comment. Interested parties were given sixty (60) days in which to submit comments, suggestions or objections regarding the proposed form of the order.

No comments having been received, the Commission has ordered the issuance of the complaint in the form contemplated by the agreement, made its jurisdictional findings and entered an order to cease and desist, as set forth in the proposed consent agreement, in disposition of this proceeding.

(Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interprets or applies sec. 5, 38 Stat. 719, as amended; 15 U.S.C. 45)

Donald S. Clark,

Secretary.

[FR Doc. 97–6053 Filed 3–10–97; 8:45 am]

BILLING CODE 6750–01–M

[Dkt C–3709]

Time Warner Inc., et al.; Prohibited Trade Practices, and Affirmative Corrective Actions

AGENCY: Federal Trade Commission.

ACTION: Consent order.

SUMMARY: In settlement of alleged violations of federal law prohibiting unfair or deceptive acts or practices and unfair methods of competition, this consent order requires the restructuring of the acquisition by Time Warner of Turner Broadcasting Systems, Inc. by, among other things, requiring Tele-Communications, Inc. (TCI) to divest its interest in Time Warner to a separate company, requiring TCI, Turner and Time Warner to cancel long-term carriage agreements, barring Time Warner's programming interests from discriminating in carriage decisions against rival programmers, and requiring Time Warner's cable interests to carry a rival to CNN.

DATES: Complaint and Order issued February 3, 1997.[1]

FOR FURTHER INFORMATION CONTACT: William Baer, FTC/H–374, Washington, D.C. 20580. (202) 326–2932.

SUPPLEMENTARY INFORMATION: On Wednesday, September 25, 1996, there was published in the Federal Register, 61 FR 50301, a proposed consent agreement with analysis In the Matter of Time Warner Inc., et al., for the purpose of soliciting public comment. Interested parties were given sixty (60) days in which to submit comments, suggestions or objections regarding the proposed form of the order.

Comments were filed and considered by the Commission. The Commission has ordered the issuance of the complaint in the form contemplated by the agreement, made its jurisdictional findings and entered an order to divest, as set forth in the proposed consent agreement, in disposition of this proceeding.

(Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interpret or apply sec. 5, 38 Stat. 719, as amended; sec. 7, 38 Stat. 731, as amended; 15 U.S.C. 45, 18)

Donald S. Clark,

Secretary.

[FR Doc. 97–6054 Filed 3–10–97; 8:45 am]

BILLING CODE 6750–01–M

[1] Copies of the Complaint, the Decision and Order, and statements by Commissioners Pitofsky, Steiger, Varney, Azcuenaga and Starek are available from the Commission's Public Reference Branch, H–130, 6th Street & Pennsylvania Avenue, NW., Washington, DC. 20580.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement 718]

Cooperative Agreement for 1997 National Breast and Cervical Cancer Early Detection Program

Introduction

The Centers for Disease Control and Prevention (CDC) announces the availability of funds in fiscal year (FY) 1997 for cooperative agreements to develop State, territorial, and tribal comprehensive breast and cervical cancer early detection programs.

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 area of Cancer. (To order a copy of ''Healthy People 2000,'' see the section ''Where to Obtain Additional Information.'')

Authority

This program is authorized by sections 1501, 1502 and 1507 (42 U.S.C. 300k, 42 U.S.C. 300*l*, and 42 U.S.C. 300n–3) of the Public Health Service Act, as amended.

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

Assistance will be provided only to the official health departments of States, or their bona fide agents or instrumentalities and to American Indian tribes. This includes American Samoa, the Commonwealth of Puerto Rico, the Federated States of Micronesia, Guam, the Republic of the Marshall Islands, and federally recognized Indian tribal governments (this includes Indian tribes, tribal organizations, and urban Indian organizations, hereby referred to as tribes).

1. The following States and territories are excluded:

a. Alabama, Delaware, Hawaii, Idaho, Indiana, Kentucky, Mississippi, Montana, New Hampshire, Nevada, North Dakota, Northern Mariana Islands, Republic of Palau, South Dakota, Tennessee, Virgin Islands, Virginia, Washington, DC, and Wyoming, which were funded in September of 1996, under Program Announcement 623 entitled ''1996 National Breast and Cervical Cancer Early Detection Program.''

b. New York, Pennsylvania, Ohio, Wisconsin, Massachusetts, and Washington, which were funded in September 1993, under Program Announcement 321 entitled ''Early Detection and Control of Breast and Cervical Cancer.''

c. Florida, Oklahoma and Utah, which were funded in September 1994, under Program Announcement 321 entitled ''Early Detection and Control of Breast and Cervical Cancer.''

d. Alaska, Georgia, Maine, Oregon, and Rhode Island, which were funded in September 1994, under Program Announcement 474 entitled ''Early Detection and Control of Breast and Cervical Cancer.''

e. Arizona, Arkansas, Connecticut, Iowa, Illinois, Kansas, Louisiana, New Jersey, and Vermont, which were funded in March 1995, under Program Announcement 474 entitled ''Early Detection and Control of Breast and Cervical Cancer.''

2. The following tribes are excluded:

a. Arctic Slope Native Association, Limited, AK; Cherokee Nation, OK; Cheyenne River Sioux Tribe, SD; Eastern Band of Cherokee Indians, NC; Maniilaq Association, AK; Pleasant Point Passamaquoddy, ME; Poarch Band of Creek Indians, AL; South Puget Planning Agency, WA; and Southcentral Foundation, AK, which were funded under the American Indian Initiative Program Announcement 442.

b. Hopi Tribe, AZ; Native American Rehabilitation Association of the NW, OR; Indian Community Health Service; AZ; and the Navajo Division of Health, AZ, which were funded in September of 1996, under Program Announcement 623 entitled ''1996 National Breast and Cervical Cancer Early Detection Program.''

States currently receiving CDC funds under Program Announcement 121 and 122, entitled ''Early Detection and Control of Breast and Cervical Cancer,'' are eligible to apply for funding under this announcement. Additionally, those programs currently funded under Program Announcement 425 (Puerto Rico and American Samoa) are eligible to apply under this announcement. If currently funded under Program Announcement 425, no additional new funding will be available at the end of the current 12-month budget period. Thereafter, a 12-month no-cost extension may be approved to complete capacity-building activities that have been initiated.

Availability of Funds

Approximately $37 million is available in FY 1997 to fund approximately fourteen awards to States/territories/tribes. It is expected that the average award will be $1,500,000 ranging from $200,000 to $3,000,000.

It is expected that these awards will begin on August 15, 1997, and will be made for 12-month budget periods within a project period of up to five 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.

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

Recipient Financial Participation

Section 1502 (a) and (b)(1), (2), and (3) of the PHS Act, as amended, states that matching funds are required from non-Federal sources in an amount not less than $1 for each $3 of Federal funds awarded under this program.

The matching funds may be in cash or its equivalent in-kind or donated services, including equipment, fairly evaluated. The contributions may be made directly or through donations from public or private entities.

In some States/territories/tribes, non-Federal funds from a variety of sources may presently be used to support one or more of the breast and cervical cancer early detection activities described in this program announcement. Maintenance of Effort (MOE)—Non-Federal funds in excess of the average amount expended during the two years preceding the first fiscal year that a State/territory/tribe applies for funding may be used as match. Supplantation of existing program efforts funded through other Federal or non-Federal sources is unallowable. Applicants may also include, as State/territory/tribe matching funds, any non-Federal amounts expended pursuant to Title XIX of the Social Security Act for the screening, follow-up and referral of women for breast and cervical cancer.

Matching funds may not include: (1) The payment for treatment services or the donation of treatment services (see note below); (2) services assisted or subsidized by the Federal Government; or (3) the indirect or overhead costs of an organization.

Note: Treatment is defined as any service recommended by a clinician including medical and surgical intervention provided in the management of a diagnosed condition.

Background

Breast Cancer

In the United States, approximately 500,000 women will die this decade from breast and cervical cancer. Among women, breast cancer accounts for 29 percent of all new cancer cases and is the second leading cause of cancer related deaths. An estimated one of every eight women in the United States will develop breast cancer in her lifetime. The American Cancer Society estimated that in 1996, 184,300 women would be diagnosed with invasive breast cancer and 44,300 women would die of this disease. Death rates from the disease are highest among women aged 40 or more years, and among black women as compared to white women for those aged less than 70 years.

It is not currently known how to prevent breast cancer from occurring. Thus, detecting carcinoma of the breast at an early stage is the key to more treatment options, improved survival, and decreased mortality. Research has shown that the use of mammography can reduce the mortality due to breast cancer among women 50 years and older by 30 percent.

The percent of women who are regularly screened for breast cancer decreases with age. The baseline data on mammography use from the 1987 National Health Interview Survey show that only 23 percent of women 50 years and older reported having received a mammogram within the past three years. This proportion was lower for racial and ethnic minority women, for women who had less than a high school education, for women who were over age 75 years, and for women who were living below the poverty level. In Healthy People 2000, the Public Health Service (PHS) recommended that by the year 2000, 60 percent of women aged 50 years and older should receive a mammogram every two years.

Cervical Cancer

The overall incidence of invasive cervical cancer has decreased steadily over the last several decades, but in recent years, this rate has increased among women who are less than 50 years old. In 1996, invasive cervical cancer was diagnosed in approximately 15,700 women, and carcinoma in situ was diagnosed in about 65,000 women, and about 4,900 women died of cervical cancer.

The primary goal of cervical cancer screening is to increase detection and treatment of precancerous cervical lesions and thus prevent the occurrence of cervical cancer. Although no clinical trials have studied the efficacy of Papanicolaou (Pap) test in reducing cervical cancer mortality, experts agree that it is an effective technology. Since the introduction of the Pap test in the 1940s, cervical cancer mortality rates have decreased by 75 percent.

In 1991, the PHS established that by the year 2000, 85 percent of women should be receiving a Pap test within the preceding one to three years. Baseline data on the use of the Pap test from the 1987 National Health Interview Survey (NHIS) showed that only 65 percent of women aged 18 years and older reported having received a Pap test within the past three years. As with mammography screening, this proportion was lower for racial and ethnic minority women, for women who had less than a high school education, for women who were over age 75 years, and for women who had low incomes.

National Breast and Cervical Cancer Early Detection Program

In 1990, the U.S. Congress passed ''The Breast and Cervical Cancer Mortality Prevention Act,'' Pub. L. 101–354. This legislation enables CDC, in partnership with State health agencies and territories, to make breast and cervical cancer screening, referral, tracking and follow-up services available and accessible to women, with priority for services given to low income, and uninsured and under-insured women. Many women do not have access to a well-coordinated and integrated health care system that provides screening, follow-up, and

treatment services because of social, financial, and geographic barriers.

In accordance with Pub. L. 101–354, a comprehensive program includes the following program components: (1) Breast and cervical cancer screening; (2) referral and follow-up; (3) public education; (4) professional education; (5) quality assurance; (6) surveillance and program evaluation; and (7) partnership development and community involvement. The importance of these program components and a systematic, coordinated approach is universally appreciated as necessary to ensure maintenance of quality, comprehensive, state/territory-/tribe-wide services. This comprehensive effort offers an opportunity to build a State/territorial/tribal infrastructure for breast and cervical cancer control.

Program success is enhanced when State/territorial/tribal resources and efforts are combined with those of other State/territorial/tribal programs, voluntary organizations, private sector organizations, and community-based organizations through partnership development. State/territorial/tribal comprehensive breast and cervical cancer control programs can make a vital contribution to the nationwide effort to reduce morbidity and mortality and improve quality of life.

Purpose

The purpose of this program is to establish a State/territorial/tribal comprehensive public health approach to reduce breast and cervical cancer morbidity and mortality through screening, referral and follow-up, public education and outreach, professional education, quality assurance, surveillance, evaluation, partnership development and community involvement. The program is established to provide for comprehensive breast and cervical cancer screening services for all women who are unable to afford them. Criteria for priority populations are uninsured or under-insured older women who are racial, ethnic and cultural minorities, such as American Indians, Alaskan Natives, African-Americans, Hispanics, Asian/Pacific Islanders, Lesbians, women with disabilities, or women who live in hard-to-reach communities in urban and rural areas. Priority populations, as defined above, will be used throughout this document.

Program Requirements

In accordance with Pub. L. 101–354, an award may not be made unless the State/territory/tribe involved agrees that:

1. Not less than 60 percent of cooperative agreement funds will be expended for screening, appropriate referral for medical treatment, and, to the extent practicable, the provision of appropriate follow-up services. The remaining 40 percent will be expended to support public education, professional education, quality assurance, surveillance, program evaluation, partnership development and community involvement, and related program activities. (Section 1503(a) (1) and (4) of the PHS Act, as amended.) Of the proportion of funds required for screening and diagnostic services, the majority should be directed toward breast health. Refer to the most current CDC National Breast and Cervical Cancer Early Detection Program Administrative Requirements and Guidelines for more information.

2. States, territories, and tribes are required to implement all program components by the schedule that follows:

a. States presently receiving comprehensive funding:

All program components should be operational at this time.

b. Territories/tribes presently receiving capacity funding:

Comprehensive breast and cervical cancer screening, referral, follow-up and tracking services should be initiated within the first twelve months of the first budget year. The capacity building program components (not the screening, referral, follow-up and tracking system) should be fully operational by the end at this time.

c. Territories/tribes not presently receiving capacity funds and applying for comprehensive funding:

The application should outline plans for the operation of all program components. The screening, follow-up and referral services should be initiated within twelve months of the award date. (Section 1503(a) (1) and (3) of the PHS Act, as amended.)

3. Cooperative agreement funds will not be expended to provide inpatient hospital or treatment services. (Section 1504(g) of the PHS Act, as amended.) Treatment is defined as any service recommended by a clinician, including medical and surgical intervention provided in the management of a diagnosed condition. Also, cooperative agreement funds will not be used for the specific diagnostic procedures of breast biopsy and Loop Electrosurgical Excisional Procedure (LEEP).

4. Not more than 10 percent of funds will be expended annually for administrative expenses. These administrative expenses are in lieu of and replace indirect costs. (Section 1504(f) of the PHS Act, as amended.)

5. Matching funds are required from non-Federal sources in an amount not less than $1 for each $3 of Federal funds awarded under this program. (Section 1502 (a) and (b) of the PHS Act, as amended.)

6. Costs used to satisfy matching requirements are subject to the same prior approval requirements and rules of allowability as those which govern project costs supported by Federal funds (Office of Management and Budget (OMB) Circular A–87 ''Cost Principles for State, Local and Indian Tribal Governments'' and PHS Grants Policy Statement, Section 6).

7. All costs used to satisfy matching requirements must be documented by the applicant and will be subject to audit.

8. If a new or improved, and superior, screening procedure becomes widely available and is recommended for use, this superior procedure will be utilized in the program. (Section 1503(b) of the PHS Act, as amended.)

9. An award may not be made unless the State Medicaid Program provides coverage for:

a. In the case of breast cancer, a clinical breast examination and screening mammography.

b. In the case of cervical cancer, both a pelvic examination and Pap test screening. (Section 1502A of the PHS Act, as amended.)

10. In 1993, congressional amendments to the National Breast and Cervical Cancer Early Detection Program included the following changes:

a. States/territories/tribes may enter into contracts with private for-profit entities to provide screening and diagnostic services only. Contracts for other kinds of services with for-profit agencies are not allowed.

b. The amount paid by a State/territory/tribe for a screening procedure may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act (Medicare).

c. All facilities conducting mammography screening procedures funded by the Program must meet the regulations for mammography quality assurance developed by the Food and Drug Administration (FDA).

d. For cervical cancer activities, facilities will meet the standards and regulations developed by the Health Care Financing Administration (HCFA) implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

In accordance with section 1504 (c)(2) of the PHS Act, as amended, CDC may waive the requirements for specific

services/activities if it is determined that compliance by the State/territory/tribe would result in an inefficient allocation of resources with respect to carrying out a comprehensive breast and cervical cancer early detection program (as described in section 1501(a)). A request from the recipient outlining appropriate and detailed justification would be required before the waiver is approved.

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

A. Recipient Activities

1. Establish a system for screening women for breast and cervical cancer as a preventive health measure. (Section 1501(a)(1) of the PHS Act, as amended.)

This program is to increase the utilization of screening services for breast and cervical cancer among all women with emphasis being given to identified priority populations as described under the ''Purpose'' section.

a. Ensure that screening procedures are available for both breast and cervical cancer and provided to women participating in the program, including a clinical breast exam, mammography, pelvic exam, and Pap smear. (Section 1503(a)(2)(A) and (B).)

b. Screening services should be made available according to the following guidelines:

Breast Health:

(1) The most important risk factors for breast cancer are being female and older age. Programs should place emphasis on screening women 50 years and older. Specific screening guidelines that outline age eligibility are provided in the Official Program Guidelines Age Eligibility for Mammography Screening (included in the application kit). Eligible women can receive an annual clinical breast examination and screening mammogram.

The following exceptions apply:

(a) Women who have an abnormal clinical breast exam may be referred for a physician consultation, diagnostic mammogram and/or other diagnostic procedures reimbursed by the program (see ''(b)'' below).

(b) Among asymptomatic women ages 40–49 who are screened for the first time by the program, priority should be given to those who have a personal history of breast cancer or a first-degree relative with pre-menopausal breast cancer.

(2) For diagnostic services following an abnormal screening result, cooperative agreement funds may be expended for additional mammogram views, fine-needle aspiration, ultrasound, and office visits for evaluation of abnormal clinical breast examinations.

a. Provide priority for screening, referral, tracking, and follow-up services to women who are uninsured or underinsured. (Section 1504(a) of the PHS Act, as amended.)

An award may not be made under this announcement unless the State/territory/tribe involved agrees to give priority to the provision of screening, follow-up, and referral services to women who are underserved and low-income.

b. Establish breast and cervical cancer screening services throughout the State/territory/tribe. (Section 1504(c)(1) of the PHS Act, as amended.)

Funds may not be awarded under this announcement, unless the State/territory/tribe involved agrees that services and activities will be made available throughout the State/territory/tribe, including availability to members of any Indian tribe or tribal organization (as such terms are defined in Section 4 of the Indian Self-Determination and Education Assistance Act).

c. Provide allowances for items and services reimbursed under other programs. (Section 1504(d)(1) and (2) of the PHS Act, as amended.)

Funds may not be awarded under this announcement, unless the State/territory/ tribe involved agrees that funds will not be expended to make payment for any item or service that will be paid or can reasonably be expected to be paid by:

(1) Any State/territory/tribe compensation program, insurance policy, or Federal or State/territory/tribe health benefits program.

(2) An entity that provides health services on a prepaid basis.

d. Establish a schedule of fees/charges for services. (Section 1504(b)(1), (2), and (3) of the PHS Act, as amended.)

Funds may not be awarded under this announcement unless the State/territory/tribe involved agrees that if charges are to be imposed for the provision of services or program activities, the fees/charges for allowable screening and follow-up services will be:

(1) Made according to a schedule of fees that is made available to the public. (Section 1504(b)(1) of the PHS Act, as amended.)

(2) Adjusted to reflect the income of the woman screened. (Section 1504(b)(2) of the PHS Act, as amended.)

(3) Totally waived for any woman with an income of less than 100 percent of the official poverty line as established by the Director of the Office of Management and Budget and revised by the Secretary of the Department of Health and Human Services in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. (Section 1504(b)(3) of the PHS Act, as amended.)

Additionally, the schedule of fees/charges should not exceed the maximum allowable charges established by the Medicare Program administered by the Health Care Financing Administration (HCFA). Fee/charge schedules should be developed in accordance with guidelines described in the interim final rule (42 CFR parts 405 and 534) which implements Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) which provides limited coverage for screening mammography services.

Cervical Health:

(1) Women who are 18 years and older, with an intact cervix, are eligible for an annual Pap test and pelvic examination. While the incidence of precancerous lesions and cancer are higher among younger women, older women have higher mortality rates and are less likely to be screened regularly. Hence, programs should provide a balanced distribution in the ages of women receiving Pap tests.

The following exceptions apply:

(a) After a woman has had three consecutive, normal, annual examinations, the Pap test may be performed less frequently at the discretion of her health care provider.

(b) Women who have had a total hysterectomy that was performed for cervical neoplasia are eligible to receive Pap screening.

(2) For diagnostic services following an abnormal screening result, cooperative agreement funds may be expended for colposcopy and colposcopy-directed biopsy.

2. Provide appropriate referrals for medical treatment of women screened in the program and ensure, to the extent practicable, the provision of appropriate diagnostic and treatment services. (Section 1501(a)(2) of the PHS Act, as amended.)

A system for providing the appropriate diagnostic and treatment services for women whose screening test results are abnormal or suspicious is an essential component of any comprehensive breast and cervical cancer early detection program. Priority for diagnostic services should be given to women participating in the screening program who have abnormal screening results. The operational plan and budget for diagnostic services should reflect the projected number of women to be

screened by the program annually and the estimated number of abnormal screening exams expected.

a. Establish and maintain a system for the timely and appropriate referral and follow-up of women with abnormal or suspicious screening tests.

Referral systems should include the regular updating of information on local resources available in the community to which health care providers can refer women for additional diagnostic procedures not paid for by the program, as well as treatment services. Health care providers should assist clients in need of treatment services in obtaining eligibility for public-supported third party reimbursement programs.

b. Develop and implement a tracking system for women screened in the breast and cervical cancer early detection program. (Section 1501(a)(6) of the PHS Act, as amended.)

Tracking the women screened is essential to ensure that those who have abnormal results receive appropriate and timely follow-up for repeat screening, diagnostic procedures, and treatment. Tracking also includes reminders and outreach to women with normal results to return for timely rescreening. A useful tracking system is one that can be effectively integrated into the State/territory/tribe health care delivery system. The tracking system should provide women with a unique identification number to document the outcome of individual screening tests, regardless of the screening cycle or site. It should also provide information on needed follow-up. Confidentiality must be assured.

To meet the intent of Pub. L. 101–354 in ensuring the appropriate follow-up of women with abnormal screening results, the State/territory/tribe tracking system must include information on screening location (e.g., county, city), demographic characteristics (e.g., race, date of birth), and screening procedures and results (e.g., mammography, Pap tests) for all women in the program. For women identified with abnormal screening results, information on diagnostic procedures (e.g., colposcopy) and diagnoses, treatment (e.g., date initiated), and stages of disease must be included.

In collaboration with CDC, States/territories/tribes with currently funded comprehensive programs have compiled a list of some of the information necessary to ensure the appropriate follow-up of women. This list is available for the use of States, territories, and tribes awarded new funding under this announcement.

3. Develop and disseminate public information, education and outreach programs for the early detection and control of breast and cervical cancer. (Section 1501 (a)(3) of the PHS Act, as amended.)

Public information, education, and outreach include the systematic design and sustained delivery of clear and consistent health messages to women using a variety of methods and strategies that contribute to the early detection of breast and cervical cancer. Successful public education and outreach programs are those that increase women's knowledge, and ultimately have an impact on attitudes and screening behavior.

Public education and outreach activities should increase the number of women screened especially those who are identified as priority populations as defined in the ''Purpose'' section. State/territory/tribe and local programs should clearly demonstrate, through evaluation, the relationship of public education and outreach strategies to the number of women screened through the program.

4. Improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer. (Section 1501(a)(4) of the PHS Act, as amended.)

Health care providers (including, but not limited to, primary care physicians, radiologists, cytopathologists, surgeons, gynecologists, nurse practitioners, physician's assistants, registered nurses, radiologic technologists, health educators, and outreach workers) play a key role in assuring that women are screened at appropriate intervals, that screening tests are performed optimally, and that women with abnormal test results receive timely and appropriate diagnostic follow-up and treatment. Professional education strategies can be focused in two directions. One direction could provide direct educational opportunities to those health care professionals who provide breast and cervical cancer screening. A second focus is to develop clinical systems of practice that promote ongoing appropriate screening.

5. Establish mechanisms through which the State/territory/tribe can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures. (Section 1501(a)(5) of the PHS Act, as amended.)

Cooperative agreement funds may not be awarded (under Section 1501 of the PHS Act, as amended, Pub. L. 101–354) unless the State/territory/tribe involved agrees to assure the implementation of quality assurance procedures for mammography and cervical cytology. (Section 1503(c) and (d) of the PHS Act, as amended.)

a. Develop and implement a quality assurance system for breast cancer screening. The mammography services provided to women screened in the program must be conducted in accordance with the following guidelines issued by the Secretary of the Department of Health and Human Services. (Section 1503(e) of the PHS Act, as amended):

(1) All facilities conducting mammography screening procedures funded by the program must meet the requirements for mammography quality assurance developed by the Food and Drug Administration (FDA).

(2) Radiologists participating in the program will record their findings using the second edition American College of Radiology (ACR) Breast Imaging Reporting and Data System (BI–RADS). The BI–RADS' reporting categories are as follows:

(1) Negative; (2) Benign finding; (3) Probably benign finding—short interval follow-up suggested; (4) Suspicious finding; (5) Highly suggestive of malignancy; (6) Assessment incomplete.

(3) A report of the results of a mammogram performed through this program will be placed in a woman's permanent medical records that are maintained by her health care provider.

b. Develop and implement a quality assurance system for cervical cancer screening. The laboratory services provided to women for cytological screening must be conducted in accordance with the following guidelines issued by the Secretary of the Department of Health and Human Services. (Section 1503(e) of the PHS Act, as amended):

(1) Facilities will meet the standards and regulations promulgated by the Health Care Financing Administration (HCFA) under the Clinical Laboratory Improvement Act (CLIA) of 1988.

(2) All cervical cytology interpretation is required to be done on the premises of a qualified laboratory.

(3) A report of the results of a Pap test performed through this program will be placed in the woman's permanent medical records that are maintained by her health care provider.

(4) Pathologists participating in the program will record their Pap test findings using the Bethesda System which specifies specimen adequacy and incorporates these categories:

(1) Within Normal Limits; (2) Infection/Inflammation/Reactive Changes; (3) Atypical squamous cells; (4) Low Grade Squamous Intra epithelial Neoplasia (SIL); (5) High Grade SIL; (6) Squamous Cell Carcinoma; (7) Other.

6. Establish mechanisms which enhance the State/territory/tribe cancer surveillance system (i.e., the Central Cancer Registry and other databases) and facilitate program planning and evaluation. (Section 1501(a)(5)) of the PHS Act, as amended.)

Monitoring the distribution and determinants of breast and cervical cancer incidence and mortality is necessary to effectively plan, implement, and evaluate a comprehensive early detection program. Linkages with, and in some cases enhancements of, State/territory/tribe vital statistics, the Central Cancer Registry, the Behavioral Risk Factor Surveillance System and other State/territory/tribe and local surveys are needed to evaluate the status of program process (i.e., management, professional education, public education and outreach), impact (i.e., changes in participant screening behavior or screening practices of providers) and outcome (i.e., State/territory/tribe program screening data, cancer staging, morbidity, mortality).

a. To do this, surveillance systems should be established or enhanced which will:

(1) Collect State/territory/tribal population-based information on the demographics, incidence, staging at diagnosis, and mortality from breast and cervical cancer.

(2) Identify segments of the population at higher risk for disease and for the failure to be screened.

(3) Identify factors contributing to the disease burden, such as behavioral risk factors and limited or inequitable access to early detection and treatment services.

(4) Monitor the number and characteristics of women screened in the program and the outcome of screening by analyzing data from the State/territory/tribe tracking system.

(5) Monitor screening resources, including the number of available mammography facilities, cytology laboratories, and providers of cervical cancer screening.

(6) When appropriate, develop linkages between the above-mentioned data bases.

b. Measuring the effectiveness of program activities to modify the screening behavior of women (impact evaluation) and on morbidity and mortality (outcome evaluation) is important for the identification of successful intervention strategies for the early detection of breast and cervical cancer. Equally important is process evaluation or the assessment of factors that contributed to the successful or unsuccessful establishment and implementation of program activities.

The design of each program component should ensure that there can be meaningful process, impact, and outcome evaluation. The evaluation plan should assess the implementation and effectiveness of each program component. At a minimum, the evaluation plan should identify those program activities that will be evaluated, the process, impact, and outcome indicators to be measured, how they will be measured, the proposed program time-lines, and resources needed. Activities could include:

(1) An inventory of specific services provided and a systematic description of the infrastructure developed with cooperative agreement funds;

(2) A description of the women who received services, including the number of women and demographic information such as age, race and ethnicity;

(3) An assessment of the referral system including the number of women referred for diagnostic and treatment services, number who received these services, and the capacity of the system to identify community resources to assist women in obtaining access to available services;

(4) An assessment of the availability and accessibility of breast and cervical cancer screening services and an estimation of the number of uninsured women by age and racial/ethnic distribution in the State/territory/tribe to be served by the program;

(5) An assessment of the planning, development, implementation, and accomplishment of program activities (e.g., goals, objectives, time lines, recruiting, hiring, and retaining staff; training staff; establishing and maintaining contracts with provider agencies, and assuring the quality of contractor performance);

(6) An assessment of changes in participant and provider knowledge, attitudes, behaviors, and practices related to screening for breast and cervical cancer;

(7) An assessment of the quality of screening tests provided by the program.

7. Ensure the coordination of services and program activities with other similar programs and establish a broad-based council to advise and support the program. (Section 1504(e) of the PHS Act, as amended.)

Coordination with other similar programs maximizes the availability of services and program activities, promotes consistency in screening procedures and educational messages, and reduces duplication. An award may not be made under this program announcement unless the State/territory/tribe agrees that the services and activities provided in this program are coordinated with other Federal, State/territory/tribe, and local breast and cervical cancer early detection programs through the development of collaborative partnerships. (Section 1504(e) of the PHS Act, as amended.)

The success of a comprehensive breast and cervical cancer early detection program is improved by broad-based support in the community and active public and private sector involvement. Partnership development with a broad range of stakeholders, including consumers, brings valuable knowledge, skills, and financial resources to the program, and provides access to, and information about, populations of women who have been missed by traditional screening systems.

Linkages should be established with federally funded programs such as the Regional Offices of the National Cancer Institute/Cancer Information Service (NCI/CIS), the Health Resources and Services Administration (HRSA) community/migrant health centers, Title X Family Planning programs, State Offices for Aging and Minority Health, the Indian Health Service (IHS) and the Medicare Program of the Health Care Financing Administration (HCFA).

Linkages and active collaboration are strongly encouraged with private sector organizations such as the American Cancer Society (ACS), the Young Women's Christian Association (YWCA), the Susan G. Komen Breast Cancer Foundation, the National Breast Cancer Coalition (NBCC), the National Alliance of Breast Cancer Organizations (NABCO), the American Association of Retired Persons (AARP), professional organizations, private physicians, survivors of breast and cervical cancer, local women's support groups, community leaders, managed care organizations, and other agencies and businesses in the community that provide health care and related support services to women.

8. Develop an operational and management plan for the implementation of a comprehensive breast and cervical cancer screening program.

The success of a comprehensive breast and cervical cancer early detection program is increased by the existence of a comprehensive, integrated, and realistic plan to address these diseases among all women, with emphasis given to women identified as priority populations under the ''Purpose'' section. All program components of the comprehensive program should be addressed.

A comprehensive breast and cervical cancer screening operational plan should relate to the State/territory/tribe Year 2000 Objectives and to the State/territory/tribe Cancer Control Plan. The operational and management plan should also reflect the development of qualified and diverse technical, program, and administrative staff, appropriate organizational relationships including lines of authority, adequate internal and external communication systems, and a system for sound fiscal management.

9. Representation or attendance at CDC sponsored trainings, meetings, site visits, and conferences.

B. CDC Activities

1. Convene a workshop of the funded programs every one to two years for information-sharing and problem-solving and hold a Program Director's meeting twice a year.

2. Provide funded States/territories/tribes with ongoing consultation and technical assistance to plan, implement, and evaluate each component of the comprehensive program as described under Recipient Activities above. Consultation and technical assistance will be provided in the following areas:

a. Interpretation of current scientific literature related to the early detection of breast and cervical cancer;

b. Practical application of Pub. L. 101–354, including amendments to the law;

c. Nationally recognized clinical and quality assurance guidelines for the assessment and diagnosis of breast and cervical cancer;

d. Design and implementation of each program component (screening, referral, tracking, and follow-up; public education and outreach; professional education; collaborative partnerships; quality assurance; surveillance; and evaluation);

e. Evaluation of each program component (process, impact, and outcome) through the analysis and interpretation of program outcomes, screening data, and surveillance data;

f. Overall operational planning and program management.

3. Provide two training opportunities and a video teleconference with self-study educational packets on selected topics to State, territorial, and tribal program staff through the National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control's (DCPC's) National Training Center.

4. Conduct site visits to assess program progress and mutually resolve problems, as needed, and/or coordinate reverse site visits to CDC in Atlanta, GA.

5. At the request of the applicant, and if available, assign Federal personnel to a project in lieu of a portion of the financial assistance. (Section 1507(b) of the PHS Act, as amended.)

Technical Reporting Requirements

Semiannual progress reports are required and must be submitted no later than 30 days after each semiannual reporting period. The semiannual progress reports must summarize the following: (1) Major accomplishments including information on women screened; (2) problems encountered in program implementation; and (3) efforts or proposed strategies to resolve problems. The final progress report is required no later than 90 days after the end of the project period. All manuscripts published as a result of the work supported in part or whole by the cooperative agreement will be submitted with the progress reports.

An annual financial status report (FSR) must be submitted no later than 90 days after the end of each budget period. The final financial status report is due no later than 90 days after the end of the project period.

An original and two copies of all reports should be submitted to the Grants Management Branch, Procurement and Grants Office, CDC.

Application Content

All applicants must develop their applications in accordance with information contained in this program announcement and the instructions below. Applications should not exceed 100 pages including budget and justification; this does not include appendices.

1. Executive Summary

The applicant should provide a clear, concise one or two page written summary to include: (1) The need for the program; (2) the major objectives and activities of the proposed comprehensive breast and cervical cancer early detection program; (3) the requested amount of Federal funding; and (4) capability to implement the program.

2. Background and Need

The applicant should describe:

a. The disease burden by age and race/ethnicity: (1) The State/territory/tribe breast and cervical cancer age-adjusted mortality rates averaged over five years and their ranking nationally, (2) the incidence rates for these diseases (where available);

b. Total number of women in the State/territory/ tribe, including those women who are uninsured, by age and racial/ethnic distribution;

c. Unmet screening and rescreening needs of uninsured and underinsured women (where available);

d. Barriers to early detection screening services;

e. State/territory/tribe's relevant experiences in the development and implementation of a breast and cervical cancer early detection program.

3. Implementation Plan

The applicant should:

a. Propose measurable, time-phased, and realistic objectives for: (1) The overall program, and (2) specific program components as described under the ''Recipient Activities'' section, including a projection of the number of women to be screened by age, racial and ethnic groups, and areas or locality in the State/territory/tribe. (Section 1505(2) of the PHS Act, as amended.)

b. Describe the State/territory/tribe's: (1) Health care delivery system; (2) proposed State/ territorial/tribal screening system; (3) proposed follow-up and referral system for women requiring diagnostic procedures and medical treatment not provided by the program; and (4) proposed tracking system for women screened and rescreened by the program. (Section 1501(a) (1) and (2) of the PHS Act, as amended.)

c. Proposed specific outreach strategies to reach women who are identified as priority populations as defined under the ''Purpose'' section. (Section 1504 (a) of the PHS Act, as amended.)

d. Document available resources in the State/territory/tribe for the payment or reimbursement of breast and cervical cancer screening, including the Medicaid Program. [Section 1504 (d) of the PHS Act, as amended.]

e. Describe, in detail, the current or proposed: (1) Professional education; (2) public education and outreach activities; and (3) and surveillance activities for breast and cervical control. (Section 1501(a)(3), (4), (5), and (6) of the PHS Act, as amended.) Information provided should include program objectives, proposed activities and evaluation.

f. Describe the ability to establish a screening program that meets FDA regulations for mammography screening; uses the American College of Radiology Breast Imaging Reporting and Data System (BI-RADS); and meet the standards and regulations of the Clinical Laboratory Improvement Act (CLIA) for cervical cancer screening.

g. Provide a projected timetable for program implementation that displays

dates for the accomplishment of specific proposed activities.

h. Describe process and outcome evaluation strategies for each program component, including how the information will be used to plan, develop, and manage the program on an ongoing basis. (Section 1501 (a)(6) of the PHS Act, as amended.)

i. Describe how the State/territory/tribe will assure that funds will be used in a cost-effective manner. (Section 1505 (4) of the PHS Act, as amended.)

4. Collaborative Partnership and Community Involvement

The applicant should describe:

a. How the program will develop linkages and coordinate with other Federal, State, and local programs, voluntary and professional organizations, private physicians, and mammography facilities and other groups, agencies, and businesses in the community that provide health care and related support services to women. (Section 1504(e) of the PHS Act, as amended.)

b. The current or proposed broad-based council that will advise and support the breast and cervical cancer early detection program, including the identification of current members or proposed representatives, their charge, and their proposed roles and responsibilities. Specific subcommittees of the council should be described (e.g., clinical services, public education and outreach, and professional education).

5. Management and Organizational Structure

The applicant should submit a description of the structure to ensure the implementation of a breast and cervical cancer program that describes the development of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management. The information should also include the following:

a. Provide a copy of the organizational chart indicating the placement of the proposed program in the department/organization.

b. Document available resources in the State/territory/tribe for the payment or reimbursement of breast and cervical cancer screening, including the Medicaid and Medicare Programs. (Section 1504 (d) of the PHS Act, as amended.)

c. Submit the proposed schedule of fees and charges for breast and cervical cancer screening and diagnostic services, consistent with maximum Medicare reimbursement rates, and include a description of its use in the program. In States/territories/tribes where there are multiple Medicare rates and a single reimbursement rate is being proposed, the applicant must provide justification for approval. (Section 1504 (b) of the PHS Act, as amended.)

d. Letters of support (dated within the last three months) from key partners, participants, and community leaders should be included in the application.

6. Capability for Program Implementation

The applicant should describe proposed activities as measured by:

(a) Accomplishments of an existing breast and cervical cancer early detection program funded by CDC or relevant past experiences funded by other sources:

(1) States Currently Receiving CDC Comprehensive Funds:

Accomplishments in establishing a comprehensive breast and cervical cancer early detection program, including the total number, age and racial/ethnic distribution of women screened; percent of abnormal findings by age and race/ethnicity; rate of cancers identified by age; follow-up time between screening and diagnosis and between diagnosis and treatment initiation; and, percent of women who are routinely rescreened by the program.

Accomplishments in establishing an infrastructure to support a breast and cervical cancer screening program and in resolving program challenges, such as mammography screening for women 50 years and older, the timely follow-up of women with abnormal screening and diagnostic results, or the use of the ACR Lexicon final reporting categories by radiologists to report mammogram results.

(2) Territories/Tribes Currently Receiving CDC Capacity Building Funds:

Accomplishments in establishing a comprehensive infrastructure to support a breast and cervical cancer screening program including screening, referral, tracking, and follow-up, public education and outreach, professional education, quality assurance, surveillance, and partnership activities.

(3) Territories/Tribes Not Currently Receiving CDC Breast and Cervical Cancer Funds:

Relevant past experiences of the applicant in conducting screening, referral, tracking, and follow-up, public education and outreach, professional education, quality assurance, surveillance, partnership activities for cancer control, chronic disease control or other relevant areas.

7. Source Data for Matching Requirement

Identify and describe:

a. Maintenance of Effort (MOE)—The average amount of non-Federal dollars expended for breast and cervical cancer programs and activities made by a State/territory/tribe for the two year period preceding the first Federal fiscal year of the program funding for breast and cervical cancer early detection activities. This amount will be used to establish the maintenance of effort baseline for current and future match requirements;

b. State/territory/tribe allowable sources of matching funds for the program and the estimated amounts from each;

c. Procedures for documenting the value of non-cash matching funds;

d. Procedures for documenting the actual amount of match received.

8. Budget with Justification

Provide a detailed budget request and complete line item justification (for both Federal and non-Federal funds) of all proposed operating expenses consistent with the program activities described in this announcement. Not less than 60 percent of Federal funds will be expended for screening, tracking, and follow-up services. Not more than 10 percent of Federal funds will be expended for administrative expenses.

The applicant should submit a chart showing the expected funding levels and the number of women to be screened by mammography and Pap tests by contract, county, or locality in the State/territory/tribe.

Evaluation Criteria (Total 100 Points)

Applications will be reviewed and evaluated according to the following criteria:

1. Background and Need (5 points)

The extent of the disease burden and the need among the priority populations as measured by:

(a) The State/territorial/tribal breast and cervical cancer age-adjusted mortality rates averaged more than five years and ranking nationally;

(b) The disease burden, including the incidence rates of breast and cervical cancer by age, race and ethnicity (where available);

(c) The number of uninsured women by race/ethnicity who are 18–49 years, 50–64 years, and the number of women eligible for Medicare;

(d) The unmet screening needs of uninsured and under-insured women;

(e) Existing access and barriers to early detection services, (e.g., social, financial, geographic).

2. Implementation Plan (60 points)

The degree of comprehensiveness and quality of the Operational Plan in relation to:

a. The number of women projected for screening, quality of screening, re-screening, and surveillance programs, and compliance with Federal requirements (i.e., screening guidelines, FDA mammography certification requirements, BI-RAD reporting, and CLIA regulations). (20 Points).

b. The extent to which proposed public education activities appear likely to increase the number of women screened, especially women identified in priority populations (see ''Purpose'). (15 Points)

c. The extent to which proposed professional education activities provide training options and educational opportunities to improve the quality of care of women. (15 Points)

d. The extent to which proposed surveillance and evaluation appears to use reliable data and program results to measure program effectiveness and to facilitate program planning, development, and implementation, and to enhance program goals and objectives. (10 Points)

3. Collaborative Partnerships and Community Involvement (15 points)

The feasibility and extent of the applicant's proposal to develop collaborative partnerships with other Federal, State and local programs, territories, tribes and voluntary, professional, and private-sector agencies, and to establish and maintain a broad-based council of partners at State, territory, tribe and local levels.

4. Management and Organizational Structure (10 points)

The feasibility and appropriateness of the applicant's management plan that describes the development of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management.

5. Capability for Program Implementation (10 points)

The extent to which the applicant appears likely to be successful in implementing the proposed activities as measured by:

a. Accomplishments by comprehensive-funded States in implementing a breast and cervical cancer early detection program as required through previous funding agreements.

b. Accomplishments by capacity-funded States in establishing a comprehensive public health infrastructure to support a breast and cervical cancer early detection program.

c. Relevant past experiences of unfunded applicants in conducting breast and cervical cancer early detection programs.

6. Budget and Justification (Not Weighted)

The extent to which the proposed budget is adequately justified, reasonable, and consistent with this program announcement.

Non-competing Continuation Application Content

In compliance with 45 CFR 74.51(d) and 92.10(b)(4), as applicable, non-competing continuation applications submitted within the project period need only include:

A. A brief progress report describing the accomplishments of the previous budget period.

B. Any new or significantly revised items or information (objectives, scope of activities, operational methods, evaluation, etc.) not included in the 01 Year application.

C. An annual budget and justification. Existing budget items that are unchanged from the previous budget period do not need rejustification. Simply list the items in the budget and indicate that they are continuation items. Supporting justification should be provided where appropriate.

Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs as governed by Executive Order 12372. This order sets up a system for State/territory/tribe and local review of proposed Federal assistance applications. Applicants (other than federally recognized Indian tribal governments) should contact their State Single Point of Contact (SPOC) as early as possible to alert them to expected announcements of cooperative agreement funds 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 of each State. A current list of SPOCs is included in the application kit. Indian territories are strongly encouraged to request tribal government review of the proposed application. If tribal governments have any tribal process recommendations or if SPOCs have any State process recommendations on applications submitted to CDC, they should reference this Announcement Number 718 and forward recommendations to Sharron P. Orum, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 305, Mailstop E–18, Atlanta, GA 30305, no later than 60 days after the application deadline date. 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 or tribal 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 93.919.

Other Requirements

Paperwork Reduction Act

Projects which involve the collection of information from ten or more individuals and funded by 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 completed application Form PHS–5161–1 (OMB Number 0937–0189) must be submitted to Sharron P. Orum, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 305, Mailstop E–18, Atlanta, GA 30305 on or before May 9, 1997.

1. Deadline: Applications will be considered as meeting the deadline if they are either:

a. Received on or before the stated 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 accepted as proof of timely mailing.)

2. Late Applications: Applications which 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. Please refer to Announcement #718. You will receive a complete program description, information on application procedures and application forms. If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from Gladys T. Gissentanna, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 314, Mailstop E–18, Atlanta, GA 30305, telephone (404) 842–6801, fax (404) 842–6513. Programmatic technical assistance may be obtained from Kevin Brady, MPH, Assistant Branch Chief, Program Services Branch, Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop K–57, Atlanta, GA 30341–3724, telephone (404) 488–4343, fax (404) 488–4727. You may also obtain this announcement, and other CDC announcements, from one of two Internet sites on the actual publication date: CDC's homepage at http://www.cdc.gov or the Government Printing Office homepage (including free on-line access to the Federal Register at http://www.access.gpo.gov).

Please refer to Announcement Number 718 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'' section through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325, telephone (202) 512–1800.

Dated: March 5, 1997.

Joseph R. Carter,

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

[FR Doc. 97–5956 Filed 3–10–97; 8:45 am]

BILLING CODE 4163–18–P

Current Status of the Vessel Sanitation Program and Experience to Date With Program Operations—Public Meeting

The National Center for Environmental Health (NCEH) of the Centers for Disease Control and Prevention (CDC) announces the following meeting.

Name: Current Status of the Vessel Sanitation Program (VSP) and Experience to Date with Program Operations—Public meeting between CDC and the cruise ship industry, private sanitation consultants, and other interested parties.

Time and Date: 9 a.m.–12 noon, Thursday, April 3, 1997.

Place: Port of Miami, Terminal #10, Miami, Florida 33132. For directions call 305/536–4307, or fax 305/536–4528.

Status: Open to the public for participation, comment, and observation, limited only by the space available. The meeting room accommodates approximately 400 people.

Purpose: To discuss current status of the VSP and experience to date with program operations.

Matters to be Discussed: During the past 10 years, as part of the revised VSP, CDC has conducted a series of public meetings with members of the cruise ship industry, private sanitation consultants, and other interested parties. This meeting is a continuation of that series of public meetings. Some of the topics to be discussed at this meeting include the finalization of CDC's ''Final Recommended Shipbuilding Construction Guidelines for Cruise Vessels Destined to Call on U.S. Ports,'' the finalization of ''Interim Recommendations to Minimize Transmission of Legionnaires' Disease from Whirlpool Spas on Cruise Ships,'' revising the current VSP Operations Manual, status of development of a VSP Hazard Analysis Critical Control Point training seminar and future plans for program direction.

For a period of 15 days following the meeting, through April 18, 1997, the official record of the meeting will remain open so that additional material or comments may be submitted to be made part of the record of the meeting.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Dan Harper, Program Manager, VSP, Special Programs Group (F29), NCEH, CDC, 4770 Buford Highway, NE, Atlanta, Georgia 30341–3724, telephone 770/488–3524.

Dated: March 5, 1997.

Carolyn J. Russell

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

[FR Doc. 97–5960 Filed 3–10–97; 8:45 am]

BILLING CODE 4163–18–P

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Application Requirements or the Low Income Home Energy Assistance Program (LIHEAP) and Detailed Model Plan (submitted every 3 years. Abbreviated applications to be submitted in intervening years.)

OMB No.: 0970–0075.

Description: This information requirement is an annual activity which is required by law for the receipt of federal block grant funds under the LIHEAP statute. By law, we must make this model plan available to grantees. It provides grantees an optional management tool that may alleviate the burden of preparing additional information to complete plans. The detailed mode plan is to be filed only once every three years or sooner if major changes are made to grantee's program. We are also seeking approval for a streamlined application to be used in alternate years.

Respondents: State, Territories and Tribal Govts.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Detailed model plan	65	1	1	65
Abb. model plan	115	1	.33	38

Estimated Total Annual Burden Hours: 103.