

referenced above, email your request, including your address, phone number, OMB number, and OS document identifier, to

Sherette.funncoleman@hhs.gov, or call the Reports Clearance Office on (202) 690-5683. Send written comments and recommendations for the proposed information collections within 30 days of this notice directly to the OS OMB Desk Officer; faxed to OMB at 202-395-5806.

Proposed Project: Public Health Service Policies on Research Misconduct

(42 CFR part 93)—OMB No 0937-0198—Extension—Office of Research Integrity

Abstract: This is a request for an extension of the currently approved collection. The purpose of the Annual Report on Possible Research Misconduct (Annual Report) form is to provide data on the amount of research misconduct activity occurring in institutions conducting PHS supported research. In addition this provides an annual assurance that the institution has established and will follow administrative policies and procedures for responding to allegations of research

misconduct that comply with the Public Health Service (PHS) Policies on Research Misconduct (42 CFR part 93). Research misconduct is defined as receipt of an allegation of research misconduct and/or the conduct of an inquiry and/or investigation into such allegations. These data enable the ORI to monitor institutional compliance with the PHS regulation. Lastly, the form will be used to respond to congressional requests for information to prevent misuse of Federal funds and to protect the public interest.

ESTIMATED ANNUALIZED BURDEN TABLE

Forms (if necessary)	Type of respondent	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
PHS-6349	Awardee Institutions	6,096	1	10/60	1,016

Keith A. Tucker,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. 2012-11921 Filed 5-16-12; 8:45 am]

BILLING CODE 4150-30-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Statement of Organization, Functions, and Delegations of Authority; Office of The National Coordinator for Health Information Technology

ACTION: Notice.

SUMMARY: The Office of the National Coordinator for Health Information Technology has reorganized its office in order to more effectively meet the mission outlined by The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA). The reorganization includes one change and five functional realignments.

FOR FURTHER INFORMATION CONTACT: Sam Shellenberger, Office of the National Coordinator, Office of the Secretary, 200 Independence Ave. SW., Washington, DC 20201, 202-690-7151.

Part A, Office of the Secretary, Statement of Organization, Functions and Delegations of Authority for the Department of Health and Human Services, Chapter AR, Office of the National Coordinator for Health Information Technology (ONC), as amended at 74 FR 62785-62786, dated December 1, 2009, as corrected at 75 FR 49494, dated August 13, 2010, as

amended at 76 FR 6795, dated February 8, 2011, and as last amended at 76 FR 65196, dated October 20, 2011, is amended as follows:

I. Under Section AR.10 Organization, insert “Office of the Chief Medical Officer (ARG)” as item C as follows and renumber items C through G accordingly.

II. Under Section AR. 10 Organization, delete “E. Office of the Chief Scientist (ARC)” and replace it with “E. Office of Science and Technology (ARC).”

III. Under Section AR.10 Organization, add a new line, “I. Office of Communications (ARH).”

IV. Under Section AR.20 Functions, insert the following new Paragraph C and renumber Paragraphs C through G accordingly:

C. Office of the Chief Medical Officer (ARG): The Office of the Chief Medical Officer works with and reports directly to the National Coordinator and will be responsible for working with private sector medical organizations to achieve widespread use of health information technology by physicians.

V. Under Section AR.20 Functions, Paragraph B, “Office of the Principal Deputy (ARA1),” at the end of the second sentence, remove “and, Office of the Chief Scientist” and add the following new language to the end of the sentence, “Office of Science and Technology, and Office of Communications.”

VI. Under Section AR.20 Functions, Paragraph E, “Office of the Chief Scientist (ARC)”:

A. Replace all instances of “Office of the Chief Scientist” with “Office of Science and Technology.”

B. Remove “and” before item (6) in the second sentence and add the following new language to the end of the sentence, “; and (7) developing the mechanisms for establishing and implementing standards necessary for nationwide health information exchange.”

VII. Under Section AR.20 Functions, Paragraph F, “Office of the Deputy National Coordinator for Programs & Policy (ARD)”:

A. Under the second sentence, remove “(3) developing the mechanisms for establishing and implementing standards necessary for nationwide health information exchange;” and renumber items (4) through (6) accordingly.

B. Remove the “and” before “(5)” and add the following new language to the end of the second sentence: “; (6) overseeing consumer use of electronic personal health information; and (7) leading activities for certification of health information technology.”

VIII. Under Section AR.20 Functions, Paragraph G, “Office of the Deputy National Coordinator for Operations (ARE),” third sentence, remove “(5) stakeholder communications;” and renumber item (6) accordingly.

IX. Under Section AR.20 Functions, insert new Paragraph I, as follows:

I. Office of Communications (ARH): The Office of Communications is headed by a Director. The Office is responsible for: (1) Setting the strategic direction for ONC communications efforts; (2) guiding the development of a comprehensive stakeholder

communications and constituency relations plan; and, (3) ensuring that all communications activities are developed and implemented consistent with and in support of this plan. The Office's activities promote ONC's broader mission of the nationwide implementation of interoperable health information technology in both the public and private health care sectors. Such activities include identifying ways to increase awareness of the value of electronic health records (EHRs) to improve health care and to create awareness of the HITECH Act provisions among all stakeholders.

X. Delegation of Authority. Pending further delegation, directives or orders by the Secretary or by the National Coordinator for Health Information Technology, all delegations and redelegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further redelegations, provided they are consistent with this reorganization.

Dated: May 7, 2012.

E.J. Holland, Jr.,

Assistant Secretary for Administration.

[FR Doc. 2012-11910 Filed 5-16-12; 8:45 am]

BILLING CODE 4150-24-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-12-12EL]

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 (404) 639-7570 or send an email to omb@cdc.gov. Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395-5806. Written comments should be received within 30 days of this notice.

Proposed Project

Critical Thinking and Cultural Affirmation (CTCA): Evaluation of a Locally Developed HIV Prevention Intervention—New—National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In 2005, the Centers for Disease Control and Prevention (CDC) reported that 80,187 African Americans were diagnosed with HIV/AIDS, which represents 51% of persons diagnosed. African-American men with HIV/AIDS represented 44% of all cases among males (Centers for Disease Control and Prevention [CDC], 2005). These statistics have been consistently disproportional since the late 1990s, with African Americans bearing the greatest burden of new HIV cases in most regions of the United States. The Centers for Disease Control and Prevention estimates that at the end of 2006, Blacks were disproportionately affected by HIV. The 2006 HIV infection rate in Blacks was nearly twice the rate of Whites (92 out of every 100,000 Blacks compared to 48 per 100,000 Whites and 31 per 100,000 Hispanics). Among males, Black males accounted for the largest number of diagnosed HIV infections and have the highest HIV infection rate of any race/ethnicity group (144 per 100,000, compared to 94 per 100,000 for White males and 50 per 100,000 for Hispanic males).

While many HIV prevention and intervention studies include samples of African-American men and African-American Men who have Sex with Men (AAMSM), beyond demonstrating disparities in seroprevalence between and among racial groups, few have been specifically designed and evaluated for efficacy among African American men. Because few HIV prevention interventions targeting AAMSM have been developed and rigorously evaluated, while their HIV infection rates remain disproportionately high and continue to rise, identifying effective interventions for AAMSM is a public health imperative.

The purpose of this project is to test the efficacy of an HIV transmission prevention intervention for reducing sexual risk among African American men who have sex with men in Chicago, Illinois. The intervention is a 3-day weekend retreat, group-level CTCA intervention that combines cultural affirmation with critical thinking and empowerment, to increase reasoning skill, problem solving capacity, self-protective behavior change, and well-being which facilitates the reduction of risky sexual behaviors. A convenience sample of 438 AAMSM will be recruited to participate in the study. We anticipate recruiting potential participants for the CTCA RCT through a variety of community venues, using both active (i.e., venue outreach) and passive (i.e., referral, flyers/handcards,

Internet) recruitment techniques. The intervention will be evaluated using baseline, 3-month and 6-month follow up assessments. This project will also conduct exit surveys to identify men who were more favorable—men who agreed with positive comments about the intervention and those who were less favorable—men who disagreed with positive comments about the intervention. Exit interviews will be conducted with 15 favorable and 15 less favorable men identified by the Exit Survey to help understand participants' experiences with the CTCA intervention and their thoughts about the content of the intervention and ways in which it could be improved. Using the participant responses to the exit survey, we will categorize participants into two categories: Favorable (those men reporting a favorable reaction to the intervention) and unfavorable (those men reporting an unfavorable reaction to the intervention). Once we have 50 participants in each category, we will randomly select 15 participants from each group and invite them to participate in the exit interview. We anticipate that we will need to repeat these procedures and extend an invitation to at least 65 participants in order to reach and successfully interview 15 participants in each group.

CDC is requesting approval for a 3-year clearance for data collection. The data collection system involves a pre and full screening, brief locator information, record locator information, baseline assessment, 3-month follow-up assessment, 6-month follow-up assessment, participant evaluation forms, exit survey, and exit interviews. An estimated 1000 men will be pre-screened and 515 will be full-screened for eligibility in order to enroll 438 men. The baseline and follow up questionnaires will be administered electronically using audio computer assisted self-interview (ACASI). The ACASI interview includes questions about participants' socio-demographic information, health and healthcare, sexual activity, substance use, and other psychosocial issues. The duration of each baseline, 3-month, and 6-month assessments are estimated to be 60 minutes; the exit survey 10 minutes; the exit interview 30 minutes; pre-screening form 5 minutes; full-screening form 10 minutes; brief locator information form 5 minutes; record locator information form 10 minutes; each participant evaluation survey 5 minutes.

There is no cost to participants other than their time. The total estimated annual burden hours are 527.