NASUA [National Association of State Units on Aging] and the NAAAA [National Association of Area Agencies on Aging]. The transmittal must be approved by OMB prior to final issuance. If the AoA's authorizing legislation is amended or GPRA [Government Performance and Review Act] performance measures are formalized, AoA will meet with OMB immediately to discuss appropriate amendments to the SPR. As a result of these discussions, OMB may request that an amended SPR be resubmitted for OMB review pursuant to the Paperwork Reduction Act. In addition, in the next submission for OMB review, the AoA will continue to evaluate the appropriateness of performance measurement and accountability reporting for each of its services, as well as the statistical validity and reliability of these data; and, to enhance cross cutting research within HHS, AoA ensures that its uniform ADL/IADL [activities of daily living/instrumental activities of daily living] definitions for FY 1997 can be cross walked with the definitions in the Public Health Service's National Health Interview Survey.''

The Administration on Aging has complied with the request that it be flexible in granting extensions of the deadline when requested and continues to do so. This submission includes an analysis of state compliance with the November 30, 1996 deadline but is actually based upon the FY 1997 requirements because that was the first fiscal year that compliance with the full set of items in the current collection instrument was requested by the AoA. The AoA's authorizing legislation has not been amended. The information collected through this effort is needed to meet the baseline performance measures identified in the AoA GPRA Performance Plan. Also, AoA is developing in conjunction with state and area agencies on aging a core set of outcome measures which may be voluntarily adopted by the network.

For copies of the reporting requirements and/or a copy of the analysis of states' compliance with the November 30, 1996 deadline call the Administration on Aging, Office of State and Community Programs at (202) 619–0011. Written comments and recommendations for the proposed information collection requirements should be sent, within thirty days of the publication of this notice, to the following address: Office of Information and Regulatory Affairs, Attention: Allison Eydt, OMB Desk Officer, Office of Management and Budget, Washington, DC 20503.

Dated: June 23, 1999.

Jeanette C. Takamura,

Assistant Secretary for Aging.

[FR Doc. 99–16790 Filed 6–30–99; 8:45 am]

BILLING CODE 4150–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control And Prevention

[INFO–99–23]

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, the Centers for Disease Control and Prevention (CDC) is providing opportunity for public comment on proposed data collection projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call the CDC Reports Clearance Officer on (404) 639–7090.

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 the use of automated collection techniques for other forms of information technology. Send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS–D24, Atlanta, GA 30333. Written comments should be received with 60 days of this notice.

Proposed Project

1. National Hospital Discharge Survey—(0920–0212)—Extension—National Center for Health Statistics (NCHS)

The National Hospital Discharge Survey (NHDS), which has been conducted continuously by the National Center for Health Statistics, CDC, since 1965, is the principal source of data on inpatient utilization of short-stay, non-Federal hospitals and is the only annual source of nationally representative estimates on the characteristics of discharges, the lengths of stay, diagnoses, surgical and non-surgical procedures, and the patterns of use of care in hospitals in various regions of the country. It is the benchmark against which special programmatic data sources are compared. Data collected through the NHDS are essential for evaluating health status of the population, for the planning of programs and policy to elevate the health status of the Nation, for studying morbidity trends, and for research activities in the health field. NHDS data have been used extensively in the production of goals for the Year 2000 Health Objectives and the subsequent monitoring of these goals. In addition, NHDS data provide annual updates for numerous tables in the Congressionally-mandated NCHS report, Health, United States. Data for the NHDS are collected annually on approximately 300,000 discharges from a nationally representative sample of noninstitutional hospitals, exclusive of Federal, military and Veterans' Administration hospitals. The data items collected are the basic core of variables contained in the Uniform Hospital Discharge Data Set (UHDDS). Data for approximately fifty-five percent of the responding hospitals are abstracted from medical records while the remainder of the hospitals supply data through commercial abstract service organizations, state data systems, in-house tapes or printouts. There is no actual cost to respondents since hospital staff who actively participate in the data collection effort are compensated by the government for their time.

Respondents (hospitals)	Number of respondents	Number of responses/respondent	Avg. rurden/response (in hrs)	Total burden (in hrs)
Medical Record Abstracts:				
Primary Procedure Hospitals	73	250	.08333	1,521
Alternate Procedure Hospitals	189	250	.01667	788
In-House Tape or Printout Hospitals	37	12	.18333	81

Respondents (hospitals)	Number of respondents	Number of responses/respondent	Avg. rurden/response (in hrs)	Total burden (in hrs)
Update Form (Abstract Service Hospitals)	175	2	.03333	12
Quality Control Forms	50	40	.01667	33
Induction Forms	15	1	2	30
Total				2,465

Nancy Cheal,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention (CDC).

[FR Doc. 99–16751 Filed 6–30–99; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 99149]

Changing Antimicrobial Prescribing To Reduce Antimicrobial Resistance in Hospitalized Patients; Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1999 funds for a cooperative agreement program for Changing Antimicrobial Prescribing to Reduce Antimicrobial Resistance in Hospitalized Patients. This program addresses the ''Healthy People 2000'' priority area(s) of Immunization and Infectious Diseases.

The impact of antimicrobial resistant infections on patients is considered to be substantial, and the societal cost to the United States (U.S.) has been estimated to be as high as $4 Billion each year. Hospitalized patients are at greatest risk of acquiring these resistant infections. An increasing number of hospitals and other healthcare facilities are reporting the presence of antimicrobial resistant bacteria each year. The knowledge that a defined program to change antimicrobial prescribing activity will reduce the incidence of these infections will benefit all U.S. hospitals in their battle against antimicrobial resistant infections. The proposed study in this program announcement will impart such knowledge to the infection control and hospital community.

The purpose of the program is to assist U.S. healthcare institutions and public health agencies in evaluating the impact of changes in antimicrobial prescribing on the incidence of antimicrobial resistance and other health outcomes among hospitalized patients. Recipients of this award will form a collaborative network of researchers, using similar methodology to allow aggregation of surveillance data from all sites into a multi-site study. The change in antimicrobial prescribing would be considered a part of routine medical practice for the selected patient population groups. Evaluating the impact of routine cycling of available select antimicrobial agents for empiric therapy is the top priority for this collaborative network. Results of this multi-site study will provide other U.S. hospitals with guidance to implement programs to reduce antimicrobial resistance at their institutions. The objective of this program is to measure (see recipient activities) the change in incidence and prevalence of patient colonization and infection with select antimicrobial resistant bacteria of epidemiologic concern in the following scenario:

1. During a time of altered antimicrobial prescription activity (specifically the routine cycling of available antimicrobial agents).

2. In a (1) medical intensive care unit and (2) other target patient population group(s) (e.g., trauma intensive care unit, transplant patients, diabetic patients, etc.).

B. Eligible Applicants

Applications may be submitted by public and private nonprofit organizations and by governments and their agencies; that is, universities, colleges, research institutions, hospitals, other public and private nonprofit or for-profit organizations participating in the healthcare delivery to patients in hospitals. These hospitals must fulfill the following criteria and provide appropriate documentation (see application instructions) in the application:

1. Have >250 licenced beds.

2. Have a medical intensive care unit in which a limited number (i.e., 1–4) of attending physicians have ultimate responsibility for patient care in that intensive care unit during a typical month (*i.e.,* a closed unit).

3. Have ongoing surveillance in the medical intensive care unit of two types: (1) nosocomial infections and (2) rectal (or stool) surveillance cultures, on admission or at some standard period, for some antimicrobial resistant bacteria.

4. Have access to a clinical microbiology laboratory which can demonstrate proficiency at:

a. Identifying extended-spectrum ''β-lactamase producing enterobactericea.

b. Maintain viable frozen specimens from surveillance samples.

Note: Public Law 104–65 states that an organization described in section 501(c)(4) of the Internal Revenue Code of 1986 that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, cooperative agreement, contract, loan, or any other form.

C. Availability of Funds

Approximately $200,000 is available in FY 1999 to fund approximately 3 awards. It is expected that the average award will be $80,000, ranging from $60,000 to $100,000. It is expected that the awards will begin on or about September 30, 1999 and will be made for a 12-month budget period within a project period of up to 3 years. The funding estimate may change.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds.

Funding Preferences

To achieve appropriate geographic representation of the study network, funding preference may be given to approved applications that would enhance the geographic diversity of the network (e.g., network ideally comprised of sites from different cities or states).

D. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under 1. (Recipient Activities), and CDC will be responsible for the activities listed under 2. (CDC Activities).

1. Recipient Activities

a. Develop consensus among appropriate patient-care, pharmacy and infection control personnel towards