training, is based on the TeamSTEPPS 2.0 instructional materials and will be delivered online to 3,000 participants. The training will cover the core TeamSTEPPS tools and strategies, coaching, organizational change, and implementation science.

2. *TeamSTEPPS 2.0 Online Post-Training Survey.* This online instrument will be administered to all participants who complete the TeamSTEPPS 2.0 Online Master Training. The survey will be administered 6 months after participants complete the training program.

This data collection is for the purpose of conducting an evaluation of the TeamSTEPPS 2.0 Online Master Trainer program which was last approved by OMB on November 14, 2014 (OMB Control Number is 0935–0224), and will expire November 30, 2017. The evaluation is primarily formative in nature as AHRQ seeks information to improve the delivery of the training.

This is a new data collection for the purpose of conducting an evaluation of TeamSTEPPS 2.0 Online Master Trainer program. The evaluation will be primarily formative in nature as AHRQ seeks information to improve the delivery of the training.

The OMB Control Number for the MEPS–HC and MPC is 0935–0118, which was last approved by OMB on December 20, 2012, and will expire on December 31, 2015.

To conduct the evaluation, the *TeamSTEPPS 2.0 Online Post-Training Survey* will be administered to all individuals who completed the TeamSTEPPS 2.0 Online Master Trainer program, 6 months after completing training. The purpose of the survey is to assess the degree to which participants felt prepared by the training and what they did to implement TeamSTEPPS. Specifically, participants will be asked about their reasons for participating in the program; the degree to which they feel the training prepared them to train others in and use TeamSTEPPS; what tools they have implemented in their organizations; and resulting changes they have observed in the delivery of care.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondent's time to participate in the study. The *TeamSTEPPS 2.0 Online Post-Training Survey* will be completed by approximately 3,000 individuals. We estimate that each respondent will require 20 minutes to complete the survey. The total annualized burden is estimated to be 1,000 hours.

Exhibit 2 shows the estimated annualized cost burden based on the respondents' time to participate in the study. The total cost burden is estimated to be $45,320.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Training participant questionnaire	3,000	1	20/60	1,000
Total	3,000	N/A	N/A	1,000

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Training participant questionnaire	3,000	1,000	$45.32	$45,320
Total	3,000	1,000	N/A	$45,320

* Based on the mean of the average wages for all health professionals (29–0000) and wages for medical and health services managers (11–9111) for the training participant questionnaire presented in the National Compensation Survey: Occupational Wages in the United States, May 2016, U.S. Department of Labor, Bureau of Labor Statistics (*https://www.bls.gov/oes/current/oes_nat.htm*).

Request for Comments

In accordance with the Paperwork Reduction Act, 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 and health care 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.

Sharon B. Arnold,

Deputy Director.

[FR Doc. 2017–17502 Filed 8–17–17; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–17–17ABD]

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

Backyard Integrated Tick Management Project—Existing Collection in Use without an OMB Number—National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The combined number of confirmed and probable Lyme disease cases has exceeded 30,000 in all years since 2008, and recent estimates suggest that the true number of Lyme disease cases may be 10-fold higher. There is no Lyme disease vaccine for use in humans and prevention of infection is therefore completely reliant on personal protective measures (avoiding tick habitat, use of repellent, tick checks or prompt tick removal, etc.), and methods to suppress vector ticks in the environment.

The primary goal of this project is to evaluate the effectiveness of specific tick/pathogen control methods used on single versus multiple adjacent properties on the risk of human exposure to ticks. The secondary goal is to better understand human landscape use patterns and tick exposure locations. The project was initiated in direct response to knowledge gaps, identified by CDC Subject Matter Experts, for the use of integrated tick vector/rodent reservoir management to reduce human risk of exposure to Ixodes scapularis ticks, the sole vector of Lyme disease in the Northeast.

Resulting data is intended to be used to provide suggestions for improving tick/pathogen control methods used in the environment.

Information will be collected, under protocols approved by the Institutional Review Boards (IRBs) at Western Connecticut State University (WCSU) and the University of Rhode Island (URI), from inhabitants of residential properties to (i) compare the effectiveness of an integrated tick management approach at single-treated residential properties vs. contiguously-treated residential properties to reduce human tick bites, and (ii) increase the understanding of where people encounter ticks, both near their homes and in other outdoor settings.

Another potential positive outcome of the information collection is more effective targeting of tick control efforts to high-risk areas, minimizing pesticide use. Not collecting the information would lead to inadequate evaluation of the implemented integrated tick management program (solely focusing on host-seeking ticks collected from the vegetation), as well as the unacceptable status quo for detailed knowledge of where people encounter ticks within their residential properties and on the residential properties versus elsewhere.

Information will be collected by WCSU and URI researchers from inhabitants (adults and children) of participating residential properties (freestanding homes with tick habitat on the property) located in Connecticut and Rhode Island. Consenting participants will complete one introductory survey by telephone, projected to last no more than 15 minutes. In May–August of Years 1–4, participants will also complete an emailed monthly tick encounter survey about the number of ticks found on each member of the household and each household member's tick-borne disease status, projected to take no more than 10 minutes per month to complete. An end-of-season survey will also be administered in March/April each year, projected to take no more than 10 minutes to complete.

In addition, participants will be asked to record location of daily activity on behalf of themselves and household members each day over the first week of June in a single year via emailed daily surveys, projected to take 70 minutes over the week of participation. Lastly, an end-of-study survey will be administered in September 2020, projected to take no more than 15 minutes. In total, we expect approximately two hours or less of total time spent on surveys by consented participants in each year of the study. All survey instruments have also been approved by the IRBs at WCSU and URI.

The collection of information is conducted by WCSU, and its subcontractor, URI, as part of a Cooperative Agreement with the CDC (1U01CK0004912–01). The Cooperative Agreement was established based on WCSU competing successfully for CDC RFA–CK–16–002 (Spatially Scalable Integrated Tick Vector/Rodent Reservoir Management to Reduce Human Risk of Exposure to Ixodes scapularis Ticks Infected with Lyme Disease Spirochetes).

This study is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241).

There is no cost to respondents other than the time to participate. The total estimated annual burden hours are 557.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Households or Individuals	Eligibility Survey	125	1	15/60
	Introductory Survey (including Consent Form)	58	1	30/60
	Monthly Surveys	230	4	10/60
	Daily Surveys	230	7	10/60

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
	Annual End of Year Survey	230	1	15/60
	Final Survey	58	1	15/60

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

[30Day–17–17ABC]

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

Zika Postpartum Emergency Response Survey (ZPER), Puerto Rico, 2017—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In December 2015, the Puerto Rico Department of Health (PRDH) reported the first locally acquired (index) case of Zika virus disease in the United States. Since then, 38,733 cases have been confirmed in Puerto Rico, including 3,076 among pregnant women. Because the most common mosquito vector of Zika virus, Aedes aegypti, is present throughout Puerto Rico, Zika virus transmission is ongoing. The island has been designated at the highest level of risk according to a 3-tiered Zika virus infection risk scale developed by CDC's Emergency Operations Center.

While pregnant women do not differ from the general population in terms of susceptibility to Zika virus infection or severity of disease, they are at risk for adverse pregnancy and birth outcomes associated with Zika virus infection during pregnancy. After review of the available evidence, CDC concluded that Zika virus infection during pregnancy is a cause of microcephaly and other brain defects.

Given the adverse pregnancy and birth outcomes associated with Zika virus infection during pregnancy, it is more important than ever to understand the Zika-related concerns of pregnant women, interactions regarding Zika between pregnant women and their health care providers, sources of information that pregnant women consult regarding Zika virus, and use of recommended precautions by pregnant women to reduce the risk of exposure to Zika virus. This information was successfully collected for the first time in a hospital-based survey of women 24–48 hours after delivery by the Puerto Rico Department of Health in the fall of 2016 (Emergency OMB approval, Control #0920–1127), and has been critical for informing clinical guidance, developing communication messages, and providing resources for pregnant women.

The currently proposed data collection includes three components to follow-up on the initial effort. The first component is a telephone follow-back survey among a subset of the original participants. This component would be the first population-based sample of postpartum women who were pregnant during the early period of the Zika outbreak, and would provide information on the accessibility and utilization of postpartum and newborn services, and continued adherence to Zika prevention behaviors. The second component would be to repeat the hospital-based survey of pregnant women to assess the effectiveness of emergency response efforts and to determine where there is a need for further refinement of efforts and outstanding resource gaps; as with the first hospital-based survey, there would be subsequent telephone follow-up survey with a subset of the participants. The third and final component is the addition of a separate hospital-based survey for fathers of the infants born to surveyed mothers. This component would assess father's concerns about Zika related birth defects and contribution to prevention efforts.

There are no costs to respondents other than their time to participate.