conducted quality improvement projects and had relevant data for completion of evidence reviews. Phase 2 (September 2007–November 2008) and Phase 3 (December 2008–September 2009), involved further methods development and pilot tests to obtain, review, and evaluate published and unpublished evidence for practices associated with the topics of patient specimen identification, communicating critical value test results, and blood culture contamination. Exploratory work by CDC supports the existence of relevant unpublished studies or completed quality improvement projects related to laboratory medicine practices from healthcare organizations. The objective for successive LMBP evidence reviews of practice effectiveness is to supplement the published evidence with unpublished evidence to fill in gaps in the literature. Healthcare organizations and facilities (laboratory, hospital, clinic) will have the opportunity to voluntarily enroll in an LMBP registrant network and submit readily available unpublished studies; quality improvement projects, evaluations, assessments, and other analyses relying on unlinked, anonymous data using the LMBP Submission Form. LMBP registrants will also be able to submit unpublished studies/data for evidence reviews on an annual basis using this form. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hrs)	Total burden (in hours) *
Healthcare Organizations	150	1	40/60	100
Total				100

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. 2012–29176 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-13–0849]

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 a 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 information technology. Written comments should be received within 60 days of this notice.

Proposed Project

School Dismissal Monitoring System (OMB Control No. 0920–0849 Exp. 5/31/2013)—Revision—National Center Emerging and Zoonotic Infectious Diseases (NCEZID), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In the spring of 2009, the beginning of H1N1 influenza pandemic, illness among school-aged students (K–12) in many states and cities resulted in at least 1,351 school dismissals due to rapidly increasing absenteeism among students or staff. These dismissals impacted at least 824,966 students and 53,217 teachers. During that time, the U.S. Department of Education (ED) and the Centers for Disease Control and Prevention (CDC) received numerous daily requests about the overall number of school dismissals nationwide and the number of students and teachers impacted by the school dismissals. CDC and ED recognized the importance of having a mechanism in place to collect this information and gauge the impact of school dismissals during the pandemic. Although an informal process was put in place in conjunction with ED to track school closures, there was no formal monitoring system established. Consequently, CDC and ED launched the School Dismissal Monitoring System to track reports of school closures during public health emergencies and generate accurate, real-time, national summary data daily on the number of closed schools and the number of students and teachers impacted by the dismissals. The system, initially approved under OMB Control No. 0920–0008, Emergency Epidemic Investigations, facilitated CDC's and ED's efforts to track implementation of CDC pandemic guidance, characterized factors associated with differences in morbidity and mortality due to pandemic influenza in the schools and surrounding communities, and described the characteristics of the schools experiencing outbreaks as well as control measures undertaken by those schools. In the fall of 2009, CDC's School Dismissal Monitoring System detected 1,947 school dismissals impacting approximately 623,616 students and 40,521 teachers nationwide. These data were used widely throughout the U.S. Government for situational awareness and specifically at CDC to assess the impact of CDC guidance and community mitigation efforts in response to the 2009 H1N1 influenza pandemic.

The purpose of this monitoring system is to generate accurate, real-time, national summary data daily on the number of school dismissals and the number of students and teachers impacted by the dismissals due to public health emergencies. This collection request includes dismissals initiated for infectious disease outbreaks or weather related events when school dismissals are recommended by federal, state or local public health authorities.

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.

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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,