research relating to innovative methods, techniques, and approaches dealing with occupational safety and health problems.

This research relates to occupational safety and health problems in the coal mining industry. In recent years, coal mining safety has attained national attention due to highly publicized disasters. Despite these threats to worker safety and health, the U.S. relies on coal mining to meet its electricity needs. For this reason, the coal mining industry must continue to find ways to protect its workers while maintaining productivity. One way to do so is through improving the safety culture at coal mines. In order to achieve this culture, operators, employees, the inspectorate, etc. must share a fundamental commitment to it as a value. This type of culture is known in other industries as a ''safety culture.'' Safety culture can be defined as the characteristics of the work environment, such as the norms, rules, and common understandings that influence employees' perceptions of the importance that the organization places on safety.

NIOSH requests OMB approval to collect safety culture data from underground coal mine employees over a three-year period to continue the assessment of the current safety culture of underground coal mining in order to identify recommendations for promoting and ensuring the existence of a positive safety culture across the industry. Up to four underground coal mines will be studied for this assessment in an attempt to study mines of different characteristics. Small, medium, and large unionized as well as nonunionized mines will be recruited to diversify the research sample. Data will be collected one time at each mine; this is not a longitudinal study. The assessment includes the collection of data using several diagnostic tools: functional analysis, structured interviews, behavioral observations, and surveys.

It is estimated that across the four mines, approximately 1,144 respondents will be surveyed. The exact number of interviews conducted will be based upon the number of individuals in the mine populations, but it is estimated that, across the four mines, approximately 201 interviews will be conducted. An exact number of participants is unavailable at this time because not all mine sites have been selected.

The use of multiple methods to assess safety culture is a key aspect to the methodology. After all of the information has been gathered, a variety of statistical and qualitative analyses are conducted on the data to obtain conclusions with respect to the mine's safety culture. The results from these analyses will be presented in a report describing the status of the behaviors important to safety culture at that mine.

Data collection for this project had previously taken place between the dates of January 1, 2010 and May 1, 2012. During this time period, safety culture assessments were conducted at five underground coal mines, including one small, two medium, and two large mines located in the Northern Appalachian, Central Appalachian, Southern Appalachian, and Western coal regions. One of the assessments was conducted at a unionized mine and the four other assessments were conducted at non-union mines. Data were collected from 274 interview participants and 1,356 survey respondents.

From this previous data collection, some trends are beginning to emerge. These include safety culture characteristic differences depending on the size of the mine and also differences between union and non-union mines. However, the sample of participating mines from the previous data collection is not sufficient for conclusions to be drawn regarding these emerging trends. Therefore, the need for continuation of data collection is needed in order to include additional union mines and small mines into the study sample.

Upon completion, this project will provide recommendations for the enactment of new safety practices or the enhancement of existing safety practices across the underground coal mining industry. This final report will present a generalized model of a positive safety culture for underground coal mines that can be applied at individual mines. In addition, all study measures and procedures will be available for mines to use in the future to evaluate their own safety cultures. There is no cost to respondents other than their time. The total estimated annualized burden hours are 582.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Underground Coal Mine Employees	Safety Culture Survey	1144	1	20/60
	Behavioral Anchored Rating Scale Interview	201	1	1

Dated: October 2, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI), Office of the Associate Director for Science (OADS), 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–13–12GF]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Adoption, Health Impact and Cost of Smoke-Free Multi-Unit Housing—New—National Center for Chronic

Disease Prevention and Health Promotion (NCCDPHP) and National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The health risks associated with cigarette smoking and exposure to Secondhand Smoke (SHS) are well established. In 2006, the Surgeon General's report documented that over the past two decades, the scientific, engineering and medical literature have established a wide range of adverse health effects from SHS. The Surgeon General's report concluded that there is no safe level of exposure to SHS.

Approximately 85 million Americans reside in multi-unit housing (MUH) facilities, which comprise nearly 30% of all housing in the U.S. Although residents may choose not to smoke, they may still be exposed to SHS through the routine operation of facility-wide heating, ventilating and air conditioning systems.

The private sector has begun to institute smoke-free policies in MUH on a voluntary basis through changes in leasing agreements and advertising, however, smoking restrictions in MUH have largely been limited to common areas and spaces, not individual dwelling units. There are no studies that have examined the impact of smoke free policies by comparing pre- and post SHS exposure and changes in health outcomes after local governments adopt regulatory policies that protect residents from the effects of exposure to SHS in their housing units.

CDC proposes to conduct a study to address the gap in scientific evidence about the impact of jurisdiction-wide strategies (hereafter known as smoke-free MUH policies) to protect individuals from SHS in MUH settings. Through the collection and analysis of environmental and biometric data, the study will demonstrate how SHS exposure can be measured and will quantify how exposure changes when smoke-free policies are implemented. In addition, the study will examine barriers and facilitators to implementation of smoke-free policies in MUH and the cost-effectiveness of these policies. CDC is authorized to conduct this investigation by the Public Health Service Act. The activities are funded through the Prevention and Public Health Fund of the Patient Protection and Affordable Care Act.

The proposed study consists of two components. The first component involves data collection in Los Angeles County, California, and includes a number of ''intervention'' communities that have adopted, or are scheduled to adopt, smoke-free MUH laws by mid-2012, as well as ''comparison'' communities that have not adopted laws regulating SHS in MUH. Communities being considered for participation in the study as intervention communities include Sierra Madre, Lawndale, Culver City, El Monte, Artesia, San Fernando, San Gabriel, Hawthorne, Carson, Huntington Park, South Pasadena, and Compton. Communities being considered for participation in the study as comparison communities include Lomita, Lynwood, Monrovia, Montebello, Alhambra, LaPuente, Monterey Park, Inglewood, Gardena, Maywood, El Segundo, and South Gate.

The availability of both intervention and comparison communities will enable use of a quasi-experimental, baseline and follow-up study design for examining the impact of smoke-free policies in MUH. Over a period of two years, a sample of 500 MUH residents and 130 MUH operators will be selected from intervention cities and a comparable sample of 500 MUH residents and 130 MUH operators will be selected from comparison cities. Baseline and follow-up surveys will be conducted involving MUH operators, MUH residents, and parents of children who reside in MUH facilities. Also, MUH residents will be recruited to collect environmental air quality data, and both parents and children who reside in MUH facilities will be recruited to provide saliva samples. These samples will be analyzed for the presence of cotinine, a biomarker of exposure to SHS.

The second component of the study will involve focus groups in Maine, Minnesota, and Florida—states have adopted and implemented smoke-free MUH policies for a longer period of time, either as a response to local regulations or voluntarily. A one-time survey of MUH operators will be conducted, and a sample of 12 MUH operators will be selected from communities in Minnesota, Maine, and Florida. In addition, a total of 120 residents will be selected to participate in short focus groups, with a maximum of 4 focus groups per state. The primary data sources for this component of the study will be (a) quantitative data obtained from interviews with 12 MUH operators (4 operators in the three study locations, using the same questionnaire as Los Angeles County); (b) qualitative data from participants from up to 12 focus groups (an expected total of 120 residents); and (c) quantitative data on the same residents from pre-focus group questionnaires. Results from studies in these three geographic areas and from cities in LA County, will provide insights more useful at the national population level than results based solely on information collected in LA County.

OMB approval is requested for two years. Participation is voluntary. The only cost to respondents is their time. The total estimated annualized burden hours are 1,920.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)
MUH Operators in Los Angeles County	Telephone Script for Recruitment of MUH Operators in LA County.	173	1	5/60
	MUH Operator Baseline Survey	130	1	75/60
	MUH Operator Post-Intervention Survey	130	1	75/60
MUH Operators in Minnesota, Maine, and Florida.	Telephone Script for Recruitment of MUH Operators in MN, ME, FL.	6	1	5/60
	MUH Operator Baseline Survey	6	1	75/60
	MUH Operator Post-Intervention Survey	6	1	75/60
Adult MUH Residents in Los Angeles County	Resident Survey—Baseline: Screening Eligibility.	833	1	5/60
	Resident Survey—Baseline: Core	500	1	45/60
	Resident Survey—Baseline: Children's Module.	250	1	15/60

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)
Child MUH Residents in LA County	Resident Survey—Post Intervention: Core	500	1	45/60
	Resident Survey—Post Intervention: Children's Module.	250		15/60
	Protocol for Saliva Collection (Adult)	1,000	1	10/60
	Airborne Particle Monitoring Diary	200	1	90/60
	Protocol for Saliva Collection (Child)	500	1	10/60
MUH Residents in Minnesota, Maine and Florida.	Resident Focus Group Telephone Screening Interview Script.	60	1	5/60
	Resident Pre-Focus Group Demographic and Attitudinal Survey.	60	1	5/60
	MUH Resident Focus Group Guide—Process Oriented.	30	1	1
	MUH Resident Focus Group Guide—Outcome Oriented.	30	1	1

Dated: October 2, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI) Office of the Associate Director for Science (OADS), 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

[30-Day–13–12SF]

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Proposed Project

Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery—NEW—Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health (NIOSH).

As part of a Federal Government-wide effort to streamline the process to seek feedback from the public on service delivery, the CDC has submitted a Generic Information Collection Request (Generic ICR): ''Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery '' to OMB for approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*).

To request additional information, please contact Kimberly S. Lane, Reports Clearance Officer, Centers for Disease Control and Prevention, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

SUPPLEMENTARY INFORMATION:

Title: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

Abstract: The information collection activity will garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. By qualitative feedback we mean information that provides useful insights on perceptions and opinions, but are not statistical surveys that yield quantitative results that can be generalized to the population of study. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communications between the Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

Feedback collected under this generic clearance will provide useful information, but it will not yield data that can be generalized to the overall population. This type of generic clearance for qualitative information will not be used for quantitative information collections that are designed to yield reliably actionable results, such as monitoring trends over time or documenting program performance. Such data uses require more rigorous designs that address: The target population to which generalizations will be made, the sampling frame, the sample design (including stratification and clustering), the precision requirements or power calculations that justify the proposed sample size, the expected response rate, methods for assessing potential non-response bias, the protocols for data collection, and any testing procedures that were or will be undertaken prior fielding the study. Depending on the degree of influence the results are likely to have, such collections may still be eligible for submission for other generic mechanisms that are designed to yield quantitative results.

The Agency received no comments in response to the 60-day notice published in the **Federal Register** on December 22, 2010 (75 FR 80542).

This is a new collection of information. Respondents will be screened and selected from Individuals and Households, Businesses, Organizations, and/or State, Local or Tribal Government. Below we provide CDC's projected annualized estimate for the next three years. There is no cost to respondents other than their time. The estimated annualized burden hours for this data collection activity are 28,750.