**RETRIEVABILITY:**

Information is most frequently retrieved by first name, last name, middle initial, date of birth, or Social Security Number (SSN).

**SAFEGUARDS:**

HHS has safeguards in place for authorized users and monitors such users to ensure against unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and HHS policies and standards as they relate to information security and data privacy. These laws and regulations include but are not limited to: The Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the E-Government Act of 2002, and the Clinger-Cohen Act of 1996. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and HHS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications; and the HHS Information Systems Program Handbook. HHS will give a contractor, consultant, or HHS grantee the information necessary for the contractor or consultant to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor, consultant, or grantee from using or disclosing the information for any purpose other than that described in the contract and requires the contractor, consultant, or grantee to return or destroy all information at the completion of the contract. Contractors are also required to provide the appropriate management, operational, and technical controls to secure the data.

**RETENTION AND DISPOSAL:**

Records are maintained with identifiers for all transactions after they are entered into the system for a period of 10 years. Records are housed in both active and archival files in accordance with HHS data and document management policies and standards. All sponsor applications, claims, and other program-related records are encompassed by the document preservation order and will be retained until notification is received from the Department of Justice.

**SYSTEM MANAGER AND ADDRESS:**

David Gardner, Acting Director, Early Retiree Reinsurance Division, Office of Insurance Programs, Office of Consumer Information and Insurance Oversight, U.S. Department of Health & Human Services, 200 Independence Avenue, SW., Suite 738F, Washington, DC 20201.

**NOTIFICATION PROCEDURE:**

For purpose of notification, the subject individual should write to the system manager who will require the system name, and the retrieval selection criteria (*e.g.,* name, SSN, *etc.*).

**RECORD ACCESS PROCEDURE:**

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also reasonably specify the record contents being sought. (These procedures are in accordance with Department regulation 45 CFR 5b.5(a)(2)).

**CONTESTING RECORD PROCEDURES:**

The subject individual should contact the system manager named above, and reasonably identify the record and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These procedures are in accordance with Department regulation 45 CFR 5b.7).

**RECORD SOURCE CATEGORIES:**

Record source categories include program participants, individuals on whose behalf reimbursements are being sought, and those who voluntarily submit data and personal information for the ERRP program.

**SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:**

None.

[FR Doc. 2010–13178 Filed 6–2–10; 8:45 am]

**BILLING CODE 4150–65–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Agency for Healthcare Research and Quality

### Agency Information Collection Activities: Proposed Collection; Comment Request

**AGENCY:** Agency for Healthcare Research and Quality, HHS.

**ACTION:** Notice.

**SUMMARY:** This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: "Reductions of Infection Caused by Carbapenem Resistant Enterobacteriaceae (KPC) Producing Organisms through the Application of Recently Developed CDC/HICPAC Recommendations." In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3520, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on March 31st, 2010 and allowed 60 days for public comment. No comments were received. The purpose of this notice is to allow an additional 30 days for public comment.

**DATES:** Comments on this notice must be received by July 6, 2010.

**ADDRESSES:** Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by e-mail at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk officer).

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

**FOR FURTHER INFORMATION CONTACT:** Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by e-mail at *doris.lefkowitz@AHRQ.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

#### Proposed Project

Reductions of Infections Caused by Carbapenem Resistant Enterobacteriaceae (KPC) Producing Organisms Through the Application of Recently Developed CDC/HICPAC Recommendations.

Healthcare Acquired Infections (HAIs) caused almost 100,000 deaths among the 2.1 million people who acquired infections while hospitalized in 2000, and HAI rates have risen relentlessly

since then. On March 20, 2009, the Centers for Disease Control (CDC) and the Healthcare Infections Control Practices Advisory Committee (HICPAC) developed infection control (IC) guidance for Klebsiella pneumonia carbapenemase-producing (KPC) isolates, as they have been rapidly emerging as a significant challenge in healthcare settings. The danger of these bacteria is that they are resistant to carbapenem (a class of beta-lactam antibiotics with a broad spectrum of antibacterial activity) and cannot be treated by the most commonly prescribed antibiotics. Limited treatment options mean that infections caused by carbapenem-resistant bacteria result in substantial mortality and morbidity.

The CDC and HICPAC recommendations draw on infection control strategies which have been applied to these pathogens in other settings, and other evidence-based strategies in infection control. There has been little research, however, on the implementation of control strategies to prevent the spread of these KPC infections. The goal of this project is to understand how these recommendations can best be implemented and how effective these recommendations will be in practice. This research will advance private and public efforts to improve health care quality by improving measures to control the spread of a dangerous organism. This research will also provide data for the development of an implementation toolkit that hospitals can use to prevent the spread of carbapenem resistant bacteria. The toolkit may include the following types of resources: General information about the implementation of evidence-based clinical practices, resource materials, and tools and methods that users can adopt to conduct point prevalence surveys, protocols and tools that users can adopt to specify when active KPC surveillance is needed, and resources for approaching the problem as a team-based quality-improvement effort. OMB clearance will be sought for this toolkit once it is developed.

This study is being conducted by AHRQ through its contractor, Boston University, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

**Method of Collection**

*This project will include the following data collections from the intensive care unit (ICU) staff within each of three participating hospitals:*

(1) Pre-intervention focus groups will be conducted separately with managers and staff. The purpose of these focus groups is to identify potential problems in the implementation that can be addressed through various means (*e.g.,* additional education, other changes in process). Another purpose is to understand the existing approach to quality improvement, the connection(s) between overall approach to quality improvement and to KPC infection control practices, current practices at the hospital of quality reporting and accountability, and constraints and obstacles to quality improvement as seen in their roles. Staff members identified for the focus groups will be those with the most first-hand knowledge of existing quality improvement efforts, and KPC infection control practices.

(2) Clinical staff survey. Factors identified in the pre-intervention focus groups will be used to inform the development of a self-administered survey of staff knowledge of and attitudes toward KPC surveillance and infection control procedures. Respondents will be health care workers on the units where these new guidelines have been implemented. Findings from the survey will be used to assess barriers perceived by the staff, potential differences across units, and potential differences by employee/occupational group.

(3) Post-intervention focus groups (6 months after implementation of new KPC IC guidelines) will be conducted separately with managers and staff. The purpose of these focus groups is to identify actual problems experienced in the initial implementation and possible measures to address, and to identify successful practices to include in a toolkit that hospitals can use to implement the CDC and HICPAC recommendations.

In addition to developing a toolkit, AHRQ plans to disseminate the lessons learned from this project about how hospitals can best implement the CDC guidance for KPC screening and infection control, in order to inform efforts to change practice in this area.

**Estimated Annual Respondent Burden**

The estimated annualized burden hours for respondents to participate in this two year research project are presented in Exhibit 1. Pre-intervention focus groups with clinical staff will be conducted with 18 staff members (an average of 9 per year for 2 years) from each of the 3 participating hospitals and will take about 1 hour. Pre-intervention focus groups with also be conducted with 2 managers (an average of I per year for 2 years) from each hospital and will take about an hour to complete.

The clinical staff survey will be administered to 20 clinical staff (an average of 10 per year for years) from each hospital and will take 15 minutes to complete.

Finally, respondents from the pre-intervention focus groups will participate in post-intervention focus groups approximately four months after the initiation of the intervention. They will not last more than an hour each. The total annualized burden hours are estimated to be 68 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this research. The total annualized cost burden is estimated to be $3,108.

EXHIBIT 1. ESTIMATED ANNUALIZED BURDEN HOURS

| Data collection | Number of respondents | Number of responses per respondent | Hours per response | Total burden hours |
|---|---|---|---|---|
| Pre-intervention focus groups with clinical staff * | 3 | 9 | 1 | 27 |
| Pre-intervention focus groups with managers* | 3 | 1 | 1 | 3 |
| Clinical staff survey | 3 | 10 | 15/60 | 8 |
| Post-intervention focus groups with clinical staff * | 3 | 9 | 1 | 27 |
| Post-intervention focus groups with managers* | 3 | 1 | 1 | 3 |

EXHIBIT 1. ESTIMATED ANNUALIZED BURDEN HOURS—Continued

| Data collection | Number of respondents | Number of responses per respondent | Hours per response | Total burden hours |
|---|---|---|---|---|
| Total | 15 | n/a | n/a | 68 |

* Individuals that cannot attend the focus groups will be interviewed one-on-one. Clinical staff includes IC leaders, QI team members and unit staff. Managers include the chief nursing officer and chief medical officer.

EXHIBIT 2. ESTIMATED ANNUALIZED COST BURDEN

| Data collection | Number of respondents | Total burden hours | Average hourly wage rate | Total cost burden |
|---|---|---|---|---|
| Pre-intervention focus groups with clinical staff * | 3 | 27 | $36.73 * | $992 |
| Pre-intervention focus groups with managers * | 3 | 3 | $138.38 ** | $415 |
| Clinical staff survey | 3 | 8 | $36.73 * | $294 |
| Post-intervention focus groups with clinical staff * | 3 | 27 | $36.73 * | $992 |
| Post-intervention focus groups with managers * | 3 | 3 | $138.38 ** | $415 |
| Total | 15 | 68 | na | $3,108 |

* Based upon the mean hourly wage for Registered Nurses in Nassau and Suffolk County, NY as reported by the Bureau of Labor Statistics in May 2008.

** Based on report of a private survey of HR departments conducted in November 2009 in New York, NY published by *http://www.salary.com;* 3 chief nursing officers at $101.14/hr and 3 chief medical officers at $175.61/hour.

**Estimated Annual Costs to the Federal Government**

Exhibit 3 shows the annualized and total cost to the federal government for this two year research project. Project development covers steps taken to revise the research plan and begin implementation. The total cost is estimated to be $500,001.

EXHIBIT 3. ANNUALIZED AND TOTAL COST TO THE FEDERAL GOVERNMENT

| Cost component | Annualized cost | Total cost |
|---|---|---|
| Project Management | $125,526 | $251,052 |
| Project Development | $54,622 | $109,244 |
| Data Collection Activities | $41,864 | $83,728 |
| Travel | $4,000 | $8,000 |
| Overhead | $23,754 | $47,507 |
| Total | $250,001 | $500,001 |

**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 healthcare research and healthcare 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 will become a matter of public record.

Dated: May 21, 2010.

**Carolyn M. Clancy,**

*Director.*

[FR Doc. 2010–13107 Filed 6–2–10; 8:45 am]

**BILLING CODE 4160–90–M**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Administration for Children and Families

### Agency Recordkeeping/Reporting Requirements Under Emergency Review by the Office of Management and Budget

*Title:* State Personal Responsibility Education Program.

*OMB No.:* New Collection.

*Description:* An emergency request is being made to solicit comments from the public on paperwork reduction as it relates to ACYF's receipt of the following documents from applicants and awardees:

- Application for Formula Grant
- Performance Progress Reports
- Year 1 Implementation Plan
- Performance Measure Reporting