participating public health departments also submit data elements which are specific to each condition. With the coordination with other CDC programs conducting surveillance on notifiable conditions, this application includes disease-specific tables for 68 diseases. The 2010 NNDSS OMB application included disease-specific data elements for only 14 of those conditions.

Because this information collection request includes case notifications that were not part of the 2010 NNDSS/NEDSS application, replaces one application and replaces parts of three other OMB applications, burden estimates have been adjusted to incorporate burden estimates from the other four applications. The estimates are adjusted for the increased number of conditions reported to NNDSS, the expansion of core data elements, and the inclusion of more disease-specific tables. These changes have increased the burden estimates in this application in comparison with the burden estimates in the 2010 NNDSS/NEDSS OMB application (OMB Control No. 0920–0728). As CDC works with state, territorial and local health departments to develop and implement new information technologies to submit these data through NNDSS, burden will also increase as the public health departments commit resources to implementing the new technologies. However, over the next 3 years, as the new automated electronic systems are implemented, burden will be decreased. The estimated annual burden is 28,340 hours.

ESTIMATES OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
States	50	52	10	26000
Territories	5	52	5	1300
Cities	2	52	10	1040
Total				28,340

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific 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

[60Day–13–0916]

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 LeRoy Richardson, 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

Evaluation of Core Violence and Injury Prevention Program (Core VIPP)—Revision—(0920–0916, Expiration 1/13/2014)—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Injuries and their consequences, including unintentional and violence-related injuries, are the leading cause of death for the first four decades of life, regardless of gender, race, or socioeconomic status. More than 179,000 individuals in the United States die each year as a result of unintentional injuries and violence, more than 29 million others suffer non-fatal injuries and over one-third of all emergency department (ED) visits each year are due to injuries. In 2000, injuries and violence ultimately cost the United States $406 billion, with over $80 billion in medical costs and the remainder lost in productivity. Most events that result in injury and/or death from injury could be prevented if evidence-based public health strategies, practices, and policies were used throughout the nation.

CDC's National Center for Injury Prevention and Control (NCIPC) is committed to working with their partners to promote action that reduces injuries, violence, and disabilities by providing leadership in identifying priorities, promoting tools, and monitoring effectiveness of injury and violence prevention and to promote effective strategies for the prevention of injury and violence, and their consequences. One tool NCIPC will use to accomplish this is the Core Violence and Injury Prevention Program (Core VIPP). This program funds state health departments (SHDs) to build their capacity to disseminate, implement, and evaluate evidence-based/best practice programs and policies. Although some states were funded previously through similar CDC-funded programs, this evaluation will only consider the implementation and outcomes of Core VIPP during the five-year funding period from August 2011 to July 2016. The program includes one Basic Integration Component (BIC) and four expanded components: Regional Network Leader (RNLs), Surveillance Quality Improvement (SQI), Motor Vehicle Child Injury Prevention Policy (MVP), and Multi-component Interventions in Multiple Setting to Prevent Falls in Older Adults (Falls). This Core VIPP evaluation only includes the BIC, RNL, SQI, and MVP

components. The Falls' program is being evaluated separately by the Division of Unintentional Injury (NCIPC/DUIP).

BIC and the expanded components are intended to support funded states in building capacity and achieving health impact in their states. The key components of violence and injury prevention (VIP) capacity for Core BIC VIPP are defined as: Infrastructure, Evaluation, Strategies, Collaboration, and Surveillance. States funded with the expanded components MVP and SQI are anticipated to be building increased capacity for motor vehicle-related policy strategies and surveillance, respectively. States funded through the RNL expanded component are anticipated to be facilitators of knowledge-sharing in order to support building VIP infrastructure for Core-funded and non-Core-funded states in their regions. The evidence-informed strategies that states implement as part of Core VIPP are anticipated to lead to health impact.

CDC requests OMB approval to continue to collect Core VIPP program evaluation data for an additional three-year period. The purpose of the evaluation is to track states' progress toward: (1) Achieving the Performance Measures identified in the Funding Opportunity Announcement (FOA); (2) Building and/or sustaining their VIP capacity; and (3) Achieving their focus area SMART (Specific, Measurable, Attainable, Reasonable, and Time-bound) objectives. The ability of states to make progress towards their SMART objectives will serve as a measure of Core VIPP's impact on the burden of violence and injury related morbidity and mortality in funded states.

The primary data collections methods will be used in the evaluation include: (1) Interim and Annual Progress Reports, (2) State of the States (SOTS) online surveys, (3) Interviews, and (4) Online surveys related to the Regional Network Leader component. The progress reports will track states' performance measures and the activities stated in the Core VIPP FOA and monitor states' progress toward their focus area SMART objectives; the SOTS surveys will be used to measure grantees' changes in VIP capacity. Interviews will be used to provide more in-depth information about the key facilitators and barriers states have encountered while implementing BIC and the expanded components. The interviews also provide states the opportunity to share more specific information about their experiences implementing BIC. The online surveys for RNL will be delivered through the Regional Network Leaders to assess the strength and effectiveness of regional networks to connect states to each other for peer-to-peer knowledge and information sharing.

This is a mixed method evaluation, and data will be collected using a variety of methods to answer the evaluation questions. Qualitative and quantitative data will be collected through progress reports, surveys, the health impact tracking tool, and interviews. Quantitative data will be analyzed using descriptive statistics. Qualitative data will be collected through interviews, which will be transcribed and analyzed to identify common themes that emerge.

The table below details the annualized number of respondents, the average response burden per interview, and the total response burden for the surveys and telephone interviews. Estimates of burden for the survey are based on previous experience with evaluation data collections conducted by the evaluation staff. For the Base Integration Component (BIC), the State of the States (SOTS) web-based survey assessment will be completed by 20 Core Funded State Health Departments (SHDs) and will take 3 hours to complete. The SOTS Financial Module will also be completed by the 20 BIC funded SHD and will take 1 hour to complete. The supplemental SOTS Survey Questions will be completed by 20 BIC funded SHDs and take 1.5 hours to complete. The BIC telephone interviews will take 1.5 hours and will be completed by the 20 Core funded SHDs. We expect that each of the 20 BIC funded SHDs will complete three web-based surveys and three telephone interviews annually during the last three years of Core funding.

The annual surveys and interviews for the subcomponents (SQI, RNL, and MVP) are also detailed below. The Regional Network Leader (RNL) surveys will be completed by the five RNL funded SHDs and will take 1 hour to complete. The five RNL funded SHDs will also complete a telephone interview that will take 1 hour to complete. The four Surveillance Quality Improvement (SQI) funded SHDs will complete a telephone interview that will take 1 hour to complete. The four Motor Vehicle Child Injury Prevention Policy (MVP) SHDs will complete a telephone interview that will take 1 hour to complete.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	No. of respondents	No. of responses per respondent	Avg. burden per response (in hrs.)	Total burden (in hrs.)
Core VIPP Funded SHD Injury Program director.	State of the States Survey (SOTS)—Attachment C.	20	1	3	60
Core VIPP Funded SHD Injury Program director.	SOTS Financial Module—Attachment E.	20	1	1	20
Core VIPP Funded SHD Injury Program management and staff.	Supplemental SOTS Survey Questions—Attachment F.	20	1	1.5	30
Core VIPP Funded SHD Injury Program management and staff.	BIC Telephone Interview—Attachment D.	20	1	1.5	30
RNL awardees	RNL Telephone Interview—Attachment G.	5	1	1	5
RNL awardees	RNL Surveys—Attachment H & I	5	1	2	10
SQI awardees	SQI Telephone Interview—Attachment G.	4	1	1	4
MVP awardees	MVP Telephone Interview—Attachment D.	4	1	1	4
Total					163

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–19271 Filed 8–8–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[CDC–2013–0016; NIOSH 129–A]

National Institute for Occupational Safety and Health (NIOSH) Personal Protective Technology (PPT) Program; Framework Document for the Healthcare Worker Personal Protective Equipment Action Plan

AGENCY: The National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of draft document for public comment.

SUMMARY: The National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC) announces the availability of a document titled ''Framework for Setting the NIOSH PPT Program Action Plan for Healthcare Worker Personal Protective Equipment: 2013–2018'', now available for public comment at *http://www.regulations.gov*.

DATES: *Public comment period:* Comments must be received by Friday, September 13, 2013.

ADDRESSES: You may submit comments, identified by CDC–2013–0016 and Docket Number NIOSH–129–A, by either of the two following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail:* NIOSH Docket Office, Robert A. Taft Laboratories, MS–C34, 4676 Columbia Parkway, Cincinnati, Ohio 45226.

Instructions: All information received in response to this notice must include the agency name and docket number (CDC–2013–0016; NIOSH–129–A). All relevant comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. All electronic comments should be formatted as Microsoft Word. Please make reference to CDC–2013–0016 and Docket Number NIOSH–129–A. Access to any prior background documents or previous comments received please go to NIOSH Docket 129 (*http://www.cdc.gov/niosh/docket/archive/docket129.html*).

SUPPLEMENTARY INFORMATION: The NIOSH personal protective technology (PPT) program publishes and periodically updates its research agenda on personal protective equipment (PPE) for healthcare workers. The research agenda or action plan describes the near term and long term strategy for the PPT program's research and intervention, standards development, and information dissemination program to improve the efficacy and effectiveness of PPE used in healthcare settings. Since the healthcare worker PPE action plan was last updated in 2010 (revision 4), several reports have been published that provide updated national priorities related to PPE for healthcare workers. For example, in 2011, the Institute of Medicine (IOM) published a report entitled *Preventing Transmission of Pandemic Influenza and Other Viral Respiratory Diseases: Personal Protective Equipment for Healthcare Personnel Update 2010* that assessed the nation's progress on improving PPE for healthcare personnel exposed to infectious respiratory diseases and made recommendations to address research gaps (to access this document please go to *http://www.regulations.gov*).

The NIOSH PPT program has started the process to update the PPE for healthcare workers action plan for 2013–2018. A framework document titled ''Framework for Setting the NIOSH PPT Program Action Plan for Healthcare Worker Personal Protective Equipment: 2013–2018'' has been drafted to:

1. Identify proposed ''recommendations'' and ''activities'' to use in an updated healthcare worker PPE action plan;

2. Compare current NIOSH intramural and extramural program activities versus the proposed recommendations and activities;

3. Propose an overarching strategy for NIOSH PPT program management to prioritize among competing recommendations, activities, and future action steps; and

4. Outline the process planned for seeking stakeholder input on what ''action steps'' should be taken by NIOSH and the NIOSH PPT program to address the recommendations.

Comments are sought in three specific areas:

1. Proposed use of the 2011 IOM report recommendations as the basis for the 12 overarching recommendations and 36 activities in next revision of the action plan;

2. Proposed use of improving healthcare worker PPE compliance as the overarching goal for prioritization; and

3. Specific actions that NIOSH and the NIOSH PPT program should take to address the proposed recommendations

FOR FURTHER INFORMATION CONTACT: Dr. Ronald E. Shaffer, Senior Scientist, NIOSH NPPTL Office of the Director at *RShaffer@cdc.gov,* telephone (412) 386–4001, fax (412) 386–6617.

Dated: August 2, 2013.

John Howard,

Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.

[FR Doc. 2013–19273 Filed 8–8–13; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Announcement of Requirements and Registration for Million Hearts® Hypertension Control Challenge

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Disease Control and Prevention (CDC) located within the Department of Health and Human Services (HHS) announces the launch of the Million Hearts® Hypertension Control Challenge on August 9, 2013. The challenge will be open until September 9, 2013.

Award Approving Official: Thomas R. Frieden, MD, MPH, Director, Centers for Disease Control and Prevention, and Administrator, Agency for Toxic Substances and Disease Registry.

Million Hearts® is a national initiative to prevent 1 million heart attacks and strokes by 2017. Achieving this goal means that 10 million more Americans must have their blood pressure under control. Million Hearts® is working to control high blood pressure through clinical approaches, such as using health information technology to its fullest potential and integrating team-based approaches to care, as well as community approaches, such as strengthening tobacco control, and lowering sodium consumption.

To support improved blood pressure control, HHS/CDC is announcing the Million Hearts® Hypertension Control