

and in-depth interview participants (total 1000) will complete a brief paper

and pencil survey. The total estimated annual burden hours are 2311.

There are no costs to the respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Individuals (males and females) aged 18–64	Study screener .....	2338	1	2/60
Individuals (males and females) aged 18–64	In-Depth Interview Guide .....	500	1	1
Individuals (males and females) aged 18–64	Focus Group Guide .....	500	1	2
Individuals (males and females) aged 18–64	Paper and Pencil Survey .....	1000	1	30/60
Individuals (males and females) aged 18–64	Intercept Interview Guide .....	700	1	20/60

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*Deputy Director, Office of Science Integrity,  
 Office of the Associate Director for Science,  
 Office of the Director, Centers for Disease  
 Control and Prevention.*  
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**DEPARTMENT OF HEALTH AND  
 HUMAN SERVICES**

**Centers for Disease Control and  
 Prevention**

[60Day–12–12QR]

**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 404–639–7570 and send comments to Kimberly S. Lane, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email 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**

Monitoring And Reporting System For DELTA FOCUS Awardees—New—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

Intimate Partner Violence (IPV) is a serious, preventable public health problem that affects millions of Americans and results in serious consequences for victims, families, and communities. IPV occurs between two people in a close relationship. The term “intimate partner” describes physical, sexual, or psychological harm by a current or former partner or spouse. IPV can impact health in many ways, including long-term health problems, emotional impacts, and links to negative health behaviors. IPV exists along a continuum from a single episode of violence to ongoing battering; many victims do not report IPV to police, friends, or family.

Research indicates that on average, 24 people per minute are victims of rape, physical violence, or stalking by an intimate partner in the United States. Over the course of one year, more than 12 million women and men reported being a victim of rape, physical violence, or stalking by an intimate partner. Also, on average nearly three women are murdered each day by an intimate partner. In 2007, IPV resulted in more than 2,300 deaths. Of these deaths, 30 percent were men and 70 percent were women. The medical care, mental health services, and lost productivity (e.g., time away from work) cost of IPV is estimated at \$8.3 billion per year.

The objective of primary prevention is to stop IPV before it occurs. In 2002, authorized by the Family Violence Prevention Services Act (FVPSA), CDC developed the Domestic Violence Prevention Enhancements and

Leadership Through Alliances (DELTA) Program, with a focus on the primary prevention of IPV. The CDC funded DELTA Program provides funding to state domestic violence coalitions (SDVCs) to engage in statewide primary prevention efforts and to provide training, technical assistance, and financial support to local communities for local primary prevention efforts. DELTA FOCUS (Domestic Violence Prevention Enhancement and Leadership Through Alliances, Focusing on Outcomes for Communities United with States) builds on that history by providing focused funding to states and communities for intensive implementation and evaluation of IPV primary prevention strategies that address the structural determinants of health at the societal and community levels of the social-ecological model (SEM).

By emphasizing primary prevention, the DELTA FOCUS program will support comprehensive and coordinated approaches to IPV prevention. The strategies will address the structural determinants of health at the outer layers (societal and community) of the SEM that coordinate and align with existing prevention strategies at the inner layers of the SEM. This program addresses the “Healthy People 2020” focus area(s) of Injury and Violence Prevention and Social Determinants of Health.

Information will be collected from the 12 DELTA FOCUS awardees through an electronic Performance Management Information System (PMIS). The PMIS will collect information about the staffing resources dedicated by each awardee, as well as partnerships with external organizations. Information collected through the PMIS will be used to inform performance monitoring and program evaluation. Information will also be used to respond to requests from the National Center for Injury Prevention and Control, Department of Health and Human Services, White House, Congress, and other sources.

DELTA FOCUS awardees will use the information collection to manage and coordinate their activities and to improve their efforts to prevent IPV.

The PMIS will collect a limited amount of information in identifiable form (IIF) for key program staff (e.g., Executive Director). Only names and professional contact information will be

collected, limiting the potential negative impact this data collection might have on the privacy of respondents. No personal contact information will be collected. All respondents will be state and territorial domestic violence coalitions. The time commitments for data entry and training are greatest

during the initial population of the PMIS, typically in the first six months of funding. Estimated burden for the first-time population of the PMIS is fifteen hours. Semi-Annual Reporting is estimated at three hours per respondent.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN TO RESPONDENTS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response in hours	Total burden (in hours)
State and/or Territorial Domestic Violence Coalitions.	DELTA FOCUS PMIS: Initial population.	12	1	15	180
	DELTA FOCUS PMIS: Semi-annual reporting.	12	2	3	72
Total .....	.....	.....	.....	.....	252

**Kimberly S. Lane,**

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

[CMS-9074-N]

**Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—April Through June 2012**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Notice.

**SUMMARY:** This quarterly notice lists CMS manual instructions, substantive

and interpretive regulations, and other **Federal Register** notices that were published from April through June 2012, relating to the Medicare and Medicaid programs and other programs administered by CMS.

**FOR FURTHER INFORMATION CONTACT:** It is possible that an interested party may need specific information and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing contact persons to answer general questions concerning each of the addenda published in this notice.

Addenda	Contact	Phone No.
I CMS Manual Instructions .....	Ismael Torres .....	(410) 786-1864
II Regulation Documents Published in the <b>Federal Register</b>	Terri Plumb .....	(410) 786-4481
III CMS Rulings .....	Tiffany Lafferty .....	(410) 786-7548
IV Medicare National Coverage Determinations .....	Wanda Belle .....	(410) 786-7491
V FDA-Approved Category B IDEs .....	John Manlove .....	(410) 786-6877
VI Collections of Information .....	Mitch Bryman .....	(410) 786-5258
VII Medicare-Approved Carotid Stent Facilities .....	Sarah J. McClain .....	(410) 786-2294
VIII American College of Cardiology-National Cardiovascular Data Registry Sites.	JoAnna Baldwin, MS .....	(410) 786-7205
IX Medicare's Active Coverage-Related Guidance Documents.	Lori Ashby .....	(410) 786-6322
X One-time Notices Regarding National Coverage Provisions	Lori Ashby .....	(410) 786-6322
XI National Oncologic Positron Emission Tomography Registry Sites.	Stuart Caplan, RN, MAS .....	(410) 786-8564
XII Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities.	JoAnna Baldwin, MS .....	(410) 786-7205
XIII Medicare-Approved Lung Volume Reduction Surgery Facilities.	JoAnna Baldwin, MS .....	(410) 786-7205
XIV Medicare-Approved Bariatric Surgery Facilities .....	Kate Tillman, RN, MAS .....	(410) 786-9252
XV Fluorodeoxyglucose Positron Emission Tomography for Dementia Trials.	Stuart Caplan, RN, MAS .....	(410) 786-8564
All Other Information .....	Annette Brewer .....	(410) 786-6580

**I. Background**

Among other things, the Centers for Medicare & Medicaid Services (CMS) is

responsible for administering the Medicare and Medicaid programs and coordination and oversight of private

health insurance. Administration and oversight of these programs involves the following: (1) Furnishing information to