findings is to ''be submitted to the appropriate Committees of jurisdiction of Congress.''

In response, CDC has contracted with the Academy for Educational Development (AED) to conduct focus groups to identify key audience concepts around food choices, and develop and test concepts and messages aimed at increasing healthy food choices among children. For the research to be useful to Congress and to the nation's public health agenda, a thorough understanding of children at different developmental stages regarding their attitudes toward healthy food choices, and the barriers and motivations for adopting and sustaining these choices is essential. Additionally, a thorough understanding of parents who can influence the health behaviors of children is important. This understanding will facilitate the development of messages, strategies, and tactics that resonate with children, parents, and other influencers.

The focus groups will be conducted in three phases: Phase One will address ''tweens'' (ages 9–13) and parents of tweens; Phase 2 will focus on children 6–8 years old and their parents, and Phase 3 will conduct groups with parents of children under 6 years old. Current literature and opinion leaders both strongly suggest that tweens greatly influence their parents' and younger siblings' nutritional decisions.

For each phase, 36 focus groups will be conducted; thus, three phases will amount to 108 total focus groups. In Phases 1 and 2, focus groups will involve both youth and their parents or key caregivers. In this way, CDC can gain insight into both parents' and children's views and family shared decision-making associated with food choices and attitudes toward healthy eating patterns. For Phase 3, 36 focus groups about the toddler/young child set (ages 1–5) will be held with their parents and other important influencers such as educators, primary caregivers, health care providers. (See chart below for specifics on structure and related burden.)

All focus group recruiting will incorporate appropriate representation of diverse ethnic groups, and the groups will be held in several cities to ensure broad geographic representation. Participants will be recruited by focus group facilities utilizing their database to solicit and screen interested parties. The screening process will include two calls for every successful recruit, each taking approximately 5 minutes. Each focus group will be asked to respond verbally. The moderator will utilize a prepared guide which is designed to specifically ensure that the discussion is limited to 2 hours.

The intent of this research is to solicit input and feedback from potential audiences. The information gathered will be used to develop, refine, and modify messages and strategies to increase healthy food choices by children and parents. There is no cost to respondents other than their time to participate in the survey.

Estimated Annualized Burden Hours

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (hours)
Phase 1: Recruitment	528	1	10/60	88
Phase 1: Tweens (ages 9–13);	264	1	2	528
Phase 1: Parents of tweens;	120	1	2	240
Phase 2: Recruitment	528	1	10/60	88
Phase 2: Elementary aged children (ages 5–8);	264	1	2	528
Phase 2: Parents of elementary aged children	120	1	2	240
Phase 3: Recruitment	720	1	10/60	120
Phase 3: Parents of preschoolers (ages 1–4);	360	1	2	720
Total				2552

Dated: August 28, 2006.

Joan F. Karr,

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

[FR Doc. E6–14620 Filed 9–1–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–06–0398x]

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 Seleda Perryman, CDC Assistant 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

Evaluation of an Intervention to Increase Colorectal Cancer Screening in Primary Care Clinics—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Colorectal cancer (CRC) is the third most frequent form of cancer and the second leading cause of cancer-related deaths among both men and women in the United States. Research shows that screening can reduce both the occurrence of colorectal cancer and

colorectal cancer deaths. Screening is beneficial for: (1) Detection and removal of precancerous polyps, resulting in patients recovering without progression to a diagnosis of cancer, and (2) early detection of CRC for more effective treatment and improved survival. Regular CRC screening is recommended for people aged 50 years and older. Many screening tests are widely available and screening has been shown to be effective in reducing CRC mortality. Despite this demonstrated effectiveness, CRC screening remains low. Some reasons attributed to the low screening rates include limited public awareness of CRC and the benefits of screening, failure of health care providers to recommend screening to patients, and inefficient surveillance and support systems in many health care settings.

The purpose of this one-time study is to evaluate and understand the effect of a multi-component intervention on CRC screening rates in primary care clinics. The study will also examine the effects of the intervention conditions on behavioral outcomes (*e.g.*, clinician-patient discussions about CRC screening) and on attitudes, beliefs, opinions, and social influence surrounding CRC screening among patients. The target population includes average-risk patients aged 50–80 years, clinicians, and clinic support staff within the primary care clinics in two managed care organizations (MCOs). There are three tasks in this study. In Task 1, 140 primary care clinicians will complete a survey assessing demographics, opinions about preventive services, CRC screening training and practices, satisfaction with CRC screening, and CRC screening beliefs, facilitators, and barriers. The survey will be administered to primary care clinicians post-intervention. In Task 2, 140 clinic support staff will complete a survey assessing demographics, work-related responsibilities, opinions about preventive services, CRC training and practices, satisfaction with CRC screening, and CRC screening beliefs, facilitators and barriers. The survey will be administered to clinic support staff post intervention. In Task 3, clinic patients will complete a survey assessing demographics, health status, receipt of previous CRC screening and other preventive services, knowledge and opinions about CRC and CRC screening, and social support. The survey will be administered to 3307 patients pre-intervention and 3307 patients post-intervention. Of these, 972 patients will receive both the pre- and post-intervention survey.

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

Estimated Annualized Burden Hours

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (hours)
Clinicians	140	1	30/60	70
Clinic Support Staff	140	1	25/60	58
Patients surveyed only at baseline	2335	1	20/60	788
Patients surveyed at baseline and follow-up	972	2	20/60	648
Patients surveyed only at follow-up	2335	1	20/60	788
Totals				2352

Dated: August 28, 2006.

Joan F. Karr,

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

[FR Doc. E6–14622 Filed 9–1–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Advisory Committee on Rural Health and Human Services; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given that the following committee will convene its fifty-second meeting.

Name: National Advisory Committee on Rural Health and Human Services.

Dates and Times: September 28, 2006, 2 p.m.–5:30 p.m.; September 29, 2006, 8:30 a.m.–4:30 p.m.; September 30, 2006, 9 a.m.–10:30 a.m.

Place: Center for Rural Health, University of North Dakota, 501 N. Columbia Rd., Grand Forks, North Dakota 58203; Holiday Inn Grand Forks, 1210 N 43rd Street, Grand Forks, North Dakota 58203; Spirit Lake Casino and Resort, 7889 Highway 57, St. Michael, North Dakota 58370, Phone: 701–766–4747.

Status: The meeting will be open to the public.

Purpose: The National Advisory Committee on Rural Health and Human Services provides advice and recommendations to the Secretary with respect to the delivery, research, development and administration of health and human services in rural areas.

Agenda: Thursday afternoon, September 28, at 2 p.m., a press conference with be held with the Chairperson of the Committee, the Honorable David Beasley. The meeting will begin at 2:30 p.m., at the University of North Dakota, with opening remarks by the Honorable David Beasley. Introductions will be made by Mary Wakefield, Associate Dean for Rural Health and Director of the Center for Rural Health at the University of North Dakota and Charles Kupchella, President of the University of North Dakota. This will be followed by a brief history of North Dakota by Mike Jacobs (invited speaker), editor of the Grand Forks Herald, and an overview of rural health innovation by Bruce Gjovig with the Center for Innovation and Rural Technology Center. The next session will be an overview of the Rural Assistance Center by Kristine Sande. The final session of the day will be a discussion on the purpose of the site visits and future agenda setting led by the Honorable David Beasley and Tom Morris, Committee Executive Secretary. The Thursday meeting will close at 5:30 p.m.

Friday morning, September 29, at 8:30 a.m., the Committee will convene at the Holiday Inn Grand Forks, Grand Forks, North Dakota. The meeting will begin with an explanation of the day and an overview of the site visits. At 9 a.m., the Committee will break into subcommittee format for the site visits. At 9:15 a.m., the Medicare Advantage Subcommittee will depart for Mercy Hospital in Devils Lake, North Dakota. Also, at 9:15 a.m., the Head Start Subcommittee will depart for the Early Explorers Head Start Program in Devils Lake, North Dakota. The Substance Abuse Subcommittee will depart for the Center for Solutions, Towner County Medical Center in Cando, North Dakota, at 9:30 a.m. Transportation to these sites will not be provided. The Subcommittees will return to Spirit Lake Casino and Resort in St. Michael, North Dakota, for the remainder of the meeting. The Subcommittees will meet at 2:15 p.m. to discuss the site visits. The Committee of the whole will reconvene at 3:30 p.m. for a discussion of the 2007 report topics. The Friday meeting will close at 4:30 p.m.