EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annualized cost
Project Development	$23,267	$11,633
Data Collection Activities	32,573	16,287
Data Processing and Analysis	31,022	15,511
Publication of Results	15,511	7,756
Project Management	12,408	6,204
Overhead	40,329	20,164
Total	155,110	77,555

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ health care research, quality improvement and information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) 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 upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: May 4, 2009.

Carolyn M. Clancy,

Director.

[FR Doc. E9–11009 Filed 5–12–09; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Pub. L. 104–13), the Health Resources and Services Administration (HRSA) publishes periodic summaries of proposed projects being developed for submission to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995. To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, e-mail *paperwork@hrsa.gov* or call the HRSA Reports Clearance Officer on (301) 443–1129.

Comments are invited on: (a) The proposed collection of information for the proper performance of the functions of the agency; (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.

Proposed Project Title: Interim Evaluation of the Bright Futures for Women's Health and Wellness (BFWHW) Initiative, Emotional Wellness Consumer Tools—NEW.

Purpose: The purpose of this project is to design and implement a three-year interim evaluation to address initial outcomes for the BFWHW emotional wellness tools targeted at consumers. The project is funded by the Health Resources and Services Administrations (HRSA), Office of Women's Health (OWH). The evaluation will seek to determine (1) the acceptability of the tools by the target audiences, (2) strategies for ensuring their ongoing use, and (3) the outcomes associated with the use of these tools in three to four selected primary care sites.

The evaluation team will work with HRSA OWH and an Expert Committee to identify the questions of interest for the evaluation plan and methodology. There will be two major components—a descriptive/process component focusing on the design and implementation of the program's intervention and an impact component focusing on the preliminary outcomes of the intervention on the target audiences and their behavioral intentions.

Respondents:

Female consumers (adolescents between the ages of 13 and 17 and adults 18 and older) who receive services from primary care sites or community service organizations will receive a written survey on site at the time of service.

Distributors of the Consumer Tools (e.g., healthcare providers, program staff, and community stakeholders/organizations) from the three to four selected HRSA-funded program sites will respond to a web-based written survey.

Female consumers (adolescents between the ages of 13 and 17 and adults 18 and older) who receive services from primary care sites or community service organizations will be invited to participate in a focus group.

ANNUAL BURDEN ESTIMATES

Form	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Survey of Consumers	563	1	563	0.5	281.5
Survey of the Distributors of the Consumer Tools.	40	1	40	0.5	20
Consumer Focus Groups	4 sites × 16 focus group participants per site = 64.	1	64	1.5	96
Total	667	3	667	2.5	397.5

E-mail comments to *paperwork@hrsa.gov* or mail the HRSA Reports Clearance Officer, Room 10–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: May 5, 2009.

Alexandra Huttinger,

Director, Division of Policy Review and Coordination.

[FR Doc. E9–11086 Filed 5–12–09; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–09–0607]

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 404–639–5960 or send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail 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

The National Violent Death Reporting System (NVDRS) OMB# 0920–0607—Revision—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Violence is an important public health problem. In the United States, homicide and suicide are the second and third leading causes of death, respectively, in the 1–34 year old age group. Unfortunately, public health agencies do not know much more about the problem than the numbers and the sex, race, and age of the victims, all information obtainable from the standard death certificate. Death certificates, however, carry no information about key facts necessary for prevention such as the relationship of the victim and suspect and the circumstances of the deaths, thereby making it impossible to discern anything but the gross contours of the problem. Furthermore, death certificates are typically available 20 months after the completion of a single calendar year. Official publications of national violent death rates, *e.g.* those in Morbidity and Mortality Weekly Report, rarely use data that is less than two years old. Public health interventions aimed at a moving target last seen two years ago may well miss the mark.

Local and Federal criminal justice agencies such as the Federal Bureau of Investigation (FBI) provide slightly more information about homicides, but they do not routinely collect standardized data about suicides, which are in fact much more common than homicides. The FBI′s Supplemental Homicide Report (SHRs) does collect basic information about the victim-suspect relationship and circumstances related to the homicide. SHRs do not link violent deaths that are part of one incident such as homicide-suicides. It also is a voluntary system in which some 10–20 percent of police departments nationwide do not participate. The FBI′s National Incident Based Reporting System (NIBRS) provides slightly more information than SHRs, but it covers less of the country than SHRs. NIBRS also only provides data regarding homicides. Also, the Bureau of Justice Statistics Reports does not use data that is less than two years old.

CDC therefore proposes to continue a state-based surveillance system for violent deaths that will provide more detailed and timely information. It taps into the case records held by medical examiners/coroners, police, and crime labs. Data is collected centrally by each state in the system, stripped of identifiers, and then sent to the CDC. Information is collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States use standardized data elements and software designed by CDC. Ultimately, this information will guide states in designing programs that reduce multiple forms of violence.

Neither victim families nor suspects are contacted to collect this information. It all comes from existing records and is collected by state health department staff or their subcontractors. Health departments incur an average of 2.5 hours per death in identifying the deaths from death certificates, contacting the police and medical examiners to get copies of or to view the relevant records, abstracting all the records, various data processing tasks, various administrative tasks, data utilization, training, communications, etc.

This revision is a request to allow 10 new state health departments to be added to the currently funded 17, if funding becomes available. This may bring the total to 27 by the year 2012.