DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the National Coordinator for Health Information Technology; American Health Information Community Chronic Care Workgroup Meeting

ACTION: Announcement of meeting.

SUMMARY: This notice announces the 14th meeting of the American Health Information Community Chronic Care Workgroup in accordance with the Federal Advisory Committee Act (Pub. L. 92–463, 5 U.S.C., App.)

DATES: March 22, 2007, from 1 p.m. to 4 p.m.

ADDRESSES: Mary C. Switzer Building (330 C Street, SW., Washington, DC 20201), Conference Room 4090. Please bring photo ID for entry to a Federal building.

FOR FURTHER INFORMATION: *http://www.hhs.gov/healthit/ahic/chroniccare/*

SUPPLEMENTARY INFORMATION: The Workgroup will continue its discussion on ways to deploy widely available, secure technologies solutions for remote monitoring and assessment of patients and for communication between clinicians about patients.

The meeting will be available via Web cast. For additional information, go to: *http://www.hhs.gov/healthit/achic/chroniccare/cc_instruct.html*

Dated: February 12, 2007.

Judith Sparrow,

Director, American Health Information Community, Office of Programs and Coordination, Office of the National Coordinator for Health Information Technology.

[FR Doc. 07–816 Filed 2–22–07; 8:45 am]

BILLING CODE 4150–24–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the National Coordinator for Health Information Technology; American Health Information Community Population Health and Clinical Care Connections Workgroup Meeting

ACTION: Announcement of meeting.

SUMMARY: This notice announces the 15th meeting of the American Health Information Community Population Care and Clinical Care Connections Workgroup [formerly BioSurveillance Workgroup] in accordance with the Federal Advisory Committee Act (Pub. L. no. 92–463, 5 U.S.C., App.)

DATES: March 29, 2007, from 1 p.m. to 4 p.m.

ADDRESSES: Mary C. Switzer Building (330 C Street, SW., Washington, DC 20201), Conference Room 4090. Please bring photo ID for entry to a Federal building.

FOR FURTHER INFORMATION CONTACT: *http://www.hss.gov/healthit/ahic/population/.*

SUPPLEMENTARY INFORMATION: The Workgroup will continue its discussion on how to facilitate the flow of reliable health information among population health and clinical care systems necessary to protect and improve the public's health.

The meeting will be available via Web cast. For additional information, go to: *http://www.hhs.gov/healthit/ahic/population/pop_instruct.html.*

Dated: February 12, 2007.

Judith Sparrow,

Director, American Health Information Community, Office of Programs and Coordination, Office of the National Coordinator for Health Information Technology.

[FR Doc. 07–817 Filed 2–22–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–07–0242X]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–5960 or send an e-mail to *omb@cdc.gov*. Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project

Estimating the Cost of Sigmoidoscopy and Colonoscopy for Colorectal Cancer Screening in U.S. Healthcare Facilities (SECOST) —New—National Center for Chronic Disease and Public Health Promotion (NCDDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. In 2005, it was estimated that approximately 56,300 Americans died from CRC and about 145,300 new cases were diagnosed. The risk of developing CRC increases with advancing age. More than 90% of newly diagnosed CRCs occur in persons 50 years of age and older. Several scientific studies have demonstrated that regular screening for CRC reduces the incidence and mortality from this disease. Other studies have shown that regular screening for CRC is also cost-effective in terms of years of life saved.

Despite strong scientific evidence and evidence-based clinical guidelines recommending screening, current screening rates remain low. A recent CDC study reported that more than 40 million Americans who are 50 years of age or older and at average risk for CRC have not been screened in accordance with current guidelines. The study also reported that screening this population with current endoscopic (*i.e.*, flexible sigmoidoscopy and colonoscopy) capacity in the health care system could require as much as ten years to complete. An effective national effort to promote CRC screening could increase the demand for endoscopic procedures.

It has been reported that reimbursements for endoscopic procedures in publicly-funded programs may not be adequate to cover the costs of performing these procedures. This may be a disincentive for providers to perform endoscopy procedures. Currently, there is little information available about the resources required or the cost of providing these procedures in different types of healthcare facilities in the United States.

The purpose of this project is to conduct a survey of a nationally representative sample of healthcare facilities in order to estimate the average variable costs of providing colonoscopy and flexible sigmoidoscopy for CRC screening and follow-up services. Over time, payments need to cover fixed costs in addition to variable costs. If some facilities have the ability to provide more procedures without additional investment in space or equipment, then recovering fixed costs is not necessary at least in the short run. The estimated average variable cost by procedure will be compared to the reimbursement rates for both screening procedures in order to determine whether the payments to facilities exceed this minimum threshold. Otherwise, facilities will find reimbursement a potential barrier to expansion of CRC screening to