Respondents for this data collection are individuals representing schools, school districts, and public health agencies. CDC has determined that the information to be collected is necessary to study the impact of a public health emergency as it relates to community mitigation activities. The information has been used to help understand how CDC guidance on school dismissals has been implemented at the state and local levels nationwide and to help determine how this guidance might be more helpful in the future. Specifically, data collection will be utilized to:

1. Determine the scope and extent of school dismissals in the United States during public health emergencies:

a. Prospectively monitor data to identify schools and school districts that have high dismissal rates due to infectious diseases, or that implement pre-emptive school dismissals due to other public health emergencies due to other reasons when recommended by public health officials.

b. Retrospectively review data collected to describe impact school dismissals had on students and teachers

2. Describe the characteristics of schools and school districts with high dismissal rates due to infectious diseases

Respondents are required to identify their respective institutions by providing non-sensitive information, to include the name and zip code of schools and school districts and their dates of closure, as well as reason for the dismissal (due to illness rates among students and staff or pre-emptive to slow the spread of infection). The respondents have the option of providing their position titles, phone number of the institution they represent, and email address. The estimates for burden hours are derived from the 627 total number of reported closures during the fall in 2009. We have multiplied that number by four as an estimate for a calendar year. Respondents are providing this information as public health and education officials and representatives of their agencies and organizations and not as private citizens. The data collection does not involve personally identifiable information and should have no impact on an individual's privacy. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
School, school district, or public health authorities.	School Dismissal Monitoring Form ..	2500	1	5/60	208
Total	.....	.....	.....	.....	208

Dated: November 26, 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.

[FR Doc. 2012–29175 Filed 12–3–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–13–0852]

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 404–639–7570 and send comments to Ron Otten, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email 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

Prevalence Survey of Healthcare-Associated Infections (HAIs) and Antimicrobial Use in U.S. Acute Care Hospitals—Extension (0920–0852 expiration 5/31/13)—National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Preventing healthcare-associated infections (HAIs) is a CDC priority. An essential step in reducing the occurrence of HAIs is to estimate accurately the burden of these infections in U.S. hospitals, and to describe the types of HAIs and causative organisms. The scope and magnitude of HAIs in the United States were last directly estimated in the 1970s in which comprehensive data were collected from a sample of 338 hospitals; 5% of hospitalized patients acquired an infection not present at the time of admission. Because of the substantial resources necessary to conduct hospital-wide surveillance in an ongoing manner, most of the more than 4,500 hospitals now reporting to the CDC's current HAI surveillance system, the National Healthcare Safety Network (NHSN 0920–0666 expiration 1/31/15), focus instead on device-associated and procedure-associated infections in selected patient locations, and do not report data on all types of HAIs occurring hospital-wide. Periodic assessments of the magnitude and types of HAIs occurring in all patient populations within acute care hospitals are needed to inform decisions by local and national policy makers and by hospital infection control personnel regarding appropriate targets and strategies for HAI prevention.

In 2008–2009 in the previous project period, CDC developed a pilot protocol for a HAI point prevalence survey,

conducted over a 1-day period at each of nine acute care hospitals in one U.S. city. This pilot phase was followed in 2010 by a phase 2, limited roll-out HAI and antimicrobial use prevalence survey, conducted during July and August in 22 hospitals across 10 Emerging Infections Program sites (in California, Colorado, Connecticut, Georgia, Maryland, Minnesota, New Mexico, New York, Oregon, and Tennessee). Experience gained in the phase 1 and phase 2 surveys was used to conduct a full-scale, phase 3 survey in 2011, involving 183 hospitals in the 10 EIP sites. Over 11,000 patients were surveyed, and analysis of HAI and antimicrobial use data is ongoing at this time.

An extension of the prevalence survey's existing OMB approval is sought, to allow a repeat HAI and antimicrobial use prevalence survey to be performed in 2014. A repeat survey will allow further refinement of survey methodology and assessment of changes over time in prevalence, HAI distribution, and pathogen distribution. It will also allow for a re-assessment of the burden of antimicrobial use, at a time when antimicrobial stewardship is an area of active engagement in many acute care hospitals. The 2014 survey will be performed in a sample of up to 500 acute care hospitals, drawn from the acute care hospital populations in each of the 10 EIP sites (and including participation from many hospitals that participated in prior phases of the survey). Infection prevention personnel in participating hospitals and EIP site personnel will collect demographic and clinical data from the medical records of a sample of eligible patients in their hospitals on a single day in 2014, to identify CDC-defined HAIs. The surveys will provide data for CDC to make estimates of the prevalence of HAIs across this sample of U.S. hospitals as well as the distribution of infection types and causative organisms. These data can be used to work toward reducing and eliminating healthcare-associated infections—a Department of Health and Human Services (DHHS) Healthy People 2020 objective (*http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=17*). This survey project also supports the CDC Winnable Battle goal of improving national surveillance for healthcare-associated infections (*http://www.cdc.gov/winnablebattles/Goals.html*).

This survey assumes one respondent per hospital, a median of 75 patients per hospital, and average data collection time of 15 minutes per patient. There are no costs to respondents other than their time. The estimated annualized burden is 9,375 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	No. of respondents	Number of responses per respondent	Average burden per response in hours	Total burden (in hours)
Infection Prevention Personnel in Participating Hospitals.	Data Collection Form	500	75	15/60	9,375
Total					9,375

Dated: November 27, 2012.

Ron Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012–29173 Filed 12–3–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day-13–13DB]

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 404–639–7570 and send comments to Kimberly S. Lane, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email 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

Emerging Infections Program—New—National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Emerging Infections Programs (EIPs) are population-based centers of excellence established through a network of state health departments collaborating with academic institutions; local health departments; public health and clinical laboratories; infection control professionals; and healthcare providers. EIPs assist in local, state, and national efforts to prevent, control, and monitor the public health impact of infectious diseases. Various parts of the EIP have received separate Office of Management and Budget (OMB) clearances (Active Bacterial Core Surveillance [ABCs]—OMB number 0920–0802 and All Age Influenza Hospitalization Surveillance—OMB number 0920–0852); however this request seeks to have these core EIP activities under one clearance.

Activities of the EIPs fall into the following general categories: (1) Active surveillance; (2) applied public health epidemiologic and laboratory activities; (3) implementation and evaluation of pilot prevention/intervention projects; and (4) flexible response to public health emergencies. Activities of the