Attachment 3

Copy of Federal Register Notice

Maryland 20850, *Gloria.Washington@ahrq.hhs.gov*.

Nomination Submissions

Nominations may be submitted in writing or electronically, but must include (1) the applicant's current curriculum vitae and contact information, (2) a letter explaining how this individual meets the qualification requirements and how he/she would contribute to the Task Force. The letter should also attest to the nominee's willingness to serve as a member of the Task Force.

AHRQ will later ask persons under serious consideration for membership to provide detailed information that will permit evaluation of possible significant conflicts of interest. Such information will concern matters such as financial holdings, consultancies, and research grants or contracts.

Nomination Selection

Nominations for the Task Force will be selected on the basis of qualifications as outlined above (see Qualification Requirements) and the current expertise needs of the Task Force.

Arrangement for Public Inspection

Nominations and applications are kept on file at the Center for Primary Care, Prevention and Clinical Partnerships, and are available for review during business hours. AHRQ does not reply to individual responses, but considers all nominations in selecting members. Information regarded as private and personal, such as a nominee's social security number, home and internet addresses, home telephone and fax numbers, or names of family members will not be disclosed to the public. This is in accord with agency confidentiality policies and Department regulations (45 CFR 5.67).

FOR FURTHER INFORMATION CONTACT: Gloria Washington at *Gloria.Washington@ahrq.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Background

Under Title IX of the Public Health Service Act, AHRQ is charged with enhancing the quality, appropriateness, and effectiveness of health care services and access to such services. AHRQ accomplishes these goals through scientific research and promotion of improvements in clinical practice, including prevention of diseases and other health conditions, and improvements in the organization, financing, and delivery of health care services (42 U.S.C. 299–299c–7 as amended by the Healthcare Research and Quality Act of 1999, codified in scattered sections of 42 U.S.C.

The Task Force is an independent expert panel, first established in 1984 under the auspices of the U.S. Public Health Service. Currently, the USPSTF, under AHRQ's authorizing legislation (see in particular, 42 U.S.C. 299b–4(a), is convened at the call of the Director of AHRQ. The Task Force is charged with rigorously evaluating the effectiveness, cost-effectiveness and appropriateness of clinical preventive services and formulating or updating recommendations for primary care clinicians regarding the appropriate provision of preventive services. The USPSTF transitioned to a standing Task Force in 2001. Current Task Force recommendations and associated evidence reviews are available on the Internet (*http://www.preventiveservices.ahrq.gov*).

Dated: March 27, 2007.

Carolyn M. Clancy,

Director.

[FR Doc. 07–1639 Filed 4–3–07; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–07–06BD]

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 404–639–5960 and send comments to Joan Karr, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail 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

Economic Analysis of the National Breast and Cervical Cancer Early Detection Program—New National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC administers the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) that provides critical breast and cervical cancer screening services to underserved women in the United States, the District of Columbia, 4 U.S. territories, and 13 American Indian/Alaska Native organizations. The program provides breast and cervical cancer screening for eligible women who participate in the program as well as diagnostic procedures for women who have abnormal findings. For the past decade, the NBCCEDP has provided over 5 million breast and cervical cancer screening and diagnostic exams to almost 2.1 million low-income women. Women diagnosed with cancer through the program are eligible for Medicaid coverage through the Breast and Cervical Cancer Prevention and Treatment Act passed by Congress in 2000.

The NBCCEDP is the largest organized cancer screening program in the United States but to date there has been no systematic analysis of the economic costs incurred by the program. CDC is proposing to collect one year (period covering 07/01/2005–06/30/2006) of cost data from all the 68 NBCCEDP grantees to assess the cost and cost-effectiveness of the program. The information required to perform an activity-based cost analysis includes: staff and consultant salaries, screening costs, contracts and material costs, provider payments, in-kind contributions, administrative costs, allocation of funds and staff time devoted to specific program activities. CDC has developed and tested a draft questionnaire with 9 NBCCEDP grantees to assess the ability of the grantees to provide the cost data elements requested, identify the cost information required, and to complete the questionnaire within the allocated timeframe. The grantees were able to

complete the questionnaire with the instructions provided.

The activity-based cost data provided by the 68 grantees will be used to evaluate the programs to ensure the most appropriate use of limited program resources. Performing an assessment of the resources expended on NBCCEDP will provide valuable information to the CDC and it partners for improving program efficiency within the various components of the NBCCEDP including screening, case management, outreach, and overall management. The detailed cost data will allow CDC to assess the costs of the various program components, identify factors that impact average cost, perform cost-effectiveness analysis and develop a resource allocation tool. The collection and analysis of the cost data will allow CDC to utilize a more systematic process to allocate program resources based on grantees' past performance, level of efficiency, and future needs.

Since information on screening and diagnosis volumes (the effectiveness measures) are already collected as part of the Minimum Data Elements (MDEs), the additional burden on grantees to provide the requested cost data will be modest. If future cost data collection efforts are undertaken, the response burden would be further reduced because the infrastructure established to capture the data is already in place.

There are no costs to respondents except their time to participate in the survey.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours
Program Director	Cost Assessment Tool	68	1	4	272
Business Manager		68	1	4	272
Data Manager		68	1	14	952
Total					1,496

Dated: March 28, 2007.

Joan F. Karr,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E7–6275 Filed 4–3–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–07–06AY]

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 404–639–5960 and send comments to Joan Karr, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

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Proposed Project

Evaluation of the Spanish-Language Campaign "Good Morning Arthritis, Today you will not defeat us."—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Arthritis affects nearly 43 million Americans, or about one in every six people, and is the leading cause of disability among adults in the United States. Because of the broad public health impact of this disease, the Centers for Disease Control and Prevention (CDC) developed the National Arthritis Action Plan in 1998 as a comprehensive approach to reducing the burden of arthritis in the United States.

As part of its efforts to implement the National Arthritis Action Plan, CDC developed and tested a health communications campaign promoting physical activity among Caucasian and African-American adults with arthritis. In 2003–2004, CDC developed a similar campaign for Spanish-speaking people with arthritis. Hispanic populations have a slightly lower prevalence rate of self-reported, doctor-diagnosed arthritis, but Hispanics with arthritis report greater work limitations, and higher rates of severe pain than do Caucasian populations with arthritis.

The Spanish-language campaign, Good Morning Arthritis, Today you will not defeat us, is designed to reach Spanish speaking adults with arthritis who are aged 45–64, who have high school education or less, and whose annual income is less than $35,000. The key message elements of the Spanish language health communications campaign are similar to its English counterpart, as are the campaign objectives and materials. The campaign objectives are to increase target audience members' (1) Beliefs about physical activity as an arthritis management strategy (there are "things they can do" to make arthritis better, and physical activity is an important part of arthritis management); (2) Knowledge of the benefits of physical activity and appropriate physical activity for people with arthritis; (3) Confidence in their ability to be physically active, and (4) Trial of physical activity behaviors. Based on formative research, campaign materials refer to exercise instead of physical activity. Campaign materials include; print ads, 30- and 60-second radio ads and public service announcements, and desktop displays with brochures for