

Type of collection	Average number of respondents per activity	Annual frequency per response	Average number of activities	Average hours per response
Online surveys, Telephone Surveys, Focus Groups, In person observation/testing	200	1	5	48/60

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-12-0607]

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 Kimberly Lane, at CDC, 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

The National Violent Death Reporting System (NVDRS) OMB# 0920-0607—Extension—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Violence is an important public health problem. In the United States, homicide and suicide are the second and third leading causes of death, respectively, in the 1-34 year old age group. Unfortunately, public health agencies do not know much more about the problem than the numbers and the sex, race, and age of the victims, all information obtainable from the standard death certificate. Death certificates, however, carry no information about key facts necessary for prevention such as the relationship of the victim and suspect and the circumstances of the deaths, thereby making it impossible to discern anything but the gross contours of the problem. Furthermore, death certificates are typically available 20 months after the completion of a single calendar year. Official publications of national violent death rates, e.g. those in *Morbidity and Mortality Weekly Report*, rarely use data that is less than two years old. Public health interventions aimed at a moving target last seen two years ago may well miss the mark.

Local and Federal criminal justice agencies such as the Federal Bureau of Investigation (FBI) provide slightly more information about homicides, but they do not routinely collect standardized data about suicides, which are in fact much more common than homicides. The FBI's Supplemental Homicide Report (SHRs) does collect basic information about the victim-suspect relationship and circumstances related to the homicide. SHRs, do not link violent deaths that are part of one incident such as homicide-suicides. It also is a voluntary system in which some 10-20 percent of police departments nationwide do not participate. The FBI's National Incident Based Reporting System (NIBRS)

provides slightly more information than SHRs, but it covers less of the country than SHRs. NIBRS also only provides data regarding homicides. Also, the Bureau of Justice Statistics Reports do not use data that is less than two years old.

CDC therefore proposes to continue a state-based surveillance system for violent deaths that will provide more detailed and timely information. It taps into the case records held by medical examiners/coroners, police, and crime labs. Data is collected centrally by each state in the system, stripped of identifiers, and then sent to the CDC. Information is collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States use standardized data elements and software designed by CDC. Ultimately, this information will guide states in designing programs that reduce multiple forms of violence.

Neither victim families nor suspects are contacted to collect this information. It all comes from existing records and is collected by state health department staff or their subcontractors. Health departments incur an average of 2.5 hours per death in identifying the deaths from death certificates, contacting the police and medical examiners to get copies of or to view the relevant records, abstracting all the records, various data processing tasks, various administrative tasks, data utilization, training, communications, etc.

CDC requests an extension to continue data collection with this system in the 18 funded states, and allow 9 new state health departments to be added if funding becomes available. This may bring the total to 27 by the year 2015. Violent deaths include all homicides, suicides, legal interventions, deaths from undetermined causes, and unintentional firearm deaths. The average state will experience approximately 1,000 such deaths each year.

There is no cost to respondents to participate other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses/ respondent	Average burden/ response (in hours)	Total burden (in hours)
State Health Departments	27	1,000	2.5	67,500
Public Agencies	27	1,000	30/60	13,500
Total				81,000

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day-12-0222]

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

Proposed Project

NCHS Questionnaire Design Research Laboratory (QDRL) 2012-2014, OMB No. 0920-0222 expiration 3/31/2013)—Revision—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 that the Secretary of Health and Human Services (DHHS), acting through NCHS, shall undertake and support (by grant or contract) research, demonstrations, and evaluations respecting new or improved methods for obtaining current data to support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.

The Questionnaire Design Research Laboratory (QDRL) conducts questionnaire development, pre-testing, and evaluation activities for CDC surveys (such as the NCHS National Health Interview Survey, OMB No. 0920-0214) and other federally sponsored surveys. NCHS is requesting 3 years of OMB Clearance for this generic submission.

The QDRL conducts cognitive interviews, focus groups, usability tests, field tests/pilot interviews, and experimental research in laboratory and field settings, both for applied questionnaire development and evaluation as well as more basic research on response errors in surveys.

QDRL Staff use various techniques to evaluate interviewer administered, self-administered, telephone, Computer Assisted Personal Interviewing (CAPI), Computer Assisted Self-Interviewing (CASI), Audio Computer-Assisted Self-Interviewing (ACASI), and web-based questionnaires.

The most common questionnaire evaluation method is the cognitive interview. The interview structure consists of respondents first answering a draft survey question and then providing textual information to reveal the processes involved in answering the test question. Specifically, cognitive interview respondents are asked to describe how and why they answered the question as they did. Through the interviewing process, various types of question-response problems that would not normally be identified in a traditional survey interview, such as interpretive errors and recall accuracy, are uncovered. By conducting a comparative analysis of cognitive interviews, it is also possible to determine whether particular interpretive patterns occur within particular sub-groups of the population. Interviews are generally conducted in small rounds of 20-30 interviews; ideally, the questionnaire is re-worked between rounds, and revisions are tested iteratively until interviews yield relatively few new insights.

In addition to its traditional QDRL activities, NCHS is requesting approval

for a large field test that will be conducted in 2012. This is a 5,000-case test which involves testing the use of ACASI in the full National Health Interview Survey (NHIS). The ACASI content included in the 5,000-case test is consistent with the content studied in two smaller approved tests. The module includes questions on sexual identity, alcohol consumption, HIV testing, mental health, height and weight, sleep, and financial worries. The objective of asking a question on sexual identity in the NHIS is to fill the gaps that exist in the state of knowledge about the general health behaviors, health status, and health care utilization of Lesbian, Gay, Bisexual, and Transgender (LGBT) persons.

The 5,000-case test will include one or more built-in experiments to assess the impact of ACASI, and components of ACASI, on prevalence estimates and data quality. First and foremost, test cases will be randomly assigned to receive the above described questions in either CAPI or ACASI. In particular, prevalence estimates for the sexual identity questions will be compared by mode of administration. Since a documented advantage of ACASI is the enhanced level of privacy it affords, we anticipate higher prevalence estimates of sexual minorities (Lesbian, Gay, Bisexual or Transgender persons) from this mode of administration. Estimates for sensitive items on mental health, alcohol consumption, HIV testing, height and weight, financial worries, and others will also be compared.

Cognitive interviewing is inexpensive and provides useful data on questionnaire performance while minimizing respondent burden. Cognitive interviewing offers a detailed depiction of meanings and processes used by respondents to answer questions—processes that ultimately produce the survey data. As such, the method offers an insight that can transform understanding of question validity and response error. Documented findings from these studies represent tangible evidence of how the question performs. Such documentation also serves CDC data users, allowing