time. The total estimated annualized burden is 208 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
School, school district, or health department.	School Dismissal Monitoring System Reporting Form.	2500	1	5/60

Dated: March 21, 2013.

Ron Otten,

Director, 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

[60Day–13–0912]

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 or send written 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

Frame development for the long-term care component of the National Health Care Surveys (OMB No. 0920–0912, expired 1/31/2013)—Reinstatement without change—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Section 306 of the Public Health Service (PHS) Act (42 U.S.C. 242k), as amended, authorizes that the Secretary of Health and Human Services (DHHS), acting through NCHS, ''shall collect statistics on health resources * * * [and] utilization of health care, including extended care facilities, and other institutions.''

NCHS seeks approval to collect data needed to develop up-to-date sampling frames of residential care facilities. The sampling frames will be used to draw nationally representative samples for two waves of the National Study of Long-Term Care Providers (NSLTCP). The frame-related data will be collected from representatives in state regulatory agencies in the 50 states and the District of Columbia primarily via telephone calls, emails, and in a few cases, via formal written requests. The frame information was first collected in 2012 (OMB No. 0920–0912, expired 1/31/2013). The data to be collected from these state officials include (1) confirming that we have identified the appropriate licensure categories of residential care facilities within each state that meet the NSLTCP definition and (2) for each relevant licensure category, requesting an electronic file of the licensed residential care facilities for which the agency is responsible if such files with the needed variables are not downloadable from the state's Web site.

The NSLTCP study definition of a residential care facility is one that is licensed, registered, listed, certified, or otherwise regulated by the state to provide room and board with at least two meals a day, provide around-the-clock on-site supervision, and help with activities of daily living (*e.g.,* bathing, eating, or dressing) or health related services, such as medication supervision; serves primarily an adult population; and has at least four licensed, certified, or regulated beds. Facilities licensed to serve the mentally ill or the intellectually disabled/developmentally disabled populations exclusively are excluded. Nursing homes and skilled nursing facilities are also excluded, unless they have a unit or wing meeting the above definition and residents can be separately enumerated.

The electronic files we seek to obtain from the states should include the name, address, phone number, and Web site (if available) of the residential care facility; name, phone number, and email address (if available) of facility director; licensure category; chain affiliation; ownership type; and bed size. Data on individual facilities are confidential and a public-use file will not be produced.

Expected users of the findings from the frame data include, but are not limited to CDC's NCHS and its contractors; other Department of Health and Human Services (DHHS) agencies, such as the Office of the Assistant Secretary for Planning and Evaluation and the Agency for Healthcare Research and Quality; associations, such as Leading Age (formerly the American Association of Homes and Services for the Aging), National Center for Assisted Living, American Seniors Housing Association, and Assisted Living Federation of America; universities; foundations; and other private sector organizations.

Burden is estimated at approximately 2.5 hours per state each time the frame will be developed, including time to verify contact information, to respond to a semi-structured telephone protocol, and to develop the facility listing in an electronic format. Three year clearance is requested to cover two collections of frame information. The burden for the two collections is shown in Table 1 below. There is no cost to respondents other than their time to participate.

TABLE 1—ESTIMATED ANNUALIZED BURDEN TABLE

Type of respondent	Form name	Number of respondents	Number of responses/ respondent	Average burden/ response (in hours)	Response burden (in hours)
State Government Representatives ..	Contact info verification	34	1	5/60	3
State Government Representatives ..	Telephone protocol	34	1	30/60	17
State Government Representatives ..	Electronic file development	34	1	2	68
Total	.....	.....	.....	.....	88

Dated: March 21, 2013.

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

[60Day–13–0307]

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 or 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

The Gonococcal Isolate Surveillance Project (GISP), OMB No. 0920–0307 exp. 12/31/2013—Revision—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The purpose of this request is to obtain Office of Budget and Management (OMB) approval to revise the data collection for the Gonococcal Isolate Surveillance Project (GISP) (OMB No. 0920–0307, expires 12/31/2013). CDC seeks a three-year approval to conduct the GISP project. Revisions to this ICR consist of removing 4 variables from the approved Form 1: Demographic and Clinical Data. The variables to be removed have not proven useful in the past and will not increase or decrease the burden. The objectives of GISP are: (1) To monitor trends in antimicrobial susceptibility of strains of *Neisseria gonorrhoeae* in the United States and (2) to characterize resistant isolates. Surveillance of *N. gonorrhoeae* antimicrobial resistance is important because: (1) Nearly all gonococcal infections are treated empirically and susceptibility testing data is not routinely available in clinical practice; (2) *N. gonorrhoeae* has consistently demonstrated the ability to develop resistance to the antimicrobials used for treatment; (3) effective treatment of gonorrhea is a critical component of gonorrhea control and prevention; and (4) untreated or inadequately treated gonorrhea can cause serious reproductive health complications. GISP is the only source in the United States of critical national, regional, and site-specific gonococcal antimicrobial resistance data. GISP provides information to support informed and scientifically-based treatment recommendations.

GISP was established in 1986 as a voluntary surveillance project and now involves 5 regional laboratories and 30 publicly funded sexually transmitted disease (STD) clinics around the country. The STD clinics submit up to 25 gonococcal specimens (or isolates) per month to the regional laboratories, which measure susceptibility of the isolates to multiple antibiotics. Limited demographic and clinical information corresponding to the isolates (and that do not allow identification of the patient) are submitted directly by the clinics to CDC.

During 1986–2012, GISP has demonstrated the ability to effectively achieve its objectives. The emergence of resistance in the United States to penicillin, tetracyclines, and fluoroquinolones among *N. gonorrhoeae* isolates was identified through GISP. Increased prevalence of fluoroquinolone-resistant *N. gonorrhoeae* (QRNG), as documented by GISP data, prompted CDC to update treatment recommendations for gonorrhea in CDC's Sexually Transmitted Diseases Treatment Guidelines, 2006 and to release an MMWR article stating that CDC no longer recommended fluoroquinolones for treatment of gonococcal infections. Recently, GISP isolates demonstrated increasing minimum inhibitory concentrations of cefixime, which can be an early warning of impending resistance. This worrisome trend prompted CDC to again update treatment recommendations and no longer recommend the use of cefixime as first-line treatment for gonococcal infections.

Under the GISP protocol, each of the 30 clinics submit an average of 20 isolates per clinic per month (i.e., 240 times per year) recorded on Form 1: Demographic/Clinical Data. The estimated time for clinical personnel to abstract data for Form 1: Demographic/ Clinical Data is 11 minutes per response.

Each of the five Regional laboratories receives and processes approximately 20 isolates from each referring clinic per month (i.e., 121 isolates per regional laboratory per month [based on 2011 specimen volume]) using Form 2: Antimicrobial Susceptibility Testing.