Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The American Recovery and Reinvestment Act of 2009 (ARRA) allotted $650 million to the Department of Health and Human Services (HHS) to support evidence-based prevention and wellness strategies. The cornerstone of the initiative is the Communities Putting Prevention to Work (CPPW) Community Program, administered by the Centers for Disease Control and Prevention (CDC). In March 2010, HHS made 44 CPPW awards for community-based obesity and tobacco preventions efforts, followed in September 2010 by additional awards made possible by Affordable Care Act (ACA) funding. Between the two funding sources, there are 50 communities that are part of CPPW: 28 are funded only for obesity-related initiatives; 11 are funded for both obesity and tobacco initiatives; and 11 are funded only for tobacco-related initiatives.

CPPW program efforts are supported by a National Prevention Media Initiative. Although originally planned as a national campaign, CDC determined that the best support for the CPPW communities would be to shift to a localized approach. CDC plans to conduct two cycles of information collection in the 39 target communities that are addressing obesity: the first in Fall 2012 and the second in Winter/Spring 2013. The target is 6,000 completed responses for each cycle of data collection. A separate sample will be drawn for each of the 39 communities. All information will be collected through brief telephone interviews with adults aged 25 years or older. The insights to be gained from this information collection will be valuable to assessing the impact of CPPW-related program activities. The information will specifically be used to assess aided and unaided awareness of CPPW media efforts, beliefs and attitudes about obesity, and behaviors that encourage active eating and healthy living. Results will be used to inform the design and delivery of future media campaigns.

OMB approval is requested for one year. The estimated burden per response is one minute or less for eligibility screening, five minutes for an incomplete telephone interview, and 10 minutes for a complete telephone interview. Participation in the telephone interviews is voluntary and there are no costs to respondents other than their time. The total estimated annualized burden hours are 2,406.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)
Adult General Public ≥25 years of age	Screener for the Community Telephone Interview.	22,400	1	1/60
	Community Telephone Interview (incomplete)	400	1	5/60
	Community Telephone Interview (complete)	12,000	1	10/60

Dated: August 21, 2012.

Ron A. Otten,

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

[FR Doc. 2012–21033 Filed 8–24–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day-12–0571]

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 the CDC Reports Clearance Officer at (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 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Minimum Data Elements (MDEs) for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (OMB No. 0920–0571, exp. 11/30/2012)—Extension—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Many cancer-related deaths in women could be avoided by increased utilization of appropriate screening and early detection tests for breast and cervical cancer. Mammography is extremely valuable as an early detection tool because it can detect breast cancer well before the woman can feel the lump, when the cancer is still in an early and more treatable stage. Similarly, a substantial proportion of cervical cancer-related deaths could be prevented through the detection and treatment of precancerous lesions. The Papanicolaou (Pap) test is the primary method of detecting both precancerous cervical lesions as well as invasive cervical cancer. Mammography and Pap tests are underused by women who have no source or no regular source of health care and women without health insurance.

The CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides screening services to underserved women through cooperative agreements with 50 States, the District of Columbia, 5 U.S. Territories, and 11 American Indian/Alaska Native tribal programs. The program was established in response to the Breast and Cervical Cancer Mortality Prevention Act of 1990. Screening services include clinical breast examinations, mammograms and Pap tests, as well as timely and adequate diagnostic testing for abnormal results, and referrals to treatment for cancers detected. NBCCEDP awardees collect patient-level screening and tracking data to manage the program and clinical services. A de-identified subset of data on patient demographics, screening tests and outcomes are reported by each awardee to CDC twice per year.

CDC is requesting OMB approval to collect MDE information for an additional three years. CDC anticipates a reduction in the overall burden estimate due to a decrease in the number of awardees from 68 to 67.

There are no changes to the currently approved minimum data elements, electronic data collection procedures, or the estimated burden per response. Because NBCCEDP awardees already collect and aggregate data at the state, territory and tribal level, the additional burden of submitting data to CDC will be modest. CDC will use the information to monitor and evaluate NBCCEDP awardees; improve the availability and quality of screening and diagnostic services for underserved women; develop outreach strategies for women who are never or rarely screened for breast and cervical cancer, and report program results to Congress and other legislative authorities.

There are no costs to respondents other than their time. The total estimated annualized burden hours are 536.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
NBCCEDP Awardees	Minimum Data Elements	67	2	4

Dated: August 21, 2012.

Ron A. Otten,

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

[FR Doc. 2012–21030 Filed 8–24–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day-12–0824]

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

BioSense 2.0 Recruitment of Data Sources (OMB No. 920–0824, exp. 10/31/2012)—Revision—Office of Surveillance, Epidemiology, and Laboratory Services (OSELS), Public Health Surveillance and Informatics Program Office (PHSIPO) {Proposed} Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The BioSense Program was created by congressional mandate as part of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, and it was launched by the Centers for Disease Control and Prevention (CDC) in 2003. BioSense is a near real-time surveillance system that receives and processes electronic healthcare encounter data from participating public health jurisdictions' non-federal hospital emergency departments and inpatient facilities in addition to all United States Department of Defense (DoD) and Veterans Affairs (VA) outpatient hospitals and clinics nationwide. The BioSense Program also receives pharmacy data from a private sector health information exchange firm and laboratory data from two national-level private sector clinical laboratories.

The BioSense Program is in the process of transitioning from the original BioSense application to the BioSense 2.0 application that has new governance, a new organizational structure, and a new process for data submission and management. The Association of State and Territorial Health Officials (ASTHO) has been funded through a cooperative agreement with CDC's Division of Notifiable Disease and Healthcare Information (DNDHI) within the Public Health Surveillance and Informatics Program Office (PHSIPO) of the Office of Surveillance, Epidemiology, and Laboratory Services (OSELS) to facilitate the governance of BioSense 2.0, and through a contract with a vendor, ASTHO will offer access and use of BioSense 2.0 on a voluntary basis to state, local, and territorial public health jurisdictions.

All data collected by BioSense 2.0 will reside in a cloud-enabled, Web-based platform that sits in the secure, private Government Cloud and is in compliance with the Federal Information Security Management Act. The platform will provide users with an exclusive secure space as well as tools for posting, receiving, controlling, analyzing, and sharing their public health surveillance information with other public health jurisdictions, CDC, or other public health partners. The public health jurisdiction will retain ownership of any data it contributes to its exclusive secure space within BioSense 2.0.

CDC has agreements with VA, DoD, two national-level private sector clinical laboratories, and a private sector health information exchange firm to provide healthcare encounter data to CDC's exclusive secure space for the purpose of national public health situation awareness and syndromic surveillance. These organizations automatically chose to share with CDC when they were recruited to submit data to the BioSense 2.0 cloud environment. Because they are not required to choose sharing permissions, collecting already existing healthcare encounter data submitted via electronic record transmission from them entails no burden hours.

Whenever possible, the BioSense Program plans to share aggregate-level pharmacy and laboratory data with public health jurisdictions in the shared space. To participate in the shared space, jurisdiction administrators must simply select from drop-down lists to choose their sharing permissions on the BioSense 2.0 application, and they will have the right at any time to revise the level of sharing permissions regarding the data in their secure space.

In order to continue meeting the congressional mandate in the BioSense 2.0 application BioSense Program maintains 3 different types of information collection: (1) contact information (name, telephone number, email address, and street address) needed for recruitment of participating public health jurisdictions to BioSense 2.0 each year; (2) one-time collection of information (name, email address, title, organizational affiliation, security questions, and password) to provide access to the BioSense 2.0 cloud and its