with ''Vaccine to Protect Children from Anthrax—Public Engagement Workshop'' as the subject line and provide name, address, and affiliation. If you need special assistance, such as sign language interpretation or other reasonable accommodations, please include that in your registration e-mail. A ''listen-only'' teleconference number will be provided on the Web site. Written comments and/or questions may be submitted in advance or during the Workshop and will be provided to the Workshop hosts. There will be two scheduled public comment periods during the Workshop. Public comments will be limited to 2 minutes per person.

Dated: June 8, 2011.

Nicole Lurie,

Assistant Secretary for Preparedness and Response.

[FR Doc. 2011–14722 Filed 6–14–11; 8:45 am]

BILLING CODE 4150–37–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day-11–11HJ]

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 or send comments to Daniel Holcomb, CDC Reports Clearance Officer, 1600 Clifton Road, MS D–74, 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

Comparing the Effectiveness of Traditional Evidence-Based Tobacco Cessation Interventions to Newer and Innovative Interventions Used by Comprehensive Cancer Control Programs—New—Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Tobacco use remains the leading preventable cause of death in the United States, causing over 443,000 deaths each year and resulting in an annual cost of more than $96 billion in direct medical expenses. The only proven strategy for reducing the risk of tobacco-related morbidity and mortality is to never smoke, or to quit if tobacco use has been initiated. In 1999, CDC's Office on Smoking and Health established the National Tobacco Control Program (NTCP) to encourage coordinated, national efforts to reduce tobacco-related morbidity and mortality. The NTCP provides funding and technical support to Tobacco Control Programs (TCPs) in all 50 states, the District of Columbia, eight Tribal support centers, eight U.S. territories or jurisdictions, and six national networks. TCPs offer evidence-based cessation interventions to increase successful quit attempts.

Tobacco control is also a top priority for Federally-funded Comprehensive Cancer Control (CCC) programs. Currently, 65 organizations are funded through CDC's National Comprehensive Cancer Control Program (NCCCP): All 50 states, the District of Columbia, seven Tribes/Tribal organizations, and seven U.S. territories/Pacific Island Jurisdictions. CCCs work to establish coalitions, assess the burden of cancer, and implement state cancer plans that address interventions from primary prevention to treatment and survivorship. The NCCCP is managed by CDC's Division of Cancer Prevention and Control (DCPC).

Evidence-based tobacco cessation interventions include counseling offered through telephone quitlines (QLs) as well as Web-based counseling services. Although all states currently provide a telephone QL, only 0.05% to 7.25% of adult smokers receive tobacco cessation services via a state QL each year. Mass media (*e.g.,* television, radio, print) has been shown to be the most important and consistent driver of call volume to QLs in some localities, but is resource intensive. Two recent studies comparing the relative effectiveness of telephone versus Web-based interventions have begun to clarify the impact of each intervention but are limited in their generalizability to current TCP activities. To date there are no comprehensive studies that have examined TCP promotional strategies, the populations affected by these strategies, and their effect on QL and Web-based cessation program usage.

To address this gap in knowledge, CDC proposes to conduct a new study of state-based TCPs and their client populations. The study will consist of two components: (1) Quitline promotional activities, and (2) cessation intervention.

Quitline Promotional Activities. The overall goal of this study component is to characterize state-based TCP promotional activities in terms of type and level of advertising; impact in relation to QL call volume; and client characteristics. This study component is based on existing sources of information and entails minimal burden to respondents. Up to 50 state-based TCPs will be asked to participate over a 15-month period. Responding states will provide media purchasing information related to cessation promotional activities and permission to extract de-identified QL call volume data from the National Quitline Data Warehouse (NQDW, OMB No. 0920–0856, exp. 7/31/2012). CDC's data collection contractor will also attempt to obtain Web traffic data using publicly available tools.

Cessation Intervention. The overall goal of this study component is to describe relationships among mode of cessation service delivery (telephone vs. Web); client demographics; and quit success in the last 30 days. A total of 8,000 respondents aged 18 years (4,000 clients who use QL services and 4,000 clients who use Web-based services) will be recruited to participate in the study on a voluntary basis. Regular access to cessation services will be provided to individuals who choose not to participate in this study. Respondents will be recruited from up to four states over a period of up to 12 months. The four participating states must be current NCCCP grantees, have existing relationships with their state TCP, have both telephone and Web-based tobacco cessation programs, and have a state-wide QL registry that conforms to the North American Quitline Consortium's Minimal Data Set (MDS), which provides the framework for the NQDW data collection.

Information collection for the cessation study component will consist of an intake data using MDS-compliant

questions and a follow-up survey seven months after intake. There is minimal burden associated with transmission of intake information to CDC, since this information is already collected by states that are eligible to participate in the study. The seven-month follow-up survey for the cessation study component is a modified version of the follow-up survey administered for the NQDW data collection, and will replace or supplement the NQDW follow-up process. The follow-up survey for the cessation study component will be administered online or by telephone.

The results of this study will provide TCPs, policymakers, CDC, and others with additional evidence for decisionmaking regarding the impact of promotional activities and the comparative effectiveness of traditional versus new and innovative cessation services. The proposed study will complement and extend the usefulness of a companion study of partnerships between CCC programs and tobacco control programs. Both studies are made possible by funding through the American Reinvestment and Recovery Act (ARRA).

OMB approval is requested for two and one-half years. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)	Total burden (in hr)
Tobacco Control Programs.	Quitline Promotion Activities Data	25	4	1	100
	Intake Data for QL Clients	2	4	15/60	2
	Follow-up Survey for QL Clients	2	1,000	15/60	500
	Intake Data for Web Services Clients	2	4	15/60	2
	Follow-up Survey for Web Services Clients	2	1,000	15/60	500
Total					1,104

Dated: June 8, 2011.

Daniel Holcomb,

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–11–11HI]

Proposed Data Collections Submitted for Public Comment and Recommendations

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Proposed Project

Frame Development for the Long-Term Care Component of the National Health Care Surveys—NEW—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Section 306 of the Public Health Service (PHS) Act (42 U.S.C. 242k), as amended, authorizes that the Secretary of Health and Human Services (DHHS), acting through NCHS, ''shall collect statistics on health resources * * * [and] utilization of health care, including extended care facilities, and other institutions.''

NCHS seeks approval to collect data needed to develop an up-to-date sampling frame of residential care facilities. The sampling frame will be used to draw a nationally representative sample for a planned new survey, the National Survey of Long-Term Care Providers (NSLTCP). The frame-related data will be collected from officials in state regulatory agencies in the 50 states and the District of Columbia primarily via telephone calls, e-mails, and in a few cases, via formal written requests. The data to be collected from these state officials include (1) confirming the appropriate licensure categories of residential care facilities within each state that meet the NSLTCP definition and (2) for each relevant licensure category, requesting an electronic file of the licensed residential care facilities for which the agency is responsible. The NSLTCP study definition of a residential care facility is one that is licensed, registered, listed, certified, or otherwise regulated by the state; provides room and board with at least two meals a day; provides around-the-clock on-site supervision; helps with activities of daily living (*e.g.,* bathing, eating, or dressing) or medication supervision; serves primarily an adult population; and has at least four beds. Nursing homes, skilled nursing facilities, and facilities licensed to serve the mentally ill or the mentally retarded/developmentally disabled populations exclusively are excluded.

The electronic files we seek to obtain from the states should include the name and address of the residential care facility, name of facility director, licensure category, chain affiliation, and ownership.

NCHS also seeks approval to collect data on state licensing requirements regarding infection control practices during the frame development process. During the conversations with state officials to collect frame-related data,