and women's health, child well-being, and marriage and the family; academic researchers in the social and public health sciences; journalists, and many others.

No questionnaire changes are requested in the first 15 months of this clearance; some limited changes may be requested after that, to be responsive to emerging public policy issues.

There is no cost to respondents other than their time. The total estimated annualized burden hours are 7,192.

TABLE 1—ESTIMATED ANNUALIZED BURDEN HOURS

Respondents/Instrument	Number of responses	Responses per respondent	Average burden per response (in hours)
Screener	14,000	1	3/60
Female Interview	2,750	1	1.5
Male Interview	2,250	1	1
Verification	1,400	1	5/60

Dated: March 19, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–12–12GF]

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 404–639–7570 or send comments to Ron Otten, at 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an email 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

Adoption, Health Impact and Cost of Smoke-Free Multi-Unit Housing—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) and National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The health risks associated with cigarette smoking and exposure to Secondhand Smoke (SHS) are well established. In 2006, the Surgeon General's report documented that over the past two decades, the scientific, engineering and medical literature have established a wide range of adverse health effects from SHS, including cardiovascular disease, lung, breast and nasal sinus cancer, asthma and other respiratory illnesses, and low birth weight and sudden infant death syndrome in newborn babies. SHS exposure is estimated to result in $5 billion a year in direct medical costs and an additional $5 billion in indirect costs in the U.S. The Surgeon General's report concluded that there is no safe level of exposure to SHS.

Approximately 85 million Americans reside in multi-unit housing (MUH) facilities, which comprise nearly 30% of all housing in the U.S. There are significant challenges to maintaining a smoke-free environment in MUH residential settings. Although residents may choose not to smoke, they may still be exposed to SHS through the routine operation of facility-wide heating, ventilating and air conditioning systems.

The private sector has begun to institute smoke-free policies in MUH on a voluntary basis through changes in leasing agreements and advertising, however, smoking restrictions in MUH have largely been limited to common areas and spaces, not individual dwelling units. There are no studies that have examined the impact of smoke free policies by comparing pre- and post SHS exposure and changes in health outcomes after local governments adopt regulatory policies that protect residents from the effects of exposure to SHS in their housing units.

CDC proposes to conduct a study to address the gap in scientific evidence about the impact of jurisdiction-wide strategies (hereafter known as smoke-free MUH policies) to protect individuals from SHS in MUH settings. Through the collection and analysis of environmental and biometric data, the study will demonstrate how SHS exposure can be measured and will quantify how exposure changes when smoke-free policies are implemented. In addition, the study will examine barriers and facilitators to implementation of smoke-free policies in MUH and the cost-effectiveness of these policies. CDC is authorized to conduct this investigation by the Public Health Service Act. The activities are funded through the Prevention and Public Health Fund of the Patient Protection and Affordable Care Act, which is designed to expand and sustain the necessary infrastructure for preventing disease, detecting it early, and managing conditions before they become severe.

The proposed study consists of two components. The first component involves data collection in Los Angeles County, California, and includes a number of ''intervention'' communities that have adopted, or are scheduled to adopt, smoke-free MUH laws by mid-2012, as well as ''comparison'' communities that have not adopted laws regulating SHS in MUH. Communities being considered for participation in the study as intervention communities include Culver City, Huntington Park,

Lawndale, Sierra Madre, San Fernando, San Gabriel, Carson, Artesia, and Hawthorne. Communities being considered for participation in the study as comparison communities include Temple City, Hawaiian Gardens, Monrovia, Maywood, Alhambra, La Puente, Monterey Park, Inglewood, and San Dimas.

The availability of both intervention and comparison communities will enable use of a quasi-experimental, baseline and follow-up study design for examining the impact of smoke-free policies in MUH. Over a period of two years, a sample of 500 MUH residents and 130 MUH operators will be selected from intervention cities and a comparable sample of 500 MUH residents and 130 MUH operators will be selected from comparison cities. Baseline and follow-up surveys will be conducted involving MUH operators, MUH residents, and parents of children who reside in MUH facilities. Also, MUH residents will be recruited to collect environmental air quality data, and both parents and children who reside in MUH facilities will be recruited to provide saliva samples. These samples will be analyzed for the presence of cotinine, a biomarker of exposure to SHS.

The second component of the study will involve focus groups in Maine, Minnesota, and Florida—states have adopted and implemented smoke-free MUH policies for a longer period of time, either as a response to local regulations or voluntarily. A one-time survey of MUH operators will be conducted, and a sample of 12 MUH operators will be selected from communities in Minnesota, Maine, and Florida. In addition, a total of 120 residents will be selected to participate in short focus groups, with a maximum of 4 focus groups per state. The primary data sources for this component of the study will be (a) quantitative data obtained from interviews with 12 MUH operators (4 operators in the three study locations, using the same questionnaire as Los Angeles County); (b) qualitative data from participants from up to 12 focus groups (an expected total of 120 residents); and (c) quantitative data on the same residents from pre-focus group questionnaires. Results from studies in these three geographic areas and from cities in Los Angeles County, will provide insights more useful at the national population level than results based solely on information collected in Los Angeles County.

OMB approval is requested for two years, with first data collection beginning approximately May 2012. Participation is voluntary. The only cost to respondents is their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
MUH Operators in Los Angeles County.	Telephone Script for Recruitment of MUH Operators in Los Angeles County.	130	1	5/60	11
	MUH Operators Survey	130	2	75/60	325
MUH Operators in Minnesota, Maine and Florida.	Telephone Script for Recruitment of MUH Operators in MN, ME, FL.	6	1	10/60	1
	MUH Operators Survey	6	1	75/60	8
MUH Residents in Los Angeles County.	MUH Residents Survey-Core	500	2	45/60	750
	MUH Residents Survey-Supplement—Survey of Child's Health.	250	2	15/60	125
	Saliva Cotinine Samples (Adult)	500	2	10/60	167
	Saliva Cotinine Samples (Child)	250	2	10/60	83
	Airborne Particle Monitoring Diary	100	1	75/60	125
MUH Residents in Minnesota, Maine and Florida.	Telephone Screening Interview Script for MUH Resident Focus Groups.	60	1	10/60	10
	Resident Pre-Focus Group Demographic and Attitudinal Survey.	60	1	5/60	5
	MUH Resident Focus Group Guide—Process Oriented.	60	1	1	60
	MUH Resident Focus Group Guide—Outcome Oriented.	60	1	1	60
Total					1,730

Dated: March 19, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–12–11EC]

Proposed Data Collections Submitted for Public Comment and Recommendations

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