

Rights, 200 Independence Ave. SW., Room 509F, Washington, DC 20201.

**NOTIFICATION PROCEDURE:**

Contact System Manager (above). Include name and address of complainant, and name of the recipient against which the allegation was filed. The Department is exempting all investigative records from this provision (see below: Records Exempted).

**RECORD ACCESS PROCEDURE:**

Same as notification procedures. Requesters should also reasonably specify the record contents being sought. Requests should be made to the system manager (above). The Department is exempting all investigative records from this provision (see below: Records Exempted).

**CONTESTING RECORD PROCEDURE:**

Contact the official(s) at the address specified under System Manager, and reasonably identify the record and specify the information to be contested and corrective action sought with supporting justification. (These procedures are in accordance with Department Regulations (45 CFR 5b.7) *Federal Register*, October 8, 1975, page 47411.) The Department is exempting all investigative records from this provision (see below: Records Exempted).

**RECORD SOURCE CATEGORIES:**

Information is provided by complainants and covered entities.

**SYSTEM RECORDS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:**

OCR investigative records maintained in PIMS, either as paper records or electronic documents are records compiled for law enforcement purposes are exempt under subsection (k)(2) from the notification, access, correction and amendment provisions of the Privacy Act.

**APPENDIX NUMBER 1—SYSTEM LOCATIONS:**

This system is located at HHS offices in the following cities.  
 Headquarters, PIMS Project Manager, Resource Management Division, Office for Civil Rights, 200 Independence Ave., SW., Room 509F, Washington, DC 20201.  
 Region I, Regional Manager, OCR/HHS, J.F. Kennedy Federal Building—Room 1875 Boston, Massachusetts 02203.  
 Region II, Regional Manager, OCR/HHS, 26 Federal Plaza—Suite 3312, New York, NY 10278.  
 Region III, Regional Manager, OCR/HHS, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106.

Region IV, Regional Manager, OCR/HHS, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW., Atlanta, GA 30303.

Region V, Regional Manager, OCR/HHS, 233 N. Michigan Ave, Suite 240, Chicago, IL 60601.

Region VI, Regional Manager, OCR/HHS, 1301 Young Street, Suite 1169, Dallas, TX 75202.

Region VII, Regional Manager, OCR/HHS, 601 E. 12th Street—Room 248, Kansas City, MO 64106.

Region VIII, Regional Manager, OCR/HHS, Federal Office Building, 1961 Stout Street—Room 1185, Denver, CO 80294.

Region IX, Regional Manager, OCR/HHS, 50 United Nations Plaza—Room 322, San Francisco, CA 94102.

Region X, Regional Manager, OCR/HHS, 2201 Sixth Avenue—Suite 900, Seattle, WA 98121.

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Disease Control and Prevention**

[60Day-07-05CZ]

**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](mailto: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**

Assessing Diabetes Detection Initiative for Policy Decision—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

Type 2 diabetes is a chronic disease that affects more than 18 million Americans, approximately 5 million of whom do not know that they have the disease. As the disease progresses, it often causes severe complications, including heart disease, blindness, lower extremity arterial disease, and kidney failure. American Indians, African Americans, Latino Americans, and some Asian Americans and Pacific Islanders are disproportionately affected by diabetes. Identifying persons who have undiagnosed diabetes and treating them could prevent or delay diabetes complications.

In November 2003 the Diabetes Detection Initiative (DDI) was launched in 10 locations around the U.S. to identify a portion of the estimated 5 million people with undiagnosed Type 2 diabetes, targeting specific areas in each of 10 locales in which residents are likely to be at higher risk for Type 2 diabetes. Implementation of the DDI involved distributing a paper-and-pencil risk test. Individuals whose score indicated that they were at an increased risk for diabetes were advised to see their regular doctor (or to schedule an appointment at one of several clinics that had agreed to participate in the DDI), to receive a finger-stick or other tests to confirm whether or not they have diabetes. Whether or not the DDI should be expanded to other communities depends on the health benefits and costs of the program. The CDC is planning to conduct a study to provide this critical information.

The planned study will assess the resources used, the cost per case detected, and the perceived benefit of the DDI to participants. Data for the economic assessment will be obtained by conducting three separate surveys: (1) A local implementation team survey will be administered to the 10 DDI local implementation leaders to obtain information on resources used by the members of DDI local implementation teams and community based organizations to implement the non-medical service delivery activities for the DDI program; (2) a health clinic

leadership survey will be sent to the clinic directors in each of the 43 clinics that participated in the DDI across the 10 locations to obtain information on the cost of delivering the medical services required in diabetes screening and diagnosis; and (3) a patient survey will be administered to a sample of 600 patients at the 43 participating clinics to obtain information regarding patient out-of-pocket medical and non-medical direct health care costs and the perceived economic benefits of diabetes screening. The results of the study will also provide information needed for conducting a more complete cost-effectiveness analysis of screening for undiagnosed diabetes.

The local implementation team survey will be mailed to the local DDI implementation team leader in each of the 10 regions to collect information regarding the staff time and other

resources used to implement the DDI program (including the staff time and resources used by community-based organizations that participated in the DDI implementation). These planning and implementation activities include participating in meetings and conference calls, recruiting clinics and community-based organizations to participate in the DDI, distributing risk tests, organizing health fairs and other community events, and designing media campaigns to promote the DDI.

The health clinic leadership survey will be mailed to the clinic director at each of the 43 clinics across the 10 locations that participated in the DDI implementation. The survey will collect information regarding the costs associated with the clinic's participation in the DDI. These will include the medical costs of providing care to patients who visited the clinic as a

result of the DDI, staff time associated with DDI planning and implementation, and any staff time that was devoted to performing finger stick tests at locations other than the health clinic (e.g., health fairs, shopping malls, work sites, housing complexes). Of the 43 clinics to be surveyed, we expect that 30 (70%) will complete the survey.

A computer-assisted in-person patient survey will be administered to a sample of 600 clinic patients at the 43 clinics that participated in the DDI. The survey will collect background information, out-of-pocket medical and non-medical direct health care costs (e.g., co-payments, transportation costs, value of patients' time associated with the clinic visit), and preferred features of a diabetes screening program. There are no costs to respondents other than their time.

**ESTIMATED ANNUALIZED BURDEN HOURS**

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Implementation team members .....	10	1	2	20
Clinic staff .....	30	1	1	30
Patients at DDI clinics .....	600	1	20/60	200
<b>Total .....</b>				<b>250</b>

Dated: February 22, 2007.

**Joan F. Karr,**

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

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Disease Control and Prevention**

[60Day-07-07AJ]

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**Proposed Project**

Racial and Ethnic Approaches to Community Health across the U.S. (REACH US) Management Information System (MIS)—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

Racial and Ethnic Approaches to Community Health (REACH) currently funds forty local coalitions to establish community based programs and culturally appropriate interventions to eliminate racial and ethnic health disparities. Communities served by REACH include: African American, American Indian, Hispanic American, Asian American, and Pacific Islander. These communities select among infant mortality, deficits in breast and cervical cancer screening and management, cardiovascular diseases, diabetes, HIV/AIDS, and deficits in childhood and adult immunizations to focus their interventions. Guided by logic models, each community articulates goals, objectives, and related activities; tracks whether goals and objectives are met, ongoing, or revised; and evaluates all program activities. This information will then be entered into the REACH Management Information System (REACH MIS). REACH MIS is a customized internet-based support system that allows REACH grantees to perform remote data entry and retrieval of data. The contract for our current Information Network (REACH IN), OMB