

54 measures in OASIS. To facilitate discussion, these 41 measures were put into 13 categories (used in consumer testing) and three domains (adapted from the Foundation for Accountability framework) as follows:

- Domain: Getting Better

Category 1: Physical Health

Improvements in: Dyspnea, status of surgical wounds, number of surgical wounds, urinary tract infection, urinary incontinence, bowel incontinence.

Category 2: Mental Health

Improvements in: Behavior problem frequency, cognitive functioning, confusion frequency, anxiety level.

Category 3: Meeting Basic Daily Needs

Improvements in: Eating, upper body dressing, lower body dressing, in bathing, grooming, management of oral medications.

Category 4: Getting Around

Improvements in: Ambulation/ locomotion, toileting, transferring, pain interfering with activity.

Category 5: Meeting Household Needs

Improvements in: Light meal preparation, laundry, shopping, housekeeping.

Category 6: Talking With People

Improvements in: Speech and language, phone use.

Category 7: Staying at Home Without Home Care

Discharged to community.

- Domain: Living With Illness or Disability

Category 8: Meeting Basic Daily Needs

Stabilization in: Bathing, grooming, management of oral medications.

Category 9: Meeting Household Needs

Stabilization in: Light meal preparation, laundry, shopping, housekeeping.

Category 10: Mental Health

Stabilization in: Cognitive functioning, anxiety level.

Category 11: Getting Around

Stabilization in: Transferring.

Category 12: Talking With People

Stabilization in: Speech and language, phone use.

- Domain: Staying Healthy/Avoiding Injury or Harm

Category 13: Medical Emergencies

Any emergency care provided, acute care hospitalization.

CMS and AHRQ focused panel attention on just these 41 measures because they assess long-term quality improvement issues that every home health agency should address. These OASIS measures are not specific to particular diagnoses but the functional outcomes they measure apply to many diagnoses. There are an additional 13 adverse event outcome OASIS measures that were not considered by the panel because they cover events that occur infrequently.

4. AHRQ Proposed Recommendations for Home Health Care Measures for the NHQR

Based on the Home Health Quality Measures Technical Expert Panel input, including: the individual panelist prioritization lists (*i.e.*, a significant proportion of panelists listed particular measures as priority items for inclusion), their written comments and the meeting discussion, AHRQ proposes using results collected on the following 12 OASIS measures for reporting on the quality of home health care in the NHQR:

- Improvement in dyspnea (physical health category);
- Improvement in urinary incontinence (physical health category);
- Improvement in upper body dressing (basic daily needs category);
- Improvement in management of oral medications dressing (basic daily needs category);
- Improvement in ambulation/ locomotion (getting around category);
- Improvement in toileting (getting around category);
- Improvement in transferring (getting around category);
- Improvement in pain interfering with activity (getting around category);
- Improvement in bathing (basic daily needs category);
- Stabilization in bathing (basic daily needs category);
- Improvement in confusion frequency (mental health);
- Acute care hospitalization (medical emergencies category).

AHRQ is soliciting public comment on this proposed set of 12 home health care measures selected from the 41 OASIS measures considered. Ten of these measures are the same as CMS has announced for use in its initial home health public reporting effort. Based on panel input regarding the NHQR, AHRQ is recommending two additional measures, “Improvement in dyspnea” and “Improvement in urinary incontinence.” Finally, although CMS is using the measure, “Any Emergency Care,” (one of the OASIS measures

listed above in Category 13), AHRQ is not recommending this measure for the NHQR at this time because we believe that this measure raises some significant issues that warrant further investigation. AHRQ would like to hear comments on the advantages and disadvantages of this measure in particular.

Carolyn M. Clancy,

Director.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–03–53]

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 the CDC Reports Clearance Officer on (404) 498–1210.

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. Send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS–D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project: The National Violent Death Reporting System—New—National Center for Injury prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

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 don't 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 system (SHRs) does collect basic

information about the victim-suspect relationship and circumstances, like death certificates, it does 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) addresses some of these deficiencies, but it covers less of the country than SHRs, still includes only homicides, and collects only police information. Also, the Bureau of Justice Statistics Reports do not use data that is less than two years old.

CDC therefore proposes to start a state-based surveillance systems for violent deaths that will provide more detailed and timely information. It will tap into the case records held by medical examiners/coroners, police, and crime labs. Data will be collected centrally by each state in the system, stripped of identifiers, and then sent to the CDC. Information will be collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States will 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.

The number of state health departments to be funded may be as high as 14 once FY03 cooperative agreements are awarded. Six states were funded thru FY02 cooperative agreements, and up to 8 more may be funded in 2003. NCIPC hopes to eventually fund all 50 states. Violent deaths include all homicides, suicides, legal interventions, deaths from undetermined causes, and unintentional firearm deaths. There are 50,000 such deaths annually among U.S. residents, so the average state will experience approximately 1,000 such deaths each year.

Respondents	Number of respondents	Number of responses/respondent	Average burden/response (in hours)	Total burden (in hours)
State Health Departments	14	1,000	150/60	35,000
Total	35,000

Dated: March 13, 2003.

Thomas Bartenfeld,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–03–51]

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Clearance Officer, 1600 Clifton Road, MS–D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project: Centers for Disease Control and Prevention's Performance Evaluation Program for Mycobacterium Tuberculosis and Non-Tuberculosis Mycobacterium (NTM) Drug Susceptibility Testing—New—Public Health Practice Program Office (PHPPO), Centers for Disease Control and Prevention (CDC).

As part of the continuing effort to support both domestic and global public health objectives for treatment of tuberculosis (TB), prevention of multi-drug resistance and surveillance programs, the Division of Laboratory Systems seeks to collect information from domestic private clinical and public health laboratories twice per year. Participation and information collections from international laboratories will be limited to those