respirable dust, and (2) identify the types of changes that miners could make in order to try to reduce their exposure. Although the most recent data on the prevalence of Coal Workers' Pneumoconiosis (CWP) in the United States indicates that it is declining, substantial numbers of CWP cases continue to be diagnosed. In recent years, CWP has contributed to the deaths of approximately 1,000 people in the U.S. each year.

A personal dust monitor (PDM) has recently been developed through a collaboration involving NIOSH, the Bituminous Coal Operators' Association, the United Mine Workers of America, the National Mining Association, and Rupprecht & Patashnick Co., Inc. This new device represents a major advance in the tools available for assessing coal miners' exposure to respirable dust levels. It will soon be field tested with coal miners throughout the U.S. As with the introduction of any new technology, it is very important to systematically document how workers react to it and make use of it. If miners know how to properly use the information PDMs are capable of providing, they should be able to make adjustments to their work place or work procedures that will reduce their exposure to respirable coal dust.

Various parties have speculated about the processes by which miners will use the information to reduce their exposure to respirable dust. There appears to be great potential. However, no one knows precisely how miners performing a wide variety of tasks and jobs are actually going to use this new information to reduce their exposure to dust. It is assumed that, once PDMs are introduced, miners will eventually find new ways to reduce their exposure to dust. Once these discoveries are made, they need to be documented and shared throughout the industry. The diffusion of this innovation will occur much more rapidly and efficiently if this proposed study takes place. Effective strategies for using PDM information will be well documented and quickly shared throughout the coal industry. The alternative is to wait for the miners at each of the 439 actively producing coal mines in the U.S. to go through their own trial and error process of discovering how PDMs can and cannot be used to reduce dust exposure. The proposed study will help to significantly reduce the incidence of lung disease among coal miners, leading to improvements in their longevity and quality of life. The information for this study will be collected by conducting one-on-one structured interviews with approximately 20 miners at each of 5 mines located throughout the major coal producing regions of the U.S. This survey will last 2 years. There will be no cost to respondents except their time to participate.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Coal Miners	100	1	30/60	50
Total				50

Dated: November 17, 2004.

B. Kathy Skipper,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–05–0212]

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 404–498–1210 or send comments to Sandi Gambescia, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS–E11, Atlanta, GA 30333 or send an e-mail 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

National Hospital Discharge Survey (OMB No. 0920–0212)—Extension—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

The National Hospital Discharge Survey (NHDS) has been conducted continuously by CDC, National Center for Health Statistics since 1965. It is the principal source of data on inpatient utilization of short-stay, non-Federal hospitals and is the only annual source of nationally representative estimates on the characteristics of discharges, the lengths of stay, diagnoses, surgical and non-surgical procedures, and the patterns of use of care in hospitals in various regions of the country. It is the benchmark against which special programmatic data sources are compared. Data collected through the NHDS are essential for evaluating the health status of the population, planning of programs and policy to elevate the health status of the Nation, studying morbidity trends, and research activities in the health field. NHDS data have been used extensively in the development and monitoring of goals for the Year 2000 and 2010 Health Objectives. In addition, NHDS data provide annual updates for numerous tables in the Congressionally-mandated NCHS report, Health, United States.

Data for the NHDS are collected annually on approximately 300,000 discharges from a nationally representative sample of noninstitutional hospitals exclusive of Federal, military and Veterans' Administration hospitals. The data items collected are the basic core of

variables contained in the Uniform Hospital Discharge Data Set (UHDDS) in addition to two data items (admission type and source) which are identical to those needed for billing of inpatient services for Medicare patients. In the 2003 NHDS, 426 hospitals participated. Data for approximately forty-four percent of the responding hospitals (186) are abstracted from medical records. The remaining hospitals supply data through in-house tapes or printouts (80 hospitals) or are hospitals that belong to commercial abstract service organizations or state data systems (160 hospitals) from which electronic data files are purchased. There is no actual cost to respondents since hospital staff who actively participate in the data collection effort are compensated by the government for their time.

Medical record abstracts	Number of respondents (hospitals)	Number of responses/ respondent	Average burden/response (in hrs.)	Total burden hours
Primary Procedure Hospitals	62	250	5/60	1,292
Alternate Procedure Hospitals	124	250	1/60	517
In-House Tape or Printout Hospitals	80	12	12/60	192
Induction Forms	15	1	2	30
Non-response Study	50	1	2	100
Total				2,131

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–05AH]

Proposed Data Collections Submitted for Public Comment and Recommendations

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Proposed Project

A Comprehensive Evaluation of an Approach to Self-Management: ''Diabetes: Living My Best Life''—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description: African-American women are more than twice as likely as white women to be diagnosed with diabetes, and two and one-half times as likely to die from diabetic complications. The onset of type 2 diabetes in African-American adults is attributable not only to a genetic link, but also to an unhealthy lifestyle. The vast number of African-American women with type 2 diabetes report having a sedentary lifestyle and eating a diet high in fat. In addition to taking medications, lifestyle modifications, such as changes in diet, weight loss and participating in a low-impact exercise program, can significantly reduce the complications experienced by women with type 2 diabetes. Unfortunately, there is a scarcity of training and educational materials on type 2 diabetes targeting the African-American woman. The limited availability of targeted educational materials has undoubtedly contributed to an inability to manage and control this disease in this population and has resulted in a higher prevalence of disease-related co-morbidities. There is a need for innovative interventions that can be used in a variety of settings and which feature culturally appropriate information that will engage African-American women with type 2 diabetes in a proactive role in the treatment and management of their disease.

The proposed project is the evaluation of a CD–ROM educational program: ''Diabetes: Living My Best Life.'' This product has been developed to teach African American women with type 2 diabetes self-management skills. Social Learning Theory (SLT) was used in the development of the product and the selection of the media elements. Selection of the information and tools was guided by input from an advisory board composed of professionals in the field and African American women with type 2 diabetes.

To evaluate this program there will be two questionnaires: a pre-test and a post-test. The two questionnaires will include questions on:

- Respondent demographic information (pre-test only).
- Respondent use of computers (pre-test only).
- Knowledge of diabetes.
- Self-efficacy in addressing diabetes self-management issues.
- Diabetes self-care activities.
- Feeling of empowerment around diabetes self-management.
- Social learning theory elements (post-test only).

Pre and post intervention data will be collected by computer. Burden estimates are based on observation of African-American women with type 2 diabetes who completed a formal pilot test of the pre and post-test forms. There are no costs to respondents except their time to participate in the survey.