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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-13-0853]

Agency Forms Undergoing Paperwork Reduction Act Review

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 (404) 639-7570 or send an email to omb@cdc.gov. Send written comments to 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

Asthma Information Reporting System (AIRS) (0920-0853, Expiration 06/30/2013) – Extension – Air Pollution and Respiratory Health Branch (APRHB), National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Under the authority of the Public Health Service Act, CDC is seeking a three-year extension of OMB approval for the Asthma Information Reporting System (AIRS) information collection. In 1999, the CDC initiated its National Asthma Control Program, a population-based public health approach to address the burden of asthma. The program supports the goals and objectives of "Healthy People 2020" for asthma and is based on the public health principles of surveillance, partnerships, and interventions. Through AIRS, the information collection request has and will continue to provide NCEH with routine information about the activities and performance of the state and territorial grantees funded under the National Asthma Control Program http://www.cdc.gov/asthma/nacp.htm.

The primary purpose of the National Asthma Control Program is to develop program capacity to address asthma from a public health perspective to bring about: (1) a focus on asthma-related activity within states; (2) an increased understanding of asthma-related data and its application to program planning and evaluation through the development and maintenance of an ongoing asthma surveillance system; (3) an increased recognition, within the public health structure of states, of the potential to use a public health approach to reduce the burden of asthma; (4) linkages of state health agencies to other agencies and organizations addressing asthma in the population; and (5)

implementation of interventions to achieve positive health impacts, such as reducing the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activity due to asthma.

Prior to the implementation of AIRS, data were collected on a semi-annual basis from state asthma control programs as part of regular reporting of cooperative agreement activities. States reported information such as progress-to-date on accomplishing intended objectives, programmatic changes, changes to staffing or management, and budgetary information.

As implemented since 2010, the AIRS management information system is comprised of multiple components that enable the electronic reporting of three types of data/information from state asthma control programs: (1) Information that is currently collected as part of regular programmatic reporting, (2) Aggregate level reports of surveillance data on long-term program outcomes, and (3) Specific data indicative of progress made on partnerships, surveillance, interventions, and evaluation.

Regular reporting of this information remains a requirement of the current cooperative agreement mechanism utilized to fund state asthma control programs. States are asked to submit interim and year-end progress report information into AIRS, thus

this type of programmatic information on activities and objectives will continue to be collected twice per year.

The National Asthma Control Program at CDC has access to and analyzes national-level asthma surveillance data (http://www.cdc.gov/asthma/asthmadata.htm). With the exception of data from the Behavioral Risk Factor Surveillance System (BRFSS), state level analyses cannot be performed. Therefore, as part of AIRS, state asthma control programs submit aggregate surveillance data to allow calculation of asthma surveillance indicators across all funded states (where data are available) in a standardized manner. Data requests through this system regularly include: hospital discharges (with asthma as first listed diagnosis), and emergency department visits (with asthma as first listed diagnosis). Under AIRS, participating states annually submit this information to the AIRS system in conjunction with an end-of-year report describing state activities that meet project objectives described above.

National and state asthma surveillance data provide information useful to examine progress on long-term outcomes of state asthma programs. To identify appropriate indicators of program implementation and short-term outcomes for AIRS, CDC previously convened and facilitated workgroups comprised of state asthma control program representatives to generated specific questions to collect data on key features of state

asthma control programs: partnerships, surveillance, interventions, and evaluation.

With technical assistance provided by NCEH staff, AIRS has provided states with uniform data reporting methods and linkages to other states' asthma programs and data. Thus, AIRS has saved state resources and staff time when they embark on asthma activities similar to those being done elsewhere. Also, the AIRS system has been similarly helpful in linking states together on occasions when a given state seeks to report their results at national meetings or publish their findings and program results in scholarly journals. For example, with CDC staff, three state programs co-presented on a panel regarding evaluations of their asthma partnerships at the November, 2012 American Evaluation Association's *Evaluation 2012* conference.

In addition, CDC staff have regularly made requests from AIRS to obtain standardized summaries of state programs regarding such activities as the number of states meeting staffing requirements, number and timeliness of state strategic evaluation plans, topics for individual evaluation selected by states, types and targets of interventions, and use of asthma surveillance data in state programs.

Furthermore, access to standardized AIRS surveillance and programmatic data allows CDC to provide timely and accurate responses to the public and Congress regarding the NCEH asthma

program (e.g., how many states have asthma interventions targeting schools, how many children are treated in emergency departments, etc.).

There will be no cost for respondents, other than their time, to participate in AIRS. Based on the program's evaluation of past performance, it was noted that the hours for the interim report should be increased from 2 to 4 hours and those of the end of year be decreased from 6 to 4 hours; however, total burden hours remain at 8 hours per year per respondent. The total estimated annual burden hours are 288.

Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs.)
State Health Departments	Interim report on activities and objectives	36	1	4
State Health Departments	End of year report on activities, objectives and aggregate surveillance	36	1	4

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