

Administrator, HRSA, regarding activities related to prevention and control of HIV/AIDS and other STDs, the support of health care services to persons living with HIV/AIDS, and education of health professionals and the public about HIV/AIDS and other STDs.

Matters To Be Discussed: Agenda items include: (1) Treatment Cascade—Linkage to Care/Retention in Care—Treatment as Prevention; (2) Ryan White HIV/AIDS Program Client Level Data Update; (3) Viral Hepatitis Action Plan and Implementation Update; (4) Update on Translation of International HIV/AIDS Work Domestically; and (5) CHAC Workgroups Update.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Margie Scott-Cseh, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC, 1600 Clifton Road NE., Mailstop E-07, Atlanta, Georgia 30333, Telephone: (404) 639-8317.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** Notices pertaining to announcements of meetings and other committee management activities, for both the CDC and the Agency for Toxic Substances and Disease Registry.

Dated: October 22, 2012.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget (OMB), in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, email paperwork@hrsa.gov or call the HRSA Reports Clearance Office on (301) 443-1984.

The following request has been submitted to the Office of Management

and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: Sickle Cell Disease Treatment Demonstration Program—Quality Improvement Data Collection for the Hemoglobinopathy Learning Collaborative (OMB No. 0915-xxxx)—[NEW]

Background: In response to the growing need for resources devoted to sickle cell disease and other hemoglobinopathies, the United States Congress, under Section 712 of the American Jobs Creation Act of 2004 (Pub. L. 108-357), authorized a demonstration program for the prevention and treatment of sickle cell disease (SCD) to be administered through the Bureau of Primary Health Care and the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services. The program is known as the *Sickle Cell Disease Treatment Demonstration Program* (SCDTDP). The SCDTDP is designed to improve access to services for individuals with sickle cell disease, improve and expand patient and provider education, and improve and expand the continuity and coordination of service delivery for individuals with sickle cell disease and sickle cell trait.

In 2006, the MCHB Genetic Services Branch (GSB) awarded funding to a National Coordinating Center (NCC). The NCC was established to: (1) Collect, coordinate, monitor, and report on best practices and findings regarding the activities of the demonstration program; (2) identify a model protocol for eligible entities with respect to the prevention and treatment of Sickle Cell Disease; (3) identify educational materials regarding the prevention and treatment of Sickle Cell Disease; and, (4) prepare a final report on the efficacy of the demonstration program based on evaluation and quality improvement (QI) findings.

To achieve the goals/objectives of the NCC, the National Initiative for Children's Healthcare Quality (NICHQ) and partners are facilitating the Hemoglobinopathy Learning Collaborative (HLC). The HLC includes grantee teams funded from the SCDTDP and the Sickle Cell Disease for Newborn Screening Program (SCDNBSP). The HLC uses a process known as the Model for Improvement, which is a widely used approach to QI in health care settings. The Model for Improvement utilizes a structured process that asks grantee teams, who hereafter will be referred to as improvement teams, to build on small tests of change in their

health care setting, while providing monthly reporting on measurements. The proposed QI Data Collection and reporting system is an integral component of this model.

Purpose: The purpose of this QI Data Collection strategy is to implement a system to monitor the progress of MCHB-funded activities in improving care and health outcomes for individuals living with sickle cell disease/trait and meeting the goals of the SCDTDP. Each improvement team will be asked to report on a core set of measures related to quality improvement for hemoglobinopathies. Through an evidence-based process, a bank of QI measures has been developed to assess health care utilization of the SCD population as well as several aspects of the system of care.

The QI Data Collection strategy will provide an effective and efficient mechanism to do the following: (1) Assess the services provided by grantees under the SCDTDP and monitor and drive improvement on quality measures; (2) collect, coordinate, and distribute data, best practices, and findings from network sites; (3) refine a common model protocol regarding the prevention and treatment of sickle cell disease; (4) examine/address barriers that individuals and families living with sickle cell disease face when accessing quality health care and health education; (5) evaluate the grantees' performance in meeting the objectives of the SCDTDP; and, (6) provide HRSA/Congress information on the overall progress of the program.

The proposed data collection and entry forms are as follows: (1) Participant Profile Form, (2) Acute Care Visit Form, and (3) Ambulatory Care Visit Form.

Respondents: Grantees funded by HRSA under the SCDTDP will be the respondents for this data collection activity. Each month, SCDTDP teams will complete up to three data collection and entry forms for 20 patients with SCD or sickle cell trait who were seen in their network that month. The Participant Profile form will collect demographic and basic health information. The Acute Care Visit and Ambulatory Care Visit forms will assess care in acute and ambulatory care settings, respectively.

All information will be collected via medical chart review. Data will be entered directly into a secure web-based data collection tool, Research Electronic Data Capture (REDCap). The data entered into REDCap will be analyzed via a custom measurement generator that will calculate and export the QI

measures for viewing by improvement teams, the NCC, and HRSA.

The annual estimate of burden is as follows:

Instrument	Number of respondents	Responses per respondent*	Total responses	Hours per response	Total burden hours
Participant Profile Form	9	12	108	5.0	540
Acute Care Visit Form	9	12	108	10.0	1080
Ambulatory Care Visit Form	9	12	108	10.0	1080
Total	27	324	2700

* This burden table has been revised from the one published in the 60-day notice to reflect the accurate count of responses per respondent. The number 12 reflects the number of times a respondent will be approached for data collection annually, not the total number of data collection forms completed as was previously reported.

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to the desk officer for HRSA, either by email to OIRA_submission@omb.eop.gov or by fax to (202) 395-6974. Please direct all correspondence to the "attention of the desk officer for HRSA."

Dated: October 25, 2012.

Bahar Niakan,

Director, Division of Policy and Information Coordination.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Methodology for Designation of Frontier and Remote Areas

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Request for public comment on methodology for designation of frontier and remote areas.

SUMMARY: This notice announces a request for public comment on a methodology derived from the Frontier and Remote (FAR) system for designating U.S. frontier areas. This methodology was developed in a collaborative project between the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA); and the Economic Research Service (ERS) in the U.S. Department of Agriculture (USDA). While other agencies of the Department of Health and Human Services (HHS) and the ERS may in the future choose to use the FAR methodology to demarcate the frontier areas of the U.S., there is no requirement that they do so, and they may choose other, alternate

methodologies and definitions that best suit their program requirements.

DATES: The public is encouraged to submit written comments on the proposed FAR methodology no later than January 4, 2013. All public comments received will be available for public inspection at HRSA's ORHP on weekdays between 8:30 a.m. and 5:00 p.m.

ADDRESSES: Comments may be submitted via email to shirsch@hrsa.gov; mail to Office of Rural Health Policy, Health Resources and Services Administration, 5600 Fishers Lane, Parklawn Building, 5A-05, Rockville, MD 20857; or fax to (301) 443-2803.

FOR FURTHER INFORMATION CONTACT: Questions about this request for public comment can be directed to Steven Hirsch using the contact information listed above.

SUPPLEMENTARY INFORMATION:

Background

ORHP was authorized by Congress in December of 1987 by Section 711 of the Social Security Act [42 U.S.C. 912], and charged with informing and advising HHS on matters affecting rural hospitals and health care and coordinating activities within the Department that relate to rural health care.

Definition of "rural." ORHP considers all nonmetropolitan (nonmetro) counties to be "rural" for the purposes of eligibility for its grant programs. Over the years, ORHP has funded development of a rational, data-driven method to designate rural areas inside of metropolitan counties. The Rural-Urban Commuting Area (RUCA) codes are used for determining grant eligibility. The RUCAs, which were developed by Richard Morrill and Gary Hart of the University of Washington and John Cromartie of the USDA's ERS, are based on a sub-county unit, the census tract, permitting a delineation of what constitutes rural areas inside metropolitan areas (see: [http://](http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx)

www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx). Using data from the Census Bureau, every census tract in the United States is assigned a RUCA code. Codes range from 1 through 10, with 23 sub codes, with code 1 representing the most densely populated urban areas and code 10 representing rural areas with primary commuting to a tract outside an Urbanized Area or Cluster. HRSA believes that the use of RUCAs allows more accurate targeting of resources intended for the rural population. Both ORHP and the Centers for Medicare & Medicaid Services have been using RUCAs for several years to determine programmatic eligibility for rural areas inside of metropolitan counties.

ORHP currently considers all census tracts with RUCA codes 4 through 10 to be rural. While use of the RUCA codes has allowed identification of rural census tracts in metropolitan counties, among the more than 60,000 tracts in the U.S., there are some that are extremely large and where use of RUCA codes alone fails to account for distance to services and sparse population. In response to these concerns, ORHP has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile. There is also a ZIP code-based version of the RUCA codes that is often used for policy analysis, research, and other purposes (see: <http://depts.washington.edu/uwruca/>).

Need for definition of "frontier and remote." Rural experts, researchers, and others have been calling for an improved way to identify frontier and remote areas. The most commonly used standard to date has been to identify frontier areas as those counties with six or fewer people per square mile. Researchers and policy experts have noted the shortcomings of this approach since it relies solely on population density and uses counties as the unit of measure despite the great disparity in