Influenza epidemics usually cause an average more than 200,000 hospitalizations and 36,000 deaths per year in the U.S. Respiratory illnesses caused by influenza viruses are not easily differentiated from other respiratory infections based solely on symptoms. Also influenza viruses may adversely affect different subpopulations.

The effective use of rapid influenza diagnostic testing practices is an important component of the differential diagnosis of influenza-like-illness in both inpatient and outpatient treatment facilities. Test results are used for making decisions about antiviral versus antibiotic use, and in making admission or discharge decisions. In many cases, rapid influenza tests are the only tests that can provide results while the patient is still present in the facility. Thus, the appropriate use of the tests, and interpretation of test results is critical to the treatment and control of influenza. More than a dozen rapid tests have been approved by the U.S. Food and Drug Administration and are in widespread use. The reliability of rapid influenza tests is influenced by the individual test product used and the setting. Reported sensitivities range from 10–75%; while the median specificities reported are 90–95%. Other factors influencing accuracy are the stage (or duration) of illness when the diagnostic specimen is collected, type and adequacy of the specimen collected, variability in user technique for specimen collection or assay performance, and disease activity in the community. Given these and other collective findings, it is imperative for public health and for response planning that CDC develops sector-specific guidance and effective outreach to the clinicians on appropriate use of RIDT in their practices.

Previous studies by CDC of outpatient facilities showed that clinical laboratories usually perform the rapid tests for emergency departments, and provide results for both inpatient and outpatient treatment. Thus, understanding the use of rapid influenza testing in clinical laboratories in both hospitals and outpatient settings, how the results are reported to emergency departments, treatment facilities and health departments, and what quality assurance practices are used will guide future efforts of the CDC to continue to develop and update appropriate influenza testing guidelines and sector-specific training materials for clinicians and improve health outcomes of the American public. In fact, CDC has developed a rapid testing course, ''Strategies for Improving Rapid Influenza Testing in Ambulatory Settings,'' with continuing education credits that is available to clinicians and laboratorians free of charge. We would like to ask survey respondents if they have taken the course, and ask them to rate its usefulness.

The survey covers basic laboratory demographic characteristics, specimen collection and processing, testing practices, reporting results to emergency departments and other treatment facilities, reporting results to health departments, quality assurance practices, and methods of receiving updated influenza-related information. The respondents would be clinical laboratory supervisors, nurses, and other clinicians. The majority of the questions request information about laboratory influenza testing practices. For this request, we have also added a question about whether or not the participants have taken the free CDC rapid influenza testing course and to rate its usefulness in their clinical setting.

No updated systematic study has been conducted to investigate how laboratories now use these tests, how they report results, or how they interact with outpatient treatment facilities, whether they have taken the free rapid influenza testing course, or how they rate the course. The survey will be conducted on a national sample of laboratories and clinical facilities, including those in outpatient facilities that perform rapid influenza diagnostic tests.

There are no costs to respondents except 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
Clinical Laboratory Supervisors	Survey of Rapid Influenza Diagnostic Test Practices in Clinical Laboratories.	600	1	30/60	300
Nurses	Survey of Rapid Influenza Diagnostic Test Practices in Clinical Laboratories.	600	1	30/60	300
Other Clinicians	Survey of Rapid Influenza Diagnostic Test Practices in Clinical Laboratories.	600	1	30/60	300
Total					900

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

[30-Day–14–0212]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) has submitted the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The notice for the proposed information collection is published to obtain comments from the public and affected agencies.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your

comments should address any of the following: (a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) Enhance the quality, utility, and clarity of the information to be collected; (d) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses; and (e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Written comments and/or suggestions regarding the items contained in this notice should be directed to the Attention: 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

The National Hospital Care Survey (NHCS) (OMB Control Number 0920–0212; Expires 04–30–2016)—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 collect statistics on the extent and nature of illness and disability of the population of the United States. This three-year clearance request for NHCS includes the collection of all impatient and ambulatory Uniform Bill-04 (UB–04) claims data or electronic health record (EHR) data from a sample of 581 hospitals as well as the collection of additional clinical data from a sample of emergency department (ED) and outpatient department (OPD) visits (including ambulatory surgeries) through the abstraction of medical records.

NHCS integrates the former National Hospital Discharge Survey (OMB No. 0920–0212), the National Hospital Ambulatory Medical Care Survey (NHAMCS) (OMB No. 0920–0278) and the Drug-Abuse Warning Network (DAWN) (OMB No. 0930–0078, expired 12/31/2011) previously conducted by the Substance Abuse and Mental Health Services Administration's (SAMHSA). Integration of NHAMCS and DAWN into the NHCS is part of a broader strategy to improve efficiency by minimizing redundancy in data collection; broadening our capability to collect more relevant data on transitions of care; and identifying opportunities to exploit electronic and administrative clinical data systems to augment primary data collection.

NHCS consists of a nationally representative sample of 581 hospitals. These hospitals are currently being recruited, and participating hospitals are submitting all of their inpatient and ambulatory care patient data in the form of electronic UB–04 administrative claims or EHR data. Currently, hospital-level data are collected through a paper questionnaire and additional clinical data are being abstracted from a sample of visits to EDs and OPDs. This activity continues in 2014, and as more hospitals choose to send EHR data that includes clinical information, the need to conduct abstraction will be reduced.

This revision seeks approval to continue voluntary recruitment and data collection for NHCS, including inpatient, outpatient and emergency care; to revise the hospital-level questionnaire with additional items needed to improve weighting procedures; to combine the OPD and ambulatory surgery location patient record forms to more effectively capture ambulatory procedures in these settings; to continue collection of substance-involved ED visit data previously collected by DAWN; and to eliminate data collection from freestanding ambulatory surgery centers in order to concentrate efforts on hospital-based settings of care.

NHCS collects data items at the hospital, patient, inpatient discharge, and visit levels. Hospital-level data items include ownership, number of staffed beds, hospital service type, and EHR adoption. Patient-level data items are collected from both electronic data and abstraction components and include basic demographic information, personal identifiers, name, address, social security number (if available), and medical record number (if available). Discharge-level data are collected through the UB–04 claims or EHR data and include admission and discharge dates, diagnoses, diagnostic services, and surgical and non-surgical procedures. Visit-level data are collected through either EHR data, or for those hospitals submitting UB–04 claims, through the claims as well as through abstraction of medical records for a sample of visits. These visit-level data include reason for visit, diagnosis, procedures, medications, substances involved, and patient disposition.

NHCS users include, but are not limited to, CDC, Congressional Research Office, Office of the Assistant Secretary for Planning and Evaluation (ASPE), National Institutes of Health, American Health Care Association, Centers for Medicare & Medicaid Services (CMS), SAMHSA, Bureau of the Census, Office of National Drug Control Policy, state and local governments, and nonprofit organizations. Other users of these data include universities, research organizations, many in the private sector, foundations, and a variety of users in the media.

Data collected through NHCS are essential for evaluating health status of the population, for the planning of programs and policy to improve health care delivery systems of the Nation, for studying morbidity trends, and for research activities in the health field. Historically, data have been used extensively in the development and monitoring of goals for the Year 2000, 2010, and 2020 Healthy People Objectives.

There is no cost to respondents other than their time to participate. The total burden is 8,232 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avgerage burden per response (in hrs)
Hospital DHIM or DHIT	Initial Hospital Intake Questionnaire	160	1	1
Hospital CEO/CFO	Recruitment Survey Presentation	160	1	1

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avgerage burden per response (in hrs)
Hospital DHIM or DHIT	Prepare and transmit UB–04 for Inpatient and Ambulatory.	481	12	1
Hospital DHIM or DHIT	Prepare and transmit EHR for Inpatient and Ambulatory.	100	4	1
Hospital CEO/CFO	Annual Hospital Interview	581	1	2
Hospital CEO/CFO	Annual Ambulatory Hospital Interview	385	1	1.5

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

[60-Day–14–0913]

Proposed Data Collections Submitted for Public Comment and Recommendations

The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995. To request more information on the below proposed project or to obtain a copy of the information collection plan and instruments, call 404–639–7570 or send comments to Leroy A. Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov*.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget (OMB) approval. 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;(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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information. Written comments should be received within 60 days of this notice.

Proposed Project

Evaluating Locally-Developed HIV Prevention Interventions for African-American MSM in Los Angeles (OMB Control No. 0920–0913, expires 01/15/2015)—Extension — National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Data on HIV cases reported in 33 U.S. states with HIV reporting indicate the burden of HIV/AIDS is most concentrated in the African-American population compared to other racial/ethnic groups. Of the 49,704 African-American males diagnosed with HIV between 2001 and 2004, 54% of these cases were among men who have sex with men (MSM). In Los Angeles County (LAC), the proportion of HIV/AIDS cases among African-American males attributable to male-to-male sexual transmission is even greater (75%).

In the absence of an effective vaccine, behavioral interventions represent one of the few methods for reducing high HIV incidence among African American MSM (AAMSM). Unfortunately, in the third decade of the epidemic, very few of the available HIV-prevention interventions for African-American populations have been designed specifically for MSM. In fact, until very recently, none of CDC's evidence-based HIV-prevention interventions had been specifically tested for efficacy in reducing HIV transmission among MSM of color. Given the conspicuous absence of (1) evidence-based HIV interventions and (2) outcome evaluations of existing AAMSM interventions, our collaborative team intends to address a glaring research gap by implementing a best-practices model of comprehensive program evaluation.

The purpose of this project is to test, in a real-world setting, the efficacy of an HIV transmission prevention intervention for reducing sexual risk among African-American men who have sex with men in Los Angeles County. The intervention is a three-session, group-level intervention that will provide participants with the information, motivation, and skills necessary to reduce their risk of transmitting or acquiring HIV.

The intervention is being evaluated using baseline, 3-month and 6-month follow up assessments. This project also intends to conduct in-depth qualitative interviews with a total of 36 men in order to assess the experiences with the intervention, elicit recommendations for improving the intervention, and to better understand the factors that place young African American MSM at risk for HIV.

CDC is requesting approval for a 1-year clearance to complete data collection. The data collection system involves screenings, limited locator information, contact information, baseline questionnaire, client satisfaction surveys, 3-month follow-up questionnaire, 6-month follow-up questionnaire, and case study interviews.

An estimated 160 men will be screened for eligibility in order to enroll 80 additional men to reach the desired