1101 Wootton Parkway, Suite 600, Rockville, Maryland 20852. Phone: 240–453–2882, Fax: 240–453–2883.

SUPPLEMENTARY INFORMATION: In accordance with Public Law 105–392, the ACMH was established to provide advice to the Deputy Assistant Secretary for Minority Health in improving the health of each racial and ethnic minority group and on the development of goals and specific program activities of the Office of Minority Health.

Topics to be discussed during these meetings will include strategies to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities, as well as other related issues.

Public attendance at this meeting is limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the designated contact person at least fourteen (14) business days prior to the meeting. Members of the public will have an opportunity to provide comments at the meeting. Public comments will be limited to three minutes per speaker. Individuals who would like to submit written statements should mail or fax their comments to the Office of Minority Health at least seven (7) business days prior to the meeting. Any members of the public who wish to have printed material distributed to ACMH committee members should submit their materials to the Executive Director, ACMH, Tower Building, 1101 Wootton Parkway, Suite 600, Rockville, Maryland 20852, prior to close of business Monday, March 18, 2013.

Dated: January 29, 2013.

Monica A. Baltimore,

Executive Director, Advisory Committee on Minority Health, Office of Minority Health, U.S. Department of Health and Human Services.

[FR Doc. 2013–03782 Filed 2–19–13; 8:45 am]

BILLING CODE 4150–29–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day–13–0941]

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

Evaluation of Dating Matters: Strategies to Promote Healthy Teen Relationships™ (OMB# 0920–0941, Expiration 06/30/2015)—REVISION—National Center for Injury Prevention and Control (NCIPC)—Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Dating Matters: Strategies to Promote Healthy Teen Relationships™ is the Centers for Disease Control and Prevention's new teen dating violence prevention initiative.

To address the gaps in research and practice, CDC has developed Dating Matters, teen dating violence prevention program that includes programming for students, parents, educators, as well as policy development. Dating Matters is based on the current evidence about what works in prevention and focuses on high-risk, urban communities where participants include: Middle school students age 11 to 14 years; middle school parents; brand ambassadors; educators; school leadership; program implementers; community representatives; and local health department representatives in the following communities: Alameda County, California; Baltimore, Maryland; Broward County, Florida; and Chicago, Illinois.

The primary goal of this revision is to expand and add a limited number of instruments to the approved outcome and implementation evaluation of Dating Matters in the four metropolitan cities to determine its feasibility, cost, and effectiveness. In the evaluation, a standard model of TDV prevention (Safe Dates administered in 8th grade) will be compared to a comprehensive model (programs administered in 6th, 7th, and 8th grade as well as parent, educator, policy, and communications interventions).

The current revision request has two aims:

(1) Request to revise follow-up outcome evaluation instruments and drop mid-year outcome evaluation student survey, and

(2) Request to add process evaluation instruments to enhance implementation.

Population. The study population includes students in 6th, 7th and 8th grades at 44 schools in the four participating sites. At most, schools are expected to have 6 classrooms per grade, with an average of 30 students per classroom yielding a population of 23,760 students (44 schools × 3 grades × 6 classrooms per grade × 30 students per classroom). All student evaluation activities will take place during the school year. The sampling frame for parents, given that we would only include one parent per student, is also 23,760 for the three years of data collection covered by this package. If we assume 40 educators per school, the sampling frame for the educator sample is 1,760.

Students: In each year of data collection, we will recruit 11,880 students (30 students per classroom × 3 classrooms per grade × 3 grades × 44 schools). We assume a 95% participation rate (n = 11,286) for the baseline student survey and 90% participation rate (n = 10,692) at follow-up survey. In this revision, we request to drop the mid-term survey to reduce burden on schools.

Parents: We will recruit a sample of 2,020 parents. We expect that 95% of the 2,020 parents will agree to participate at baseline (n = 1,919) and 90% will participate in the follow-up survey (n = 1,818) parents.

Educators: We will attempt to recruit all educators in each school (44 schools × 40 educators per school = 1,760). We expect a 95% participation rate for an estimated sample of 1,672 educators at baseline and 90% participation rate at follow-up for an estimated sample of 1,584.

School data extractors: We will attempt to recruit one data extractor per 44 schools to extract school data to be used in conjunction with the outcome data for the students. Data extractors in each school will access individual school-level data for those students in their school who consented and participated in the baseline student survey ($3 \times 4 \times 30 \times 95\% = 342$).

Implementation Evaluation

For the student focus groups, we will recruit groups of 10 students per group. Two groups will be held per each of the 4 sites ($10 \times 2 \times 4 = 80$ total student participants).

Student implementer focus groups will be organized by site, with two annual focus groups per site with 10 implementers in each group ($10 \times 2 \times 4 = 80$ total student program implementer participants).

Communications focus groups will be organized by site with up to four groups

per site (4 × 4 × 6 = 96 total student participants).

Parent program implementer focus groups will be organized by site, with two annual focus groups per site with 10 implementers in each group (10 × 2 × 4 = 80 total parent program implementer participants).

School Leadership: Based on the predicted number of two school leadership per comprehensive school (21 schools), the number of respondents will be 42.

Local Health Department representative: Based on the predicted number of four communities/sites and four local health department representatives working on Dating Matters per community, the number of respondents will be 16.

Community Advisory Board Representative: Based on the predicted number of 20 community representatives per 4 communities/sites, the number of respondents will be 80.

Parent Program Manager: With a maximum of one parent program manager per community/site, the number of program manager respondents will be 4. It is anticipated that they will receive up to 50 TA requests per year and complete the form 50 times.

Student Program Master Trainer TA Form: With a maximum of 3 master trainers per community. There will be 12 master trainers. It is anticipated that they will receive up to 50 TA requests per year and complete the form 50 times.

Parent Curricula Implementers: It is expected that each school implementing the comprehensive approach (n = 21) will have two implementers (or 42 parent program implementer respondents).

Please note that on the burden table the number of respondents is multiplied by the number of sessions in each parent program.

Student Curricula Implementers: Based on the predicted number of 20 student curricula implementers per grade per site that will be completing fidelity instruments, the total number of respondents will be 80 per grade (20 × 4).

Brand Ambassadors: The Brand Ambassador Implementation Survey will be provided to each brand ambassador (n = 20) in each community with a maximum of 80 brand ambassadors.

Communications Implementers (''Brand Ambassador Coordinators''): The Communications Campaign Tracking form will be provided to each brand ambassador coordinator in each community. With a maximum of one brand ambassador coordinator per community (n = 4), the feedback form will be collected from a total of 4 brand ambassador coordinators.

Parent Program Participants: The 6th and 7th grade parent satisfaction questionnaires will be completed by parent participating in the parent program in each community. There is a maximum number of parent respondents of 1,890 (18 × 5 × 21) for the 6th grade satisfaction questionnaire and 1,890 for the 7th grade satisfaction questionnaire.

There are no costs to the respondents other than their time. The total estimated annual burden hours are 27923.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (hours)
Student Program Participant	Student Outcome Survey Baseline	11,286	1	45/60
Student Program Participant	Student Outcome Survey Follow-up	10,692	1	45/60
School data extractor	School Indicators	44	342	15/60
Parent Program Participant	Parent Outcome Baseline Survey	1,919	1	1
Parent Program Participant	Parent Outcome Follow-up Survey	1,818	1	1
Educator	Educator Outcome Survey (baseline)	1,672	1	30/60
Student Brand ambassador	Brand Ambassador Implementation Survey	80	2	20/60
School leadership	School Leadership Capacity and Readiness Survey.	42	1	1
Parent Curricula Implementer	Parent Program Fidelity 6th Grade Session 1–Session 6.	210	3	15/60
Parent Curricula Implementer	Parent Program Fidelity 7th Grade Session 1, 3, 5.	126	3	15/60
Student Curricula Implementer	Student Program Fidelity 6th Grade Session 1–Session 6.	480	1	15/60
Student Curricula Implementer	Student Program Fidelity 7th Grade Session 1–Session 7.	560	1	15/60
Student Curricula Implementer	Student Program Fidelity 8th Grade Session 1–Session 10 (comprehensive).	800	1	15/60
Communications Coordinator	Communications Campaign Tracking	4	4	20/60
Local Health Department Representative	Local Health Department Capacity and Readiness.	16	1	2
Student Program Participant	Student participant focus group guide (time spent in focus group).	80	1	1.5
Student Curricula Implementer	Student curricula implementer focus group guide (time spent in focus group).	80	1	1
Parent Curricula Implementer	Parent curricula implementer focus group guide (time spent in focus group).	80	1	1
Student Curricula Implementer	Safe Dates 8th Grade Session 1–Session 10 (standard).	800	1	15/60
Student Master Trainer	Student program master trainer TA form	12	50	10/60
Educator	Educator Outcome Survey (follow-up)	1584	1	30/60
Community Advisory Board Member	Community Capacity/Readiness Assessment	80	1	1
Students	Communications Focus Groups	96	1	1.5
Parent Program Manager	Parent Program Manager TA Tracking Form	4	50	10/60

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (hours)
Parent Program Participant	6th Grade Curricula Parent Satisfaction Questionnaire.	1890	1	10/60
Parent Program Participant	7th Grade Curricula Parent Satisfaction Questionnaire.	1890	1	10/60

Dated: February 12, 2013.

Ron A. Otten,

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

[FR Doc. 2013–03891 Filed 2–19–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–13–0853]

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, 1600 Clifton Road, MS–D74, 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

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

Background and Brief Description

CDC is seeking a three-year extension of OMB approval for the AIRS information collection. In 1999, the CDC began developing its National Asthma Control Program, a population-based, public health approach to addressing 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.

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 interim (semi-annual) and end-of-year progress 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.

Prior to implementation of AIRS, data were collected on an interim (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.

Regular reporting this information is a requirement of the cooperative agreement mechanism utilized to fund state asthma control programs. States are asked to submit interim (semi-annual) 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 (interim report and end-of-year report).

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 state asthma surveillance indicators across all funded states (where data is 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