

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Delegation of Authorities

Notice is hereby given that I have delegated to the Administrator, Centers for Medicare & Medicaid Services (CMS), and the Commissioner, Food and Drug Administration (FDA), with authority to re-delegate, the authorities vested in the Secretary of the Department of Health and Human Services under Section 6004 of the Patient Protection and Affordable Care Act, Public Law 111-148, which adds Section 1128H [42 U.S.C. 1320a-7i] to the Social Security Act.

I hereby delegate to CMS the authority vested in the Secretary to issue guidance and take other appropriate actions, to the extent that Section 1128H [42 U.S.C. 1320a-7i] relates to Titles XVIII (Medicare), XIX (Medicaid), or XXI (State Children's Health Insurance Program) of the Social Security Act.

I hereby delegate to FDA all other authority vested in the Secretary under Section 1128H [42 U.S.C. 1320a-7i]. This shall include, but is not limited to, issuing guidance and taking other appropriate action to the extent that Section 1128H [42 U.S.C. 1320a-7i] relates to Section 503 of the Federal Food, Drug, and Cosmetic Act; identifying the information to be collected as allowed by Sections 1128H(a)(1)(B) [42 U.S.C. 1320a-7i(a)(1)(B)] and 1128H(a)(2)(B) [42 U.S.C. 1320a-7i(a)(2)(B)]; and generally, with respect to the information to be submitted under Section 1128H(a) [42 U.S.C. 1320a-7i(a)], issuing guidance and taking other appropriate action to identify the information to be submitted and the manner of submission, and overseeing and making arrangements for the collection, maintenance, and availability of such information.

This delegation shall be exercised in accordance with the Department's applicable policies, procedures, and guidelines.

I hereby affirm and ratify any actions taken by the Administrator, CMS, the Commissioner, FDA, or other CMS and FDA officials, which involve the exercise of these authorities prior to the effective date of this delegation.

This delegation of authorities is effective upon date of signature.

Authority: 44 U.S.C. 3101.

Dated: September 30, 2011.

Kathleen Sebelius,

Secretary of Health and Human Services.

[FR Doc. 2011-25851 Filed 10-5-11; 8:45 am]

BILLING CODE 4150-03-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Meeting of the National Advisory Council for Healthcare Research and Quality

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Notice of public meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, 5 U.S.C. App. 2, this notice announces a meeting of the National Advisory Council for Healthcare Research and Quality.

DATES: The meeting will be held on Friday, November 4, 2011, from 8:30 a.m. to 3:30 p.m.

ADDRESSES: The meeting will be held at the Hubert H. Humphrey Building, Room 800, 200 Independence Avenue, SW., Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT:

Karen Brooks, Coordinator of the Advisory Council, at the Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland 20850, (301) 427-1801. For press-related information, please contact Karen Migdail at (301) 427-1855.

If sign language interpretation or other reasonable accommodation for a disability is needed, please contact the Food and Drug Administration (FDA) Office of Equal Employment Opportunity and Diversity Management on (301) 827-4840, no later than October 21, 2011. The agenda, roster, and minutes are available from Ms. Bonnie Campbell, Committee Management Officer, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland 20850. Ms. Campbell's phone number is (301) 427-1554.

SUPPLEMENTARY INFORMATION:

I. Purpose

The National Advisory Council for Healthcare Research and Quality is authorized by Section 941 of the Public Health Service Act, 42 U.S.C. 299c. In accordance with its statutory mandate, the Council is to advise the Secretary of the Department of Health and Human Services and the Director, Agency for Healthcare Research and Quality (AHRQ), on matters related to AHRQ's conduct of its mission including providing guidance on (A) Priorities for health care research, (B) the field of health care research including training needs and information dissemination on health care quality and (C) the role of

the Agency in light of private sector activity and opportunities for public private partnerships.

The Council is composed of members of the public, appointed by the Secretary, and Federal ex-officio members specified in the authorizing legislation.

II. Agenda

On Friday, November 4, there will be a subcommittee meeting for the National Healthcare Quality and Disparities Report scheduled to begin at 7:30 a.m. The Council meeting will convene at 8:30 a.m., with the call to order by the Council Chair and approval of previous Council summary notes. The AHRQ Director will present her update on current research, programs, and initiatives. The final agenda will be available on the AHRQ Web site at <http://www.ahrq.gov> no later than October 31, 2011.

Dated: September 26, 2011.

Carolyn M. Clancy,

Director.

[FR Doc. 2011-25692 Filed 10-5-11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-11-11KS]

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

Community-Based Surveillance of Supports for Healthy Eating and Active Living—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

There is growing consensus among experts that the environment plays a critical role in promoting or discouraging healthy choices and behaviors. For example, consumption of a healthful diet may be constrained by lack of access to fresh foods, and physical activity, particularly as it relates to active forms of transportation, such as walking and bicycling, may be limited by poor street design or concerns about safety. Policies implemented by municipalities can change local environments to support residents' decisions to consume healthful diets and be physically active.

CDC has identified 24 strategies that local communities can implement to encourage healthy eating and active living, as well as indicators for monitoring community-level progress in implementing these strategies. However, at this time, there is no systematic national information collection about community-level policies related to healthy eating and active living, or how these policies are changing over time. Although some public health surveillance systems measure health and behavioral factors at the individual level, these systems are insufficient to address broader contextual factors, such as community-level supports and

policies related to nutrition and physical activity.

To address this gap in information, CDC proposes to conduct a pilot study to examine the feasibility of establishing a national community-level surveillance system on policy supports for healthful eating and active living. The pilot study will be conducted in two states with a sample of 400 communities, 200 in each state. Respondents will be local governments from a representative sample of municipalities in each state. The sample frame will be generated from the U.S. Census of Governments.

The proposed pilot study is designed to address three key methodological objectives. The first objective is to test the feasibility of the proposed sampling frame and to answer sample design issues related to determining sampling criteria for inclusion, as well as the development of weights and estimates.

The second objective is to identify and critically evaluate whether respondents in diverse municipalities of various sizes and organizational structures are able to answer a self-administered survey questionnaire. The survey questionnaire includes 42 items on the following topics: Community-wide planning efforts for healthy eating and active living, the built environment and policies that support physical activity, and policies and practices that support access to healthy food and healthy eating. The estimated burden per response is one hour. Issues to be addressed include critical assessment of the strengths and weaknesses of methods for identifying the best respondents for completing the survey questionnaire; conducting a limited process evaluation that identifies the barriers and challenges respondents may incur in providing reasonable and current data for the questionnaire; and arriving at a data collection instrument with the lowest possible threshold for respondent burden.

The third objective is to identify and critically evaluate different methods of study recruitment and non-response follow-up. A split-sample approach will be used to assign each target respondent to one of two groups: A low-intensity recruitment group or a moderate-intensity recruitment group. All target respondents in the study sample will receive e-mail reminders to encourage participation in the survey. Target respondents in the moderate-intensity recruitment group will also receive up to three telephone contacts to address questions. These follow-up contacts will serve as additional reminders. The estimated burden per telephone contact is five minutes.

Results of the methodological component of the feasibility study will be used to assess the feasibility of establishing a national surveillance system and the best methods for encouraging a high response rate in a representative sample of communities.

The overall goal is to establish a surveillance system that will be useful to local, state, and federal public health programs that promote healthful eating and physical activity. Information to be collected through surveillance will help these groups identify areas for community-level interventions, track the progress of communities in changing policy and environmental supports, and evaluate interventions that address the obesity epidemic through changing diet and physical activity.

Target respondents will be city/town planners and managers, or individuals with similar responsibilities. The majority of survey responses will be collected using a secure, web-based survey data collection system. A paper version of the survey will also be available. OMB approval is requested for one year. Participation is voluntary and 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)
City/Town Manager-Planner	Survey Questionnaire	400	1	1	400
	Telephone Follow-up for Non-Responders.	200	3	5/60	50
Total					450

Dated: September 29, 2011.

Daniel Holcomb,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2011-25753 Filed 10-5-11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-11-0805]

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

Racial and Ethnic Approaches to Community Health (REACH) US Evaluation—Revision—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In 2007, the Centers for Disease Control and Prevention (CDC) launched Racial and Ethnic Approaches to Community Health across the U.S. (REACH US), a national multilevel program to reduce and eliminate health disparities in racial and ethnic minorities. Priority populations for the program are African American, American Indian, Alaska Native, Hispanic American, Asian American, and Pacific Islander citizens. Each state or community funded through the REACH US program developed a community action plan building on the application, synthesis, and dissemination of promising community public health practices in one or more priority areas: Breast and cervical cancer; cardiovascular disease; diabetes mellitus; adult/older adult immunization, hepatitis B, and/or tuberculosis; asthma; and infant mortality. The program priority areas were selected based on statistical analysis of "excess deaths," which examined differences in minority health in relation to non-minority health and identified the specific health areas that accounted for the majority of the higher

annual proportion of minority deaths in the U.S.

As part of the REACH US evaluation plan, CDC sponsored household-based risk factor surveys in 2009, 2010, and 2011 (OMB No. 0920-0805, exp. 2/28/2012). Respondents were selected based on a unique address-based sampling approach that targets specific geographic areas across the country where REACH U.S. interventions have been implemented. The risk factor survey data allow CDC to track trends in community health in the areas where REACH U.S. interventions have been launched.

CDC is requesting OMB approval to conduct two additional cycles of data collection in 2012 and 2013. Risk factor surveys will be conducted in 28 REACH U.S. communities (900 individuals per community). After households have been selected through address-based sampling, health information will be collected through a self-administered, mailed questionnaire, or through interviews conducted by telephone or in-person with members of the selected households. The surveys will help to assess the prevalence of various risk factors associated with chronic diseases, deficits in breast and cervical cancer screening and management, and deficits in adult immunizations. Survey results will also be used to assess progress towards the national goal of eliminating health disparities within minority populations.

OMB approval is requested for two years. Minor changes to the survey questions will be implemented, and adjustments will be made to the estimated number of respondents. Respondents will be adults ages 18 years and older. Participation is voluntary and there are no costs to respondents except their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Members of REACH U.S. communities.	Screening Interview	14,700	1	3/60	735
	Household Member Interview	10,600	1	15/60	2,650
	REACH Study Booklet self-administered questionnaire.	24,300	1	15/60	6,075
Total					9,460