businesses offering pest control services to residents in areas where *I. scapularis* ticks transmit diseases to humans. Specifically, these target populations include those residing or working in the 14 highest incidence states for Lyme disease (CT, DE, ME, MD, MA, MN, NH, NJ, NY, PA, RI, VT, VA, WI). We anticipate conducting one to two surveys per year, for a maximum of six surveys conducted over a three year period. Depending on the survey, we aim to enroll 500–10,000 participants per study. It is expected that we will need to target recruitment to about twice as many people as we intend to enroll.

Surveys may be conducted daily, weekly, monthly, or bi-monthly per participant for a defined period of time (whether by phone or web survey), depending on the survey or study. The surveys will range in duration from approximately 5–30 minutes. Each participant may be surveyed 1–64 times in one year; this variance is due to differences in the type of information collected for a given survey.

Specific burden estimates for each study and each information collection instrument will be provided with each individual project submission for OMB review. The maximum estimated, annualized burden hours are 98,833 hours. There is no cost to respondents other than their time.

Insights gained from KAP surveys will aid in prioritizing which prevention methods should be evaluated in future randomized, controlled trials and ultimately help target promotion of proven prevention methods that could yield substantial reductions in TBD incidence.

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 hours
General public, individuals or households.	Screening instrument	20,000	1	15/60	5,000
	Consent form	10,000	1	20/60	3,333
	Introductory Surveys	10,000	1	30/60	5,000
	Monthly surveys	10,000	12	15/60	30,000
	Final surveys	10,000	1	30/60	5,000
	Daily surveys	10,000	60	5/60	50,000
Pest Control Operators	PCO Survey	1,000	1	30/60	500
Total					98,833

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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

[30Day–16–16KA]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) has submitted the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The notice for the proposed information collection is published to obtain comments from the public and affected agencies.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address any of the following: (a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) Enhance the quality, utility, and clarity of the information to be collected; (d) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and (e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Written comments and/or suggestions regarding the items contained in this notice should be directed to the Attention: 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

Monitoring and Coordinating Personal Protective Equipment (PPE) in Healthcare to Enhance Domestic Preparedness for Ebola Response—New—National Center for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The National Institute for Occupational Safety and Health (NIOSH) has the authority under the Occupational Safety and Health Act [29 CFR 671] to ''develop recommendations for health and safety standards'', to ''develop information on safe levels of exposure to toxic materials and harmful physical agents and substances'', and to ''conduct research on new safety and health problems''. There is growing national concern for better understanding of the particular personal protective equipment (PPE) needs of healthcare workers to ensure the health and safety of this workforce during times of pandemic disease or bioterrorist threat. The use and effectiveness of the proper PPE are paramount to the management and mitigation of the effects of a disaster. NIOSH is requesting a three approval from OMB to develop an ongoing Personal Protective Technology (PPT) sentinel surveillance system in the

hospital setting that will document data used to evaluate and monitor use and effectiveness for PPE usage in healthcare workers including Ebola protection.

NIOSH conducted a pilot study and partnered with four hospitals where respirator-related data were collected from a variety of stakeholders (less than 10 respondents) including Infection Control, Occupational Health, Emergency Preparedness, Environmental Health & Safety, and Purchasing. Surveillance metrics were established and shared with pilot participants on a regular basis throughout the pilot. Partners identified key performance indicators that this data might provide, such as the average number of respirators used per isolation order in the hospital, and identification of stakeholders and protocols impacting effective respirator use. Recommendations were made for monitoring schedules and survey improvement. The data collected during the pilot study provided experience and knowledge of respirator selection, availability, fit testing, usage patterns, outcomes, and confounders of respirator use and effectiveness at the four participating hospitals.

NIOSH now seeks approval to execute an approach for a minimum viable product (MVP) multi-hospital (15–20), real-time monitoring phase. The 15–20 facilities shall reflect the tiered approach recommended by CDC involving Frontline Healthcare Facilities, Ebola Assessment Hospitals and Ebola Treatment Centers. The effort shall be built upon the experience and knowledge obtained from the pilot projects, and shall be structured as the next step in the establishment of a national system to monitor usage and training for PPE used to protect against the Ebola virus based on current CDC recommendations. With this effort, the contractor shall develop and deploy the system to include a contingent of the domestic acute healthcare facilities in this three tier approach. The system content shall include status information for all PPE categories identified for protection against the hazards of Ebola exposure. The system will use a general interface engine designed to accept, validate, and process data from multiple, disparate sources.

The system will be developed to identify PPE replenishment needs to facilitate local, state, and eventually regional resource sharing and local purchasing as needed. It will also be compatible with PPE previously used at these facilities to allow seamless continuity of patient care and worker protection. This capacity will offer a much-improved process for monitoring and maintaining appropriate PPE supplies through the constant, real-time monitoring of user demand, thus avoiding the misdirection of tens of millions of dollars' worth of respirators and other PPE to facilities that may not use distributed supplies due to a mismatch between products typically used and the supplies provided.

Respondents targeted for this study include hospital managers (also referred to in some cases as executives, coordinators or supervisors). These individuals are responsible for the day-to-day administration and/or implementation of the MVP. It is estimated that a sample of up to 20 hospitals will agree to participate among a variety of Ebola and Frontline treatment facilities. Participation will require no more than 255 minutes of workers' time per quarter. The hospitals will complete a baseline form and will also send quarterly and annual response as explained in the table below.

The Emergency and Crisis surveys are administered to hospitals via text message. The emergency survey is designed for an event spanning multiple weeks (*e.g.,* pandemic). There are 3 preset questions that are related to Ebola and PPT supply concerns. The crisis survey is designed for an unanticipated scenario in which we may need to push ad hoc questions on a daily basis to hospitals. They will only be administered in a non-routine situation. During the 3 year approval period, we will test/train hospitals on each survey. However, they will not be part of the regular data collection.

Estimated Annualized Burden Hours

The baseline form is completed once by each hospital as they come onboard. It is the same as the annual survey but will take longer to complete, because all fields in the collection tool will need to be entered. The annual form is completed by the hospitals in each year following their start and will take about a third of the time to complete than the baseline form. Example: Year one, 5 hospitals on start (baseline); year two, 6 new (baseline) and 5 from previous year (annual); year three, 9 new (baseline) and 11 from previous years (annual). Thus, taking the sum of the previous year hospitals (annual) leads to a total of 16. The quarterly form is completed by all participating hospitals four times a year. The emergency and crisis forms are completed by all participating hospitals as needed, but at least once for training, and uses the annualized number in the baseline form.

The total estimated annual burden hours are 230. There are no costs to respondents other than their time.

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Hospital	Baseline	7	1	8
Hospital	Annual	5	1	3
Hospital	Quarterly	12	4	3
Hospital	Emergency	7	4	15/60
Hospital	Crisis	7	7	10/60

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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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