with only one establishment; however, some are associated with multiple establishments. We estimate that a maximum average of four manager interviews will be conducted per outbreak. Each interview will take about 20 minutes.

The total estimated annual burden is 4,667 hours. There is no cost to the respondents other than 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)
Food safety program personnel	Reporting environmental assessment data into NVEAIS.	1,400	1	2	2,800
Retail food personnel	Manager interview	1,400	4	20/60	1,867
Total					4,667

Kimberly S. Lane,

Deputy Director, Office of Scientific Integrity, 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

[30Day–12–12IN]

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

Developing a Responsive Plan for Building the Capacity of Community Based Organizations (CBOs) to Implement HIV Prevention Services—New—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) estimates that over 1 million people in the United States are living with HIV. Each year, approximately 50,000 people in the United States become newly infected. Some groups are disproportionately affected by this epidemic. For example, between 2006 and 2009, there was an almost 50% increase in the number of new HIV infections among young Black men who have sex with men (MSM). In order to address these health disparities, the CDC funded 34 community-based organizations via cooperative agreement PS11–1113 to implement HIV prevention programs targeting young MSM of color and young transgender persons of color.

Building the capacity of community based organizations (CBOs) is a priority to ensure effective and efficient delivery of HIV prevention services. Since the late 1980s, CDC has been working with CBOs to broaden the reach of HIV prevention efforts. Over time, the CDC's program for HIV prevention has grown in size, scope, and complexity, responding to changes in approaches to addressing the epidemic, including the introduction of new guidances; effective behavioral, biomedical, and structural interventions; and public health strategies. The Capacity Building Branch within the Division of HIV/AIDS Prevention (DHAP) provides national leadership and support for capacity building assistance (CBA) to help improve the performance of the HIV prevention workforce. One way that it accomplishes this task is by funding CBA providers via cooperative agreement PS09–906 to work with CBOS, health departments, and communities to increase their knowledge, skills, technology, and infrastructure to implement and sustain science-based, culturally appropriate interventions and public health strategies.

CBOs funded under PS11–1113 will collaborate with CBA providers to develop *Strategic Plans for Enhanced CBO Capacity.* CBA providers will conduct face-to-face field visits with the CBOs utilizing a structured organizational needs assessment tool that was developed in collaboration with CDC. This comprehensive tool offers a mixed-methods data collection approach consisting of checklists, close-ended (quantitative) questions, and open-ended (qualitative) questions. CBOs will be asked to complete the tool prior to the field visits in order to maximize time during the visits for discussion and strategic planning.

Findings from this project will be used by the participating CBOs, the CBA providers, and the Capacity Building Branch. By the end of the project, the participating CBOs will have CBA strategic plans that will help guide the success of their programs. Based on these plans, the CBA providers (in collaboration with CDC) will be able to better identify and address those needs most reported by CBOs. Finally, the Capacity Building Branch will be able to refine its approach to conceptualizing and providing CBA on a national level in the most cost-effective manner possible.

There is no cost to respondents other than their time. The CBA providers will complete their field visits in one day (8 hours). Eighteen of the participating CBOs are dually funded under both PS11–1113 and PS10–1003; they participated in a similar process under the earlier cooperative agreement. Therefore, they will not need to complete the full tool nor participate in a full-day field visit; the burden will be reduced for these respondents.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
CBOs only funded under PS11–1113	CBO/CBA Needs Assessment	16	1	3
Dually funded CBOs (funded under both PS11–1113 and PS10–1003).	CBO/CBA Needs Assessment	18	1	1.5

Dated: July 25, 2012.

Kimberly S. Lane,

Deputy Director, Office of Science Integrity, Office of the Associate Director for Science, 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 12–0914]

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 and send comments to Kimberly S. Lane, at 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

Workplace Violence Prevention Programs in NJ Healthcare Facilities (0920–0914, Expiration 1/31/2015)—Revision—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. NIOSH received OMB approval (0920–0914) to evaluate the legislation at hospitals and to conduct a nurse survey. Data collection is ongoing at the hospitals and for the nurse survey. We are revising our existing ICR to include 2 new respondents which are nursing homes and home healthcare aides.

First, we will conduct face-to-face interviews with the Chairs of the Violence Prevention Committees in 20 nursing homes 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). The details of their Workplace Violence Prevention Program are in their existing policies and procedures. Second, we will also collect assault injury data from nursing home's violent event reports 3 years pre-regulation (2009–2011) and 3 years post-regulation (2012–2014).This data is captured in existing OSHA logs and is publicly available. The purpose of collecting these data is to evaluate changes in assault injury rates before and after enactment of the regulations. A contractor will conduct the interviews, collect the nursing home's policies and procedures, and collect the assault injury data. Third, we will also conduct a home healthcare aide survey (4000 respondents or 1333 annually). This survey will describe the workplace violence prevention training home healthcare aides receive. 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 nursing home workplace violence prevention programs before and after enactment of the New Jersey regulations in nursing homes; *Working hypothesis:* Based on our preliminary research, we hypothesize that enactment of the regulations will improve the comprehensiveness of nursing home workplace violence prevention program policies, procedures and training.

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

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

Healthcare facilities falling under the regulations are eligible for study