDC will be collecting data using a mix of process and performance measures. Process measures, which will be completed by all funded agencies, are important to assess the extent to which planned program activities have been implemented and lead to feasible and sustainable programmatic outcomes. Process measures include items on school health policy assessment and monitoring, and on providing training and technical assistance to partner education agencies and schools. Performance measures, which will be completed by only state and local education agencies, assess whether funded activities at each site are leading to intended outcomes including public health impact of systemic change in schools. These measures drove the development of questionnaires that have been tailored to each funded agencies' approach (i.e., exemplary sexual health education, sexual health services, and safe and supportive environments).

Respondents include 19 state education agencies, 17 local education agencies, and 6 non-governmental organizations that have all been funded under PS13–1308. The questionnaires will be submitted to CDC semi-annually using the Program Evaluation and Reporting System, an electronic web-based interface specifically designed for this data collection.

Each funded agency will receive a unique log-in to the system and technical assistance to ensure they can use the system easily. The dates when data are requested reflect Procurement and Grants Office deadlines to provide timely feedback to funded agencies and CDC staff for accountability and optimal use of funds. CDC anticipates that semi-annual information collection will begin in October 2014 and will describe activities conducted during the period August 2014–July 2017.

The estimated burden per response ranges from 0.5 hours to 6 hours. This variation in burden is due to the variability in the questions on the forms based on the approach and type of funded agency. For instance, non-governmental organizations have fewer questions to respond to because they only have questions for process evaluation. Local education agencies have the highest burden because it takes more time to gather information as they gather data at the school- and student-level as compared with state education agencies that report only state- and district-level data. Annualizing this collection over three years results in an estimated annualized burden of 820 hours for all funded agencies.

There are no costs to respondents other than their time.