SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the OMB control number 4040–0001 and document identifier HHS–EGOV–18380–30D for reference.

Information Collection Request Title: SF–424 Research & Related (R&R).

OMB No.: 4040–0001.

Abstract: The SF–424 Research & Related Information Collection is an information collection comprised of a set of standardized forms used for grant applications to research-based agencies.

Need and Proposed Use of the Information: The SF–424 R&R is used by the public to apply for Federal financial assistance in the forms of grants. These forms are submitted to the Federal grant-making research-based agencies for evaluation and review.

Likely Respondents: Organizations and institutions seeking research-based grants.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions, to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information, to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information, and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

HHS estimates that the SF–424 Research and Related form will take 1 hour to complete.

We expect that 128,378 respondents will use this form.

Once OMB approves the use of this common form, federal agencies may request OMB approval to use this common form without having to publish notices and request public comments for 60 and 30 days. Each agency must account for the burden associated with their use of the common form.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
SF–424 Research and Related Application for Federal Assistance	128,378	1	1	128,378
Total	128,378			128,378

Keith A. Tucker,

Information Collection Clearance Officer.

[FR Doc. 2013–09046 Filed 4–17–13; 8:45 am]

BILLING CODE 4151–AE–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Findings of Misconduct in Science/ Research Misconduct

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: Notice is hereby given that effective on March 14, 2013, a Settlement Agreement was made and entered into by and between Dr. Philippe Bois and the United States Department of Health and Human Services (HHS), Kathleen Sebelius, Howard K. Koh, Nancy Gunderson, and Donald Wright (collectively HHS) by and through the United States Attorney for the District of Columbia in *Bois* v. *HHS, et al.,* Civil Action no. 11-cv-1563, which was pending before the U.S. District Court for the District of Columbia.

In the Settlement Agreement, HHS and Dr. Bois agreed to settle the proceedings before the District Court of the District of Columbia as well as to resolve all administrative matters pending at HHS.

ORI found that Philippe Bois, Ph.D., former postdoctoral fellow, Department of Biochemistry, St. Jude Children's Research Hospital, engaged in research misconduct in research funded by National Institute of General Medical Sciences (NIGMS), National Institutes of Health (NIH), grant R01 GM071596, and National Cancer Institute (NCI), NIH, grants P30 CA021765, P01 CA071907, R01 CA072996, and R01 CA100603.

In the Settlement Agreement, the parties agreed that ORI found by a preponderance of the evidence that the Respondent committed misconduct in science and research misconduct by:

1. Knowingly and intentionally falsely reporting that FOXO1a was not expressed in cell lysates from alveolar rhabdomyosarcoma (ARMS) tumor biopsies, by selecting a specific FOX01a immunoblot to show the desired result, in Figure 1A of the following paper: Bois, P.R., Izeradjene, K., Houghton, P.J., Cleveland, J.L., Houghton, J.A., & Grosveld, C.G. ''FOXO1a acts as a selective tumor suppressor in alveolar rhabdomyosarcoma.'' *J. Cell. Biol.* 170:903–912, September 2005 (''*JCB* 2005'')

2. Falsifying data showing SDS–PAGE for papain digestion of VBS3 and αVBS, by falsely labeling lane 1 to represent papain only digestion, by falsely labeling lane 5 to represent papain digestion of the αVBS peptide, and by falsely inserting a band in lane 3 to represent the αVBS peptide, in Figure 4B of the following paper: Bois, P.R., Borgon, R.A., Vornhein, C., & Izard, T. ''Structural dynamics of α-actinin-vinculin interactions.'' *Mol. Cell. Biol.* 25:6112–6122, July 2005 (''*MCB* 2005'').

The parties further agreed that Dr. Bois denied committing research misconduct and, pursuant to 42 CFR part 93, filed a timely request for a hearing at which to contest ORI's findings. An HHS Administrative Law Judge (ALJ) denied Dr. Bois' request for a hearing. HHS subsequently entered a debarment order against Dr. Bois. Dr. Bois filed the above referenced lawsuit in the United States District Court for the District of Columbia asking the Court to vacate the debarment order and remand the matter for further proceedings before HHS, including but not limited to granting Dr. Bois' request for a hearing.

On March 2, 2012, Judge Berman Jackson of the United States District Court for the District of Columbia issued an order vacating HHS' debarment order, affirming Finding #1, and remanding the matter to HHS for further proceedings regarding Finding #2. On March 30, 2012, HHS filed a Motion for Reconsideration before Judge Berman Jackson.

On March 14, 2013, Dr. Bois and HHS entered into a Settlement Agreement (Agreement) to settle and dismiss the pending civil action. The terms of the

Settlement Agreement include that Dr. Bois denied that he committed research misconduct but he agreed not to further appeal ORI's findings of research misconduct set-forth above. Dr. Bois and HHS further agreed to the following administrative actions beginning on March 14, 2013:

(1) To have his research supervised for a period of three (3) years beginning on the effective date of the Agreement; he agreed that prior to the submission of an application for U.S. Public Health Service (PHS) support for a research project on which his participation is proposed and prior to his participation in any capacity on PHS-supported research, he shall ensure that a plan for supervision of his duties is submitted to ORI for approval; the supervision plan must be designed to ensure the scientific integrity of his research contribution; he agreed that he shall not participate in any PHS-supported research until such a supervision plan is submitted to and approved by ORI, with such review and approval to be conducted promptly by ORI and not unreasonably withheld; he agreed to maintain responsibility for compliance with the agreed upon supervision plan;

(2) that for three (3) years beginning with the effective date of the Agreement, any institution employing him shall submit, in conjunction with each application for PHS funds, or report, manuscript, or abstract involving PHS-supported research in which Dr. Bois is involved, a certification to ORI that the data provided by him are based on actual experiments or are otherwise legitimately derived and that the data, procedures, and methodology are accurately reported in the application, report, manuscript, or abstract; and

(3) to exclude himself voluntarily from serving in any advisory capacity to PHS, including, but not limited to, service on any PHS advisory committee, board, and/or peer review committee, or as a consultant for a period of three years (3) beginning with the effective date of the Agreement.

Dr. Bois further agreed to dismiss his lawsuit with prejudice and to withdraw further proceedings before HHS. Dr. Bois and HHS both agreed to waive or abandon all other claims. This notice supercedes the notice regarding this matter that was previously published in: **Federal Register** 76:111, June 9, 2011.

FOR FURTHER INFORMATION CONTACT: Director, Division of Investigative Oversight, Office of Research Integrity, 1101 Wootton Parkway, Suite 750, Rockville, MD 20852, (240) 453–8800.

David E. Wright,

Director, Office of Research Integrity.

[FR Doc. 2013–09134 Filed 4–17–13; 8:45 am]

BILLING CODE 4150–31–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities; Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: ''Pilot Test of the Proposed Value and Efficiency Surveys and Communicating with Patients Checklist.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on January 7th, 2013 and allowed 60 days for public comment. No comments were received. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by May 20, 2013.

ADDRESSES: Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by email at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk officer).

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by email at *doris.lefkowitz@AHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Pilot Test of the Proposed Value and Efficiency Surveys and Communicating With Patients Checklist

Maximizing value within the American health care system is an important priority. Value is often viewed as a combination of high quality, high efficiency care, and there is general agreement by consumers, policy makers, payers, and providers that it is lacking in the U.S. A recent report by the Institute of Medicine estimated that 20 to 30 percent ($765 billion a year) of U.S. healthcare spending was inefficient and could be reduced without lowering quality.

Multiple overlapping initiatives are currently seeking to improve value using a variety of approaches. Public reporting efforts led by the Centers for Medicare and Medicaid Services (CMS), other payers and consumer groups seek to enable consumers to make more informed choices about the quality, and in some cases, the costs of their care. A variety of demonstration projects and payment reforms initiated by CMS and private insurers are attempting to more closely link care quality with payments to create incentives for higher value care. And national improvement initiatives led by AHRQ (comprehensive unit-based safety programs [CUSP] for central line-associated blood stream infection [CLABSI], catheter-associated urinary tract infections [CUTI], and surgical units [SUSP]) and CMS (hospital engagement networks, QIO scopes of work) are seeking to raise care quality and reduce readmissions. Results from the CUSP–CLABSI project have demonstrated that central line infections can be reduced and unnecessary costs can be avoided across the health care system by concerted, unit-based improvement efforts.

As a systems level example, Denver Health, with initial funding from AHRQ, has taken major steps towards redesigning clinical and administrative processes so as to reduce staff time, patient waiting, and unnecessary costs. These improvements occurred without harm to quality and in some instances actually improved quality.

In many cases, improving quality improves efficiency naturally. Reducing the number of hospital errors, for example, will reduce costs associated with longer length of stay or error-triggered readmissions. It is more cost-effective to do things right the first time. But higher value may be more likely if organizations doing quality improvement link efforts to improve care quality with efforts to reduce unnecessary costs. AHRQ understands that many of the root causes of inefficiencies that drive up costs are closely linked to root causes of inefficiencies that lead to poor quality, uncoordinated care where redundancies and system failures place patients at risk. Enhancing value in healthcare