Administration on Aging

[Program Announcement No. AoA–97–1]

Fiscal Year 1997 Program Announcement; Availability of Funds and Notice Regarding Applications

AGENCY: Administration on Aging, HHS.

ACTION: Announcement of availability of funds and request for applications to demonstrate models that assist retired persons to serve in their communities as volunteer expert resources and educators in combatting health care waste, fraud and abuse.

SUMMARY: The Administration on Aging announces that it will hold a competition for cooperative agreement awards for model projects that demonstrate effective ways of utilizing retired persons as expert resources and educators in community efforts to combat health care waste, fraud, and abuse. In accordance with Senate Report 104–368, the Health Care Financing Administration will transfer funds to the Administration on Aging to facilitate a collaboration of aging network agencies, health insurance counseling programs, senior centers, and other appropriate entities in carrying out the demonstration program.

The deadline date for the submission of applications is April 11, 1997. Prospective applicants should note that, consistent with the terms of Senate Report 104–368, preference will be given to projects to be carried out by consortia headed by agencies/organizations representative of health insurance counseling programs, area agencies on aging, and other senior advocacy efforts. Agencies/organizations representative of senior centers should also have prominent roles in the consortia since Senate Report 104–368 further provides that senior centers should be the test sites in at least one-half of the model projects funded.

Application kits are available by writing to: Department of Health and Human Services, Administration on Aging, Office of Governmental Affairs and Elder Rights, 330 Independence Avenue, S.W., Room 4254, Washington, DC 20201. Please include an organizational capability statement.

Dated: February 6, 1997.

Robyn I. Stone,

Acting Assistant Secretary for Aging.

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Centers for Disease Control and Prevention

[Announcement 716]

Traumatic Brain Injury 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 population-based data systems for Traumatic Brain Injury (TBI). The intent of the program is to further develop a multi-state, population-based surveillance system for TBI that began in FY 1995. The development of population-based surveillance for TBI fulfills, in part, activities mandated in Public Law 104–166, The Traumatic Brain Injury Act, enacted in 1996. This program will serve two purposes:

Part I—To enhance existing State or territory surveillance systems for TBI, to ensure they are population-based and provide high quality, useful data.

Part II—To develop TBI surveillance systems in States or territories that have not received past funding from CDC for this purpose and have legal authority to collect TBI data but have little or no surveillance infrastructure. 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 Injury, 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.'')

Authority

This program is authorized under sections 301, 317, 391, and 392, of the Public Health Service Act (42 U.S.C. 241, 247b, 280b, and 280b-1) as amended, including Pub. L. 104–166.

Smoke-Free Workplace

CDC strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products, and Pub. L. 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 other State agencies or departments. 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.

State agencies applying under this announcement that are other than the official State health department must provide written concurrence for the application from the official State health agency.

Only *one* application from each State may enter the review process and be considered for an award under this program. Applicants may apply for either Part I or Part II funding as most appropriate, *but not both*.

For Part I, applicants who are funded under Announcement 526 are not eligible for this program.

For Part II, applicants who have received past funding for TBI Surveillance from CDC (from the National Center for Injury Prevention and Control (NCIPC) or the National Center for Environmental Health (NCEH)) are not eligible for this program.

Availability of Funds

Approximately $1,550,000 is available in FY 1997 to fund up to eleven awards under Parts I and II of this announcement:

Part I—Approximately $1,200,000 is available in FY 1997 to fund six to eight awards to enhance existing State surveillance systems for TBI. It is expected that the average award will be $150,000, ranging from $125,000 to $175,000.

Part II—Approximately $350,000 is available in FY 1997 to fund two to three awards to assist in planning TBI surveillance systems. It is expected that the average award will be $115,000, ranging from $90,000 to $125,000.

Projects are expected to begin on or about August 1, 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.

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 surveillance or registry activities, for construction costs, or to lease or purchase facilities or space.

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

Funding Preferences: During the selection process CDC will make every effort to ensure a balanced geographic distribution.

Use of Funds

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

Background

Among all types of injury, traumatic brain injury is most likely to result in death or permanent disability. The incidence and prevalence, severity, and cost indicate that these injuries are important public health problems. TBI is also preventable.

- Some estimates and studies of incidence have indicated that traumatic brain injuries may result in 260,000 hospitalizations and 52,000 deaths each year.
- The severity of the nonfatal injuries is shown by estimates that each year 70,000 to 90,000 people sustain TBI resulting in permanent disability.
- The costs of TBI—acute care, rehabilitation, chronic care, and indirect costs—are unknown but certainly enormous. One estimate suggests that head injuries impose an annual economic burden of $37 billion in direct and indirect costs. These estimates of cost fail to account for the extraordinary losses experienced by the families and friends of those who have died or sustained disability from TBI.
- Injuries are largely preventable. The leading causes of TBI are motor-vehicle crashes, falls, and violence.

Despite the magnitude of the problem of TBI, surveillance systems in only a few U.S. jurisdictions are adequately monitoring its impact. In the past, most of the data on TBIs have been collected in: (1) Hospital-based clinical case series, (2) epidemiological studies restricted to particular times and locales, (3) registries maintained by government agencies responsible for providing services for persons with these injuries, and (4) state-based public health surveillance systems for TBI.

Hospital-based clinical case series. Data collected at hospitals treating persons with Central Nervous System (CNS) injuries have been used mainly to assess clinical course, treatment efficacy and quality of care. Usually these data are not collected from all the hospitals serving a geographic area; instead these data include only persons who present at a particular hospital or group of hospitals for treatment. Thus, the data may be unrepresentative of injury occurrence in the entire population of the geographic area. They provide no information on persons in the area who fail to receive treatment at the hospitals collecting the data, persons whose characteristics may differ substantially from those who do receive treatment at these hospitals.

Epidemiological Studies. Although epidemiological studies designed to estimate the incidence of TBI have been useful, published studies have been limited to certain geographic areas and to earlier time periods. These studies, although valuable in defining the size of the problem and describing etiologies of injury, have not been ongoing. Therefore, they have not provided sufficient data to define patterns in TBI over time, to assess changes in such patterns, and to evaluate the effectiveness of current prevention programs. Furthermore, in specialized studies, investigators have used varying definitions of TBI and inclusion criteria, making comparison across studies (and therefore across jurisdictions) difficult. Studies of these injuries have produced a broad range of incidence estimates.

Service-based registries. Until recently, TBI case reports were often collected in registries developed to plan and provide for patient and family services. These were often collected by agencies of State government not involved in traditional public health prevention activities (e.g., mental health, vocational rehabilitation, and other rehabilitation services). Because of the service delivery focus of registries, little information was collected on the etiologies of injuries, limiting the usefulness of these data for prevention program planning. These data are seldom used for public health program planning.

State-based Surveillance. Over the past several years, many States have responded to the need for better TBI data by developing public health surveillance systems—some efforts growing out of previous registry efforts. These data systems are just beginning to provide ongoing population-based incidence and etiologic information that is useful to plan and evaluate public health programs. Building on these efforts, in 1995, CDC funded four States to conduct ongoing population-based surveillance for TBI. Methods of data collection vary among these surveillance systems, some employing legal reporting requirements for CNS injuries similar to reporting requirements for certain communicable diseases, some using existing hospital discharge data systems or trauma registries, and some relying on a combination of these methods.

Definitions

Traumatic Brain Injury (TBI) and essential data elements for TBI surveillance are fully defined in CDC's ''Guidelines for Surveillance of Central Nervous System Injury.'' For ordering a copy of the Guidelines, see the sections ''WHERE TO OBTAIN ADDITIONAL INFORMATION'' and ''TRAUMATIC BRAIN INJURY SURVEILLANCE REFERENCES.''

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

Hospital discharge data (HDD) are summary data compiled by hospitals for all patients admitted and discharged. These data, which are usually entered in a computer data base maintained by each hospital, include information on patient age, sex, residence, diagnoses coded according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM codes), services provided, service charges, and dates of hospital admission and discharge. In some jurisdictions, hospital discharge data are compiled from all patients in all hospitals and are maintained in a centralized, population-based, data collection system. In other

jurisdictions, these data are only separately maintained by each hospital.

Purpose

The purpose of this program is to improve the quality and availability of TBI data:

Part I—To enhance existing TBI surveillance systems in order to develop a multi-state surveillance system which will use common case definitions and data base. This surveillance system will better define the magnitude of TBI at a national level, define the spectrum of severity of injury, better define populations at high risk, and define the distribution of external causes of injury in order to plan injury control programs addressing prevention and service provision. CDC's Guidelines for Central Nervous System Injury Surveillance will be the standards used.

Part II—To develop new TBI surveillance systems in States or territories with authority to collect TBI data but which have had no prior funding from CDC to develop TBI surveillance and which have little or no TBI surveillance infrastructure. These State-based surveillance systems will also become part of the multi-state surveillance system described under Part I by the end of the project period. CDC's Guidelines for Central Nervous System Injury Surveillance will be the standards used.

Program Requirements

Part I—The applicant must:

1. Demonstrate the existence of a statewide (or territory-wide) population-based TBI surveillance system *or* a population-based TBI surveillance system in a geo-political jurisdiction of 1.5 million people or more.

2. Document that legislation and/or regulations are in place which support current collection of TBI data, and protect the confidentiality of this data.

3. Demonstrate the availability of at least one year of TBI data from the TBI surveillance system (from calendar year 1993, 1994, or 1995).

Part II—The applicant must: Document that legislation and/or regulations are in place which support current collection of TBI data, and protect the confidentiality of this data.

Both Part I and Part II applicants are to provide a 1 page Summary which includes:

1. Type of Federal assistance requested: Part I or Part II.

2. A succinct, but informative, response to each application program requirement.

An affirmative response to each requirement is required to qualify for the full objective review. This page should be included as the first page of the application and titled ''Program Requirements.''

Cooperative Activities

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

Part I

Recipients of awards under Part I of this announcement will develop an enhanced statewide (or territory-wide) population-based TBI surveillance or population-based TBI surveillance within a geo-political jurisdiction of 1.5 million or more.

A. Recipient Activities include but will not be limited to:

1. Conduct surveillance for TBI using the definitions and variables as defined in the CDC Guidelines for Central Nervous System Injury Surveillance. Recipients will collect information addressing demographics, etiology, severity and outcome.

2. Access and use mortality data and hospital patient data, using vital records (death certificates and/or multiple-cause-of-death data) and linking them to hospital discharge data to produce a non-duplicative data base for the population under surveillance.

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

4. Develop and submit an annual report of the analysis of surveillance data.

5. Compile and submit timely case-level surveillance data yearly (in each budget period) to CDC for use in a multi-state TBI surveillance data base formatted per CDC Guidelines for Central Nervous System Injury Surveillance.

6. Develop a yearly work plan which includes measurable objectives with appropriate time lines and associated activities.

B. CDC Activities:

1. Provide technical assistance for effective surveillance program planning and management and for application of the CDC Guidelines for Central Nervous System Injury Surveillance.

2. Provide technical assistance to evaluate the surveillance system for completeness and validity.

3. Maintain multi-state data base to develop TBI rates and other information for reports and other publications, when appropriate. Standard practices for co-authorship and publication among CDC and participating recipients will be followed according to the Manual Guide—General Administration No. CDC–69, Authorship of CDC or ATSDR Publications (12/1/95).

Part II

Recipients of awards under Part II of this announcement will develop statewide (or territory-wide) population-based TBI surveillance or population-based TBI surveillance within a geo-political jurisdiction of 1.5 million or more.

A. Recipient Activities include but are not limited to:

1. Develop and implement a 3-year plan to conduct TBI surveillance using the CDC Guidelines for Central Nervous System Injury Surveillance. Recipients will be expected to collect information addressing demographics, etiology, severity and outcome.

2. Use mortality data and hospital patient data, using vital records (death certificates and/or multiple-cause-of-death data) and linking them to hospital discharge data to produce a non-duplicative data base for the population under surveillance.

3. Develop and submit an annual report on progress of the developing TBI surveillance system.

4. Compile and submit case-level surveillance data to CDC in a timely manner for use in a multi-state TBI surveillance data base formatted per CDC Guidelines for Central Nervous System Injury Surveillance.

5. Where applicable, evaluate the surveillance system for completeness and validity of data collected using methods described in ''Guidelines for Evaluating Surveillance Systems.''

6. Develop a yearly work plan which includes measurable objectives with appropriate time lines and associated activities.

B. CDC Activities:

1. Provide technical assistance for effective surveillance program planning and management and for application of the CDC Guidelines for Central Nervous System Injury Surveillance.

2. Provide technical assistance for data management and analysis.

3. Maintain multi-state data base to develop TBI rates and other information for reports and other publications, when appropriate. Standard practices for co-authorship and publication among CDC and participating recipients will be followed according to the Manual Guide—General Administration No. CDC–69, Authorship of CDC or ATSDR Publications (12/1/95).

Technical Reporting Requirements

An original and two copies of semi-annual progress reports are required of all awardees. Time lines for the semi-annual 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 are submitted to the Grants Management Branch, Procurement and Grants Office, CDC.

Semi-annual progress reports should include:

A. A brief program description.

B. A listing of program goals and objectives, accompanied by a comparison of the actual accomplishments related to the goals and objectives established for the period.

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.

D. Other pertinent information, including the status of completeness, timeliness and quality of data, published annual reports from surveillance efforts, as well as other materials published related to the surveillance system.

For Part II, any other information about the progress of surveillance system development should be included.

Application Content

The entire application, including appendices, should not exceed 60 pages and the Proposal Narrative section contained therein should not exceed 25 pages. The first page of the application should contain the response to the Program Requirements section and be marked ''Program Requirements.'' 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.

Part I—Application Content

A. Provide a 1 page Abstract which includes:

1. Existing resources for the program.

2. Major objectives and components for the proposed program.

B. Proposal Narrative (not to exceed 25 double-space pages excluding the budget narrative and appendices): This section should include:

1. A brief description of the needs for TBI surveillance within the jurisdiction applying for assistance.

2. A description of the existing TBI surveillance program within the jurisdiction, including the following:

a. Existing staff and brief summary of their qualifications.

b. Methods of case ascertainment and data collection, including:

(1) Case definition.

(2) Data elements collected.

(3) Sources of data used to ascertain cases.

(4) Other sources of data used to provide additional information on cases.

c. A brief summary of any data analyses completed.

d. A brief summary of any evaluations of surveillance data quality or timeliness.

3. A description of goals and specific, measurable, and time-linked objectives for the proposed surveillance program. Any proposed enhancements of the program should be noted. A schedule of attainment should be included.

4. A description of methods to achieve the proposed surveillance program objectives. This must include at least the following:

a. Proposed staff and qualifications. If staff are to be hired, assurances from the agency that position(s) are available and can be filled in a timely manner must be included.

b. Proposed methods of case ascertainment and data collection, including:

(1) The TBI case definition and its consistency with the CDC case definition.

(2) A listing of data elements proposed to be collected. This should include (but need not be limited to) data elements contained in the core variables of the CDC Guidelines for Central Nervous System Injury Surveillance. Data element formats must be consistent with the CDC Guidelines. At a minimum, data elements collected for every case should include birth date, age, sex, county (or zip code) of residence, ICD–9 or ICD–9–CM diagnostic codes, dates of hospital admission and discharge (if applicable) or dates of injury and death (if applicable), and type of hospital discharge disposition (if applicable). It is also expected that in at least a representative sample of reported cases, additional data elements will be collected describing injury cause (using either E-codes or CDC etiology codes), severity, and outcome, as described in the CDC Guidelines. Other data elements may be collected electively (e.g., medical service charges).

(3) All sources of data that would be used to ascertain cases. At a minimum this should include vital records (death certificates and/or multiple-cause-of-death data) and hospital discharge data. Hospital discharge data may be obtained from state-wide hospital discharge data systems, or may be obtained directly from all individual hospitals within the jurisdiction that provide acute care for brain injuries.

(4) All other sources of data that would be used to provide additional information on cases. At a minimum this should include hospital medical records, which may be reviewed in a representative sample of cases. Other, optional sources of data might include, for example, police reports or medical examiner records.

(5) A brief description of the sampling strategy proposed to obtain additional case information from medical records and other data sources (see previous section). This is important to validate case reports and collect additional data concerning injury risk factors, causes, severity, and outcome. Because of the time required to abstract such records and the large number of reported cases, it is not expected that all reported cases be abstracted. Sampling strategies should ensure representativeness of the sample, but may involve more intensive sampling of some strata with fewer reported cases (e.g., moderate and severe cases). The qualifications of data abstractors and quality control of this data collection should be addressed.

c. Evidence of legal authority to conduct all aspects of surveillance, including authority that gives the applicant access to and authority to collect all necessary vital records data, hospital discharge data, and medical records within the jurisdiction and protect the confidentiality of this data. A letter from the official State public health agency or other State agency or department or from the Attorney General's Office assuring that appropriate State authorities exist should be provided, which cites relevant language from State laws and/or regulations. Appropriate State authorities at a minimum must provide proof of the ability to collect and protect the confidentiality of essential data from State death certificates, hospital discharge data, and hospital medical records for all cases of traumatic brain injury occurring in the State.

d. A description of the applicant's capability for the entry, management,

processing and analysis of data, including a description of computer hardware and software resources; a description of methods and timeline to ensure timely delivery of edited case-level data to CDC.

e. Appropriate letters of commitment, such as letters from agencies that will provide the project with essential data or access to data.

f. A brief description of the proposed use of data for injury prevention programs.

5. A description of plans to evaluate the attainment of proposed objectives, including plans to evaluate the sensitivity and predictive value positive of case ascertainment and the completeness and quality of data.

6. A detailed first-year budget and narrative justification with future annual projections. Budgets should include costs for travel for two project staff to attend one meeting in Atlanta with CDC staff.

Part II—Application Content

A. Provide a 1 page Abstract which includes:

1. Existing resources for the program.

2. Major objectives and components for the proposed program.

B. Proposal Narrative (not to exceed 25 double-space pages excluding the budget narrative and appendices). This Section should include:

1. A brief description of the needs for TBI surveillance within the jurisdiction applying for assistance.

2. A description of the existing TBI surveillance resources within the jurisdiction, including the following:

a. Existing staff and brief summary of their qualifications.

b. Available TBI data, including:

(1) Case definition (s).

(2) Data elements collected.

(3) Sources of data used to ascertain cases.

c. A brief summary of any available analyses of TBI data.

3. A description of goals and specific, measurable, and time-linked objectives for the development of TBI surveillance. A schedule of attainment should be included.

4. A description of planned activities to address the objectives to develop TBI surveillance. This must include at least the following:

a. Proposed staff and qualifications. If staff are to be hired, assurances from the agency that position(s) are available and can be filled in a timely manner must be included.

b. Proposed methods of case ascertainment and data collection, including:

(1) The TBI case definition, consistent with the CDC case definition.

(2) A listing of data elements proposed to be collected. This should include (but need not be limited to) data elements contained in the core variables of the CDC Guidelines for Central Nervous System Injury Surveillance. When data are submitted to CDC, they must be in a format consistent with the CDC Guidelines.

(a) At a minimum, data elements collected for every case should include birth date, age, sex, county (or zip code) of residence, ICD–9 or ICD–9–CM diagnostic codes, dates of hospital admission and discharge (if applicable) or dates of injury and death (if applicable), and type of hospital discharge disposition (if applicable). It is expected that population-based data including these variables, obtained by linking hospital discharge data with vital records data, will be compiled and submitted in a timely manner, but no later than the end of the project period.

(b) It is also expected that in at least a representative sample of reported cases, including morbidity and mortality, additional data elements will be collected describing injury cause (using either E-codes or CDC etiology codes), severity, and outcome, as described in the CDC Guidelines.

(3) All sources of data that would be used to ascertain cases. At a minimum this should include vital records (death certificates or multiple-cause-of-death data) and hospital discharge data. Hospital discharge data may be obtained from state-wide hospital discharge data systems, or may be obtained directly from all individual hospitals within the jurisdiction that provide acute care for head injuries.

(4) All other sources of data that would be used to provide additional information on cases. At a minimum this should include hospital medical records, which may be reviewed in a representative sample of cases. Other, optional sources of data might include police reports or medical examiner records.

(5) A brief description of plans to develop a sampling strategy to obtain additional case information from medical records and other data sources (see previous section).

c. Evidence of legal authority to conduct all aspects of surveillance, including authority that gives the applicant access to and authority to collect all necessary vital records data, hospital discharge data, and medical records within the jurisdiction and protect the confidentiality of this data. A letter from the official State public health agency or other State agency or department or from the Attorney General's Office assuring that appropriate State authorities exist should be provided, which cites relevant language from State laws and/or regulations. Appropriate State authorities at a minimum must provide proof of the ability to collect and protect the confidentiality of essential data from State death certificates, hospital discharge data, and hospital medical records for all cases of traumatic brain injury occurring in the State.

d. A description of the applicant's plans to develop capability for the entry, management, processing and analysis of data, including a description of computer hardware and software resources; a description of methods and timeline to ensure timely delivery of edited case-level data to CDC.

e. Appropriate letters of commitment, such as letters from agencies that will provide the project with essential data or access to data.

f. A description of the proposed use of data for injury prevention programs.

5. A description of plans for a process evaluation of the attainment of proposed objectives.

6. A detailed first-year budget and narrative justification with future annual projections. Budgets should include costs for travel for two project staff to attend one meeting in Atlanta with CDC staff.

Evaluation Criteria

Upon receipt, applications for Part I and Part II will be reviewed by CDC staff for completeness and affirmative responses as outlined under the previous heading, ''PROGRAM REQUIREMENTS.'' Incomplete applications and applications that are not responsive will be returned to the applicant without further consideration.

An Objective Review of applications that are successful in the preliminary review will then be conducted according to the following criteria:

Part I—Evaluation Criteria

1. Needs Assessment (5 points)

The extent to which the applicant describes the impact of TBI in the applicant's jurisdiction and the need for TBI data for public health programs.

2. Existing Surveillance Program and Resources (25 points)

The current status of the applicant's existing TBI surveillance program, and the degree to which it can be adapted to serve the requirements and purposes of this cooperative agreement. Important issues include access to critical data sources (vital records, hospital discharge data, and medical records); established relationships between the applicant and data providers (including

letters of support); legal authority to obtain and protect the confidentiality of data; currentness of existing TBI morbidity and mortality data analyzed by age, sex, and cause; ability to characterize the external cause, severity, and outcome of TBI (e.g., by abstracting data from medical records in a representative sample of reported cases); and established relationships with TBI advocacy and prevention organizations and programs.

3. Goals and Objectives (10 points)

The extent to which objectives are specific, achievable, practical, measurable, time-linked, and consistent with the overall purposes described in this announcement.

4. Methods and Activities (30 points)

The extent that the proposed methods and activities can achieve the proposed objectives, consistent with the purposes of this announcement. The extent to which clear explanations of appropriate methods addressing case ascertainment and data collection, TBI case definition(s), data elements, sources and availability of data, sampling methods, legal authority for surveillance activities and to protect confidentiality, and data processing and analysis are provided.

5. Project Management and Staffing (20 points)

The extent to which proposed staffing, organizational structure, staff experience and background, identified training needs or plan, and job descriptions and curricula vitae for both proposed and current staff indicate ability to carry out the objectives of the program. Assurances that proposed positions are available and can be filled in a timely manner.

6. Evaluation (10 points)

The degree to which the applicant includes adequate plans to evaluate the attainment of proposed objectives, including plans to evaluate the sensitivity and predictive value positive of case ascertainment and the completeness and quality of data.

7. Budget (not scored)

The extent to which the budget is reasonable, clearly justified, and consistent with stated objectives and proposed activities.

Part II—Evaluation Criteria

1. Needs Assessment (10 points)

The extent to which the applicant describes the impact of TBI in the applicant's jurisdiction and the need for TBI data for public health programs.

2. Existing Surveillance Resources (20 points)

The potential of the applicant's existing TBI surveillance activities and resources to serve the requirements and purposes of this cooperative agreement. Critical issues include availability of and access to critical data sources (vital records, hospital discharge data, and medical records), and legal authority to obtain and protect the confidentiality of data.

3. Goals and Objectives (15 points)

The extent to which objectives are specific, achievable, practical, measurable, time-linked, and consistent with the overall purposes described in this announcement.

4. Methods and Activities (30 points)

The extent that the proposed plans and activities can achieve the proposed objectives for surveillance, consistent with the purposes of this announcement. The extent to which clear explanations of appropriate methods addressing case ascertainment and data collection, TBI case definition(s), data elements, sources and availability of data (including letters of support), legal authority for surveillance activities and to protect confidentiality, and data processing and analysis are provided.

5. Project Management and Staffing (15 points)

The extent to which proposed staffing, organizational structure, staff experience and background, identified training needs or plan, and job descriptions and curricula vitae for both proposed and current staff indicate ability to carry out the objectives of the program. Proposed staffing should include epidemiologic and data management capacity. Assurances that proposed positions are available and can be filled in a timely manner.

6. Evaluation (10 points)

The degree to which the applicant includes adequate plans for a process evaluation of the attainment of proposed objectives.

7. Budget (not scored)

The extent to which the budget is reasonable, clearly justified, and consistent with stated objectives and proposed activities.

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 60 days after the application deadline. 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.

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 300, Mailstop E–13, Atlanta, GA 30305, on or before April 16, 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 in the current competition 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 to Announcement 716. 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 business management technical assistance may be obtained from Joanne 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 David J. Thurman, M.D., M.P.H., Division of Acute Care, Rehabilitation Research, and Disability Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop F–41, Atlanta, GA 30341–3724, telephone (770) 488–4031 or internet address <dxt9@cdc.gov>.

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 716 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: February 6, 1997.

Joseph R. Carter,

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

Traumatic Brain Injury Surveillance References

Methods and Key Resources

Thurman DJ, Sniezek JE, Johnson D, Greenspan A, Smith SM. Guidelines for Surveillance of Central Nervous System Injury. Atlanta: Centers for Disease Control and Prevention, 1995.

Klaucke DN, Buehler JW, Thacker SB, et al. Guidelines for evaluating surveillance systems. MMWR 1988;37(s-5):1–18.

Health Care Financing Administration. International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition. Washington, DC: U.S. Department of Health and Human Services, 1989.

Epidemiologic Studies and Reviews

Kraus, JF. Epidemiology of head injury. In Cooper, PR, ed., Head Injury, Third Edition. Baltimore: Williams and Wilkins, 1993; 1–25.

Sosin DM, Sniezek JE, Waxweiler RJ. Trends in death associated with traumatic brain injury, 1979 through 1992. JAMA 1995; 273:1778.

Published epidemiologic studies of TBI are also reviewed in the article ''Epidemiology of Traumatic Brain Injury in the United States'' located at the Internet website of the National Center for Injury Prevention and Control <http://www.cdc.gov/ncipc/dacrrdp/tbi.htm>.

Centers for Disease Control and Prevention. Traumatic Brain Injury—Colorado, Missouri, Oklahoma, and Utah, 1990–93. MMWR 1997; 46(1):8–11.

How to Obtain a Copy of the CDC Guidelines for Surveillance of Central Nervous System Injury:

A copy of these Guidelines can be obtained either by calling 770–488–4031, by submitting the ''NCIPC Publications Order Form'' through the Internet website of the National

Center for Injury Prevention and Control <http://www.cdc.gov/ncipc/pub-res/pubsav.htm>, or by writing to the Division of Acute Care, Rehabilitation Research, and Disability Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop F–41, Atlanta, GA 30341–3724.

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BILLING CODE 4163–18–P

Administration for Children and Families

Children's Bureau/National Center on Child Abuse and Neglect Proposed Research Priorities for Fiscal Years 1997–2001

AGENCY: Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACF), HHS.

ACTION: Notice of proposed child abuse and neglect research priorities for fiscal years 1997–2001.

SUMMARY: The National Center on Child Abuse and Neglect/Children's Bureau (NCCAN/CB) within the Administration on Children, Youth and Families (ACYF) announces the proposed priorities for research on the causes, prevention, assessment, identification, treatment, cultural and socio-economic distinctions, and the consequences of child abuse and neglect.

NOTE: The National Center on Child Abuse and Neglect (NCCAN) was established in 1974 to carry out the functions of the Child Abuse Prevention and Treatment Act (CAPTA). Pursuant to Pub. L. 104–235, the Child Abuse Prevention and Treatment Act Amendments of 1996, the Office on Child Abuse and Neglect (OCAN) will, in the near future, be established by the Secretary for the purpose of coordinating the functions and activities of CAPTA, replacing NCCAN.

Section 104(a)(2) of CAPTA, as amended by Pub. L. 104–235, requires the Secretary to publish proposed priorities for research activities for public comment and allow 60 days for public comment on such proposed priorities. The proposed priorities are being announced for the five year period that corresponds to the authorization period for CAPTA. Because the amount of Federal funds available for discretionary activities in Fiscal Years 1997–2001 is expected to be limited, respondents are encouraged to recommend how the proposed issues should be prioritized.

As research issues arise or new issues emerge through consultation with other entities, additional announcements of proposed priorities will be published for public comment.

The actual solicitation of grant applications will be published separately in the Federal Register for