Docket No.	File date	Presenter or requester
3. P–405–087	08–03–09	Benjamin L. Cardin.
4. P–12569–001	08–06–09	Gregory Griffith.
5. P–12569–001	08–04–09	Dan Boettger.
6. P–12737–002	08–06–09	Brenda Winn.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–20213 Filed 8–21–09; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–8948–4]

North Carolina Waters Along the Entire Length of New Hanover County No Discharge Zone Determination

The Environmental Protection Agency (EPA), Region 4, concurs with the determination of the North Carolina Department of Environment and Natural Resources (DENR), Division of Water Quality (DWQ) that adequate and reasonably available pumpout facilities exist for the designation of New Hanover County North Carolina Coastal Waters as a No Discharge Zone (NDZ). Specifically these waters extend three nautical miles (nm) into the Atlantic Ocean along the entire length of New Hanover County, including Futch Creek, Pages Creek, Bradley Creek, Hewlett's Creek, Howe Creek, Whiskey Creek, Snow's Cut, as well as unnamed tributaries and all unnamed tidal creeks to those waters.

The geographic description including latitudes and longitudes are as follows: Northern border of New Hanover County with southern border of Pender County (34°17′53.5″ N 77°42′32.2″ W), to a point 3 nm off the coast at the intersection of New Hanover and Pender Counties (34°16′01.9″ N 77°40′20.5″ W).

Intersection of the southern tip of New Hanover County with Brunswick County at the Cape Fear River (33°55′43.0″ N 77°56′13.6″ W), southeastward along the extended intersection of the two counties, 3 nm into the Atlantic Ocean (33°53′07.5″ N 77°55′34.5″ W).

This petition was filed pursuant to the Clean Water Act, Section 312(f)(3), Public Law 92–500 as amended by Public Law 95–217 and Public Law 100–4. A NDZ is defined as a body of water in which the discharge of vessel sewage, both treated and untreated, is prohibited.

Section 312(f)(3) states:

After the effective date of the initial standards and regulations promulgated under this section, if any State determines that the protection and enhancement of the quality of some or all of the waters within such States require greater environmental protection, such State may completely prohibit the discharge from all vessels of any sewage, whether treated or not, into such waters, except that no such prohibition shall apply until the Administrator determines that adequate facilities for the safe and sanitary removal and treatment of sewage from all vessels are reasonably available for such water to which such prohibition would apply.

According to DENR DWQ the following facilities are located in New Hanover County for pumping out vessel holding tanks:

(1) Carolina Beach Municipal Marina, Carolina Beach, 910–458–2540, open 24/7, 6′ draft at mean low tide

(2) Carolina Beach State Park Marina, Carolina Beach State Park, Carolina Beach, 910–458–7770, 8 a.m.–5:45 p.m., 7 days/week, 6′ draft at mean low tide

(3) Federal Point Yacht Club, 910 Basin Road, Carolina Beach, 910–458–4511, only available to club members, 5′ draft at mean low tide

(4) Mona Black Marina, Carolina Beach, 910–458–0575, open 24/7, 20′ draft at mean low tide

(5) Joyner Marina, Carolina Beach, 910–458–5053, open 7 a.m.–6 p.m., 7 days per week, 6′ draft at mean low tide

(6) Bridge Tender Marina, City of Wilmington, 910–256–6550, 7 a.m.–8 p.m., 7 days/week, 10′ draft at mean low tide

(7) Creekside Yacht Club, City of Wilmington, 910–350–0023, Operational December 2009, 4′ draft at mean low tide

(8) Sea Path Yacht Club, Town of Wrightsville Beach, 910–256–3747, 7 a.m.–7 p.m., 7 days/week, 10′ draft at mean low tide

(9) Wrightsville, Beach Marina & Transient Dock, Town of Wrightsville Beach, 910–256–6666, 7 a.m.–7 p.m., 7 days/week, 12′ draft at mean low tide

Two Marinas that are located within 7 nautical miles of the proposed NDZ are:

(A) Wilmington Marine Center, 910–395–5055, 8 a.m.–5 p.m. 7 days/week, 7′ draft at mean low tide

(B) Bald Head Island Marina, 910–457–7380, 8:30 a.m.–5:30 p.m. 7 days/week, 8′ draft at mean low tide

The total vessel population for New Hanover County as of August 5, 2008 was 13,940. This number reflects active vessel registrations and was obtained from the North Carolina Wildlife Resources Commission. During the period of 2006 to 2008, the total number of active registered vessels increased nearly 15%. The result is that there are nearly 1,800 more pleasure boats in the area waters today than just two years ago, with the largest increase occurring in boats between 16′ and 25′ in length. It is recognized that only a percentage of the vessels in the coastal waters of New Hanover County are equipped with a Marine Sanitation Device (MSD). To estimate the number of MSDs in use, percentages obtained from EPA (Region 2) were applied, and are listed below:

Boat Length	Percent with MSDs
<16′	8.3
16′–25′	10.6
26′–40′	78.5
>40′	82.6

This yields an estimated 2,046 MSDs in use by registered boats within New Hanover County.

Through the use of a marina survey, the number of transient boats serviced by marinas in New Hanover County was calculated to be approximately 180 per month. This figure was arrived at by using the peak season transient boat figures from each marina. Using the figures for both county and transient boats, the total number of MSDs in the New Hanover County waters is estimated to be 2,194. There are 9 marinas within New Hanover County and this yields a ratio of about 244 boats per pumpout facility. This figure does not include the two marinas that are located within 7 nautical miles of this proposed NDZ area.

All vessel pumpout facilities that are described either discharge into State approved and regulated septic tanks or State approved on site waste treatment plant, or the waste is collected into a large holding tank for transport to a sewage treatment plant. Thus all vessel sewage will be treated to meet existing standards for secondary treatment. Comments regarding this proposed action should be addressed to David Parker, Chief, Coastal Section, EPA Region 4, Water Protection Division, 61 Forsyth Street, Atlanta, Georgia 30303–

3104. Comments regarding this proposed action will be accepted until September 23, 2009.

A. Stanley Meiburg,

Acting Regional Administrator, Region 4.

[FR Doc. E9–20288 Filed 8–21–09; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Information Relevant to the Regionalization of Emergency Medical Care Delivery Systems and Demonstration Model Development

AGENCY: Department of Health and Human Services, Office of the Secretary.

ACTION: Notice.

SUMMARY: This is a time-sensitive Request for Information (RFI) issued by the Emergency Care Coordination Center in the Office of the Assistant Secretary for Preparedness and Response on behalf of the Council on Emergency Medical Care (CEMC) and the Federal Interagency Committee on Emergency Medical Services (FICEMS)—collectively known as the Emergency Care Enterprise (ECE). The information requested is meant to ascertain key concepts, best practices, and operational approaches to support regionalized, comprehensive and accountable emergency care and trauma systems. The information will be analyzed by the ECCC to help guide the development of demonstration programs that design and evaluate innovative models of regionalized, coordinated and accountable emergency care and trauma systems.

ADDRESSES: Responses to this RFI may be submitted electronically to *eccc@hhs.gov* by COB September 30th 2009.

FOR FURTHER INFORMATION CONTACT: For further information on this RFI or the Emergency Care Coordination Center (ECCC), please contact Melicia Seay, Program Analyst, by e-mail at *melicia.seay@hhs.gov* or by phone at 202–260–1383.

SUPPLEMENTARY INFORMATION: The Emergency Care Coordination Center (ECCC) was created in order to: (1) Lead an enterprise to promote and fund research in emergency medicine and trauma health care, (2) promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients, and (3) promote local, regional, and State emergency medical systems' preparedness for and response to public health events. The office addresses the full spectrum of issues that have impact on care in hospital emergency departments, encompassing the complete continuum of patient care from the pre-hospital environment to disposition from emergency or trauma care. The Office coordinates with existing executive departments and agencies that perform functions relating to emergency medical systems in order to ensure unified strategy, policy, and implementation.

The issue of regionalization is one of great interest across academic and clinical communities and is frequently touted as a potential solution to healthcare reform. The Future of Emergency Care reports published by the Institute of Medicine in 2006 recommended the establishment of a demonstration program to promote coordinated, regionalized, and accountable emergency care delivery systems. As demonstrated by existing systems for trauma, cardiac arrest, and stroke patients, regionalized emergency care systems help get the right patients to the right hospitals in the right amount of time, improve patient outcomes, and reduce costs. These systems typically require careful coordination amongst 9–1–1 dispatch, pre-hospital emergency medical services, EMS system medical direction, categorization/designation of medical facilities, interfacility transfer protocols, data collection/analysis, and ongoing system-wide quality improvement.

Yet regionalization of emergency care remains poorly defined and often misunderstood, with competing definitions, a variety of organizational and financial structures, and a lack of understanding regarding the implementation, evaluation, feasibility, and long term consequences of regional emergency care. Even amongst the State Trauma Systems, for instance, there is wide-scale variability in terms of resourcing mechanisms, support levels, functionality, and systems-wide interoperability. While some states have data mechanisms in place to monitor emergency care system status including medical facility bed availability and patient tracking, these systems vary in terms of management, sophistication and purpose, often collecting and reporting different data without uniform data definitions or agreement on which data should be collected.

The ECCC, in coordination with the CEMC and FICEMS, aims to demonstrate model systems for Emergency Care through the development of regionalization demonstration projects that will provide information and lessons learned while generating guidance for the nationwide deployment of regionalized and accountable emergency care delivery systems.

Issues on Which Information Is Requested

The ECCC seeks input regarding regionalization of emergency care, with a focus on identification of the challenges and opportunities that could be addressed through federally funded national demonstration projects. The scope of emergency care being considered is defined as beginning with an event, disease, or condition that causes an individual to seek care through EMS or in an ED setting and ending with departure from the ED (either by admission to another hospital department, through discharge from the ED, or via transfer to another hospital).

We welcome your comments, research findings, and/or practical experience on the following topics that can be used both to enhance our knowledge of regional emergency care networks and to help formulate guidance and strategies for potential Federal programs to develop regional emergency care systems. Please provide concise responses in the context of regionalization to any or all of the following topics.

A. Existing Models. Please describe existing trauma or EMS regions in terms of characteristics such as: overall structure and organization, boundaries and geography, governance or oversight mechanisms and authorities, triage-transfer protocols, sustained financial support and provider reimbursement, data collection procedures, resource tracking, and communication/coordination of relationships amongst State leadership, 9–1–1 services and/or EMS system medical direction, individual regions, etc. If desired, include opinions regarding the overall functioning and effectiveness of existing systems.

B. Analysis of Current Practices in Regionalized Clinical Care. Whether at the local, State, or inter-State level, please provide suggestions and justifications as to which existing systems or specific elements of regionalized care models specifically merit further investigation, development, or targeted alteration and which clinical conditions are most suitable to regionalized care delivery. Please provide specific evidence where available and applicable.

C. Communications Infrastructure. Please provide information on appropriate data elements that should be incorporated within regionalization systems to provide for situational