Program plans to share aggregate-level pharmacy and laboratory data with public health jurisdictions. 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.

As part of access to the shared space, public health jurisdictions will be required to grant CDC access to, at minimum, aggregate level data (city, county, or state) from their jurisdiction that has been placed in the shared space. They must also agree that CDC may review data contributed to the shared space for public health practice and surveillance purposes.

In order to continue meeting the congressional mandate in the BioSense 2.0 application, the BioSense Program maintains 3 different types of information collection: (1) Contact information (name, telephone number, email address, and street address) needed for recruitment of up to 20 participating public health jurisdictions to BioSense 2.0 per 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 tools for all appropriate users in participating jurisdictions and organizations, and (3) collection of already existing healthcare encounter data submitted to the cloud via electronic record transmission from participating public health jurisdictions' non-federal hospitals, VA, DoD, two national-level private sector clinical laboratories, and a private sector health information exchange firm. Though a large number of electronic records are transmitted from each entity each year, once the automated interfaces are set up for transmission (choosing sharing permissions), there is no human burden for record transmission.

This request is for a 3-year approval. There are no costs to survey respondents other than their time to participate.

ESTIMATES OF ANNUALIZED BURDEN HOURS

Type of respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Recruitment				
State, Local, and Territorial Public Health Jurisdictions	20	1	1	20
Federal Government	2	1	1	2
Private Sector (national clinical laboratory corporations, and a private sector health information exchange company)	3	1	1	3
Access to BioSense 2.0 Application				
State, Local, and Territorial Public Health Jurisdictions	200	1	5/60	17
Federal Government	30	1	5/60	3
Private Sector	50	1	5/60	4
Data Collection: Administrator Sharing Permissions				
State, Local, and Territorial Public Health Jurisdictions	20	1	5/60	2
Federal Government	2	0	0	0
Private Sector (national clinical laboratory corporations, and a private sector health information exchange company)	3	0	0	0
Total				51

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.

[FR Doc. 2012–13689 Filed 6–5–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–12–0822]

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, 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

National Intimate Partner and Sexual Violence Surveillance System (OMB No. 0920–0822, exp. 09/30/2012)—Revision—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The health burden of Intimate Partner Violence (IPV), Sexual Violence (SV) and stalking are substantial. To address this important public health problem, in 2010, CDC implemented the National Intimate Partner and Sexual Violence Surveillance System (NISVSS) which produces national and state level estimates of IPV, SV and Stalking on an annual basis.

NIVSS used a dual-frame sampling strategy that includes both landline and cellphone. In 2010, approximately 45.2% of interviews were conducted by landline telephone and 54.8% of interviews were conducted using respondent's cell phone. The overall weighted response for 2010 data collection was 27.5%. The weighted cooperation rate was 81.3%. The cooperation rate reflects the proportion who agreed to participate in the interview among those who were contacted and determined eligible. The cooperation rate obtained for 2010 data collection suggests that, once contact was made and eligibility was determined, the majority of respondents chose to participate in the interview.

In the first year of data collection, the NISVSS data found that approximately 6.9 million women and 5.6 million men experienced rape, physical violence and/or stalking by an intimate partner within the last year. NISVSS data also suggested that 18.3% of women and 1.4% of men in the U.S. experienced rape in their lifetime. In addition, 44.5% of women and 22.2% of men experienced sexual violence other than rape during their lifetime. NISVSS 2010 data also indicates that approximately 5 million women and 1.4 million men in the United States were stalked in the 12 months prior to the survey.

There are also overlaps between stalking and other forms of violence in intimate relationships; approximately 14% of females who were stalked by an intimate partner in their lifetime also experienced physical violence by an intimate partner; while 12% of female victims experienced rape, physical violence and stalking by a current or former intimate partner in their lifetime. Furthermore, 76% of female victims of intimate partner homicides were stalked by their partners before they were killed.

The lifetime impact of these types of violence on victims is extensive. Nearly 1 in 3 women and 1 in 10 men in the United States have experienced rape, physical violence and/or stalking by an intimate partner and reported at least one impact related to experiencing these or other forms of violent behavior within the relationship (e.g., fear, concern for safety, post-traumatic stress disorder (PTSD) symptom, injury, crisis hotline consult, at least one day of work or school missed, and needs for health care, housing, victim advocate, and legal services.

CDC proposes to continue this national surveillance system that will provide more detailed and timely information on intimate partner violence, sexual violence and stalking victimization in the U.S. The proposed changes to the National Intimate Partner and Sexual Violence Surveillance System are two-fold: First, CDC will no longer collect data on special sub-populations (i.e. military, elderly AIAN) and thus, focuses the scope of data collection to the general population. Second, CDC will reduce the number of questions asked in the survey. Currently, NISVSS asks a total of 249 questions which comprise both behavioral gateway questions asked of every respondent and follow-up questions directed towards respondents who report experiencing various forms of intimate partner violence, sexual violence and stalking.

The current proposal aims to reduce the number of questions to 178 questions which will continue to be comprised of a combination of behavioral questions asked of every respondent and a series of follow-up questions that will only be asked of respondents reporting victimization.

Focusing the scope of data collection and reducing the number of questions will result in a decrease in burden to the respondents. Previously, the estimated number of respondents screened was 20,948 and the number of respondents surveyed was 10,000. This resulted in an average burden per individual respondent screened of 3 minutes and average burden per individual surveyed of 25 minutes with a total burden of 5,214 hours.

This proposal seeks to increase the sample size and response rate. The proposed number of respondents screened is 85,000 while the proposed number of respondents surveyed is 22,000. The average burden per screened respondent remains at 3 minutes (total burden in hours equals 4,250) while the average burden per surveyed respondent is 15 minutes (total burden in hours equals 5,500). This proposal reduces the average burden per surveyed respondent by 10 minutes. The increase in the number of individuals screened and individuals surveyed equals a total burden of 9,750 hours.

Shortening the survey and reducing the burden on respondents will allow CDC to conduct more interviews thus increasing the reliability of both national and state estimates. The purpose of the information collected remains the same.

There are no costs to respondents to participate other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of responses	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Individuals	Non-Participating Individuals (Screened).	85,000	1	3/60	4,250
	Eligible Individuals (Surveyed)	22,000	1	15/60	5,500
Total					9,750

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.

[FR Doc. 2012–13692 Filed 6–5–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–12–0571]

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 Kimberly S. Lane, at CDC, 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

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.

Despite the availability and increased use of effective screening and early detection tests for breast and cervical cancers, the American Cancer Society (ACS) estimates that 226,870 new cases of invasive breast cancer will be diagnosed among women in 2012, and 39,510 women will die of this disease. The ACS also estimates that 12,170 new cases of invasive cervical cancer will be diagnosed in 2012, and 4,220 women will die of this disease.

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. Burden to respondents was significantly reduced in 2008 when the annual requirement to report infrastructure information (System for Technical Assistance Reporting, STAR), previously associated with collection of MDE information, was discontinued.

CDC plans to request 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.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)	Total burden (in hr)
NBCCEDP Awardees	Minimum Data Elements	67	2	4	536