assessing performance and capacity and identifying areas for improvement. It is anticipated that the updated data collection instrument will be voluntarily used by states for similar purposes.

From 1998–2002, the CDC National Public Health Performance Standards Program convened workgroups with the National Association of County and City Health Officials (NACCHO), The Association of State and Territorial Health Officials (ASTHO), the National Association of Local Boards of Health (NALBOH), the American Public Health Association (APHA), and the Public Health Foundation (PHF) to develop performance standards for public health systems based on the essential services of public health.

In 2005, CDC reconvened workgroups with these same organizations to revise the data collection instruments, in order to ensure the standards remain current and improve user friendliness.

There is no cost to the respondents other than their time. The total estimated annualized burden hours are 96.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
State Public Health Systems	8	1	12

Dated: April 25, 2007.

Maryam Daneshvar,

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

[FR Doc. E7–8415 Filed 5–2–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel: HIV/AIDS Risk Reduction Intervention for Heterosexually Active African American Men, Funding Opportunity Announcement (FOA) Number PS07–002

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces a meeting of the aforementioned Special Emphasis Panel.

Time and Date: 12 p.m.–4 p.m., May 24, 2007 (Closed).

Place: Teleconference. Corporate Square, Building 12, Conference Room 3106.

Status: The meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters to be Discussed: The meeting will include the review, discussion, and evaluation of research applications received in response to FOA PS07–002, ''HIV/AIDS Risk Reduction Intervention for Heterosexually Active African American Men.''

Contact Person for More Information: J. Felix Rogers, PhD, M.P.H., Scientific Review Administrator, Centers for Disease Control and Prevention, 1600 Clifton Road, NE., MS E05, Atlanta, GA 30333, telephone 404.639.6101.

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 CDC and the Agency for Toxic Substances and Disease Registry.

Dated: April 27, 2007.

Elaine L. Baker,

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

[FR Doc. E7–8457 Filed 5–2–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Request for Public Comment on Use of Rural Urban Commuting Areas (RUCAs)

AGENCY: Health Resources and Services Administration, HHS.

SUMMARY: The Health Resources and Services Administration's (HRSA) Office of Rural Health Policy (ORHP) has sought to identify clear, consistent, and data-driven methods of defining rural areas in the Metropolitan counties of the United States. ORHP has funded development of Rural-Urban Commuting Area (RUCA) codes as the latest version of the Goldsmith Modification. HRSA is seeking comments on ORHP's use of RUCAs to better target Rural Health funding and projects. While other agencies of HHS may choose to adopt ORHP's definition of ''rural'' there is no requirement that they do so and they may choose other, alternate definitions that best suit their program requirements.

Background

The Office of Rural Health Policy (ORHP) was authorized by Congress in December 1987 in Public Law 100–203 and located in the Health Resources and Services Administration (HRSA). Congress charged the Office with informing and advising the Department of Health and Human Services on matters affecting rural hospitals and health care and coordinating activities within the Department that relate to rural health care.

The fiscal year (FY) 1991 appropriation allocated funds for Health Services Outreach Grants in rural areas. The FY 1991 Senate Appropriations Committee Conference Report stated that these grants were intended for ''outreach to populations in rural areas that do not normally seek health or mental health services.''

With the creation of the Rural Health Outreach Grant Program, HRSA assumed the responsibility of determining eligibility for the grants. In 1991, there were two principal definitions of ''rural'' that were in use by the Federal Government. The oldest was the Census Bureau definition, which defined ''rural'' as all areas that were either not part of an urbanized area or were not part of an incorporated area of at least 2,500 persons. Urbanized areas were defined as densely settled areas with a total population of at least 50,000 people. The building block of urbanized areas is the census block, a sub-unit of census tracts.

The other major Federal definition in use was based on the Office of Management and Budget's (OMB) list of counties that are designated as part of a Metropolitan Area. All counties that were not designated as Metropolitan were considered ''rural'' or, more accurately, non-metropolitan. Metropolitan Areas, in 1990, had to

include ''a city of 50,000 or more population,'' or ''a Census Bureau defined urbanized area of at least 50,000 population, provided that the component county/counties of the metropolitan statistical area have a total population of at least 100,000.'' At that time, around three quarters of all counties in the United States were not classified as parts of Metropolitan Areas.

Both the Census Bureau and OMB definitions were criticized for not actually defining ''rural'' at all but simply defining rurality by exclusion; all areas that are not ''urbanized'' are rural in the Census definition, and all counties that are not ''Metropolitan'' are non-metropolitan or rural under the OMB definition. Under both definitions, rurality is not actually defined; rather, rural is simply what is not included in the defined classifications.

Due to ease of use (counties are easily recognizable administrative units, while Census blocks are not), ORHP chose to use the OMB definition as the basis of determining eligibility for its Rural Health Grant Programs. In effect, this meant that the population in all non-metropolitan counties was eligible, but none of the population in Metropolitan counties was eligible. At the same time, ORHP recognized that there were still rural areas within the Metropolitan counties. It was estimated that approximately 14 percent of the Metropolitan population, nearly 25 million people, resided in rural areas as defined by the Census Bureau in 1980.

Rather than exclude large numbers of rural citizens from eligibility for the Rural Health Outreach Grants, ORHP sought a rational, data-driven method to designate rural areas inside of Metropolitan counties. Known as the ''Goldsmith Modification'' for its principal developer, Harold F. Goldsmith, this method is described in detail in the paper ''Improving the Operational Definition of ''Rural Areas'' for Federal Programs'' available at *http://ruralhealth.hrsa.gov/pub/Goldsmith.htm.* The original Goldsmith Modification used data from the 1980 decennial census and applied only to Large Metropolitan Counties (LMCs), those of at least 1225 square miles in area. Using census tracts as a sub-county unit, the Goldsmith Modification enabled the identification of rural areas inside Metropolitan counties. The Goldsmith Modification permitted health care providers and other organizations in designated rural census tracts in LMCs to apply for and receive Rural Health grants. It was also used by the Centers for Medicare and Medicaid Services (CMS) to determine eligibility for some of its programs. There were, however, certain limitations to the use of the Goldsmith Modification. Due to the lack of availability of data from the 1990 census, data from the 1980 census was used. In addition, analysis of data was limited to counties that met the somewhat arbitrary criteria of being larger than 1225 square miles in area.

ORHP continued to pursue means of identifying rural areas using sub-county units of measurement. Ideally, use of a sub-county unit would allow consideration both of the scale of the population residing in the unit and their proximity to other services.

ORHP has funded the development of RUCA codes as an update to the Goldsmith Modification to be used for determining grant eligibility. Developed by Richard Morrill and Gary Hart, of the University of Washington, and John Cromartie, of the U.S. Department of Agriculture's (USDA) Economic Research Service, the RUCAs are described at length in a 1999 paper published in the journal *Urban Geography.*

RUCAs, like the Goldsmith modification, are based on a sub-county unit, the census tract, permitting a finer delineation of what constitutes rural areas inside Metropolitan areas. There are over 60,000 census tracts, none of which overlap county borders. The merits of using census tracts as the unit of measurement were described in a paper in the USDA publication *Rural Development Perspectives* in 1996. ''Census tracts are large enough to have acceptable sampling error rates (containing an average of 4,000 people); are consistently defined across the Nation; are usually subdivided as population grows to maintain geographic comparability over time; and can be aggregated to form county-level statistical areas when needed.''

Using data from the Census Bureau, every census tract in the United States is assigned a RUCA code. Currently, there are ten primary RUCA codes with 30 secondary codes (see Table 1).

TABLE 1.—RURAL-URBAN COMMUTING AREAS (RUCAS), 2000

1 Metropolitan area core: Primary flow within an urbanized area (UA):
- 1.0 No additional code.
- 1.1 Secondary flow 30% to 50% to a larger UA.

2 Metropolitan area high commuting: Primary flow 30% or more to a UA:
- 2.0 No additional code.
- 2.1 Secondary flow 30% to 50% to a larger UA.

3 Metropolitan area low commuting: Primary flow 5% to 30% to a UA:
- 3.0 No additional code.

TABLE 1.—RURAL-URBAN COMMUTING AREAS (RUCAS), 2000—Continued

4 Micropolitan area core: Primary flow within an Urban Cluster of 10,000 to 49,999 (large UC):
- 4.0 No additional code.
- 4.1 Secondary flow 30% to 50% to a UA.
- 4.2 Secondary flow 10% to 30% to a UA.

5 Micropolitan high commuting: Primary flow 30% or more to a large UC:
- 5.0 No additional code.
- 5.1 Secondary flow 30% to 50% to a UA.
- 5.2 Secondary flow 10% to 30% to a UA.

6 Micropolitan low commuting: Primary flow 10% to 30% to a large UC:
- 6.0 No additional code.
- 6.1 Secondary flow 10% to 30% to a UA.

7 Small town core: Primary flow within an Urban Cluster of 2,500 to 9,999 (small UC):
- 7.0 No additional code.
- 7.1 Secondary flow 30% to 50% to a UA.
- 7.2 Secondary flow 30% to 50% to a large UC.
- 7.3 Secondary flow 10% to 30% to a UA.
- 7.4 Secondary flow 10% to 30% to a large UC.

8 Small town high commuting: Primary flow 30% or more to a small UC.
- 8.0 No additional code.
- 8.1 Secondary flow 30% to 50% to a UA.
- 8.2 Secondary flow 30% to 50% to a large UC.
- 8.3 Secondary flow 10% to 30% to a UA.
- 8.4 Secondary flow 10% to 30% to a large UC.

9 Small town low commuting: Primary flow 10% to 30% to a small UC:
- 9.0 No additional code.
- 9.1 Secondary flow 10% to 30% to a UA.
- 9.2 Secondary flow 10% to 30% to a large UC.

10 Rural areas: Primary flow to a tract outside a UA or UC:
- 10.0 No additional code.
- 10.1 Secondary flow 30% to 50% to a UA.
- 10.2 Secondary flow 30% to 50% to a large UC.
- 10.3 Secondary flow 30% to 50% to a small UC.
- 10.4 Secondary flow 10% to 30% to a UA.
- 10.5 Secondary flow 10% to 30% to a large UC.
- 10.6 Secondary flow 10% to 30% to a small UC.

More complete information on the latest iteration of the RUCA codes is available at the Department of Agriculture's Web site, measuring rurality: Rural-urban commuting area codes *http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/*

and at the WWAMI (Washington, Wyoming, Alaska, Montana, & Idaho) Rural Health Research Center's Web site, *http://depts.washington.edu/uwruca/.*

In the past, ORHP has issued a list of eligible, rural ZIP codes in Metropolitan counties based on the RUCAs rather than eligible census tracts due to potential applicants for Rural Health grants being able to easily ascertain whether they lived in an eligible ZIP code area. However, with the advent of the World Wide Web, applicants are now able to easily access information about census tracts, and to identify the tract identifying number of any address—(*http://www.ffiec.gov/geocode/default.htm*). Further information on the ZIP code approximation of the census tract-based RUCA codes is available at *http://depts.washington.edu/uwruca/approx.html.*

HRSA believes that the use of RUCAs allows more accurate targeting of resources intended for the rural population. Both ORHP and CMS 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 4–10 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.

ORHP will continue to seek refinements in the use of RUCAs. This may include further data on travel times so that areas with heavy commuting to urbanized areas, but which are too distant from the urbanized area for the residents to be able to easily access health care services, can also be designated as rural.

HRSA is now seeking public comments on:

1. The use of census tract RUCA codes to determine eligibility rather than RUCA codes which have been cross-walked to ZIP code areas,

2. The possible use of RUCA sub-codes, to more accurately identify rural areas inside Metropolitan counties, and

3. The possible use of travel times along with RUCAs to identify census tracts inside Metropolitan counties as rural rather than using tract size and population density.

DATES: The public is encouraged to submit written comments on the report and its recommendations July 2, 2007.

ADDRESSES: The following mailing address should be used: Office of Rural Health Policy, Health Resources and Services Administration, 5600 Fishers Lane, Parklawn Building, 9A–55, Rockville, MD 20857. HRSA/ORHP's facsimile number is (301) 443–2803. Comments can also be sent via e-mail to *shirsch@hrsa.hhs.gov.* All public comments received will be available for public inspection at ORHP/HRSA's office between the hours of 8:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT: Questions about this request for public comment can be directed to Steven Hirsch, by e-mail (*shirsch@hrsa.hhs.gov*) or at the address above.

Dated: April 25, 2007.

Elizabeth M. Duke,

Administrator.

[FR Doc. E7–8492 Filed 5–2–07; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Comments are invited on: (a) Whether the proposed collections of information are 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.

Proposed Project: Substance Abuse Prevention and Treatment Block Grant Synar Report Format, FFY 2005–2007—(OMB No. 0930–0222)—Revision

Section 1926 of the Public Health Service Act [42 U.S.C. 300x–26] stipulates that funding Substance Abuse Prevention and Treatment (SAPT) Block Grant agreements for alcohol and drug abuse programs for fiscal year 1994 and subsequent fiscal years require States to have in effect a law providing that it is unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18. This section further requires that States conduct annual, random, unannounced inspections to ensure compliance with the law; that the State submit annually a report describing the results of the inspections, describing the activities carried out by the State to enforce the required law, describing the success the State has achieved in reducing the availability of tobacco products to individuals under the age of 18, and describing the strategies to be utilized by the State for enforcing such law during the fiscal year for which the grant is sought.

Before making an award to a State under the SAPT Block Grant, the Secretary must make a determination that the State has maintained compliance with these requirements. If a determination is made that the State is not in compliance, penalties shall be applied. Penalties ranged from 10 percent of the Block Grant in applicable year 1 (FFY 1997 SAPT Block Grant Applications) to 40 percent in applicable year 4 (FFY 2000 SAPT Block Grant Applications) and subsequent years. Respondents include the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Palau, Micronesia, and the Marshall Islands.

Regulations that implement this legislation are at 45 CFR 96.130, are approved by OMB under control number 0930–0163, and require that each State submit an annual Synar report to the Secretary describing their progress in complying with section 1926 of the PHS Act. The Synar report, due December 31 following the fiscal year for which the State is reporting, describes the results of the inspections and the activities carried out by the State to enforce the required law; the success the State has achieved in