Respondents	Number of respondents	Number of responses/ respondent	Avg. burden/response (in hrs.)	Total burden (in hrs.)
Local public health systems	320	1	6	1,920
Total				1,920

Dated: May 19, 2000.

Charles W. Gollmar,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–13244 Filed 5–25–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30DAY–36–00]

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) 639–7090. Send written comments to CDC, Desk Officer; Human Resources and Housing Branch, New Executive Office Building, Room 10235; Washington, DC 20503. Written comments should be received within 30 days of this notice.

Proposed Projects

1. Congenital Syphilis (CS) Case Investigation and Report Form (0920–0128)—Extension—The Centers for Disease Control and Prevention (CDC) proposes to continue data collection for congenital syphilis case investigations under the Congenital Syphilis Case Investigation and Report Form (CDC 73.126 REV 11–98), currently approved under OMB No. 0920–0128. This request is for a 3-year extension of clearance. Reducing congenital syphilis is a national objective in the DHHS Report entitled Healthy People 2000: Mid-course Review and 1995 Revisions. Objective 19.4 of this document states the goal: ''reduce congenital syphilis to an incidence of no more than 40 cases per 100,000 live births'' by the year 2000. In order to meet this national objective, an effective surveillance system for congenital syphilis must be continued in order to monitor current levels of disease and progress towards the year 2000 objective. This data will also be used to develop intervention strategies and to evaluate ongoing control efforts.

Respondent burden is approximately 15 minutes per reported case. The estimated annual number of cases expected to be reported using the current case definition is 1,000 or less. Therefore, the total number of hours for congenital syphilis reporting required will be approximately 260 hours per year. The annualized cost to the respondents is $9,100 based on the average hourly wage of $35.00 per hour for respondents (clerical and nursing staff from 65 project areas).

Respondents	No. of respondents	No. of responses/ respondent	Avg. burden/response (in hrs.)	Total burden (in hrs.)
State and local health departments	65	16	15/60	260
Total				260

Dated: May 19, 2000.

Charles W. Gollmar,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–13245 Filed 5–25–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 00091]

State Cardiovascular Health Programs; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2000 funds for a cooperative agreement program for State Cardiovascular Health Programs. CDC is committed to achieving the health promotion and disease prevention objectives of ''Healthy People 2010,'' a national activity to reduce the morbidity and improve the quality of life. This program addresses the ''Healthy People 2010'' focus area of Heart Disease and Stroke. For the conference copy of ''Healthy People 2010'', visit the internet site: <http://www.health.gov/healthypeople>.

The purpose of the program is assist States in developing, implementing, and evaluating cardiovascular health promotion, disease prevention, and control programs. Also, to assist States in developing their Core Capacity Programs into Comprehensive Programs. Core Capacity Programs are the foundation upon which comprehensive cardiovascular health programs can be built.

Special Guidelines for Technical Assistance

Conference Call

Technical assistance will be available for potential applicants on a conference call to be held from 2:00 EDT to 4:00 EDT on June 6, 2000. Potential applicant are requested to call in using only one telephone line. The conference can be accessed by calling 1–800–311–3437 [Federal call (404) 639–3277] and entering access code 371045. The purpose of the conference call is to help potential applicants to:

1. Understand the scope and intent of the Program Announcement for the State Cardiovascular Health Programs;

2. Be familiar with the Public Health Services funding policies and application and review procedures. Participation in this conference call is not mandatory. At the time of the call if you have problems accessing the call, contact 770–488–2525.

B. Eligible Applicants

Assistance will be provided only to the health departments of States or their bona fide agents, except for the 11 States currently receiving funds under Program Announcement 98084, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

State health departments are uniquely qualified to define the cardiovascular disease problem throughout the State, to plan and develop statewide strategies to reduce the burden of cardiovascular diseases, to provide overall State coordination of cardiovascular health promotion, disease prevention, and control activities among partners, to lead and direct communities, to direct and oversee interventions within overarching State policies, and to monitor critical aspects of cardiovascular diseases.

Eligible applicants may apply for either the Core Capacity Program or the Comprehensive Program. However, applicants choosing to apply for the Comprehensive Program must meet the matching requirement for State funds (see Recipient Financial Participation).

To improve the cardiovascular health of all Americans, every State health department should have the capacity, commitment, and resources to carry out a comprehensive cardiovascular health promotion, disease prevention and control program. Applicants may apply for one, but not both, of the following levels of support:

1. A Core Capacity Program to develop basic cardiovascular health promotion, disease prevention, and control functions and activities at the State level such as partnerships and program coordination related to primary and secondary prevention; scientific capacity; inventory of policy and environmental strategies; a State plan for cardiovascular health promotion, disease prevention, and control; training and technical assistance; culturally-competent strategies for addressing priority populations (See Attachment I); and population-based intervention strategies.

2. A Comprehensive Program to continue and enhance core capacity functions, as needed, as well as implement, disseminate, and evaluate intervention activities throughout the State using State-level organizations, health care settings, work sites, schools, media, the government, and community-based organizations as primary modes of intervention for cardiovascular health promotion, disease prevention, and control; monitor secondary prevention strategies; and complement professional education activities. In addition to the components of the Core Capacity Programs, the Comprehensive Programs extend resources to local health agencies, communities, and organizations for implementation of cardiovascular health strategies.

C. Availability of Funds

Approximately $4,950,000 is available in FY 2000 to fund approximately seven awards.

1. Approximately $1,200,000 is available for approximately 3 to 5 Core Capacity Program awards. It is expected that the average award will be $300,000, ranging from $250,000 to $450,000.

2. Approximately $3,750,000 is available for approximately 2 to 4 Comprehensive Program awards. It is expected that the average award will be $1,250,000, ranging from $1,000,000 to $1,400,000.

It is expected that the awards will begin on or about September 30, 2000 and will be made for a 12-month budget period within a project period of up to three years. Funding estimates may change.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds.

States that apply for Comprehensive Program funding should submit in their applications evidence that they have significant core capacity as specified in the Core Capacity Program Recipient Activities 1 through 5.

Direct Assistance

You may request Federal personnel as direct assistance in lieu of a portion of financial assistance.

Use of Funds

Funds provided under this program announcement are not intended to be used to conduct community-based pilot or demonstration research projects. Cooperative agreement funds may be used to support personnel and to purchase equipment, supplies, and services directly related to program activities and consistent with the scope of the cooperative agreement. Cooperative agreement funds may not be used to supplant State or local funds, to provide inpatient care or personal health services, or support construction or renovation of facilities. Secondary prevention activities cannot provide for drugs, patient rehabilitation, or other costs associated with the treatment of cardiovascular diseases.

Recipient Financial Participation

Under the Comprehensive Program of this announcement, matching funds are required from State sources in an amount not less than $1 for each $4 of Federal funds awarded. Applicants for the Comprehensive Program must provide evidence of State-appropriated resources targeting cardiovascular health promotion, disease prevention, and control of at least twenty percent of the total approved budget. The Preventive Health and Health Services (PHHS) Block Grant may not be included as State resources.

Applicants may not use these funds to supplant funds from State sources or the Preventive Health and Health Services Block Grant dedicated to cardiovascular disease. Applicants must maintain current levels of support dedicated to cardiovascular disease from State sources or the Preventive Health and Health Services Block Grant.

Funding Preferences

A preference will be given to those States in which mortality rates from ischemic heart disease or stroke exceed the national rates by ten percent or more. The States eligible for a preference (based on National Vital Records) that are not presently funded include: Arkansas, Indiana, Ohio, Oklahoma, Tennessee, and the District of Columbia.

Other States or territories may request preference status; but, they must provide evidence that their mortality rate from ischemic heart disease exceeds 189.7/100,000 or the mortality rate from stroke exceeds 44.4/100,000. Mortality statistics provided by the applicant must use ICD–9 codes of 410–414 (Ischemic heart disease) and 430–438 (Stroke), age-adjusted to the 1970 U.S. population, resident population only, for the 35–74 year-old population of the State, for 1991–1995 based on National Vital Records available on CDC WONDER.

D. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient

will be responsible for conducting the activities under 1.a. (Recipient Activities for Core Capacity Programs) or under 1.b. (Recipient Activities for Comprehensive Programs), and CDC will be responsible for the activities listed under 2. (CDC Activities).

1.a. Recipient Activities for Core Capacity Programs

(1) Develop and Coordinate Partnerships. Identify, consult with, and appropriately involve State cardiovascular health partners to identify areas critical to the development of a statewide cardiovascular health promotion, disease prevention, and control program, coordinate activities, avoid duplication of effort, and enhance the overall leadership of the State with its partners. Within the State health department, coordinate and collaborate with partners in nutrition, physical activity, tobacco, secondary prevention, diabetes, health education, Preventive Health and Health Services Block Grant, office of minority health, laboratory, as well as with data partners such as vital statistics and the State's Behavioral Risk Factor Surveillance System. Efforts to address tobacco use should be coordinated with the State tobacco program; tobacco-related activities should not be duplicated. Within State government, collaborate and partner with other departments such as education, transportation, parks and recreation and with State agency data partners, such as the youth risk behavioral surveillance system. Within the State, collaborate with other organizations such as the American Heart Association and other peer review organizations. Partnerships and collaborative efforts may develop into memorandums of agreement (MOA) or similar formalized arrangements. The State health department should organize a statewide work group or coalition with representation from other agencies, professional and voluntary groups, academia, community organizations, the media, and the public to develop a state plan.

(2) Develop Scientific Capacity to Define the Cardiovascular Disease Problem. Enhance epidemiology, statistics, surveillance, and data analysis from existing data systems such as vital statistics, hospital discharges, and Behavioral Risk Factor Surveillance System (BRFSS). This should include the collecting of cardiovascular-related data using the BRFSS protocols and time line. It is suggested that funded States collect data on the BRFSS sections or modules on Hypertension Awareness, Cholesterol Awareness, and Cardiovascular Disease in odd years (*i.e.,* 2001, 2003).

It is suggested that funded States collect data using the Module on Heart Attack and Stroke Signs and Symptoms at least every four years (*i.e.,* 2001, 2005) or, if possible, every two years (*i.e.,* 2001, 2003, 2005). The enhanced scientific capacity should include efforts to determine: (a) Trends in cardiovascular diseases, including age of onset of disease and age at death. (b) Geographic distribution of cardiovascular diseases.

(c) The racial and ethnic disparities in cardiovascular diseases.

(d) Ways to integrate systems to provide comprehensive data needed for assessing and monitoring the cardiovascular health of populations and program outcomes.

Monitoring and program evaluation are considered essential components of building scientific capacity. Scientific capacity may also extend to developing access to outside databases such as medical care, and to laboratory development consistent with the overall direction of the program. State public health laboratories, or laboratories contracted by States to perform lipid and lipoprotein testing, should be standardized by the CDC Lipid Standardization Program.

(3) Develop an Inventory of Policy and Environmental Strategies. Develop an inventory of policy and environmental issues in systems and settings (*e.g.,* State-level, communities, health care sites, work sites, schools) affecting the cardiovascular health of the general population and priority populations. The inventory should focus on physical activity, nutrition, tobacco, elevated blood pressure, and elevated cholesterol. It should initially focus on state-level systems, and by funding future years it should include the remaining four settings (*i.e.,* communities, health care sites, work sites, schools). Items inventoried could include issues related to food service policies; availability of environmental strategies for being active such as sidewalks, recreation centers, parks, walking trails; and restrictions on tobacco. Health care-related policy and environmental issues should relate to the standards of care for primary and secondary prevention and should be assessed in collaboration with purchasers of medical care, managed care organizations, and consumers. Attention should be paid to the needs of priority populations and the policy and environmental issues most vital to their cardiovascular health.

(4) Develop or Update a State Plan. Develop or update a comprehensive State Plan for cardiovascular health promotion, disease prevention, and control to include specific objectives for future reductions in cardiovascular diseases and related risk factors. Develop a thorough description of the cardiovascular disease burden geographically and demographically, set objectives, and include population-specific strategies for achieving the objectives. The strategies should emphasize population-based policy and environmental approaches and education and awareness that increase support for policy and environmental approaches. It should also address the needs of priority populations. The strategies may also include planning for program development at the community level, particularly for priority populations. Partners should be involved in the development and implementation of the cardiovascular health State Plan.

(5) Provide Training and Technical Assistance. Increase the skill-level of State health department staff and partners in areas such as approaches to population-based interventions utilizing policy and environmental strategies; cardiovascular diseases and related risk factors including nutrition, physical activity, tobacco, elevated blood pressure, and elevated cholesterol; secondary prevention; social marketing and communications; epidemiology; cultural competency; use of data in program planning; and program planning and evaluation. Training may address State and local health department staff and partners, and may include provision of technical assistance to communities, work sites, health sites, schools, and faith-based organizations.

(6) Develop Population-Based Strategies. Develop population-based intervention strategies to promote cardiovascular health, promote primary and secondary prevention of cardiovascular diseases and related risk factors (*e.g.,* nutrition, physical activity, tobacco, elevated blood pressure, and elevated cholesterol); increase awareness of first signs and symptoms of heart attack and stroke, educate about the need for policy and environmental approaches, and reduce the burden of cardiovascular diseases in the State. The strategies may use State-level organizations, health sites, work sites, schools, media, faith-based organizations, community-based organizations, and governments as effective means to reach people.

(7) Develop Culturally-Competent Strategies for Priority Populations. Develop strategies for enhanced program efforts to address priority

populations. Specify how interventions would be designed appropriately for the priority populations to be addressed. Strategies should focus on policy and environmental approaches specific for the population to be addressed but may, on a limited basis, include interventions such as community events, screenings, and campaigns designed to increase awareness of the cardiovascular disease burden and risk factors in the priority populations and to promote policy and environmental strategies to improve cardiovascular health and reduce risk factors. Initiatives may be used to demonstrate the effectiveness of selected strategies or as a means to generate community support for policy and environmental strategies.

1.b. Recipient Activities for Comprehensive Programs

(1) Implement Population-Based Intervention Strategies Consistent with the State Plan. Strategies should include policy and environmental approaches, education and awareness supportive of the need for policy and environmental approaches, and other population-based approaches. These may be disseminated through various settings and groups including State-level organizations, health care settings, work sites, schools, community-based organizations, governments, and the media. Interventions should be population-based, with objectives established that specify the population-wide changes sought. Approaches should extend to a relatively large proportion of the population to be addressed, rather than a few selected communities. Interventions should be coordinated such that health messages, policies, and environmental measures are consistent, the most cost-effective methods are used for reaching the populations, and duplication of effort is avoided. Interventions should address physical activity, nutrition, tobacco, elevated blood pressure, elevated cholesterol and secondary prevention. Efforts to address tobacco use should be coordinated with the State tobacco program; tobacco-related activities should not be duplicated. Implementation may extend to grants and contracts with local health agencies, communities, and nonprofit organizations.

(2) Implement Strategies Addressing Priority Populations. These strategies may include interventions directed to specific communities and segments of the population, and may include all appropriate modes of intervention needed to reach the populations to be addressed. These strategies may include more intensive, directed interventions by organizations concerned with improving the health and quality of life of priority populations, including community-based organizations, State-level organizations, faith-based organizations, work sites, health care sites, and schools.

(3) Specify and Evaluate Intervention Components. Design and implement a program evaluation system. The evaluation plan should address measures considered critical to determine the success of the program. Evaluation should be limited in scope to address strategy implementation, changes in policies and the physical and social environments affecting cardiovascular health and, to a lesser degree, changes in behavioral risk factors. Evaluation should not include comparison communities or quasi-experimental designs. Evaluation should cover both population-based strategies as well as targeted strategies. Evaluation should rely primarily upon existing data systems such as vital statistics and hospital discharges.

(4) Implement Professional Education Activities. Provide or collaborate with partners to provide professional education to health providers and others to assure appropriate primary and secondary prevention practices are offered routinely and to assure that appropriate standards of care are provided to all.

(5) Monitor Secondary Prevention Strategies. Secondary prevention strategies may include such issues as aspirin and drug therapy, physical activity regimens, hormone replacement therapy, dietary changes, and hypertension and lipid management. Activities in secondary prevention should include monitoring the delivery of secondary prevention practices and collaborating with partners on professional education and policy change related to the implementation of the American Heart Association guidelines on primary and secondary prevention. Development of monitoring systems for secondary prevention practices may be coordinated with managed care providers, Medicaid, major employers, insurers, other organized health care providers, and purchasers of health care. Secondary prevention strategies may be integrated with professional education initiatives. Secondary prevention should not provide for drugs, patient rehabilitation, or other costs associated with the treatment of cardiovascular diseases.

2. CDC Activities

a. Provide technical assistance in the coordination of surveillance and other data systems to measure and characterize the burden of cardiovascular diseases. Provide technical assistance in the design of surveillance instruments and sampling strategies, and provide assistance in the processing of data for States. Provide data on populations at highest risk. Provide data for national-level comparisons.

b. Collaborate with the States and other appropriate partners to develop and disseminate programmatic guidance and other resources for specific interventions, media campaigns, and coordination of activities.

c. Collaborate with the States and other appropriate partners to develop and disseminate recommendations for policy and environmental interventions including the measurement of progress in the implementation of such interventions.

d. Collaborate with appropriate public, private, and nonprofit organizations to coordinate a cohesive national program.

e. Provide technical assistance to the State public health laboratory or contract laboratory to standardize cholesterol, high density lipoproteins, and triglyceride measurements.

f. Provide training and technical assistance regarding the coordination of interventions, policy and environmental strategies, and population-based strategies.

g. If requested, provide Federal personnel in lieu of a portion of the financial assistance.

E. Application Content

Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan. Applications for the Core Capacity Program should not exceed 60 double-spaced pages, printed on one-side, in 12 point font, excluding budget, justification, and appendixes. Applications for the Comprehensive Program should not exceed 130 double-spaced pages, printed on one-side, in 12 point font, excluding budget, justification, and appendixes. Applicants should also submit appendixes including resumes, job descriptions, organizational chart, facilities, and any other supporting documentation as appropriate. All materials must be suitable for photocopying (*i.e.,* no audiovisual materials, posters, tapes, etc.)

Applicants may apply for funding of either Core Capacity activities or Comprehensive activities, but not both, and must designate in the Executive

Summary of their application the component (Core Capacity Program or Comprehensive Program) for which they are applying. Provide the following information:

1. Executive Summary

All applicants must provide a summary of the program described in the proposal (two pages maximum).

2. Core Capacity Program

a. Staffing (not included in 60-page limitation)

Describe program staffing and qualifications including contacts for physical activity, nutrition, tobacco, secondary prevention, epidemiology, and evaluation. Provide organizational chart, resumes, job descriptions, and experience for all budgeted positions. Describe lines of communication between various related chronic disease programs.

b. Facilities (not included in 60-page limitation)

Describe facilities and resources available to the program, including equipment available, communications systems, computer capabilities and access, and laboratory facilities if appropriate.

c. Background and Need

Thoroughly describe the need for funding and the current resources available for Core Capacity activities, to include:

(1) The overall State cardiovascular disease problem.

(2) The geographic patterns, trends, age, gender, racial and ethnic patterns, and other measures or assessments.

(3) The barriers the State currently faces in developing and implementing a statewide program for the prevention of cardiovascular diseases.

(4) The advisory groups, partnerships, or coalitions currently involved with the State health department for cardiovascular disease prevention and control.

(5) The current chronic disease programs within the State health department.

(6) The gaps in resources, staffing, capabilities, and programs that, if addressed, might further the progress of cardiovascular disease prevention; and how the funds will be used to fill the gaps in the core capabilities of the State cardiovascular disease prevention and control efforts.

d. Core Capacity Work Plan

Provide a work plan that addresses each of the required Core Capacity elements cited in the Recipient Activities section above, to include the following information:

(1) Program objectives for each of the elements. Objectives should describe what is to happen, by when, and to what degree.

(2) The proposed methods for achieving each of the objectives.

(3) The proposed plan for evaluating progress toward attainment of the objectives.

(4) A milestone, time line, and completion chart for all objectives for the project period.

e. Core Capacity Program Budget

Provide a detailed line-item budget with justifications consistent with the purpose and proposed objectives, using the format on CDC Form 0.1246. Applicants are encouraged to include budget items for travel for three trips to Atlanta, Georgia for three individuals to attend three-day training and technical assistance workshops.

Supporting material such as organizational charts, tables, position descriptions, relevant publications, letters of support, memorandums of agreement, etc., should be included in the appendixes and be reproducible.

3. Comprehensive Program (Narrative portions of the Comprehensive Program application may not exceed 130 double-spaced pages using 12 point font)

a. Background and Need

(1) Provide evidence that the State health department has significant core capacity as specified in the Core Capacity Program Recipient Activities 1 through 5.

(2) Provide a thorough description of the overall burden of Cardiovascular disease and related risk factors in the State and the need for support in the State; the geographic and demographic distribution, age, sex, racial and ethnic groups, educational, and economic patterns of the diseases as well as the trends over time. Describe the barriers to successful implementation of a statewide program for prevention of cardiovascular diseases within the State; partnerships and collaboration with related agencies, and the status of policies and environmental approaches in place that influence risk factors and public awareness. Describe how the funding will be used to fill the gaps in cardiovascular disease prevention activities. Provide a description of the populations to be addressed, including priority populations, and their constituencies and leadership potential to develop and conduct program activities.

b. Staffing (not included in 130-page limitation)

Describe project staffing and qualifications including contacts for physical activity, nutrition, tobacco, secondary prevention, evaluation, and epidemiology. Provide organizational chart, curriculum vitae, job descriptions, and experience needed for all budgeted positions. Describe lines of communication between various related chronic disease programs.

c. State Plan

Provide the current State plan (dated January 1997 or later) that includes population-based policy and environmental strategies as well as strategies for implementing programs which utilize health care settings, worksites, the media, schools, community-based organizations, the community at-large; and which includes strategies addressing specific priority populations and communities.

d. Evaluation

Provide description of surveillance and monitoring activities that include mortality, changes in environmental and policy indicators, and behavioral risk factors including statistically valid estimates for populations to be addressed. Describe the capability for special one-time surveys to be conducted by the state. Describe how each of the program elements will be evaluated and which measures are considered critical to monitor for evaluating the success of the program. Describe the various existing data systems to be employed, how the systems might be adapted, and the specific program elements to be evaluated by those systems. Describe the schedules for data collection and when analyses of the data will become available.

e. Comprehensive Program Work Plan

Address each of the required Comprehensive Program recipient activities cited in the Recipient Activities section above in sufficient detail to describe the results expected and how the State will achieve the results. Objectives and strategies should specify priority populations to be addressed, communities, or geographic areas of concern; complete listings of the policy and environmental changes sought to create heart-healthy environments for the population; other intervention strategies; coordination among State partners; and strategies for closing the gap in cardiovascular disease disparity. Interventions should be expressed in terms of changes sought for the general population as well as

changes in Priority populations to be addressed. Population-based approaches should extend to a relatively large proportion of the State population rather than a few selected communities. Targeted strategies should clearly define the priority populations to be addressed. Objectives should describe what is to happen, by when, and to what degree. A milestone and activities completion chart or time line should be provided for all objectives for the project period.

f. Collaboration

Provide letters of support describing the nature and extent of involvement by outside partners and coordination among State health department programs, other State agencies, and nongovernmental health and nonhealth organizations. Describe how the overall delivery of interventions for priority populations will be enhanced by these collaborative activities. Describe current data systems and how coordination will be ensured with managed care providers, Medicaid, major employers, insurers, and other organized health care providers, as well as purchasers of health care.

g. Training Capability

Provide a description of training sessions for health professionals provided within the past three years. Include agendas, dates, professional status or occupation, and number of attendees. Provide other evidence of training capabilities deemed appropriate to the program.

h. Comprehensive Program Budget Justification

Provide a line-item budget consistent with CDC Form.1246(E) along with appropriate justifications. Applicants are encouraged to include budget items for travel for three trips to Atlanta, Georgia for three individuals to attend three-day training and technical assistance workshops. State matching funds should be listed on question 15 (estimated funding) of the application face page and Section C of the Budget Information worksheet.

F. Submission and Deadline

Submit the original and two copies of new CDC Form 0.1246(E). Forms are available in the application kit. Submit the application, on or before July 14, 2000, to the Grants Management Specialist identified in Section J., ''Where to Obtain Additional Information''.

Deadline: Applications shall be considered as meeting the deadline if they are either:

(a) Received on or before the deadline date; or

(b) Sent on or before the deadline date.

(Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing.)

Late Applications: Applications which do not meet the criteria in (a) or (b) above are considered late applications, will not be considered, and will be returned to the applicant.

G. Evaluation Criteria

Each application will be evaluated individually against the following criteria by an independent review group appointed by CDC.

1. Core Capacity Program (Total 100 Points)

a. Staffing (10 Points)

The degree to which the proposed staff have the relevant background, qualifications, and experience; and the degree to which the organizational structure supports staffs' ability to conduct proposed activities. The degree of coordination between relevant programs within the State health department.

b. Facilities (5 Points)

The adequacy of the applicant's facilities and resources.

c. Background and Need (15 Points)

The extent to which the applicant identifies specific needs and resources available for Core Capacity activities. The extent to which the funds will successfully fill the gaps in State capabilities. The extent to which the applicant demonstrates a review of journals and other publications particularly for policy and environmental strategies.

d. Core Capacity Work Plan (60 Points)

(1) (20 Points) The extent to which the plan for achieving the proposed activities appears realistic and feasible and relates to the stated program requirements and purposes of this cooperative agreement.

(2) (20 Points) The extent to which the proposed methods for achieving the activities appear realistic and feasible and relate to the stated program requirements and purposes of the cooperative agreement.

(3) (10 Points) The extent to which the proposed plan for evaluating progress toward meeting objectives and assessing impact appears reasonable and feasible.

(4) (10 Points) The degree to which partnerships are demonstrated through collaborative activities or letters of support.

e. Objectives (10 Points)

The degree to which objectives are specific, time-phased, measurable, realistic, and related to identified needs, program requirements, and purpose of the program.

f. Budget (Not Scored)

The extent to which the budget appears reasonable and consistent with the proposed activities and intent of the program.

Content of Noncompeting Continuation Applications submitted within the project period need only include:

1. A brief progress report that describes the accomplishments of the previous budget period.

2. Any new or significantly revised items or information (objectives, scope of activities, operational methods, evaluation, key personnel, work plans, etc.) not included in year 01 or subsequent continuation applications.

3. An annual budget and justification. Existing budget items that are unchanged from the previous budget period do not need re-justification. Simply list the items in the budget and indicate that they are continuation items.

However, States receiving Core Capacity Program funding may submit a competitive application for Comprehensive Program funding at the end of any budget period within the five-year project period, provided new funds are available to fund additional Comprehensive Programs. These applications must successfully address the application Evaluation Criteria for the Comprehensive Program; and, if successful, they will move from Core Capacity funding to Comprehensive funding. If unsuccessful, they will continue with Core Capacity funding.

2. Comprehensive Program (Total 100 Points):

a. Background and Need (30 Points)

(1) (20 Points) The extent to which the applicant provides evidence that it has significant core capacity as specified in the Core Capacity Program Recipient Activities No.1 through No.5 (see Program Requirements section).

(2) (10 Points) The extent to which the funds will fill the gaps in the State's cardiovascular disease prevention activities. The extent to which the applicant identifies specific needs in relation to geographic and demographic

distribution of cardiovascular diseases with particular emphasis on priority populations; identifies trends in mortality and risk factors; identifies barriers to successful program implementation; and describes existing policy and environmental influences in terms of their affect on public awareness and the risk factors for cardiovascular diseases.

b. Staffing (10 Points)

The degree to which the proposed staff have the relevant background, qualifications, and experience; the degree to which the organizational structure supports staffs' ability to conduct proposed activities; the degree of staff coordination between relevant program within the State health department.

c. Comprehensive Work Plan (45 Points)

(1)(20 Points) The extent to which the work plan for achieving the proposed activities appears realistic and feasible and relates to the stated program requirements and purposes of this cooperative agreement. The extent to which the plan addresses the needs of the State, the feasibility of the plan and the appropriateness of the planned interventions to the cardiovascular disease problem, and the adequacy of the plan to identify and address the needs of priority populations.

(2) (20 Points) The extent to which the work plan addresses the problem through policy and environmental strategies and other appropriate population-based approaches and the extent of program activities that appropriately use settings (*e.g.,* worksites, the media, schools, community-based organizations, faith-based organizations, the community at large).

(3) (5 Points) The extent to which collaboration of State nutrition, physical activity, tobacco, health promotion, and other chronic disease programs with external partners is used to deliver the program; the extent to which coordination with other State chronic disease programs and other State agencies enhances the cardiovascular disease program; and the extent of involvement of community-based organizations in the implementation of the program.

d. Objectives (5 Points)

The degree to which the objectives are specific, time-phased, measurable, realistic, and relate to identified needs and purposes of the program, for both the general population as well as the targeted populations.

e. Evaluation (10 Points)

The extent to which the evaluation plan appears capable of monitoring progress toward meeting specific project objectives, assessing the impact of the program on the general population, assessing changes in the Priority populations, monitoring utilization of secondary prevention strategies, and assessing the implementation of policy and environmental strategies.

f. Budget (Not Scored)

The extent to which the budget appears reasonable and consistent with the proposed activities and intent of the program. For the Comprehensive application, matching funds should be listed on question 15 (estimated funding) of the application face page and section C of the Budget Information worksheet.

H. Other Requirements

Technical Reporting Requirements

Provide CDC with original plus two copies of the following:

1. Progress reports (semiannual);
2. Financial status report, no more than 90 days after the end of the budget period; and
3. Final financial and performance reports, no more than 90 days after the end of the project period. Send all reports to the Grants Management Specialist identified in the ''Where to Obtain Additional Information'' section of this announcement.

The following additional requirements are applicable to this program. For a complete description of each, see Attachment II in the application kit.

AR–7 Executive Order 12372 Review
AR–10 Smoke-Free Workplace Requirements
AR–11 Healthy People 2010
AR–12 Lobbying Restrictions

I. Authority and Catalog of Federal Domestic Assistance Number (CFDA)

This program is authorized under sections 301(a) and 317b(k)(2) of the Public Health Service (PHS) Act, [42 U.S.C. sections 241(a) and 247b(k)(2)], as amended.

The Catalog of Federal Domestic Assistance (CFDA) number is 93.945.

J. Where To Obtain Additional Information

This and other CDC announcements can be found on the CDC home page at Internet address http://www.cdc.gov. Click on Funding then click on Grants and Cooperative Agreements.

If you have questions after reviewing the contents of all documents, business management assistance may be obtained from: Van A. King, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Announcement 00091, Centers for Disease Control and Prevention (CDC), 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone Number (770) 488–2751, Email address vbk5@cdc.gov.

For program technical assistance, contact: Nancy B. Watkins, Division of Adult and Community Health National, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway, MS K–47, Atlanta, Georgia 30341–4146, Telephone Number (770) 488–8004, Email address naw1@cdc.gov.

Dated: May 22, 2000.

John L. Williams,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–13243 Filed 5–25–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Citizens Advisory Committee on Public Health Service Activities and Research at Department of Energy (DOE) Sites: Idaho National Engineering and Environmental Laboratory Health Effects Subcommittee: Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Agency for Toxic Substances and Disease Registry (ATSDR) and the Centers for Disease Control and Prevention (CDC) announce the following meeting.

Name: Citizens Advisory Committee on Public Health Service Activities and Research at DOE Sites: Idaho National Engineering and Environmental Laboratory Health Effects Subcommittee (INEELHES).

Times and Dates: 8:30 a.m.–5 p.m., June 13, 2000. 8:30 a.m.–12:30 p.m., June 14, 2000.

Place: Coeur d'Alene Hotel, 115 South Second Street, Coeur d'Alene Idaho 83814, telephone 208/765–4000, fax 208/664–7678.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 60 people.

Background: Under a Memorandum of Understanding (MOU) signed in December 1990 with the Department of Energy (DOE) and replaced by an MOU signed in 1996, the Department of Health and Human Services (HHS) was given the responsibility and resources for conducting analytic epidemiologic investigations of residents of