and any staff time that was devoted to performing finger stick tests at locations other than the health clinic (e.g., health fairs, shopping malls, work sites, housing complexes). Of the 43 clinics to be surveyed, we expect that 30 (70%) will complete the survey.

A computer-assisted in-person interview will be administered to 600 clinic patients—60 in each of the 10 regions in which the pilot DDI was implemented. The survey will collect background information, out-of-pocket medical and non-medical direct health care costs (e.g., co-payments, transportation costs, value of patients' time associated with the clinic visit), and preferred features of a diabetes screening program. There are no costs to respondents other than their time.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Implementation team members	10	1	2	20
Clinic staff	30	1	1	30
Patients at DDI clinics	600	1	20/60	200
Total	640			250

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Betsey Dunaway,

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

[30 Day–05–0439x]

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) 371–5983 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

Assessment of State Early Hearing Detection and Intervention Programs (EHDI): A Program Operations Evaluation Protocol—New—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description: Every year, an estimated 12,000 newborns are diagnosed with permanent hearing loss, a condition that if not identified and treated early can lead to impaired functioning and development. CDC's role in the detection, diagnosis, and treatment of early hearing loss through the ''Early Hearing Detection and Intervention Program'' (EHDI) is of vital importance for families of newborns and infants affected by hearing loss. Nonetheless, recent data indicate that only 60 percent of the newborns that fail hearing screening are evaluated by the recommended 3 months of age.

The evaluation will involve an integrative evaluation approach that encompasses the following activities, conducted in Arkansas, Massachusetts, Michigan, Utah, and Virginia: (1) A 10-minute survey of 3,000 mothers whose newborns have been screened (the ''Maternal Exit Survey''); and (2) a 20-minute computer-assisted telephone interviewing (CATI) survey of 1,000 mothers of newborns who have been referred for additional hearing evaluation (the ''Maternal CATI Interview.'') To complete these interviews, it is expected that 5,000 will be contacted. The overall burden on all contacted women is expected to be approximately 940 hours. The Maternal Exit Survey and the Maternal CATI Interview will address the following research questions: (1) What are the factors that impede or enable families to follow-up for early hearing evaluation and intervention; (2) What EHDI strategies implemented by hospitals appear to be most successful in reducing loss to follow-up; and (3) Is loss to follow-up associated with maternal characteristics such as parity, age or ethnicity? Both surveys will be available in English and Spanish.

Hearing loss is the most common disorder that can be detected through newborn screening programs. Prior to the implementation of newborn hearing screening, children with hearing loss typically were not identified until 2 to 3 years of age. This is well beyond the period of early language development. Now, with comprehensive EHDI programs, the average age of identification of children with hearing loss has been reduced so that it is now possible to provide interventions for children younger than one year of age. With early identification, children with hearing loss can begin receiving appropriate intervention services that provide the best opportunity for these children to reach their maximum potential in such areas as language, communication, social and emotional development, and school achievement.

Newborn hearing screening is only the first step in the identification of children with hearing loss. Children who do not pass their screening need to be further evaluated to determine if they have hearing loss. The value of newborn hearing screening cannot be realized unless children complete the screening, evaluation, and intervention process. Since recent data indicate that nearly 40 percent of children do not complete the evaluation-intervention process, this project is designed to understand what barriers exist in following through with evaluation and intervention. This evaluation also plans to provide data necessary to develop innovative solutions that can be applied by states, hospitals, and local programs. Results from this collection have the potential to strengthen the EHDI process and minimize social and economic disability among persons born with hearing loss.

By evaluating the policy, structural, personal, and financial factors and barriers associated with loss to follow-up in the EHDI program, this study seeks to identify ''best practices'' for improving detection, referral to

evaluation and intervention, and adherence to intervention. CDC's plan to publish data and results from this evaluation will help state health officials, other Federal agencies, and other stakeholders to improve the EHDI process-providing direct benefit to infants with hearing loss and their families. The total estimated burden hours are 940.

ESTIMATED ANNUALIZED TOTAL BURDEN HOURS

Instrument	Number of respondents	Responses per respondent	Average burden per response (in hrs.)
Maternal Exit Survey			
Request to Participate	3,750	1	1/60
Complete Survey	3,000	1	10/60
Maternal CATI Interview			
Request to Participate	1,250	1	2/60
Consent and Screening, but no Hearing Test	8	1	1/60
Consent and Partially Completed Screening, Hearing Test but no Results	8	1	15/60
Consent and Completed Interview	1,000	1	20/60

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Proposed Project

Tremolite Asbestos Registry—NEW—The Agency for Toxic Substances and Disease Registry (ATSDR).

Background and Brief Description: The Agency for Toxic Substances and Disease Registry (ATSDR) is mandated pursuant to the 1980 Comprehensive Environmental Response Compensation and Liability Act (CERCLA) and its 1986 Amendments, the Superfund Amendments and Re-authorization Act (SARA), to establish and maintain a national registry of persons who have been exposed to hazardous substances in the environment and a national registry of persons with illnesses or health problems resulting from such exposure. In 1988, ATSDR created the National Exposure Registry (NER) as a result of this legislation in an effort to provide scientific information about potential adverse health effects people develop as a result of low-level, long-term exposure to hazardous substances.

The NER is a program which collects, maintains, and analyzes information obtained from participants (called registrants) whose exposure to selected toxic substances at specific geographic areas in the United States has been documented. Relevant health data and demographic information are also included in the NER databases. The NER databases furnish the information needed to generate appropriate and valid hypotheses for future activities such as epidemiologic studies. The NER also serves as a mechanism for longitudinal health investigations that follow registrants over time to ascertain adverse health effects and latency periods.

The Tremolite Asbestos Registry (TAR) is currently authorized as part of the National Exposure Registry (OMB #0923–0006, expiration 10/31/05). ATSDR is seeking a separate approval for the TAR activities. The purpose of the TAR will be to improve communication with people at risk for developing asbestos-related disease resulting from asbestos exposure in Libby, Montana, and to support research activities related to TAR registrants.

The TAR is currently composed of information about former vermiculite workers, the people that lived with them during their tenure as vermiculite workers (*i.e.*, the workers and their household contacts), and people who participated in or are eligible to participate in the ATSDR medical testing program in Libby, Montana.

ATSDR will take a phased approach to creating the TAR. Phase I, which is currently nearing completion, involved identifying, locating, and contacting former workers and their household members. Phase II will combine the data from Phase I and the data collected during the medical testing program to create a single database. Phase III will involve re-contacting registrants to update their information. There is no cost to registrants other than their time. The total estimated annual burden hours are 680.

ESTIMATED ANNUALIZED BURDEN HOURS

Forms	Number of respondents	Responses per respondent	Avg. burden per response (in hrs.)
Baseline TAR	667	1	30/60