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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–11–11IP]

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 404–639–5960 and send comments to Daniel Holcomb, CDC 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

Workplace Violence Prevention Programs in NJ Healthcare Facilities—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The long-term goal of the proposed project is to reduce violence against healthcare workers. The objective of the proposed study is two-fold: (1) To examine healthcare facility compliance with the New Jersey Violence Prevention in Health Care Facilities Act, and (2) to evaluate the effectiveness of the regulations in this Act in reducing assault injuries to workers. Our central hypothesis is that facilities with high compliance with the regulations will have lower rates of employee violence-related injury. First, we will conduct face-to-face interviews with the chairs of the Violence Prevention Committees who are in charge of overseeing compliance efforts. The purpose of the interviews is to measure compliance to the state regulations (violence prevention policies, reporting systems for violent events, violence prevention committee, written violence prevention plan, violence risk assessments, post incident response and violence prevention training). Second, we will also collect assault injury data from facility violent event reports 3 years pre-regulation (2009–2011) and 3 years post-regulation (2012–2014). The purpose of collecting these data is to evaluate changes in assault injury rates before and after enactment of the regulations. Third, we will conduct a nurse survey. The survey will describe the workplace violence prevention training nurses receive following enactment of the New Jersey regulations.

Healthcare workers are nearly five times more likely to be victims of violence than workers in all industries combined. While healthcare workers are not at particularly high risk for job-related homicide, nearly 60% of all nonfatal assaults occurring in private industry are experienced in healthcare. Six states have enacted laws to reduce violence against healthcare workers by requiring workplace violence prevention programs. However, little is understood about how effective these laws are in reducing violence against healthcare workers.

We will test our central hypothesis by accomplishing the following specific aims:

1. Compare the comprehensiveness of healthcare facility workplace violence prevention programs before and after enactment of the New Jersey regulations; *Working hypothesis:* Based on our preliminary research, we hypothesize that enactment of the regulations will improve the comprehensiveness of hospital workplace violence prevention program policies, procedures and training.

2. Describe the workplace violence prevention training nurses receive following enactment of the New Jersey regulations; *Working hypothesis:* Based on our preliminary research, we hypothesize that nurses receive at least 80% of the workplace violence prevention training components mandated in the New Jersey regulations.

3. Examine patterns of assault injuries to workers before and after enactment of the regulations; *Working hypothesis:* Based on our preliminary research, we hypothesize that rates of assault injuries to workers will decrease following enactment of the regulations.

Healthcare facilities falling under the regulations are eligible for study inclusion (*i.e.,* general acute care hospitals and psychiatric facilities). We will conduct face-to-face interviews with the chairs of the Violence Prevention Committees, who as stated in regulations, are in charge of overseeing compliance efforts. These individuals will include hospital administrators, security directors and/or risk managers, many of whom participated in the California study. The purpose of the interviews is to measure compliance to the state regulations (Aim 1). The interview form was pilot-tested by the study team in the fall 2010 and includes the following components as mandated in the regulations: Violence prevention policies, reporting systems for violent events, violence prevention committee, written violence prevention plan, violence risk assessments, post-incident response and violence prevention training. Questions will also be asked about barriers and facilitators to developing the violence prevention program.

These data will be collected in the post-regulation time period; data collected from New Jersey hospitals in the California study will be used as the baseline measure for evaluating compliance. We will also collect assault injury data from facility violent event reports 3 years pre-regulation (2009–2011) and 3 years post-regulation (2012–2014). The purpose of collecting these data is to evaluate changes in assault injury rates before and after enactment of the regulations (Aim 3). The abstraction form was developed to collect the specific reporting components stated in the regulations: Date, time and location of the incident; identity, job title and job task of the victim; identity of the perpetrator; description of the violent act, including whether a weapon was used; description of physical injuries; number of employees in the vicinity when the incident occurred, and their actions in response to the incident; recommendations of police advisors, employees or consultants, and; actions taken by the facility in response to the incident. No employee or perpetrator identifiable information will be collected.

In addition to health care facilities, nurses will also be recruited. These nurses will be recruited from a mailing list of nurses licensed from the State of New Jersey Division of Consumer Affairs Board of Nursing. The mailing list was selected as the population source of workers due to the ability to capture all licensed nurses in New Jersey. A similar listing does not exist for non-licensed frontline workers, such as aides and orderlies. Therefore, a sampling frame based on nurses (registered nurses and licensed practical nurses) will be used to select workers to participate in the study. A random sample of 2000 registered and licensed practical nurses will be recruited for study participation. A third-party contractor will be responsible for sending the survey to the random sample of 2000. The Health Professionals and Allied Employees union will promote the survey to their members. To maintain the worker's anonymity, the facility in which he/she works will not be identified. The survey will describe the workplace violence prevention training nurses receive following enactment of the New Jersey regulations (Aim 2).

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hrs)	Total burden (in hrs)
Hospital Administrators	50	1	1	50
Nurses (RN and LPN)	2000	1	20/60	667
Total				717

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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[60Day–11–0260]

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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

Health Hazard Evaluation and Technical Assistance—Requests and Emerging Problems—Revision (OMB No. 0920–0260)—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In accordance with its mandates under the Occupational Safety and Health Act of 1970 and the Federal Mine Safety and Health Act of 1977, the National Institute for Occupational Safety and Health (NIOSH) responds to requests for health hazard evaluations (HHE) to identify chemical, biological or physical hazards in workplaces throughout the United States. Each year, NIOSH receives approximately 320 such requests. Most HHE requests come from the following types of companies: Service, manufacturing companies, health and social services, transportation, construction, agriculture, mining, skilled trade and construction.

A printed Health Hazard Evaluation request form is available in English and in Spanish. The form is also available on the Internet and differs from the printed version only in format and in the fact that it uses an Internet address to submit the form to NIOSH. Both the printed and Internet versions of the form provide the mechanism for employees, employers, and other authorized representatives to supply the information required by the regulations governing the NIOSH Health Hazard Evaluation program (42 CFR 85.3–1). In general, if employees are submitting the form it must contain the signatures of three or more current employees. However, regulations allow a single signature if the requestor: Is one of three (3) or fewer employees in the process, operation, or job of concern; or is any officer of a labor union representing the employees for collective bargaining purposes. An individual management official may request an evaluation on behalf of the employer. For the purpose of the burden estimates, employers includes government, other, and joint requests. About 20% of the total number of HHE requests received per year is identified specifically as management requests. The information provided is used by NIOSH to determine whether there is reasonable cause to justify conducting an investigation and provides a mechanism to respond to the requestor.

In the case of 25% to 50% of the health hazard evaluation requests received, NIOSH determines an on-site evaluation is needed. The primary purpose of an on-site evaluation is to help employers and employees identify and eliminate occupational health hazards. In most on-site evaluations employees are interviewed to help further define concerns, and in approximately 50% these evaluations (presently estimated to be about 80 facilities), questionnaires are distributed to the employees (averaging about 40 employees per site for this last subgroup). No specific interview form is