Information Infrastructure and the 21st Century Vision on Health Statistics, as well as other activities as necessary.

Notice: This conference call is open to the public using the participants' dial-in telephone number and participants' code, but access may be limited by the number of available telephone lines.

Contact Person for More Information: Substantive program information as well as summaries of meetings and a roster of committee members may be obtained from Marjorie S. Greenberg, Executive Secretary, NCVHS, National Center for Health Statistics, Centers for Disease Control and Prevention, Room 1100, Presidential Building, 6525 Belcrest Road, Hyattsville, Maryland 20782, telephone (301) 458–4245. Information also is available on the NCVHS home page of the HHS website: //www.ncvhs.hhs.gov/, where further information will be posted when available.

Dated: April 19, 2000.

James Scanlon,

Director, Division of Data Policy, Office of the Assistant Secretary for Planning and Evaluation.

[FR Doc. 00–10277 Filed 4–24–00; 8:45 am]

BILLING CODE 4151–05–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control And Prevention

[60 Day–00–34]

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 an 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/ATSDR Reports Clearance Officer at (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 through the use of automated collection techniques for other forms of information technology. Send comments to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS–D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Projects

1. Know Your Status Media Campaign Evaluation

New—The Centers for Disease and Prevention's (CDC) National Center for HIV, STD, and TB Prevention (NCHSTP) proposes a media campaign to promote knowledge of HIV status, using marketing clusters to target media messages. The purpose of this campaign is to increase the number of HIV positive people who are aware of their status and are receiving appropriate medical treatment. It is believed that knowledge of infection will reduce risk behavior and medical treatment will reduce infectiousness. CDC will conduct an evaluation of this campaign which will examine 2 target clusters and 4 control clusters in about 4 cities selected for intervention. Data will be collected via 4 types of surveys: (1) Telephone surveys; (2) street intercept surveys; (3) Hotline surveys; and (4) counseling and testing site surveys. Assuming a sample size of 500 for each cluster and 2 rounds of data collection (baseline and post intervention) for the telephone survey, and sample sizes of 167 for each cluster in the street intercepts, plus the first 1,000 surveyed callers and counseling and testing site clients in each city, the totals are as below.

Telephone Survey: 20,000 respondents (members of marketing clusters in intervention cities) will be surveyed by telephone in 2 rounds (baseline and post intervention, 10,000 each). It will take approximately 15 minutes to complete the survey for a total burden of 5,000 hours. Because this survey will be conducted to home telephone numbers, there will be no cost burden to the respondents.

Street Survey: 4,000 respondents (members of marketing clusters in intervention cities) will be surveyed in street intercepts in 2 rounds (baseline and post intervention, 2,000 each). It will take approximately 15 minutes to complete the survey for a total burden of 1,000 hours. There will be no cost burden to the respondents.

Hotline Additional Questions: HIV Hotlines serving intervention cities will be asked to add questions to their existing quality control surveys. This will add up to 3 minutes to the existing surveys for a total burden of 200 hours. There will be no additional cost to the respondents.

Counseling and Testing Site Survey: HIV Testing and Counseling Sites in intervention cities will be asked to add questions to their existing data collection on persons seeking HIV counseling and testing. This will add up to 5 minutes to completing the intake data for a total burden of 333 hours. There will be no additional cost to the respondents.

This evaluation will determine the success of the media elements of the campaign, provide information for improving the campaign when it is spread to additional sites, and determine the usefulness of targeting media campaigns by market clusters.

The total cost of this evaluation to the Federal government will be $400,000 for the surveys. The total burden hours are expected to be 6533 hours. Total cost to respondents is $0.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total response burden (in hours)
Telephone Survey	20,000	1	15/60	5,000
Street Survey	4,000	1	15/60	1,000
Hotline Additional Questions	4,000	1	3/60	200
Counseling and Testing Site Survey	4,000	1	5/60	333.3
Total	32,000	.....	.....	6,533

2. Prevention of HIV Infection in Youth at Risk: Developing Community-Level Intervention Strategies That Work

New—The National Center for HIV, STD and TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC) proposes to amend the previously approved OMB clearance package no. 0920–0441, Prevention of HIV Infection in Youth at Risk: Developing Community-Level Intervention Strategies that Work. This package received a 3-year clearance for data collection. The purpose of this survey is to evaluate the effectiveness of an intervention to reduce risk behaviors associated with HIV infection or transmission among young men of various racial/ethnic groups. Across 12 cities, data is collected in the intervention and comparison areas and will be used to assess risk behaviors associated with HIV acquisition and transmission, determinants of those behaviors, and to monitor awareness, contact, and participation in the intervention. It is hoped that this intervention study will result in lowering HIV risk behaviors among young men in the target audiences, and strengthening HIV prevention programs in these local communities. The population being surveyed is young men between the ages of 15 and 25 who report practicing behaviors that put them at high risk for acquiring HIV. Across the 12 cities participating in this study, the target audiences include African-American, Asian and Pacific Islander, Hispanic or Latino, and white young men. A survey will also be administered to Community Health Advisors who provided peer outreach to the target communities.

At the time of the original submission, process forms to monitor the intervention were being developed by the study investigators. During the development of the process measures for the project, it was determined that a form would be developed to monitor the activities and attitudes (e.g., increase in self-efficacy, collective efficacy, and group cohesion) of Community Health Advisors providing peer outreach to the intervention communities. The study hypothesizes that these factors may influence the relative impact of the intervention. This submission is to amend the currently approved package to include a survey to monitor peer outreach activities.

In order to evaluate the effectiveness of the interventions, questionnaire data will be collected in intervention and comparison areas before the start of the intervention, and at the end of the study (3 years later). In addition, data will be collected at two periods during the intervention in order to monitor awareness of the intervention among the target population. Data will be collected from Community Health Advisors every quarter (90 days) in order to monitor the peer outreach component of the intervention. There are no costs to respondents for participation in the questionnaire or the survey other than the time it takes them to participate.

The burden for this collection is estimated to be approximately 30 minutes for the survey conducted before and at the end of the intervention, 30 minutes for the survey to monitor contact with the intervention, and 10 minutes for the survey conducted with Community Health Advisors. These estimates include the time needed to determine if the respondent is eligible to be interviewed, obtain informed consent, and administer the interview. Total cost to respondents is $0.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total response burden (in hours)
Young Men aged 15–25 surveyed before or at end of intervention	6,000	1	30/60	3,000
Young Men aged 15–25 surveyed during the intervention	6,000	1	30/60	3,000
Community Health Advisors who conduct peer outreach/surveyed during the intervention	360	8	10/60	480
Total	12,360			6,480

3. Geo-Analysis of HIV Prevention Services Provided by CDC Directly and Indirectly Funded Community-Based Organizations (CBOs)

New—The Centers for Disease Control and Prevention's (CDC), National Center for HIV, STD, and TB Prevention (NCHSTP), Division of HIV/AIDS Prevention (DHAP) proposes an evaluation project which will build on the knowledge gained from the previous studies to provide a multi-level, geo-referenced review of CDC-funded, community-based organization (CBO)-provided HIV prevention services. The purposes of this project are: (1) To contribute to the construction of a national database of HIV prevention activities by developing a geo-coded database that identifies, locates and maps all CBOs directly and indirectly funded by CDC in the US and its territories, and (2) to evaluate the comprehensiveness of HIV prevention services in geographic areas across the United States of America and territories through the use of Geographic Information Systems (GIS) technology as the primary analytical tool.

This project is being tasked under the Enhanced Program Assessments with Laboratory Capability Task Order Contract (200–96–0511) because of its program evaluation component. By using GIS to identify gaps in service provision within a given geographic area, program changes can be recommended to those health departments and CBOs participating in the project. These recommended changes may include adjusting services provided or target populations in an effort to close identified gaps.

Collaboration between government agencies and CBOs with access to a particular group at risk has been a traditional approach in public health in the United States. CDC promotes the collaboration and coordination of HIV prevention efforts between CBOs and of CBOs with State health departments, affiliates of National and Regional Minority Organizations (NRMOs), HIV prevention service agencies, and other public agencies including substance abuse programs, educational institutions and the criminal justice system. CDC promotes collaboration as a strategy for: (1) Improving access to and for at risk populations and communities; (2) improving the direct delivery of services; (3) improving referral of clients to services; and (4) creating comprehensive HIV services in designated geographical jurisdictions.

The use of GIS will enhance the accomplishment of these three goals by providing information to funders and other shareholders to enhance CBOs in their efforts to provide interventions and client referrals and services that are accessible to the populations in need of

them. This data will assist the CDC to determine the effectiveness of federal funding, whether the funding is affecting the designated high risk or infected groups such as disproportionately affected minorities where they live, or whether or not there are available programs to link with for more comprehensive services.

The project will use appropriate technology to minimize respondent burden. A self-report mailed questionnaire, three pages in length, will be mailed. Attached, will be two maps of the geographical area (city and surrounding metropolitan area) where each CBO is located. The use of maps eliminates the need to locate maps to respond to questions concerning location and distance. This project will not be requesting information of a sensitive nature. The project deals with the types of interventions offered to high risk or HIV positive individuals, location and access.

The CDC anticipates one person per CBO (total # of approximately 2000) to complete the data collection form once during the 2000 for approximately 30 minutes. Therefore, the total response burden is estimated at 1,000 hours (2000 × .5 × 1). The total cost to respondents is estimated at $17,000 assuming a working wage for assigned CBO personnel of $17.00 per hour. There are no costs to respondents for participation in the study other than the time (.5 hours) it takes to complete the questionnaire. The total cost to respondents $0.

Respondents	Number of respondents	Number of responses	Average hour burden per response	Total response burden
GIS Questionnaire for Directly and Indirectly Funded CBOs	2000	1	30/60	1000
Total	2000			1000

4. Supplement to HIV/AIDS Surveillance (SHAS) Project

Revision—The Centers for Disease Control and Prevention (CDC) is proposing revisions to the currently approved questionnaire for the Supplement to HIV/AIDS Surveillance (SHAS) project (OMB No. 0920–0262). This questionnaire provides detailed information about persons with HIV infection which continues to be of significant interest to public health, community, minority groups and affected groups. Since 1989, the CDC, in collaboration with 12 State and local health agencies, has collected data through the national Supplemental HIV/AIDS Surveillance project. The objective of this project is to obtain increased descriptive information on persons with newly reported HIV and AIDS infections, including sociodemographic characteristics, risk behaviors, use of health care services, sexual and substance abuse behaviors, minority issues and adherence to therapy. The revised questionnaire will address important emerging surveillance and prevention issues, particularly those related to the recent advances in therapy for HIV infection. This information supplements routine national HIV/AIDS surveillance and is used to improve CDC's understanding of minority issues related to the epidemic of HIV, target educational efforts to prevent transmission, and improve services for persons with HIV infection.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (hours)
Georgia	292	1	.75	219
California	301	1	.75	226
Michigan	82	1	.75	62
New Mexico	81	1	.75	61
Arizona	165	1	.75	124
Colorado	139	1	.75	104
Connecticut	229	1	.75	172
Delaware	43	1	.75	32
Florida	430	1	.75	323
South Carolina	270	1	.75	203
New Jersey	86	1	.75	65
Washington	160	1	.75	120
Total	2,278	1	.75	1,709

5. Message-Based Intervention for Technology Transfer

New—The mission of the National Institute for Occupational Safety and Health (NIOSH) is to promote safety and health at work for all people through research and prevention. Over 6 million American workers are at risk for inhalation exposure of potentially harmful metals. Workers in mining, construction, and related industries are potentially exposed to airborne contaminants such as silver, lead, nickel, manganese, chromium and zinc which can cause health problems ranging from metal fume fever and asthma to cancer and parkinsonism. NIOSH has developed analytical methods for portable field exposure assessment that would help reduce metals exposure. The goal of this project is to increase the self-reported use of NIOSH developed analytical methods for field portable exposure assessment by American industrial hygienists across the five-year period from 2000 to 2004. To achieve this technology transfer goal, NIOSH proposes three aims: (1) To create, (2) implement, and (3) evaluate a message-based intervention targeted toward American industrial hygienists. If this project is successful then NIOSH will also have

developed and validated a communication strategy that could be adapted to other technology transfer problems.

First, NIOSH will develop a message-based intervention targeted toward American industrial hygienists. To do this, NIOSH will create and pretest the message, channel, and receiver variables that will compose the intervention. Pretesting of the intervention will occur via mailout surveys and on-site pretesting with industrial hygienists attending conferences sponsored by AIHA (the American Industrial Hygiene Association), ABIH (the American Board of Industrial Hygiene), and ACGIH. Pretesting will occur during the first two years of the project (2000–1), with a total of 1,000 industrial hygienists.

Second, NIOSH will implement the multi-channel, multi-exposure, message-based intervention that was created through pretesting. NIOSH intends to employ the following four channels of: (1) Trade print sources (journal and magazine); (2) web site; (3) direct personalized mailings; and (4) face-to-face interaction through trade show demonstrations. The entire population of American industrial hygienists (approximately 13,000) will be targeted by this intervention. The intervention will occur across four years, applying modifications as needed during the time period.

Finally, NIOSH will conduct annual surveys of randomly selected samples of American industrial hygienists on their self reported use of NIOSH developed analytical methods for field portable exposure assessment through mail-in surveys based on standard HCRB communication and outcome protocols. During Year 1 (2000), a survey of 700 randomly selected industrial hygienists will be conducted to assess baseline levels of attitudes, knowledge and behaviors with regard to the use of the NIOSH developed analytical methods prior to receiving the intervention. During the next four years (2001–2004), an annual survey of 700 randomly selected industrial hygienists will be conducted to evaluate the impact of the message-based intervention on the use of NIOSH analytical methods (total across all years=2800 respondents).

The total cost to respondents is $64,770.

Respondents	Number of respondents	Number of responses	Average hour burden per response	Total response burden
Industrial Hygienist	1000 pretesting	1	.33	330
	700 Baseline Survey	1	.25	175
	2800 Annual Survey	1	.5	1,400
Total				1,905

Dated: April 18, 2000.

Nancy Cheal,

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

[FR Doc. 00–10237 Filed 4–24–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Healthcare Infection Control Practices Advisory Committee (HICPAC): Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting.

Name: Healthcare Infection Control Practices Advisory Committee (Formerly Hospital Infection Control Practices Advisory Committee).

Times and Dates: 8:30 a.m.–5 p.m., May 22, 2000. 8:30 a.m.–4 p.m., May 23, 2000.

Place: Atlanta Marriott Century Center, 2000 Century Boulevard, NE, Atlanta, Georgia 30345.

Status: Open to the public, limited only by the space available.

Purpose: The Committee is charged with providing advice and guidance to the Secretary, the Assistant Secretary for Health, the Director, CDC, and the Director, National Center for Infectious Diseases (NCID), regarding (1) the practice of hospital infection control; (2) strategies for surveillance, prevention, and control of infections (e.g., nosocomial infections), antimicrobial resistance, and related events in settings where healthcare is provided; and (3) periodic updating guidelines and other policy statements regarding prevention of healthcare associated infections and healthcare-related conditions.

Matters to be Discussed: Agenda items will include a review proposed revisions to the Guideline for Prevention of Intravascular Device-related Infections, the Guideline for Hand Hygiene, and the Recommendations for Preventing the Spread of Vancomycin Resistance in Hospitals; a discussion of strategies for evaluation of HICPAC guidelines; a review of the fourth draft of the Guideline for Environmental Controls in Healthcare Settings, 2001, and the first draft of the Guideline for Prevention of Nosocomial Pneumonia, 2001; and a review of CDC activities of interest to the Committee, including the Institute of Medicine Report on Medical Errors.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Michele L. Pearson, M.D., Medical Epidemiologist, Investigation and Prevention Branch, Hospital Infections Program, NCID, CDC, 1600 Clifton Road, NE, M/S E–69, Atlanta, Georgia 30333, telephone 404/639–6413.

The Director, Management Analysis and Services office has been delegated the authority to sign **FEDERAL REGISTER** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: April 18, 2000.

John Burckhardt,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–10238 Filed 4–24–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Information Collection Items in the Head Start Performance Standards (current rule).

OMB No.: 0970–0148.

Description: The Head Start Performance Standards are regulations which establish standards for Head Start grantee and delegate agencies to follow to administer quality programs as required by law. Local programs are monitored for compliance with these standards. The information collection aspects of the Performance Standards are one part of the many actions that local agencies must take to ensure they administer quality programs. Almost all these information collections items are