

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden / response (in hours)	Total burden hours
Written Surveys	5000	1	10/60	834
Total				834

Dated: April 6, 2005.

Joan F. Karr,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-05-05BN]

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 404-371-5983 and send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D74, 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

Web-based Reporting Systems for Tobacco Control: A Nationwide Assessment—New—The Office on Smoking and Health (OSH), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Implementation of a Web-based reporting system assessment for the state health departments' tobacco control programs.

As state health departments strive to standardize data collections to better evaluate progress toward strategic goals and objectives, a movement to develop web-based reporting systems is sweeping the field of public health. In October of 2002, through a Prevention Research Center (PRC) grant, researchers from the University of Minnesota conducted a national assessment of tobacco control program monitoring practices among state health departments. Results indicated that all states monitor tobacco control program activities through either paper or computer-based systems. In 1998, three states had computerized systems operating, whereas in 2002, thirteen states had launched systems and twenty-two more were in the planning/development stage (Blaine & Petersen, presented at National Conference on Tobacco or Health, San Francisco, November 20, 2002). Clearly, there is a trend toward developing database systems to assess and to monitor state tobacco prevention and control programs.

However, recent loss of resources available to state tobacco control programs begs several questions: (1) How have tightened public health budgets affected the development of proposed and in-progress web-based monitoring systems? (2) What can we learn from states that have already implemented and upgraded their systems that can save time and money for states still in the development process? (3) How can we institute knowledge management systems that

can facilitate horizontal information sharing? (4) Is there utility in creating a guidance document to better promote best practices in monitoring system development? (5) How can this information be used by the CDC to highlight the benefits to public health of state level computerized program reporting and monitoring systems?

Roundtable discussions facilitated by the Office on Smoking and Health with state tobacco control program staff have focused on standardized data collection for contract management and process evaluation purposes. Participants expressed frustration that states are often "recreating the wheel," with each state developing a unique system without the benefit of learning from states with web-based systems already in production. These discussions motivated the CDC to explore more efficient means of sharing lessons learned about computerized reporting systems.

The proposed research will build on the findings of the previous study. Enhanced understanding of the proliferation, costs and benefits of these web-based reporting systems can (1) improve the capacity of the CDC to service state health departments' cooperative agreement technical assistance needs, (2) provide a template for the CDC as it considers how electronic monitoring systems could be expanded to other public health arenas besides tobacco control, and (3) save state health departments time and money by using the information gleaned from this research to create an accessible forum for knowledge sharing.

The proposed study has three separate methodological components: (1) A nationwide baseline survey, (2) a follow-up phone interview with early adopters, and (3) select case studies. This is a one time only research study. This tiered research approach will provide a systematic overview of web-based reporting systems ranging from the macro-level to the micro-level. Aside from the minimal time needed to participate in the interviews, there will be no cost to participants.

ESTIMATE OF ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
States and DC baseline survey via phone interview	51	1	30/60	25.5
Early Adopters focused responses via phone interview	15	1	1.0	15.0
Case Studies 3 per state X 3 states via site visit	9	1	1.5	13.5
Totals				54

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Joan F. Karr,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-05-04JU]

Proposed Data Collections Submitted for Public Comment and Recommendations

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 the CDC Reports Clearance Officer at (404) 371-5974 or send an e-mail to omb@cdc.gov. Send written comments to CDC Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395-6974. Written comments should be received within 30 days of this notice.

Proposed Project

Factors Impacting Effective Removal of Arsenic by Household Water Purification Systems—New—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Epidemiologic evidence strongly links ingestion of water containing inorganic arsenic with an increase in bladder cancer and other cancers. In Maine, approximately 10% of private domestic wells have arsenic concentrations greater than Maine's health standard for water of 10 µg/L. In wells with high arsenic concentrations, ingestion of water can be the dominant source of arsenic exposure. The preferred method for treating domestic well water containing elevated levels of arsenic is point-of-use water-treatment devices.

The purpose of the proposed study is to evaluate how the efficacy of water-treatment devices is affected by user behaviors such as maintenance and selection of appropriate technologies and by variations in water chemistry. The requested three year clearance for this study will focus on a total of 100 households. Approximately 200 households will be recruited and screened to ascertain the 100 eligible households. Recruitment is limited to areas of Maine that have high concentrations of arsenic in groundwater.

The results will demonstrate how arsenic removal systems are working in the real world. The data will give insight into how homeowners are collecting, interpreting and utilizing information on water treatment in order to select an arsenic-removal system. The data will show how well the chosen systems are removing arsenic, and how well they are being maintained. The results will thus identify risk factors

that contribute to a failing treatment system.

The study will have a cross-sectional component and a temporal component. For the cross-sectional component, total arsenic, inorganic arsenic species, and selected geochemical constituents will be quantified by the influent and effluent (flowing in and flowing out) of filtration devices treating these 100 domestic well-water supplies. The study team will administer questionnaires to each participating household to collect data on the type of treatment unit used, routine operation parameters, and suggested and actual maintenance schedules. For the temporal component of the study, the study team will test the influent and effluent of the treatment units of 30 participating households for total arsenic one time per year. The percentage of arsenic removed by the filter will be compared to the study criterion selected to indicate that a filter is failing. If the arsenic removal level indicates that a treatment unit meets the criterion for failure, treatment unit influent and effluent water will be analyzed for inorganic arsenic species and geochemical constituents to determine whether the chemistry of the water has changed sufficiently to explain the failure.

A follow-up questionnaire will be administered biannually and at the time of a system failure to determine when the unit was last maintained and if operation and maintenance have changed. CDC/NCEH will request a 3-year clearance. There is no cost to participants other than their time. The total annual burden hours are 56.

ESTIMATE OF ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of responses/ respondent	Avg. burden response (in hrs.)	Total burden hours
Initial recruiting postcard completion	67	1	5/60	6
Follow-up telephone call	34	1	10/60	6
Initial interview	34	1	30/60	17
Biannual follow-up interview	30	2	25/60	25
System failure follow-up interview	4	1	25/60	2
Total				56