both humans and animals. Human and animal illnesses from environmental exposures to HABs in fresh and marine waters have been documented in the United States. Animal illness may be an indicator of bloom toxicity; thus, it is necessary to provide a One Health approach for reporting HAB-associated illnesses and events.

HABs are an emerging public health concern. Several outbreaks related to HABs in freshwater settings have occurred in the United States. In 2009–2010, 11 HAB-associated outbreaks in fresh water settings were reported to the CDC Waterborne Disease and Outbreak Surveillance System (WBDOSS). These 11 outbreaks represent 46% of the outbreaks associated with untreated recreational water reported in 2009–2010 and 79% of HAB-associated outbreak s reported to WBDOSS since 1978. At least 61 persons experienced health effects such as dermatologic, gastrointestinal, respiratory, or neurologic symptoms. In August 2014, detectable levels of microcystin, a potent HAB toxin, were detected in drinking water supply in Toledo, Ohio, resulting in a ''do not drink'' water advisory and an extensive emergency response.

Known adverse health effects from HABs in marine waters include respiratory illness and seafood poisoning. In 2007, 15 persons were affected with respiratory illness from exposures to brevetoxins, an algal toxin, during a Florida red tide. From 2007–2011, HAB-associated foodborne exposures were identified for 273 case reports of human illness through a separate five-year data collection effort with a subset of states. Of these reports, 248 reported ciguatera fish poisoning or poisoning by other toxins in seafood, including saxitoxin and brevetoxin. A review of national outbreak data reported to CDC for the time period 1998–2015 identified outbreaks of ciguatera fish poisoning as the second most common cause of fish-associated foodborne disease outbreaks in the United States.

The purpose of OHHABS is (1) to provide a database for routine data collection at the state/territorial and national level to identify and characterize HAB events, HAB-associated illnesses, and HAB exposures in the United States and (2) to better inform and improve our understanding of HAB-associated illnesses and exposures through routine surveillance to inform public health policy and illness prevention efforts. OHHABS (electronic, year-round collection) includes questions about HAB events and HAB-associated-illness for human and animal cases. OHHABS, a web-based reporting system, is nationally available for state and territorial health departments to voluntarily report information about HAB-associated human and animal cases and HAB events.

States and territories lacking a database to collect information on HAB events and HAB-associated illnesses may use OHHABS as a repository to track and review HAB events and HAB-associated illnesses within their state or territory. OHHABS data may help states and territories characterize the baseline frequency of HAB events and HAB-associated illnesses. Data from states and territories will be assessed by CDC to determine and characterize HAB events and HAB-associated illnesses nationally.

As with all routine public health surveillance conducted by CDC, participation by states and territorial health departments with OHHABS is voluntary. Participating states and territories will remain responsible for the collection and interpretation of these data elements at the state level and will voluntarily submit them to CDC. HAB event, and HAB-associated human and animal case definitions, which were created for OHHABS with input from state and federal partners, are available online to assist states and territories. States and territories that lack state-specific case and event definitions may use the HAB-associated human and animal case and HAB event definitions to identify suspect, probable, and confirmed HAB-associated cases and HAB events, respectively, to report to OHHABS.

There is no cost to respondents other than the time to participate. The estimated annual burden is 57 hours. Authorizing legislation comes from Section 301 of the Public Health Service Act (42 U.S.C. 241).

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
State/territorial epidemiologists	One Health Harmful Algal Bloom System (OHHABS)	57	3	20/60

Jeffrey M. Zirger,

Acting Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

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BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–19–0604; Docket No. CDC–2018–0119]

Proposed Data Collection Submitted for Public Comment and Recommendations

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

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other Federal agencies the opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a proposed information collection project titled ''School-Associated Violent Deaths Surveillance System (SAVD.'' The U.S. Department of Education (DOE) requested assistance from the Centers for Disease Control and Prevention (CDC)/National Center for Injury Prevention and Control (NCIPC) to establishing an ongoing surveillance

system of school-associated violent deaths (SAVD) in the United States in order to track and monitor school-associated violence, particularly homicides and suicides that occur in schools on an ongoing basis.

DATES: CDC must receive written comments on or before April 8, 2019.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2018–0119 by any of the following methods:

- *Federal eRulemaking Portal: Regulations.gov*. Follow the instructions for submitting comments.
- *Mail:* Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS–D74, Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and Docket Number. CDC will post, without change, all relevant comments to *Regulations.gov*.

Please note: Submit all comments through the Federal eRulemaking portal (regulations.gov) or by U.S. mail to the address listed above.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, MS–D74, Atlanta, Georgia 30329; phone: 404–639–7570; Email: *omb@cdc.gov.*

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. In addition, the PRA also requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. 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;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. 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 submissions of responses.

5. Assess information collection costs.

Proposed Project

School Associated Violent Death Surveillance System ((0920–0604, expiration 05/31/2019)—Revision—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Division of Violence Prevention (DVP), National Center for Injury Prevention and Control (NCIPC) proposes to maintain a system for the surveillance of school-associated homicides and suicides. The system relies on existing public records and interviews with law enforcement officials and school officials. The purpose of the system is to (1) estimate the rate of school-associated violent death in the United States and (2) identify common features of school-associated violent deaths. The system will contribute to the understanding of fatal violence associated with schools, guide further research in the area, and help direct ongoing and future prevention programs.

Violence is the leading cause of death among young people, and increasingly recognized as an important public health and social issue. In 2016, over 3,600 school-aged children (5 to 18 years old) in the United States died of violent deaths due to suicide, homicide, and unintentional firearm injuries. The vast majority of these fatal injuries were not school associated. However, whenever a homicide or suicide occurs in or around school, it becomes a matter of particularly intense public interest and concern. NCIPC conducted the first scientific study of school-associated violent deaths (SAVD) during the 1992–99 academic years to establish the true extent of this highly visible problem. Despite the important role of schools as a setting for violence research and prevention interventions, relatively little scientific or systematic work has been done to describe the nature and level of fatal violence associated with schools. Until NCIPC conducted the first nationwide investigation of violent deaths associated with schools, public health and education officials had to rely on limited local studies and estimated numbers to describe the extent of school-associated violent death.

SAVD is an ongoing surveillance system that draws cases from the entire United States in an attempt to capture all cases of school-associated violent deaths that have occurred. Investigators review public records and published press reports concerning each school-associated violent death. For each identified case, investigators also contact the corresponding law enforcement agency and speak with an official in order to confirm or reject the case as an SAVD, and to request a copy of the official law enforcement report for confirmed SAVD cases. In past years, investigators would interview an investigating law enforcement official (defined as a police officer, police chief, or district attorney), and a school official (defined as a school principal, school superintendent, school counselor, school teacher, or school support staff) who were knowledgeable about the case in question; however, moving forward, the interviews with these respondents will be eliminated, and instead CDC study personnel will abstract data from law enforcement reports to enter using a Data Abstraction Tool. Data to be abstracted from the law enforcement report include the following: Information on both the victim and alleged offender(s)—including demographic data, their criminal records, and their relationship to one another; the time and location of the incident precipitating the fatality; the circumstances, motive, and method of the fatal injury; and the security and violence prevention activities in the school and community where the death occurred, before and after the fatal injury event. The revised data collection process eliminating the use of telephone interviews will reduce respondents' burden greatly.

All data are secured through the use of technical, physical, and administrative controls. Hard copies of data are kept under lock and key in secured offices, located in a secured facility that can be accessed only by presenting the appropriate credentials. Digital data are password protected and then stored (and backed up routinely) onto a secure Local Area Network that can only be accessed by individuals who have been appropriately authorized. Study data are reported in the aggregate, such that no individual case can be identified from the reports.

There are no costs 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 hours (in hours)
Law Enforcement Officer	Law Enforcement Case Confirmation Script.	50	1	5/60	4
	Letter to Local Law Enforcement Officials.	50	1	15/60	13
Total					17

Jeffrey M. Zirger,

Acting Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

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BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day–19–1061]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled Behavioral Risk Factor Surveillance System (BRFSS) to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on September 18, 2018 to obtain comments from the public and affected agencies. CDC received three comments related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(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.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

Behavioral Risk Factor Surveillance System (BRFSS)—Revision—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC is requesting OMB approval to revise information collection for the Behavioral Risk Factor Surveillance System (BRFSS) for the period of 2019–2022. The BRFSS is a nationwide system of cross-sectional telephone health surveys administered by health departments in states, territories, and the District of Columbia (collectively referred to here as states) in collaboration with CDC. The BRFSS produces state-level information primarily on health risk behaviors, health conditions, and preventive health practices that are associated with chronic diseases, infectious diseases, and injury. Designed to meet the data needs of individual states and territories, the CDC sponsors the BRFSS information collection project under a cooperative agreement with states and territories. Under this partnership, BRFSS state coordinators determine questionnaire content with technical and methodological assistance provided by CDC. For most states and territories, the BRFSS provides the only sources of data amenable to state and local level health and health risk indicator uses. Over time, it has also developed into an important data collection system that federal agencies rely on for state and local health information and to track national health objectives such as Healthy People.

CDC bases the BRFSS questionnaire on modular design principles to accommodate a variety of state-specific needs within a common framework. All participating states are required to administer a standardized core questionnaire, which provides a set of shared health indicators for all BRFSS partners. The BRFSS core questionnaire consists of fixed core, rotating core, and emerging core questions. Fixed core questions are asked every year. Rotating core questions cycle on and off the core questionnaire during even or odd years, depending on the question. Emerging core questions are included in the core questionnaire as needed to collect data on urgent or emerging health topics such as influenza. In addition, the BRFSS includes a series of optional modules on a variety of topics. In off years, when the rotating questions are not included in the core questionnaire, they are offered to states as optional modules. This framework allows each state to produce a customized BRFSS survey by appending selected optional modules to the core survey. States may select which, if any, optional modules to administer. As needed, CDC provides technical and methodological assistance to state BRFSS coordinators in the