tampons and occupational or personal use of pesticides and herbicides) will also be obtained. The total cost to respondents is $ 0 .

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hrs.)	Total burden (in hrs.)
Women	100	1	.50	50
Total				50

2. (NIOSH) Occupational Asthma Identification Methods -0920–0350—Extension—Over the last decade, OCCUPATIONAL ASTHMA (OA) has emerged as the most prevalent occupational respiratory disease, resulting in morbidity, disability, diminished productivity, and rarely, death. Prevention of OA has become one of the most important goals for NIOSH. This project addresses these issues by examining the potential of different asthma screening approaches as surveillance tools when employed serially over time among workers at risk, and also characterizes the occurrence of and risk factors for occupational asthma in various high risk industries.

The primary objective of the study is to examine the potential of different asthma screening approaches as surveillance tools when employed serially over time among workers at risk. A second major objective is to characterize the occurrence of and risk factors for occupational asthma in several industries, specifically workers rearing insects for agricultural pest control, wood product workers using isocyanates, and other occupational groups with different exposure profiles.

A series of four groups of screening measures are applied to examine the potential of each measure in different situations. This includes a questionnaire (including an occupational history), lung function tests (shift spirometry, serial peak flow tests, airway responsiveness), inflammation and immunology tests (specific and nonspecific serum immunoglobulins, skin prick tests, nasal lavage for cellular and biochemical factors), and environmental measurements (gravimetric dusts, antigens, chemical vapors, viable organisms, endotoxins). Workers exposed to (1) high molecular weight sensitizing dusts, (insect particulate), (2) low molecular weight sensitizers, (methylene biphenyldiisocyanate, MDI), and (3) irritant but not sensitizing exposures, as well as a control group of unexposed workers, are followed for two years.

The results should be useful in improving tools for recognition, monitoring, and surveillance of OA. In addition, risk factors for OA will be further delineated, which will assist in targeting OA prevention strategies for agricultural and other workers. The total cost to respondents is $11,960.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hrs.)	Total burden (in hrs.)
Workers	299	2	2.0	1,196
Total				1,196

Dated: June 13, 1997.

Wilma G. Johnson,

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

[FR Doc. 97–16322 Filed 6–20–97; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement 780]

State Injury Intervention and Surveillance Program; Notice of Availability of Funds for Fiscal Year 1997

Introduction

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1997 funds for a cooperative agreement program for State injury intervention and surveillance programs, focused in four topic areas: Prevention of Unintentional Injuries (bicycle helmet promotion (Part IA1), prevention of residential fire-related injuries (Part IA2)); Trauma Care Systems (Part IB); Emergency Department Injury Surveillance (Part IC); and Basic Injury Program Development (Part II).

CDC is committed to achieving the health promotion and disease prevention objectives of ''Healthy People 2000,'' a national activity to reduce morbidity and mortality and to improve the quality of life. This announcement is related to the priority areas of Unintentional Injuries, Violent and Abusive Behavior, and Surveillance and Data Systems. (For ordering a copy of ''Healthy People 2000,'' see the section **WHERE TO OBTAIN ADDITIONAL INFORMATION.**)

Programmatic Assistance—Topic Specific Telephone Conferences

During the week of July 7–11, 1997, a series of five, one-hour each, topic-specific, programmatic assistance telephone conferences will be arranged by CDC program staff. To receive the exact date, time, and call-in information, please contact the appropriate CDC program individual (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section).

Authority

This program is authorized under sections 301, 317, 391, and 394A of the Public Health Service Act [42 U.S.C. 241, 247b, 280b, and 280b–3] as amended.

Smoke-Free Workplace

CDC strongly encourages all cooperative agreement recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products, and Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, and early childhood development services are provided to children.

Eligible Applicants

Eligible applicants are the official State public health agencies or their bona fide agents. This includes the District of Columbia, American Samoa, the Commonwealth of Puerto Rico, the Virgin Islands, the Federated States of Micronesia, Guam, the Northern Mariana Islands, the Republic of the Marshall Islands, and the Republic of Palau.

Note: Effective January 1, 1996, Public Law 104–65 states that an organization described in section 501(c)(4) of the Internal Revenue Code of 1986 which engages in lobbying activities shall not be eligible to receive Federal funds constituting an award, grant (cooperative agreement), contract, loan, or any other form.

Availability of Funds

Approximately $3,290,000 is available in FY 1997 to fund up to nineteen new and competing continuation awards:

Parts IA1 and IA2

Approximately $1,750,000 is available to fund up to ten awards in the areas of: (1) Bicycle Helmet Promotion, and (2) Residential Fire Injury Prevention. It is expected that the average award will be $175,000, ranging from $150,000 to $185,000.

Part IB

Approximately $490,000 is available to fund up to two awards for Trauma Care System development. It is expected that the average award will be $245,000, ranging from $230,000 to $260,000.

Part IC

Approximately $750,000 is available to fund up to three awards for development and enhancement of Emergency Department Injury Surveillance Programs. It is expected that the average award will be $250,000, ranging from $225,000 to $275,000.

Part II

Approximately $300,000 is available to fund up to four awards for Basic Injury Program Development. It is expected that the average award will be $75,000, ranging from $70,000 to $80,000.

States applying for Unintentional Injury Prevention Programs (Parts IA1 and IA2) may apply for Bicycle Helmet Promotion (Part IA1) funding or Residential Fire Injury Prevention (Part IA2) funding, but not both.

States applying for Basic Injury Program Development (Part II) may not apply for any Part I topics.

Projects are expected to begin on or about September 30, 1997, and will be made for a 12-month budget period within a project period of up to 3 years. Funding estimates may vary and are subject to change.

Continuation awards within the project period will be made on the basis of satisfactory progress and the availability of funds.

Note: At the request of the applicant, Federal personnel may be assigned in lieu of a portion of the financial assistance.

Funding Preferences: During the selection process, CDC will make every effort to ensure a balanced geographic distribution, including urban and rural States, for each topic area.

Use of Funds

Funds may be used for personnel services, supplies, equipment, travel, subcontracts, and services directly related to project activities. Project funds cannot be used to supplant other existing funds for planning, implementation or surveillance activities, for construction costs, or to lease or purchase buildings, office space, or vehicles.

Restrictions on Lobbying

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. Section 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying Congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition, the FY1997 HHS Appropriations Act, which became effective October 1, 1996, expressly prohibits the use of 1997 appropriated funds for indirect or ''grass roots'' lobbying efforts that are designed to support or defeat legislation pending before State legislatures. This new law, Section 503 of Pub. L. No. 104–208, provides as follows:

Sec. 503(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, * * * except in presentation to the Congress or any State legislative body itself.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1997, as enacted by the Omnibus Consolidated Appropriations Act, 1997, Division A, Title I, Section 101(e), Pub. L. No. 104–208 (September 30, 1996).

Prohibition on Use of CDC Funds for Certain Gun Control Activities

The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1997 specifies that: ''None of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control.''

Anti-Lobbying Act requirements prohibit lobbying Congress with appropriated Federal monies. Specifically, this Act prohibits the use of Federal funds for direct or indirect communications intended or designed to influence a Member of Congress with regard to specific Federal legislation. This prohibition includes the funding and assistance of public grassroots campaigns intended or designed to influence Members of Congress with regard to specific legislation or appropriation by Congress.

In addition to the restrictions in the Anti-Lobbying Act, CDC interprets the new language in the CDC's 1997 Appropriations Act to mean that CDC's funds may not be spent on political action or other activities designed to affect the passage of specific Federal, State, or local legislation intended to restrict or control the purchase or use of firearms.

Background and Definitions for Topic Areas

Part IA1: Bicycle Helmet Promotion

Bicycle riding is a popular American past time. An estimated 66.9 million Americans ride bicycles; indeed, about 29 percent of U.S. households have one or more bicyclists. Bicycle riding also has accompanying risks. Each year, an average of 879 persons die from injuries caused by bicycle crashes, and 592,000 persons are treated in emergency departments (EDs) for injuries from bicycling. Head injury is the most common cause of death and serious disability in bicycle-related crashes; head injuries are involved in about 60

percent of the deaths, and 30 percent of the bicycle-related ED visits. Many of these nonfatal head injuries produce lifelong disability from irreversible brain damage. Societal costs for bicycle-related head injuries exceed $2 billion annually.

American children, in particular, are avid bicyclists—an estimated 33 million children ride bicycles nearly 10 billion hours each year. Unfortunately, an average of 384 children die annually from bicycle crashes, and 450,000 more are treated in EDs for bicycle-riding related injuries.

Bicycle helmets are a proven intervention that reduce the risk of bicycle-related head injury by about 80 percent, yet bicycle helmets are not worn by most riders. Only 19 percent of adults and 15 percent of children use helmets all or most of the time while cycling. If all bicyclists wore helmets, from 335–393 deaths and 119,000–140,000 ED-treated head injuries could be prevented each year. Accordingly, a Healthy People 2000 goal is 50 percent bicycle helmet use by the Year 2000. To promote this goal, CDC has published recommendations that urged: (1) Helmets be worn by persons of all ages when bicycling, (2) riders wear helmets whenever or wherever they ride, (3) helmets should meet test standards, and (4) States and communities implement strategies to increase helmet use, including education and promotion, legislation, enforcement, and program evaluation.

For Bike Helmet Promotion Model Program and further background information, see the **WHERE TO OBTAIN ADDITIONAL INFORMATION** section.

Part IA2: Residential Fire Injury Prevention

In 1995, there were an estimated 414,000 home fires in the United States, which killed 3,640 individuals and injured an additional 18,650 people. Direct property damage caused by these fires exceeded $4.2 billion. In 1994, the monetary equivalent of all fire deaths and injuries, including deaths and injuries to fire fighters, was estimated at $14.8 billion.

Residential fire deaths occur disproportionately in the southeastern States. They also occur disproportionately during the winter months of December—February, a period during which more than one-third of home fires occur, compared to one-sixth in the summer months of June-August. Many subgroups within the population remain highly vulnerable to fire morbidity and mortality. The rate of death due to fire is higher among the poor, minorities, children under age 5, adults over age 65, low-income communities in remote rural areas or in poor urban communities, and among individuals living in manufactured homes built before 1976, when the U.S. Department of Housing and Urban Development construction safety standards became effective. Other risk factors for fire-related deaths include:

- Inoperative smoke detectors,
- Careless smoking,
- Abuse of alcohol or other drugs,
- Incorrect use of alternative heating sources including usage of devices inappropriate or insufficient for the space to be heated,
- Inadequate supervision of children,
- Insufficient fire safety education.

The majority of fire-related fatalities occur in fires that start at night while occupants are asleep, a time when effective detection and alerting systems are of special importance. Operable smoke detectors on every level provide the residents of a burning home with sufficient advance warning for escape from nearly all types of fires. If a fire occurs, homes with functional smoke detectors are half as likely to have a death occur as homes without smoke detectors. As a result, operable residential smoke detectors can be highly effective in preventing fire-related deaths. Accordingly, a Healthy People 2000 objective is the reduction of residential fire deaths to no more than 1.2 per 100,000 people by the Year 2000.

For Residential Fire Injury Prevention Programs the definition for high-risk target populations is a community or geographic area known to have: (1) A high prevalence of residential fire deaths, (2) a low prevalence of functional residential smoke detectors, (3) a composition of primarily low-income residents, or (4) a high proportion of rented residential units.

For Residential Fire Injury Prevention Model Program and further background information, see the **WHERE TO OBTAIN ADDITIONAL INFORMATION** section.

Part IB: Trauma Care System Development

A trauma care system (TCS) is an organized, hierarchical approach to trauma care in which the medical needs of individual trauma patients are optimally matched to the resources available in a defined geographic region. In a TCS, a lead agency categorizes hospitals on the basis of their trauma care capabilities, designated trauma centers provide 24 hour access to the highest level of care, and prehospital field protocols are used to triage injured patients to the most appropriate hospital. The finding that 30 percent to 35 percent of trauma patient deaths are preventable in conventional trauma care has mobilized support for TCS planning and implementation. Studies showing up to a 50 percent reduction in preventable trauma deaths when a TCS is implemented provide compelling evidence of TCS effectiveness.

Despite the proven effectiveness of TCSs, in 1993 only five States satisfied established criteria for a complete TCS, a modest increase from two States that met the criteria in 1988. Financial constraints are the major barrier to TCS implementation. Prohibitively high start-up costs and operating expenses deter emergency medical services (EMS) agencies from serving as the lead agencies for TCSs, and concerns about revenue loss impede greater TCS participation by acute care hospitals and trauma care professionals. Other impediments to TCS implementation include organizational and political barriers, among the most important of which is an increasingly competitive health care market that makes it difficult to establish integrated systems of care. Major planning, publicity, and educational efforts are needed to develop or enhance a TCS, along with ongoing coordination of prehospital and hospital services and continuous quality improvement efforts.

Baseline and follow-up studies of trauma incidence and outcomes are instrumental in planning, implementing, and evaluating a TCS. Among the most useful data sources are trauma registries, hospital discharge data, vital statistics, autopsy records, emergency medical services (EMS)run reports, and surveys that assess hospital trauma care capabilities. Among the most informative outcome studies are preventable trauma death audits using expert review panels, comparisons of expected and observed mortality using trauma registry data and predictive mathematical models, and studies of death rates among trauma patients based on their hospital discharge diagnoses and other data. A variety of approaches are used to evaluate structural aspects of TCSs and patient care processes before and after TCS implementation. Among the most informative of these studies are surveys that identify whether specific TCS components are in place and process indicators that focus on the timeliness and appropriateness of trauma care.

For Trauma Care System Model Program and further background information, see the **WHERE TO OBTAIN ADDITIONAL INFORMATION** section.

Part IC: Emergency Department Injury Surveillance

Public health professionals need adequate information to develop, implement, and evaluate prevention programs, and decision makers need adequate information to develop policies to prevent injuries. Public health surveillance of injuries should provide data to make sound policy decisions and to plan prevention strategies. Injury surveillance should: (1) Provide quantitative estimates of injury mortality, morbidity, and disability; (2) detect clusters of injury events; (3) identify risk factors for injury events; (4) stimulate more focused epidemiologic research; (5) help define costs associated with injuries; and (6) help determine the effectiveness of injury prevention and control programs.

Mortality Data

Relative to other sources, fatal injury data sources are the most well-developed, available and utilized. These include death certificates, medical examiner and coroner reports, the FBI's Supplemental Homicide Reports, child fatality review system reports, and the Fatal Accident and Reporting System (FARS) maintained by the National Highway Traffic Safety Administration. Death certificate data provide information about both causes and types of fatal injuries sustained. State and local programs should have the capacity to use their mortality data systems.

Morbidity Data

Fatal injuries represent only a small portion of the injury problem in the United States. The lack of adequate data on nonfatal injuries is a serious problem for injury prevention and control. Given the changing patterns of health care, hospitalized nonfatal injuries represent a smaller portion of the injury burden in the United States. Their usefulness to plan injury control programs is less clear. Because of this, the ED should be explored for nonfatal injury data. The development of standardized hospital emergency department based surveillance systems should provide useful data at State and local levels. These surveillance systems need to be relevant to local data needs (i.e., supporting local injury control efforts) and flexible enough to accommodate changing priorities (e.g., the need to estimate the risks and benefits of passenger airbags), and have standard case definitions and data elements so that data collected can be compared to those collected in other jurisdictions, including national samples.

Definitions for Emergency Department Injury Surveillance

The essential data elements for emergency departments are fully defined in CDC's ''Data Elements for Emergency Department Systems'', release 1.0. (For ordering a copy see the **WHERE TO OBTAIN ADDITIONAL INFORMATION** section.)

Surveillance is the ongoing, systematic collection, analysis, and interpretation of health data necessary for designing, implementing, and evaluating public health programs.

Hospital emergency departments are defined as facilities offering 24-hour emergency medical services affiliated with an acute care hospital of six or more beds.

Non-fatal injuries are defined as consistent with the International Classification of Disease (ICD) coding for injury (E800-E999) with the specific exclusion of adverse effects of medical care (E870–879) and of drugs (E930.0–949.9).

For Emergency Department Injury Surveillance Model Program and further background information, see the **WHERE TO OBTAIN ADDITIONAL INFORMATION** section.

Part II: Basic Injury Program Development

Injury is one of the leading causes of death and disability for all age groups. It is responsible for more deaths to children and young adults than any other cause. Each year, nearly 150,000 people die from injuries. Children, minorities, and the elderly are especially at risk. Although the greatest cost of injury is in human suffering and loss, the financial cost is also staggering. Including direct medical care and rehabilitation costs and lost income and productivity, injury costs are estimated at more than $224 billion. Without exception, preventing injuries costs less than treating them.

As late as 1989, most State and local public health agencies in this country did not have the organizational focus or capacity to systematically address injuries as a public health problem or to lead their State or community activities in injury prevention and control. Currently, each State public health agency, and many of their local counterparts, maintains a focus in injury prevention and control. While this injury focus is minimal in a portion of these agencies, an impressive track record is emerging in this still relatively new field. Lessons of importance have been learned. While the locus for injury programs in public health agencies is in a variety of organizational locations, valuable injury prevention programs are in place and accurate surveillance is being conducted. Predictably, public health agencies have shown themselves adept at forging relationships with the many new partners necessary to address the problem of injuries, and these partnerships have successfully crossed traditional zones of comfort for both the public health agencies and their partners.

However, this encouraging level of interest and competence has not yet resulted in adequate capacity to address this major public health problem in all States. This program will allow State public health agencies with minimal injury prevention and control capability to establish or strengthen the organizational focus needed to develop viable injury prevention and control activities.

Purpose

The purposes of the cooperative agreements are to enable State public health agencies to implement priority injury prevention and control activities. The areas of interest are:

Part I

A. Unintentional Injury Prevention Programs for: 1. Bicycle Helmet Promotion Programs (Part IA1), 2. Residential Fire Injury Prevention Programs (Part IA2).

B. Trauma Care System Development Programs (Part IB).

C. Emergency Department Injury Surveillance Programs (Part IC).

Part II Basic Injury Program Development Programs (Part II)

This funding will allow the applicant to establish or strengthen injury prevention and control activities in the targeted areas (e.g., Trauma Care Systems development). It is expected that programs developed or enhanced under this funding will function as a component of the public health agency's injury control program (if any exist), will coordinate related activities both within the agency and within the jurisdiction, and will mobilize, seek input from, and utilize broad coalitions.

Four Topic Areas

Part IA1—Bicycle Helmet Promotion

Bicycle Helmet Promotion Programs are used to promote the use of bicycle helmets among high-risk (unhelmeted) 5–12 year-olds. (Additional high-risk, age, or demographic groups may be targeted, but their inclusion must be justified separately and the 5–12 year-old age group must be covered.)

These programs will establish or strengthen a state-level bicycle helmet

promotion program and allow support for multifaceted local programs within the State. State-level programs will collaborate with the State Department of Education to promote school-based programs, foster adult programs on helmets, and provide public programs to change knowledge, attitudes and beliefs, support helmet discounting or giveaways, develop helmet-wearing incentive programs, enhance enforcement, encourage helmet promotion in the health care delivery setting, and collaborate with governmental and civic organizations.

State programs will foster multifaceted (See **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) programs at local levels within the State. These local programs will include elements such as school-based parental programs and public programs to change knowledge, attitudes and beliefs, bicycle rodeos, helmet discounting or giveaways, helmet-wearing incentive programs, enforcement and support of existing legislation/regulation, helmet promotion in the health care delivery setting, and partnership with civic organizations such as Safe Kids, Boy Scouts, etc. Programs will also evaluate the effectiveness of strategies for increasing bicycle helmet use (including observing pre- and post-program helmet use in the target population.)

Novel approaches to supplement the elements noted above are strongly encouraged.

Part IA2—Residential Fire Injury Prevention

Residential Fire Injury Prevention Programs are used to allow State public health agencies to compare the effectiveness of approaches to promoting residential smoke detectors in high-risk populations. The focus of the programs is smoke detector installation and maintenance. Programs can include home visits—smoke detector installation, and/or maintenance of existing detectors- as well as incentive programs that provide coupons/discounts for smoke detectors, combined with follow-up. Programs will involve educating parents and other care givers, children, teachers, policy makers, community leaders, and the general public about the importance of residential smoke detectors as an effective intervention. Programs may also involve the distribution and installation of smoke detectors in selected high risk communities, encouraging public policy (nonlegislative), or serving as a resource, when requested, as issues arise related to local ordinances requiring smoke detector use. Programs will establish or strengthen local smoke detector promotion programs which increase current residential smoke detector prevalence rates, achieve optimal adequacy of coverage, and maintain smoke detector functionality.

To achieve these goals, programs will support smoke detector installation and maintenance programs, develop smoke detector incentive programs, provide public education, form broad partnerships that may include businesses, governmental agencies, community-based and civic organizations, and fire safety personnel, enforce local ordinances, and encourage smoke detector promotion in the health care delivery setting.

Part IB—Trauma Care System Development

This program will enable State public health agencies to enhance their role as lead agencies or prospective lead agencies in order to plan and take steps toward implementing *or* improving an inclusive TCS in their State or substate region. These programs will develop or enhance their State TCS by adding components of an optimal TCS as defined in ''A National Plan for Injury Control'' (See **WHERE TO OBTAIN ADDITIONAL INFORMATION** section), and by evaluating success. Specifically, programs will assess the current level of TCS development, create plans, and implement or improve components of the optimal TCS, regardless of the level of maturity of their existing TCS. This program is designed for mature and developing TCSs.

Part IC—Emergency Department Injury Surveillance

This program is designed to expedite the development of emergency department surveillance for injuries in the United States and to provide a coordinated approach to improving the quality, comparability, and availability of ED data. State public health agencies will develop and evaluate or enhance and evaluate a hospital emergency department injury data system which can provide E-coded injury data representative of all types of emergency department treated nonfatal injuries occurring statewide or in a population of one million people or more which is representative of the State population. Specifically, programs will improve the quality and availability of population-based, hospital emergency department nonfatal injury surveillance data for use in injury control program planning.

Part II—Basic Injury Program Development

These program is designed to allow State public health agencies with minimal injury prevention and control capability to develop or strengthen their organizational focus in prevention and control of injuries. State public health agencies will identify a coordinator for injury activities, develop a profile of injuries within the State from existing data sources, develop an advisory structure to utilize collaborative relationships with public and private sector groups, organizations, agencies and individuals with interest or expertise in injury prevention or control, and develop a priority-driven State plan for injury prevention and control.

Cooperative Activities

In conducting activities to achieve the purposes of this program, the recipient will be responsible for the activities under A–E. (Recipient Activities), and CDC will be responsible for the activities listed under F. (CDC Activities).

A. Recipient Activities: Bicycle Helmet Promotion (Part IA1)

1. Provide a full-time coordinator with the authority, responsibility, and expertise to conduct and manage the state-level program and provide technical and evaluation assistance to local programs.

2. If statewide or local legislation requiring bicycle helmet use exists, promote its enforcement. Provide evaluation data, when requested, for use by legislators considering helmet legislation. When requested, serve as a resource as issues arise relating to local ordinances requiring bicycle helmet use.

3. Collaborate with highway safety officials, civic organizations, educational groups, employers, health care providers, and others to promote statewide bicycle helmet usage.

4. Collaborate with the State Department of Education to promote school-based programs that increase knowledge, affect attitudes and beliefs (including students, teachers, and parents), and encourage rules to foster helmet use. Encourage school systems to support data collection by allowing initial classroom surveys of ridership and helmet use by show-of-hands to be conducted.

5. Encourage parental programs that increase knowledge, affect attitudes and beliefs (e.g., in the workplace), provide public education (meetings, newsletters, media coverage), support helmet discounting or giveaways, develop

helmet-wearing incentive programs, and encourage helmet promotion in the health care delivery setting.

6. Conduct a multifaceted program and support the development and implementation of multifaceted community-based programs to promote the use of bicycle helmets.

7. Evaluate the effectiveness of both the State and local programs, including pre- and post-program observed helmet use among the target population and, for local programs, observation of at least 100 child bicyclists (from at least 4 different sites) in the immediate pre- and post-intervention periods.

8. Designate control communities and conduct observations in these communities in order to help differentiate program effects from background trends.

9. Participate in a process of evaluation and improvement in which lessons learned are shared with other States implementing bicycle helmet promotion programs.

B. Recipient Activities: Residential Fire Injury Prevention (Part IA2)

1. Provide a full-time coordinator with the expertise, authority, and responsibility to manage the state-level program. This individual will oversee the development of local area residential smoke detector promotion programs and coordinate evaluations of and comparison among local interventions conducted within the State during the funding cycle. This individual will provide technical and evaluation assistance to local programs.

2. Collaborate with state-level firefighters' associations, fire marshals' associations, fire safety coalitions and other grassroots organizations (e.g., SAFE KIDS Campaign) which are interested in reducing residential fire-related deaths and injuries.

3. Support the development and implementation of multifaceted community-based programs to promote the installation and maintenance of smoke detectors in all residential dwellings. Local programs will: (a) provide a coordinator who will develop residential smoke detector promotion program(s) targeted to a local high-risk group(s) (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section); (b) conduct multifaceted programs to promote the installation and maintenance of smoke detectors in all residential dwellings, including fire-safety education through door-to-door canvassing and public education; (c) canvass households (at least 400) in the targeted population to determine the functionality of residential smoke detectors and install additional units as needed, and simultaneously canvass households (at least 400) in a comparable population to determine the presence and functionality of residential smoke detectors, distribute home fire-safety literature, and recommend smoke detector installation, as needed, and (d) conduct evaluation of both groups 12 months post intervention implementation to assess the difference in effectiveness of intervention strategies. When requested, serve as a resource as issues arise relating to local ordinances requiring residential smoke detector use. If such ordinances exist promote their enforcement.

4. Evaluate the effectiveness of local programs, including pre- and post-program estimates of the proportion of functional residential smoke detectors, as well as adequacy of residential smoke detector coverage among the target population. Coordinate evaluation of installation smoke detector promotion efforts in the target communities versus other strategies utilized in comparable communities to discern the effectiveness of each intervention.

5. When requested, serve as a resource as issues arise relating to statewide legislation requiring residential smoke detector use. Promote enforcement if such legislation exists.

6. Participate in a process of evaluation and improvement in which lessons learned are shared with other States implementing residential fire injury prevention programs.

C. Recipient Activities: Trauma Care System Development (Part IB)

1. Provide a full-time coordinator with the authority, responsibility, and expertise to conduct and manage the state-level program.

2. Plan, develop, and implement a data-driven system to monitor and evaluate prehospital and hospital compliance with TCS standards, utilizing such data sources as trauma registries, EMS run reports, hospital discharge data, vital statistics and autopsy records.

3. Design, test, refine, and use methods to identify and respond to preventable trauma morbidity, complications, and disability among patients hospitalized from trauma throughout the TCS.

4. Establish administrative rules and procedures for designating trauma centers, if needed.

5. Administer and complete (if needed) a trauma center designation process.

6. Establish or improve a TCS information system and collect and analyze TCS data.

7. Develop a strategic plan to overcome specified barriers to an optimal TCS, and over time, monitor the impact of this strategic plan.

8. Identify non-federal sources of support for the TCS.

9. Participate in a process of evaluation and improvement in which lessons learned are shared with other States implementing trauma care systems.

D. Recipient Activities: Emergency Department Injury Surveillance (Part IC)

1. Provide a full-time coordinator with the authority, responsibility, and expertise to conduct and manage the state-level program.

2. Develop, implement, and evaluate a plan for conducting hospital ED surveillance.

3. Conduct hospital emergency department surveillance, which includes (but is not limited to) the essential injury elements (see definitions) as specified in ''Data Elements for Emergency Department Systems'' (DEEDS), and collect information addressing demographics, diagnoses, treatment, etiology, severity, charges, and outcome.

4. Evaluate the surveillance system for completeness and validity of data collected using methods described in ''Guidelines for Evaluating Surveillance Systems.''

5. Develop and submit an annual report of the analysis of surveillance data, and compile and share aggregated data with CDC in electronic format.

6. Participate in a process of evaluation and improvement in which lessons learned are shared with other States implementing ED surveillance.

E. Recipient Activities: Basic Injury Program Development (Part II)

1. Provide a full-time coordinator who has the authority, responsibility, and expertise to conduct and manage the state-level program.

2. Establish an advisory group to address issues relevant to injury prevention and control in the State. This group will consist of public and private individuals, organizations, agencies, and groups such as internal public health agency units (e.g., MCH, epidemiology, EMS, block grant coordination), Governor's Highway Safety Representatives, police, SAFE KIDS, NFPA Champions, National Safety Council, AARP, Brain Injury Association, trauma care organizations, violence prevention programs, and community-based organizations. The advisory group will advise and make recommendations in areas such as reviewing injury data, setting priorities,

assessing the public health agency's capacity and resources to address injury as a priority public health problem, and creating a State plan for injury prevention and control.

3. Analyze existing data to define the magnitude of the injury problem in the State, the population(s) at risk, and the causes of injury. Potential data sources include E-coded hospital discharge data, vital statistics, emergency department data, BRFSS, fire incident reports, police records, child death review records, autopsy records, and EMS run reports.

4. Prepare a report (for dissemination within the State) that includes an annotated inventory or data sources, the magnitude and causes of the injury problem in the State, and the populations affected.

5. Identify and catalog current and potential injury prevention and control resources within the State.

6. Develop a State plan which is based on data and prioritized for the prevention and control of injuries.

7. Participate in a process of evaluation and improvement in which lessons learned are shared with other States implementing basic injury prevention programs.

F. CDC Activities

1. Provide consultation on planning, implementation, evaluation, data analysis, and dissemination of results.

2. Provide coordination between and among the States, by assisting in the transfer of information and methods developed to other programs, and providing up-to-date information.

3. Provide technical assistance for program planning and management.

4. Develop and provide BRFSS and other specific injury surveillance modules.

5. Plan and coordinate review of program activities by outside experts to ensure available expertise and provide for quality assurance.

6. Operate a process of evaluation and improvement in which lessons learned are shared with other States implementing the same type of program.

Technical Reporting Requirements

An original and two copies of semiannual progress reports (and an electronic copy submitted by electronic mail to the project officer) are required of all awardees. Time lines for the reports will be established at the time of award. Final financial status and performance reports are required no later than 90 days after the end of the project period. All reports will be submitted to the Grants Management Branch, Procurement and Grants Office, CDC.

Semiannual progress reports should include:

A. A brief, updated program description, and a one-page summary of quarterly activities.

B. A status report on accomplishment of program goals and objectives, accompanied by a comparison of the actual accomplishments related to the goals and objectives established for the period. Include target population, intervention/surveillance elements and activities, collaborative activities, and evaluation.

C. If established goals and objectives were not accomplished or were delayed, describe both the reason for the deviation and anticipated corrective action or deletion of the activity from the project. Include lessons learned and recommendations.

D. Other pertinent information, including changes in staffing, contractors, or partners.

Application Content

A separate application should be submitted for each Part (topic area) for which funding is requested. Each application, including appendices, should not exceed 70 pages (75 pages for competing continuation applications) and the Proposal Narrative section should not exceed 30 pages. Competing continuation applications may add up to five pages (for a total of 35 pages) to address progress and outcomes from the prior funded program. Pages should be clearly numbered and a complete index to the application and any appendices included. The project narrative section must be double-spaced. The original and each copy of the application must be submitted unstapled and unbound. All materials must be typewritten, double-spaced, with unreduced type (font size 10 point or greater) on 8½″ by 11″ paper, with at least 1″ margins, headers and footers, and printed on one side only.

The applicant should provide a detailed description of first-year activities and briefly describe future-year objectives and activities.

For Bicycle Helmet Promotion (Part IA1) Applications, the Application Must Include

A. Abstract

A one page summary of the proposed program.

B. Progress Report: (To be completed by competing continuation applicants only.)

Provide a detailed report on the achievements of the program over the preceding three-year period of CDC funding for prevention of bicycle-related head injuries. The applicant should include the accomplishments made with CDC funding covering all areas related to that cooperative agreement. The section should not exceed five pages.

C. Background and Capacity

Identify suitable target populations and include data justifying need for the program regarding lack of helmet use in the target population and magnitude of the bicycle-related head injury problem. Justify the inclusion of high-risk, demographic, or other age groups beyond 5–12 years-old. Indicate ridership data by age and month or season if available. Provide supporting data. Demonstrate capacity to conduct the program. Include a description of current activities and previous experience in bicycle helmet promotion programs, including status of surveillance activities related to the program. Show the appropriateness of position descriptions, curriculum vitea's (CV's), and lines of command to accomplish program goals and objectives.

D. Goals and Objectives

Include goals which are relevant to the purpose of the program and feasible for the project period. Goals should be specific and measurable. Include objectives which are feasible for the budget period, and which address all activities necessary to accomplish the purpose of the proposal. Objectives should be specific, time-framed, measurable, and realistic. If groups beyond 5–12 year-olds are targeted, include goals and objectives for them separately.

E. Methods and Staffing

Describe activities at the State and local levels. Describe how the model bicycle helmet promotion program (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) will be implemented, and why deviations from this model, if any, are necessary for the applicant's setting. Provide detail on proposed multifacetedness. Describe creative approaches to impact the high-risk (unhelmeted) target population. Provide: (a) A detailed description of proposed activities designed to achieve each objective and overall program goals, and which includes designation of responsibility for each action

undertaken; (b) a complete time frame indicating when each activity will occur; and (c) a description of the roles of each unit, organization, or agency, and coordination, supervision and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities. Show allocation of staff to the activities. Describe the roles and responsibilities of the project director and each staff member. Descriptions should include the position titles, education and experience required, and the percentage of time each will devote to the program. Curriculum vitae for existing staff should be included. Document specific concurrence of plans by all other involved parties, including consultants, and provide a letter from each consultant or outside agency describing their willingness and capacity to fulfill proposed responsibilities.

For each local program conducting interventions, describe the local program's ability and commitment to: (a) Provide a coordinator who will act as liaison with the State, (b) organize a coalition of appropriate individuals, agencies, and organizations to generate community input and support for bicycle helmet promotion campaigns, (c) collaborate with the local health department, (d) state measurable objectives for the project, (e) conduct pre- and post-program observations of helmet use that collects data on at least 100 child bicyclists from 4 or more different types of sites (e.g., residential areas, bike paths, parks, to/from schools), (f) educate each child who receives a ''program'' helmet and the parents about proper use, fit, and maintenance and safe bicycle riding practices, (g) maintain records of helmet promotional activities and provide to the State coordinator at the requested interval.

Women, Racial and Ethnic Minorities. Provide a description of the proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

F. Evaluation

Provide sufficient detail on how the proposed evaluation system will document program process, effectiveness, and impact on helmet use. Evaluation should include progress in meeting program objectives. Demonstrate potential data sources for evaluation purposes, and document staff availability, expertise, experience, and capacity to perform the evaluation. Include a plan for reporting evaluation results and using evaluation information for programmatic decisions. Describe, if it exists, a capacity to monitor bicycle-related head injuries, costs associated with bicycle-related head injuries, and changes in health outcomes associated with the program. Describe the use of control populations to help differentiate program effects from background trends. Indicate willingness to participate in a process of continuous improvement which may require frequent review of progress and processes utilized, remediation of identified barriers, and adoption of modified methods and measures.

G. Collaboration

Describe the relationships between the program and other organizations, agencies, and health department units (e.g. MCH) that relate to the program. Describe coalition membership and member roles. Describe relationships with the Governor's Office of Highway Safety, public safety officials, and Injury Control Research Centers (ICRC's) or local academic institutions, and show evidence of specific support. Describe relationships with local communities conducting intervention activities and show evidence of specific support. For areas with helmet laws, letters from appropriate officials should be provided that express a commitment to enforcement and detail the nature of their involvement and measures to be taken in the enforcement effort to promote helmet use.

H. Budget and Accompanying Justification

Provide a detailed budget with accompanying narrative justifying all individual budget items which make up the total amount of funds requested. The budget should be consistent with stated objectives and planned activities. The budget should include funds for two trips to Atlanta by key State and community staff for participation in continuous improvement activities, and ''grantee'' meetings.

I. Human Subjects

Indicate whether human subjects will be involved, and if so, how they will be protected, and describe the review process which will govern their participation.

For Residential Fire Injury Prevention (Part IA2), the Application Must Include

A. Abstract

A one page abstract and summary of the proposed program.

B. Progress Report: (To be completed by competing continuation applicants only.)

Provide a detailed report on the achievements of the program over the preceding three-year period of CDC funding for prevention of residential fire-related injuries. The applicant should include the accomplishments made with CDC funding covering all areas related to that cooperative agreement. The section should not exceed five pages.

C. Background, Need, and Capacity

Describe background and need for the program, quantifying the magnitude of the residential fire-related injury problem (local versus State data), populations at risk, extent of the problem, and demographics of the targeted community. Include a description of current activities and previous experience in fire-related injury prevention programs (such as door-to-door campaigns), including status of surveillance activities related to the problem. Demonstrate capacity to conduct the program. Show the appropriateness of position descriptions, CV's, and lines of command to accomplish program goals and objectives.

D. Goals and Objectives

Specify goals which indicate what the applicant anticipates its residential fire-related injury prevention program will have accomplished at the end of the three-year project period. Include specific time-framed, measurable and achievable objectives which can be accomplished during the first budget period. Objectives should relate directly to project goals, and should include, but not be limited to, increasing smoke detector usage and maintenance, and demonstrating the effectiveness of smoke detector intervention activities.

E. Methods and Staffing

Describe how the model residential fire injury prevention program (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) will be implemented and why deviations from this model, if any, are necessary for the applicant's setting. Specify how the target population corresponds to the high-risk population, as defined (see **BACKGROUND AND DEFINITIONS** section). Describe activities at the State and local levels that are designed to achieve each of the program objectives during the budget period. A time-frame should be included which indicates when each activity will occur. Include an organizational chart identifying placement of the residential fire-related injury prevention program. Show allocation of staff to the activities. Describe the roles and responsibilities of the project director and each staff member. Descriptions should include

the position titles, education and experience required, and the percentage of time each will devote to the program. CVs for existing staff should be included. Document specific concurrence of plans by all other involved parties, including consultants, and provide a letter from each consultant or outside agency describing their willingness and capacity to fulfill proposed responsibilities.

For each local program conducting interventions, describe the program's ability and commitment to:

1. Provide a coordinator to act as liaison with the State,
2. Organize a coalition of appropriate individuals, agencies, and organizations to generate community input and support for smoke detector promotion campaigns,
3. Collaborate with the local health department,
4. State measurable objectives for the project,
5. Conduct pre- and post-program household surveys of smoke detector use within the target and comparable populations,
6. Educate residents who receive a home visit smoke detector on fire safety and smoke detector installation and maintenance,
7. Maintain records of smoke detector promotional activities and provide to the state coordinator at the requested interval.

Women, Racial and Ethnic Minorities. Provide a description of the proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

F. Evaluation

Provide a detailed description of the methods and design to evaluate program effectiveness, including what will be evaluated, data to be used, and the time-frame. Document staff availability, expertise, and capacity to evaluate program activities and effectiveness, and demonstrate evaluation data availability. Evaluation should include progress in meeting the objectives and conducting activities on residential smoke detector programs (process evaluation measures), and increasing residential smoke detector prevalence and functionality (outcome measures). Describe the use of control populations to help differentiate program effects from background trends. Indicate willingness to participate in a process of continuous improvement which may require frequent review of progress and processes utilized, remediation of identified barriers, and adoption of modified methods and measures.

G. Coordination and Collaboration

Provide a description of the relationship between the program and other organizations, agencies, and health department units that will relate to the program. Composition and roles of State and/or local coalitions should be included; specific commitments of support should be provided. Letters of support from public safety officials should also be included if related activities are undertaken. A description of proposed collaboration with ICRC's (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) local academic institutions should be included.

H. Budget and Accompanying Justification

Provide a detailed budget with accompanying narrative justifying all individual budget items which make up the total amount of funds requested. The budget should be consistent with stated objectives and planned activities. The budget should include funds for two trips to Atlanta by key State and community staff for participation in continuous improvement activities and ''grantee'' meetings.

I. Human Subjects

Indicate whether human subjects will be involved, and if so, how they will be protected, and describe the review process which will govern their participation.

For Trauma Care System Development (Part IB), the Application Must Include

A. Abstract

A one page summary of the proposed program.

B. Background and Capacity

Define the current magnitude of trauma burden, in terms of mortality, hospitalizations, and/or disability. Define the current status of the trauma care system in the State, including the extent to which the key components of a TCS are currently in place (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section). Identify a sub-state target area (if such is proposed) and justify its need and use. Specify barriers to TCS planning, development, and operations. Demonstrate capacity to utilize data systems (e.g., trauma registries, hospital discharge data, autopsy records, EMS run reports, and surveys) that assess hospital trauma care capabilities. Demonstrate capacity to conduct the program. Show the appropriateness of position, descriptions, CV's, and lines of command to accomplishment of program goals and objectives.

C. Goals and Objectives

Provide specific goals which indicate where the applicant anticipates its TCS program will be at the end of the three-year project period. Include specific time-framed, measurable, and achievable objectives that can be accomplished during the first budget period. Objectives should relate directly to the project goals, and should include, but not be limited to, improving the TCS structure and process and reducing trauma morbidity, mortality, and disability. Include objectives which address all activities necessary to accomplish the purpose of the proposal.

D. Methods and Staffing

Describe how the model trauma care system (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) will be implemented and why deviations from this model, if any, are necessary for the applicant's setting. Describe proposed activities at the State, regional, and local levels. Provide: (a) A detailed description of proposed activities which are designed to achieve each objective and overall program goals, and which includes designation of responsibility for each activity undertaken; (b) a complete time frame indicating when each activity will occur; and (c) a description of the roles of each unit, organization, or agency, and coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities. Show allocation of staff assigned to the activities. Describe the roles and responsibilities of the project director and each staff member. Descriptions should include the position titles, education and experience required, and the percentage of time each will devote to the program. CVs for existing staff should be included. Document specific concurrence of plans by all other involved parties, including consultants, and provide a letter from each consultant or outside agency describing their willingness and capacity to fulfill proposed responsibilities.

Women, Racial and Ethnic Minorities. Provide a description of the proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

E. Evaluation

Describe how the proposed evaluation system will document program progress, and how proposed evaluation measures will measure success in developing the TCS. Evaluation should include progress in meeting program objectives. Demonstrate potential data sources and

TCS information systems (or plans to develop one) for evaluation purposes, and document staff availability, expertise, experience, and capacity to perform the evaluation. Include a plan for reporting evaluation results and using evaluation information for programmatic decisions. Indicate willingness to participate in a process of continuous improvement which may require frequent review of progress and processes utilized, remediation of identified barriers, and adoption of modified methods and measures.

F. Coordination and Collaboration

Provide a description of the relationship between the program and other organizations, agencies, and health department units that will associate with the program. Composition and roles of State, regional, and/or local coalitions should be included; specific commitments of support should be provided. A description of proposed collaboration with ICRC's (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) or local academic institutions should be included.

G. Budget and Accompanying Justification

Provide a detailed budget with accompanying narrative justifying all individual budget items which make up the total amount of funds requested. The budget should be consistent with stated objectives and planned activities. The budget should include funds for two trips to Atlanta by key State and community staff for participation in continuous quality improvement activities and ''grantee'' meetings.

H. Human Subjects

Indicate whether human subjects will be involved, and if so, how they will be protected, and describe the review process which will govern their participation.

For Emergency Department Injury Surveillance (Part IC), the Application Must Include

A. Abstract

A one page summary of the proposed program.

B. Background and Capacity

Provide a brief description of the need for non-fatal injury surveillance within the State, and provide a description of the existing injury (fatal, hospitalized, and non-hospitalized) surveillance program within the jurisdiction, including:

1. Existing staff and brief summary of their qualifications.

2. Methods of current non-hospitalized injury surveillance, including: (a) Case definition(s), (b) Data elements collected, and (c) Data sources used and their completeness.

3. A brief summary of any data analyses completed.

4. A brief summary of any evaluations of surveillance system data quality which addresses the attributes of the surveillance system.

Provide evidence of the existence of a statewide (or in a population of one million or more, which is representative of the State) population-based E-coded hospital discharge data system. Provide analysis of the most recent year of data from this system. Provide documentation that legislation and/or regulations are in place which support current collection of hospital emergency department data, and which protect the confidentiality of these data. Demonstrate capacity to conduct this injury surveillance program. Show the appropriateness of position descriptions, CV's, and lines of command to accomplish program goals and objectives. Provide a description of the capability for the entry, management, processing and analysis of data, including a description of available computer hardware and software resources.

C. Goals and Objectives

Provide specific goals which indicate what the applicant anticipates its ED Injury Surveillance program will have accomplished at the end of the three-year project period. Include specific time-framed, measurable, and achievable objectives that can be accomplished during the first budget period. Objectives should relate directly to the project goals. Include objectives which address all activities necessary to accomplish the purpose of the proposal.

D. Methods and Staffing

Describe how the model ED surveillance program (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) will be implemented and why deviations, if any, are necessary for the applicant's setting. Describe proposed activities at all involved levels (State, local, organization). Provide: (a) A detailed description of proposed activities which are designed to achieve each objective and overall program goals, and which includes designation of responsibility for each activity undertaken; (b) a complete time frame indicating when each activity will occur; and (c) a description of the roles of each unit, organization, or agency and coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities. Show allocation of staff to the activities. Describe the roles and responsibilities of the project director and each staff member. Descriptions should include the position titles, education and experience required, and the percentage of time each will devote to the program. CVs for existing staff should be included. Document specific concurrence of plans by all other involved parties, including consultants, and provide a letter from each consultant or outside agency describing their willingness and capacity to fulfill proposed responsibilities.

Specifically, include proposed methods of system development or system enhancement, and data collection, including:

1. Case definitions for inclusion in the system.

2. A listing of data elements proposed for collection. Provide plans to incorporate the essential DEEDS data elements, as defined above. At a minimum, data elements collected for every case should include birthdate, age, sex, race, county (or zip code) of residence, ICD–9–CM diagnostic and external cause-of-injury codes, dates of encounter, or dates of injury and death (if applicable). Medical service charges should be included. If the plan includes use of a representative sample of hospital emergency department injury visits, provide the sampling frame and plan.

3. All other sources of data that would be used to provide additional information on cases. Other optional sources of data might include hospital medical record, EMS, or police report data. Provide a brief description of the proposed use of data for injury prevention programs.

E. Evaluation

Describe how the proposed evaluation activities will assess the sensitivity, predictive value positive, quality of the data collected, and other attributes of the surveillance system (e.g., representativeness, timeliness). Evaluation should include progress in meeting program objectives. Document staff availability, expertise, experience, and capacity to perform the evaluation. Include a plan for reporting evaluation results and using evaluation information for programmatic decisions. Indicate willingness to participate in a process of continuous improvement which may require frequent review of progress and processes utilized, remediation of identified barriers, and adoption of modified methods and measures.

F. Coordination and Collaboration

Provide a description of the relationship between the program and other organizations, agencies, and health department units that will associate with the program. Composition and roles of State, regional, and/or local partners should be included; specific commitments of support should be provided. Include a description of proposed collaboration with ICRC's or local academic institutions.

G. Budget and Accompanying Justification

Provide a detailed budget with accompanying narrative justifying all individual budget items which make up the total amount of funds requested. The budget should be consistent with stated objectives and planned activities. The budget should include funds for two trips to Atlanta by key State and community staff for participation in continuous improvement activities and ''grantee'' meetings.

For Basic Injury Prevention Programs (Part II), the Application Must Include

A. Abstract

Provide a one page summary of the proposed program.

B. Background and Need

Describe current and past injury control activities of the public health agency. Justify the need to develop a basic injury prevention and control program. Describe the benefit of creating or enhancing a State public health injury prevention and control focal point. Describe the type and nature of current and past advisory groups related to injury prevention and control. Demonstrate capacity to conduct the program.

C. Goals and Objectives

Provide specific goals which indicate what the applicant anticipates its Basic Injury Prevention Program will have accomplished at the end of the three-year project period. Include specific time-framed, measurable and achievable objectives that can be accomplished during the first budget period. Objectives should relate directly to the project goals. Include objectives which address all activities necessary to accomplish the purpose of the proposal. Specifically, they should include, but not be limited to, creation of an advisory structure, producing a profile of injuries in the State, assessing public health agency capacity to prevent injuries, and developing a State plan to address injury prevention and control.

D. Methods and Staffing

Describe how the program will be implemented. Provide: (a) A detailed description of proposed activities designed to achieve each objective and overall program goals and which includes designation of responsibility for each activity undertaken; (b) a complete time frame indicating when each activity will occur; and (c) a description of the roles of each unit, organization, or agency and coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities. Show allocation of staff to the activities. Describe the roles and responsibilities of the project director and each staff member. Descriptions should include the position titles, education and experience required, and the percentage of time each will devote to the program. CVs for existing staff should be included. Document specific concurrence of plans by all other involved parties, including consultants, and provide a letter from each consultant or outside agency describing their willingness and capacity to fulfill proposed responsibilities.

E. Evaluation

Describe how the proposed evaluation system will document program progress, and how proposed evaluation measures will measure success in developing basic injury prevention programs. Evaluation should include progress in meeting program objectives. Document staff availability, expertise, experience, and capacity to perform the evaluation. Include a plan for reporting evaluation results and using evaluation information for programmatic decisions. Indicate willingness to participate in a process of continuous improvement which may require frequent review of progress and processes utilized, remediation of identified barriers, and adoption of modified methods and measures.

F. Coordination and Collaboration

Provide a description of the relationship between the program and other organizations, agencies, and health department units that will associate with the program. Composition and roles for the advisory structure and other partners should be included; specific commitments of support should be provided. Include a description of proposed collaboration with ICRC's (see **WHERE TO OBTAIN ADDITIONAL INFORMATION** section) or local academic institutions.

G. Budget and Accompanying Justification

Provide a detailed budget with accompanying narrative justifying all individual budget items which make up the total amount of funds requested. The budget should be consistent with stated objectives and planned activities. The budget should include funds for two trips to Atlanta by key State staff for participation in continuous improvement activities and ''grantee'' meetings.

Evaluation Criteria

Applications will be reviewed and evaluated according to the following criteria (maximum 100 total points):

A. Background, Need, and Capacity (30 percent)

The extent to which the applicant presents data and information documenting the capacity to accomplish the program, positive progress in related past or current activities or programs, and, as appropriate, need for the program. The extent to which current resources demonstrate capability to conduct the program.

Note: For competing continuation applicants, the extent to which past activities are presented completely and demonstrate attainment of objectives.

B. Goals and Objectives (10 percent)

The extent to which the applicant includes goals which are relevant to the purpose of the proposal and feasible to accomplish during the project period, and the extent to which these are specific and measurable. The extent to which the applicant has included objectives which are feasible to accomplish during the budget period, and which address all activities necessary to accomplish the purpose of the proposal. The extent to which the objectives are specific, time-framed, measurable, and realistic.

C. Methods and Staffing (30 percent)

The extent to which the applicant provides: (1) A detailed description of proposed activities which are likely to achieve each objective and overall program goals, and which includes designation of responsibility for each action undertaken; (2) a reasonable and complete schedule for implementing all activities; and (3) a description of the roles of each unit, organization, or agency, and evidence of coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities.

The degree to which the applicant has met the CDC Policy requirements

regarding the inclusion of women, ethnic, and racial groups in the proposed project. This includes: (a) The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation; (b) The proposed justification when representation is limited or absent; (c) A statement as to whether the design of the study is adequate to measure differences when warranted; and (d) A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with community(ies) and recognition of mutual benefits will be documented.

D. Evaluation (20 percent)

The extent to which the proposed evaluation system is detailed, addresses goals and objectives of the program, and will document program process, effectiveness, and impact. The extent to which the applicant demonstrates potential data sources for evaluation purposes and methods to evaluate the data sources, and documents staff availability, expertise, experience, and capacity to perform the evaluation. The extent to which a feasible plan for reporting evaluation results and using evaluation information for programmatic decisions is included. The extent to which an agreement to participate in continuous improvement activities is present.

E. Collaboration (10 percent)

The extent to which relationships between the program and other organizations, agencies, and health department units that will relate to the program or conduct related activities are clear, complete and provide for complementary or supplementary interactions. The extent to which coalition membership and roles are clear and appropriate. The extent to which relationships with ICRC'S or local academic institutions are completely described and activity-specific.

F. Budget and Justification (Not Weighted)

The extent to which the applicant provides a detailed budget and narrative justification consistent with stated objectives and planned program activities.

G. Human Subjects (Applicable Parts Only) (Not Weighted)

The extent to which the applicant describes the involvement of human subjects (if any) and the process which will govern their participation. The extent to which adequate safeguards are in place.

Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs as governed by Executive Order (E.O.) 12372. E.O. 12372 sets up a system for State and local government review of proposed Federal assistance applications. Applicants should contact their State Single Point of Contact (SPOC) as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each affected State. A current list of SPOCs is included in the application kit. If SPOCs have any State process recommendations on applications submitted to CDC, they should send them to Ron S. Van Duyne, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 300, Mailstop E–13, Atlanta, GA 30305, no later than 30 days after the application deadline. (The appropriation for this financial assistance program was received late in the fiscal year and would not allow for the application receipt date which would accommodate the 60-day recommendation process period.) The Program Announcement Number and Program Title should be referenced on the document. The granting agency does not guarantee to ''accommodate or explain'' the State process recommendations it receives after that date.

Public Health System Reporting Requirements

This program is not subject to the Public Health System Reporting Requirements.

Catalog of Federal Domestic Assistance Number

The Catalog of Federal Domestic Assistance number is 93.136.

Other Requirements

Paperwork Reduction Act

Projects that involve the collection of information from 10 or more individuals and funded by the cooperative agreement will be subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Human Subjects

If the proposed project involves research on human subjects, the applicant must comply with the Department of Health and Human Services Regulations, 45 CFR Part 46, regarding the protection of human subjects. Assurance must be provided to demonstrate that the project will be subject to initial and continuing review by an appropriate institutional review committee. The applicant will be responsible for providing assurance in accordance with the appropriate guidelines and forms provided in the application kit.

Women, Racial and Ethnic Minorities

It is the policy of the Centers for Disease Control and Prevention (CDC) to ensure that individuals of both sexes and the various racial and ethnic groups will be included in CDC-supported research projects involving human subjects, whenever feasible and appropriate. Racial and ethnic groups are those defined in OMB Directive No. 15 and include American Indian, Alaskan Native, Asian, Pacific Islander, Black and Hispanic. Applicants shall ensure that women, racial and ethnic minority populations are appropriately represented in applications for research involving human subjects. Where a clear and compelling rationale exists that inclusion is inappropriate or not feasible, this situation must be explained as part of the application. This policy does not apply to research studies when the investigator cannot control the race, ethnicity, and/or sex of subjects. Further guidance to this policy is contained in the **Federal Register**, Vol. 60, No. 179, pages 47949–47951, dated Friday, September 15, 1995.

Application Submission and Deadline

The original and two copies of the application PHS Form 5161–1 (Revised 7/92, OMB Number 0937–0189) must be submitted to Joanne A. Wojcik, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 321, Mailstop E–13, Atlanta, GA 30305, on or before August 12, 1997.

1. 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 and received in time for submission to the objective review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks will not be acceptable as proof of timely mailing.)

2. Late Applications: Applications that do not meet the criteria in 1.a. or 1.b. above are considered late applications. Late applications will not be considered and will be returned to the applicant.

Where To Obtain Additional Information

To receive additional written information call (404) 332–4561. You will be asked to leave your name, address, and telephone number and will need to reference Announcement 780. You will receive a complete program description, information on application procedures, and applications forms.

If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from Joanne A. Wojcik, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Mailstop E–13, Atlanta, GA 30305, telephone (404) 842–6535 or Internet address <jcw6@cdc.gov.

Programmatic technical assistance may be obtained from:

Part IA1: Bicycle Helmet Promotion Programs, Jeffrey Sacks, M.D., MPH, telephone (770) 488–4901, Mailstop K63, Internet address <jjs3@cdc.gov>.

Part IA2: Residential Fire Injury Prevention Programs, Pauline Harvey, MSPH, telephone(770) 488–4592, Mailstop K63, Internet address <pdh7@cdc.gov>.

Part IB: Trauma Care Systems Development, Paul Burlack, telephone (770) 488–4713, Mailstop F41, Internet address <pab5@cdc.gov>.

Part IC: Emergency Department Injury Surveillance, Daniel Sosin, M.D., MPH, telephone (770) 488–4233, Mailstop K02, Internet address <dms8@cdc.gov.

Part II: Basic Injury Program Development, James Belloni, MA, telephone (770) 488–4538, Mailstop K02, Internet address <jsb1@cdc.gov>.

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop (Insert Mailstop from above), Atlanta, GA 30341–3724.

The complete application kit includes a copy of the following listed addendums. These addendums provide the applicants with additional program guidance, such as additional background information and further define model programs described in this announcement and provide a complete listing of the ICRCs.

—Addendum IA1: Bicycle Helmet Promotion Programs
—Addendum IA2: Residential Fire Injury Prevention Programs
—Addendum IB: Trauma Care Systems Development
—Addendum IC: Emergency Department Injury Surveillance
—Addendum II: Injury Control Research Centers (ICRCs)

This and other CDC announcements are available through the CDC homepage on the Internet. The address for the CDC homepage is <http://www.cdc.gov>.

CDC will not send application kits by facsimile or express mail.

Please refer to Announcement 780 when requesting information and submitting an application.

Potential applicants may obtain a copy of ''Healthy People 2000'' (Full Report, Stock No. 017–001–00474–0) or ''Healthy People 2000'' (Summary Report, Stock No. 017–001–00473–1) referenced in the **''Introduction''** through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325, telephone (202) 512–1800.

Dated: June 17, 1997.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

[FR Doc. 97–16310 Filed 6–20–97; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Ethics Subcommittee and the Advisory Committee to the Director, Centers for Disease Control and Prevention; Meetings

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 the following subcommittee and committee meetings.

Name: Ethics Subcommittee of the Advisory Committee to the Director, CDC.

Time and Date: 9 a.m.-3 p.m., July 10, 1997.

Place: CDC, Building 16, Room 1107, 1600 Clifton Road, NE, Atlanta, Georgia 30333.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 30 people.

Purpose: This subcommittee will anticipate, identify, and propose solutions to strategic and broad ethical issues facing CDC.

Matters to be Discussed: Agenda items will include updates from the Associate Director for Science, Dixie E. Snider, M.D., M.P.H., followed by a discussion on CDC's current procedures for protecting human research subjects and ethical standards for international research.

Name: Advisory Committee to the Director, CDC.

Time and Date: 8:30 a.m.–3 p.m., July 11, 1997.

Place: CDC, Auditorium A, 1600 Clifton Road, NE, Atlanta, Georgia 30333.

Status: Open to the public, limited only by the space available.

Purpose: This committee advises the Director, CDC, on policy issues and broad strategies that will enable CDC, the Nation's prevention agency, to fulfill its mission of promoting health and quality of life by preventing and controlling disease, injury, and disability. The Committee recommends ways to incorporate prevention activities more fully into health care. It also provides guidance to help CDC work more effectively with its various constituents, in both the private and public sectors, to make prevention a practical reality.

Matters To Be Discussed: Agenda items will include updates from CDC Director, David Satcher, M.D., Ph.D., followed by a report from the Ethics Subcommittee, a discussion on CDC's data for a healthy Nation, and the agency's plans for facing the challenges of health communication.

Agenda items are subject to change as priorities dictate.

Contact Person for more Information: Linda Kay McGowan, Acting Executive Secretary, Advisory Committee to the Director, CDC, 1600 Clifton Road, NE, M/S D–24, Atlanta, Georgia 30333, telephone 404/639–7080.

Dated: June 17, 1997.

Nancy C. Hirsch,

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

[FR Doc. 97–16323 Filed 6–20–97; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Breast and Cervical Cancer Early Detection and Control Advisory Committee: Meeting

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 the following committee meeting.

Name: Breast and Cervical Cancer Early Detection and Control Advisory Committee.

Times and Dates: 1 p.m.-4:45 p.m., July 10, 1997; 9 a.m.-12:30 p.m., July 11, 1997.

Place: The Westin Hotel Atlanta Airport, Hartsfield Ballroom, 4736 Best Road, College Park, Georgia 30337. Telephone 404/762–7676.

Status: Open to the public, limited only by the space available. The room will accommodate approximately 100 people.