**Background and Brief Description**

The mission of the National Institute for Occupational Safety and Health (NIOSH) is to promote safety and health at work for all people through research and prevention. The study will be conducted by NIOSH under the Federal Mine Safety and Health Act of 1977, Public Law 91–173 as amended by Public Law 95–164. Title V, Section 501 (a) states NIOSH has the responsibility to conduct research ''to improve working conditions and practices in coal or others mines, and to prevent accidents and occupational diseases originating in the coal or other mining industry (Federal Mine and Safety and Health Act, 1977, Title V, Sec. 501).''

Striking, pinning and crushing injuries are serious concerns in underground coal mining, especially around mobile equipment. Between 2010 and 2014 powered haulage accounted for 24 of the 110 underground coal fatalities. During that same time period, the Mine Safety and Health Administration (MSHA) determined that up to nine of these fatalities were striking, pinning, or crushing accidents, which may have been prevented by proximity detection systems on coal haulage machines or scoops. Following the final rule requiring proximity detection systems on continuous mining machines, on September 2, 2015, MSHA published a proposed rule requiring proximity systems on mobile machines in underground coal mines. Though it is still under development, MSHA reported that by June of 2015, 155 of approximately 2,116 coal haulage machines and scoops had been equipped with proximity detection systems. However, in recent discussions with NIOSH personnel, some mine operators have disclosed suspending the use of proximity detection systems on mobile equipment due to challenges integrating the systems into daily operations. This has further prompted concerns about how proximity detection systems are being utilized.

The goal of this study is to reduce the risk of traumatic injuries and fatalities among mine workers through assessing the current state of proximity systems for underground mobile equipment. NIOSH is seeking a one-year OMB approval in order to collect information to address two key questions: (1) In which situations do proximity detection systems on mobile haulage hinder normal operation? (2) In which situations do proximity detection systems on mobile haulage endanger miners? Data will be used to inform the development of technologies, engineering controls, administrative controls, best practices, and training approaches that eliminate striking fatalities and injuries caused by mobile mining equipment.

The study population includes mine workers in various maintenance and production roles that work in underground coal mines in the United States. Total annual time burden for this study is 45 hours, including recruitment of mines and 250 semi-formal interviews. Since workers will continue to perform their assigned duties during the optional group observations, a burden estimate was not calculated for this activity.

ESTIMATED ANNUALIZED BURDEN HOURS

| Type of respondents | Form name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) |
|---|---|---|---|---|
| Mine Operators | Mine Recruitment Scripts | 12 | 1 | 15/60 |
| Crew members | Interview Protocol | 250 | 1 | 10/60 |

**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.*

[FR Doc. 2018–00140 Filed 1–5–18; 8:45 am]

**BILLING CODE P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[30Day–18–1061]**

### 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 October 16, 2017 to obtain comments from the public and affected agencies. CDC received one comment 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) (OMB Control Number 0920–1061, Expiration Date 3/31/

2018)—Revision—National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

CDC is requesting Office of Management and Budget (OMB) approval to continue information collection for the Behavioral Risk Factor Surveillance System (BRFSS) for the period of 2018–2021. 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 an optional module. 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 construction of their state-specific surveys. The CDC and BRFSS partners produce a new set of state-specific BRFSS questionnaires each calendar year (*i.e.,* 2016 BRFSS questionnaires, 2017 BRFSS questionnaires, etc.). CDC submits an annual Change Request to OMB that outlines updates to the BRFSS core survey and optional modules that have occurred since the previous year. Each state administers its BRFSS questionnaire throughout the calendar year.

The current estimated average burden for the core BRFSS interview is 15 minutes. For the optional modules, the estimated average burden per response varies by state and year, but is currently estimated at an additional 15 minutes. Finally, the BRFSS allows states to customize some portions of the questionnaire through the addition of state-added questions, which CDC does not review nor approve. State-added questions are not included in CDC's burden estimates.

CDC periodically updates the BRFSS core survey and optional modules as new modules or adopt emerging core questions. The purpose of this Revision request is to extend the information collection period for three years and to incorporate field-testing into the approved information collection plan.

Field-testing is the final check of changes in the questionnaire, which have occurred in the preceding year. Researchers conduct field-testing in a manner that mimics the full-scale project protocol, to the degree that is feasible. Field-testing allows for necessary changes in data collection methods and data collection software. Researchers use field tests to identify problems with instrument documentation or instructions, problems with conditional logic (*e.g.,* skip patterns), software errors or other implementation and usability issues. Researchers conduct field-testing with all new modules, emerging core questions, sections, which precede and/or follow any new or changed items and extant sections, which are topically related. Researchers also conduct this testing to identify redundant and overlapping questions. Extant sections of the questionnaire unrelated to new items do not require testing. The demographic questions on the core BRFSS survey are included on each field test. CDC will submit change requests to OMB annually to gain approval to implement modifications identified in field tests. Researchers typically conduct field tests in a single state with appropriate computer-assisted telephone interview (CATI) capability. Individuals who participate in field testing are drawn from a different sample than individuals who participate in the BRFSS surveys. Participation is voluntary and there is no cost to participate. The average time burden per response will be 22 minutes. The total time burden across all respondents will be approximately 241,519 hours.

The public comment received to date requested that BRFSS be modified to include more questions about tobacco use, including use of newer nicotine-delivery devices. Because BRFSS follows the design and development process described above, CDC cannot unilaterally change the topical content of BRFSS and no change has been made to the 2018 questionnaire.

ESTIMATED ANNUALIZED BURDEN HOURS

| Type of respondents | Form name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) |
|---|---|---|---|---|
| U.S. General Population | Landline Screener | 375,000 | 1 | 1/60 |
| | Cell Phone Screener | 292,682 | 1 | 1/60 |
| | Field Test Screener | 900 | 1 | 1/60 |
| Annual Survey Respondents (Adults >18 Years). | BRFSS Core Survey | 480,000 | 1 | 15/60 |
| | BRFSS Optional Modules | 440,000 | 1 | 15/60 |

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

| Type of respondents | Form name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) |
|---|---|---|---|---|
| Field Test Respondents (Adults >18 Years) .. | Field Test Survey ..... | 500 | 1 | 45/60 |

**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.*

[FR Doc. 2018–00142 Filed 1–5–18; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[Docket No. CDC–2018–0001]**

### CDC Sex-Specific Body Mass Index (BMI)-For-Age Growth Charts

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

**ACTION:** Notice with comment period.

**SUMMARY:** The National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC) in the Department of Health and Human Services (HHS) announces the opening of a docket to obtain public comment on the production of sex-specific body mass index (BMI)-for-age growth charts for children and adolescents aged 2–19 years specifically designed for tracking extremely high values of BMI. The 2000 CDC growth charts include sex-specific BMI-for-age percentile charts based on data representative of the United States (US) population from the National Health Examination Survey (NHES) and National Health and Nutrition Examination Survey (NHANES). In US children and adolescents, obesity is defined as at or above the sex-specific 95th percentile on the CDC BMI-for-age growth charts. Severe obesity is often defined as at or above 120% of the sex-specific 95th percentile on the CDC BMI–for-age growth charts. Currently, the highest percentile displayed is the 97th percentile. Therefore, it is difficult to assess changes in weight status in children with very high BMIs that exceed this level. The new charts will provide additional lines representing 120%, 130%, 140%, and 150% of the 95th percentile. The intent of these charts is to provide a mechanism for documenting BMI percentiles for children and adolescents with severe obesity in both clinical and research settings.

**DATES:** Written comments must be received on or before March 9, 2018.

**ADDRESSES:** You may submit comments, identified by Docket No. CDC–2018–0001 by any of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail*: Verita C. Buie, DrPH, Office of Planning, Budget, and Legislation, National Center for Health Statistics, Centers for Disease Control and Prevention, 3311 Toledo Road, MS–08, Hyattsville, MD 20782.

*Instructions*: All submissions received must include the agency name and Docket Number. All relevant comments received will be posted without change to *http://regulations.gov,* including any personal information provided. For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

**FOR FURTHER INFORMATION CONTACT:** Cynthia Ogden, Ph.D., Division of Health and Nutrition Examination Survey, National Center for Health Statistics, 3311 Toledo Road, MS–P08, Hyattsville, MD 20782–2064, phone: (301) 458–4405.

**SUPPLEMENTARY INFORMATION:** The National Center for Health Statistics (NCHS) is congressionally mandated by the National Health Survey Act of 1956 to monitor the health of the nation. The National Health and Nutrition Examination Survey (NHANES), part of NCHS, is a nationally representative health survey designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews with physical examinations and laboratory studies. NHANES data are used throughout Department of Health and Human Services (HHS) agencies in addition to public health researchers world-wide. NHANES data have been used to determine national obesity estimates, produce pediatric growth and BMI charts, and monitor prevalence of infectious diseases such as the human papillomavirus (HPV).

Body mass index (BMI) is calculated as weight in kilograms divided by height in meters squared and is used in the diagnosis, clinical management, and estimation of population prevalence of obesity and severe obesity. Among adults, obesity is defined by an absolute BMI value (≥30). Among children, BMI varies with age as well as sex. Therefore, to classify obesity among children and adolescents aged 2–19 years, measurements are standardized by age and sex using BMI-for-age growth charts. The 2000 CDC growth charts include smoothed percentiles of BMI-for-age based on data representative of the US population. In the US, obesity is defined as at or above the sex-specific 95th percentile for BMI-for-age. However, categorizing severe obesity (defined in adults as BMI≥40) is problematic given specific measures are not available in standard CDC growth charts for values beyond the 97th percentile. Researchers have proposed using percent of the 95th percentile as a flexible, stable measure for extreme BMI values. Consequently, severe obesity in children is often defined as a BMI at or above 120% of the sex-specific 95th percentile of BMI-for-age.

Prevalence of severe obesity has increased among children and adolescents and very high BMI has been shown to increase risk for obesity in adulthood in addition to adverse health outcomes such as diabetes, abnormal cholesterol levels, and high blood pressure and behavioral health and social victimization impacts. Recent research has focused on effective management and treatment of children and adolescents with severe obesity, but researchers and clinicians lack a tool to determine BMI percentiles for these individuals. Specialized growth charts with lines reflecting 120%, 130%, 140% and 150% will provide an improved tool for documenting BMI in the clinical and research settings. Please see the draft example chart for boys (Attachment 1) and girls (Attachment 2).

Date: January 2, 2018.

**Lauren Hoffmann,**

*Acting Executive Secretary, Centers for Disease Control and Prevention.*

[FR Doc. 2018–00060 Filed 1–5–18; 8:45 am]

**BILLING CODE 4163–18–P**