Dated: July 20, 2007.

David A. Schwartz,

Director, National Institute of Environmental Health Sciences, and National Toxicology Program.

[FR Doc. E7–14689 Filed 7–30–07; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Notice of Meeting

In accordance with section 10(d) of the Federal Advisory Committee Act (5 U.S.C., Appendix 2), announcement is made of Health Care Policy and Research Special Emphasis Panel (SEP) meeting.

A Special Emphasis Panel is a group of experts in fields related to health care research who are invited by the Agency for Healthcare Research and Quality (AHRQ), and agree to be available, to conduct on an as needed basis, scientific reviews of applications for AHRQ support. Individual members of the Panel do not attend regularly-scheduled meetings and do not serve for fixed terms or a long period of time. Rather, they are asked to participate in particular review meetings which require their type of expertise.

Substantial segments of the upcoming SEP meeting listed below will be closed to the public in accordance with the Federal Advisory Committee Act, section 10(d) of 5 U.S.C., Appendix 2 and 5 U.S.C. 552b(c)(6). Grant applications for the Announcement of Availability of Funds for Grants regarding Family Planning Services Delivery Improvement (SDI) Research are to be reviewed and discussed at this meeting. This program is sponsored by the Office of Populations Affairs. These discussions are likely to reveal personal information concerning individuals associated with the applications. This information is exempt from mandatory disclosure under the above-cited statutes.

SEP Meeting on: Family Planning Services Delivery Improvement (SDI) Research.

Date: August 23, 2007 (Open on August 23 from 8 a.m. to 8:15 a.m. and closed for the remainder of the meeting).

Place: John M. Eisenberg Building, AHRQ Conference Center, 540 Gaither Road, Rockville, Maryland 20850.

Contact Person: Anyone wishing to obtain a roster of members, agenda or minutes of the non-confidential portions of this meeting should contact Mrs. Bonnie Campbell, Committee Management Officer, Office of Extramural Research, Education and Priority Populations, HARQ, 540 Gaither Road, Room 2038, Rockville, Maryland 20850, Telephone (301) 427–1554.

Agenda items for this meeting are subject to change as priorities dictate.

Dated: July 24, 2007.

Carolyn M. Clancy,

Director.

[FR Doc. 07–3706 Filed 7–30–07; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–07–07BE]

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 Maryam I. Daneshvar, CDC Acting 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

Research to Reduce Time to Treatment for Heart Attack/Myocardial Infraction for Rural American Indians/Alaska Natives (AI/AN)—NEW—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Every year, approximately 1.1 million Americans have a first or recurrent heart attack/myocardial infarction (MI) and about one third of these will be fatal. Early recognition of MI by both the victim and bystanders followed by prompt cardiac emergency and advanced care has a direct effect on patient outcomes (heart damage, morbidity and mortality): the shorter the delay to treatment, the better the outcomes. Results of a recent Behavioral Risk Factor Survey (BRFSS) survey showed that public recognition of major MI symptoms and the need for immediate action by calling 9–1–1 was poor and that there is a need for increased public health efforts. Patient delay accounts for most of the lag in treatment.

Data from the National MI Registry show that the greatest disparity for delay in treatment exists among the racial and ethnic groups of American Indian/Alaskan Native group. The NATIVE study shows that rural American Indians presenting with acute MI have marked delays in time to treatment (12% of patients waited between 12–24 hours and 23% waited more than 24 hours to present) thus, limiting treatment options; the primary cause of the delay was due to patient misunderstandings about the symptoms of MI.

The project will contribute to our understanding of AI/AN populations and their perceptions of and misconceptions about MI and the need for immediate treatment. Information gained from this project will provide the details needed to tailor message(s) for this population. The agency will develop culturally-tailored messages for native populations that will contribute to the existing National Heart Attack program (NHLBI) ''Act in Time'' messages.

There will be a minimum of 84 key informant interviews and 16 persons in the two focus groups. The key informants will consist of healthcare providers, community leader, and persons who have had an MI. Key informants will be identified for interviews through a clustered, multistate snowball sampling technique. In recognition of the tribal diversity; study participants will represent three AI/AN regions of the U.S.: Great Plains identified by the Aberdeen Area Indian Health Service area, the South West distinct to the Phoenix, Albuquerque and Tucson areas and Alaskan Natives. Interview participants will have established relationships with tribes or

are members of tribes, and have a good sense of cultural health beliefs.

The healthcare provider group will consist of nomination by the Indian Health Service Chief Medical Officer (IHSCMO), who will nominate 3 MD/NP's or PA's and 3 nurses in each region. The participating emergency care providers will each be asked to nominate 2 providers from a cardiology clinic (cardiologists or cardiac nurses) and/or a pre-hospital (EMT/Paramedic) provider. The 6 original from each region will subtotal to 18 emergency care providers plus the 2 individuals they each nominate will subtotal to 36 from each region, a total of 54 pre-hospital and cardiology providers (medical providers) key informant interviews covering all three regions.

The community key informants will consist of 3 tribal health directors who will nominate 3 community key informants from each region, who will then each nominate 2 additional community members to be interviewed for a sample of 30 community key informants.

The individual key informant interviews of the group of patients who have had an MI or have a high risk of MI, nominated by the physicians, nurses and community members will be asked to nominate individuals whom they know have had or are at risk for a heart attack. The medical providers and community members asked to participate in the key informant interviews will equal a *minimum* of approximately 27 health providers, 15 community members or 42 key informant interview, each contacts 2 individuals, a minimum of 168 respondents to the survey.

After the key informant interviews have been completed and analyzed there will be two community focus groups each comprised of 8 to 10 participants from all three regions held. The first involving patients who have had an MI and the second focus group will involve community members at risk for MIs.

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

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	No. of responses per respondent	Average burden per response (in hrs.)	Total burden (in hours)
Healthcare providers	54	1	1	54
Community leaders	30	1	1	30
Community members interviews	168	1	1	168
(2) Community member focus group retreats	20	1	8	160
Total				412

Dated: July 25, 2007.

Maryam I. Daneshvar,

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

[FR Doc. E7–14703 Filed 7–30–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–07–06BN]

Proposed Data Collections Submitted for Public Comment and Recommendations

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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

Conduct a Chronic Fatigue Syndrome Registry Pilot Test (Bibb County, Georgia)—New—National Center for Infectious Diseases (NCID) Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC is tasked with establishing a registry of chronic fatigue syndrome (CFS) and other fatiguing illnesses. The objective of the registry is to identify persons with unexplained fatiguing illnesses, including CFS, who access the healthcare system because of their symptoms. Patients will be between the ages of 12 and 59, inclusive.

Specific aims of the registry are; (1) Identify and enroll patients with CFS and other unexplained fatiguing illnesses who are receiving medical and ancillary medical care and describe their epidemiologic and clinical characteristics; (2) follow CFS patients and patients with other fatiguing illnesses over time to characterize the natural history of CFS and other unexplained fatiguing illnesses; (3) assess and monitor health care providers' knowledge, attitudes, and beliefs concerning CFS; (4) and to identify well-characterized CFS patients for clinical studies and intervention trials. These specific aims require inclusion of subjects in early stages of CFS (i.e., ill less than one year duration) who can be followed longitudinally to assess changes in their CFS symptoms. Data on persons with CFS in the general population has been collected in a separate study and is not an objective of this Registry.

In order to determine the most effective and cost-efficient design for achieving the objective and specific aims, CDC will conduct a pilot test of the Registry of CFS and other fatiguing illnesses in Bibb County, Georgia. The CFS Registry Pilot Test will assess two Registry designs for efficacy and efficiency in identifying adult and adolescent subjects with CFS who are