the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than May 14, 2004.

A. Federal Reserve Bank of San Francisco (Tracy Basinger, Director, Regional and Community Bank Group) 101 Market Street, San Francisco, California 94105–1579:

1. BancWest Corporation, Honolulu, Hawaii, and BNP Paribas, SA, Paris, France; to acquire 100 percent of the voting shares of Community First Bankshares, Inc., Fargo, North Dakota, and thereby indirectly acquire voting shares of Community First National Bank, Fargo, North Dakota.

Board of Governors of the Federal Reserve System, April 15, 2004.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 04–8970 Filed 4–20–04; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Notice of Proposals to Engage in Permissible Nonbanking Activities or to Acquire Companies that are Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y (12 CFR Part 225) to engage *de novo*, or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than May 5, 2004.

A. Federal Reserve Bank of San Francisco (Tracy Basinger, Director, Regional and Community Bank Group) 101 Market Street, San Francisco, California 94105–1579:

1. Security Pacific Bancorp and Network Finance, Inc., both of Ontario, California; to acquire 51 percent of the voting shares of Genuine Home Loans, Inc., Pasadena, California, and thereby engage in mortgage lending activities, pursuant to section 225.28(b)(1) of Regulation Y.

Board of Governors of the Federal Reserve System, April 15, 2004.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc.04–8971 Filed 4–20–04; 8:45 am]

BILLING CODE 6210–01–S

HARRY S. TRUMAN SCHOLARSHIP FOUNDATION

Sunshine Act Meeting; Meeting of the Trustees and Officers of the Harry S. Truman Scholarship Foundation

May 7, 2004, 9:30–11 a.m., U.S. Capitol, Room HC–8

I. Call to Order.
II. Welcome: President Albright.
III. Introduction of new Trustees and presentation of Certificates of Appointment.
IV. Approval of minutes of Meeting of September 3, 2003.
V. Report from the Executive Secretary: Ratification of the 2004 Truman Scholars.
VI. Financial Report of the Foundation.
VII. Discussion of the Report by the Task Force on Scholar Accountability.
VIII. Progress Report on the Task Force on Reinventing the Truman Scholarship Foundation.
IX. Recommendations from President Albright.
X. Old Business/New Business.
XI. Adjournment.

Louis H. Blair,

Executive Secretary.

[FR Doc. 04–9172 Filed 4–19–04; 1:51 pm]

BILLING CODE 6820–AD–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Community-Focused Initiative To Reduce the Burden of Stroke

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of Public Health and Science, Office of Minority Health.

Funding Opportunity Title: Community-Focused Initiative to Reduce the Burden of Stroke.

Announcement Type: Initial announcement of availability of funds.

Catalog of Federal Domestic Assistance Number: 93.004.

Key Dates: Application Availability Date: Monday, April 19, 2004; Technical Assistance Conference Call for Potential Applicants: Tuesday, April 27, 2004; Letter of Intent: Wednesday, May 12, 2004; Application Deadline: Thursday, June 17, 2004.

SUPPLEMENTARY INFORMATION:

I. Funding Opportunity Description

Authority: This program is authorized under section 1707 of the Public Health Service Act (PHS), as amended, 42 U.S.C. 300u–6.

Purpose: This announcement is made by the United States Department of Health and Human Services (HHS or The Department), acting through the Office of Minority Health (OMH) located within the Office of Public Health and Science (OPHS), and working in a "One-Department'' approach collaboratively with participating HHS agencies and programs (entities). As part of a new Secretary of HHS initiative, the Department announces availability of FY 2004 (future funding periods on an as-funds-are-available basis) funding for a cooperative agreement program for implementation of a core framework entitled, "The Stroke Belt Elimination Initiative (SBEI).'' (*See* Section VIII. A. Rationale, for description of the core components of SBEI.)

Project Requirements: Activities designed to achieve SBEI core goals and objectives, implement the core framework that includes an Enabling ring of collaborative activities and a core collaboration process, and use core

measures are required. Other activities may be added by the Stroke Belt Community Action Team (SBCAT) upon approval under terms of the cooperative agreement with HHS. The community recipient will be responsible for activities listed in section 1 and HHS for activities listed in section 2.

1. Required Community Recipient Activities

A. Fiduciary Responsibilities

i. *Specify the Lead (Fiduciary) Agency within the SBCAT.* The lead agency must have valid Internal Revenue Service (IRS) 501(c)(3) tax-exempt status or other IRS status indicating a bona fide not-for-profit organization or a public entity.

ii. *Allocate Funds.* Allocate and disperse funds to implement at least core activities within the community. Include adequate funds to participate fully in the orientation meeting and support a SBCAT Coordinator.

iii. *Oversight of SBCAT-linked Services.* This includes responsibility for overseeing fiscal and programmatic services linked to the SBCAT, and that are deemed necessary to accomplish the goals and objectives of this program announcement.

iv. *Link Budget to Performance.* Provide timely integrated progress and financial reports that link performance to expenditures by the SBCAT and its key partners.

B. Leadership, Coordination, and Management

i. *Establish or Designate the SBCAT and Implement Activities that include an Enabling ring.* Identify existing key partners and coalitions that focus on chronic disease, especially stroke and high blood pressure, that have existing capacity and strong track records. Strengthen partnerships and coalitions committed to participating actively in the planning, implementation, and evaluation of the SBEI. Key partners should demonstrate a high-level commitment to the initiative by their willingness to invest expertise, leadership, personnel, and other resources in the success of this initiative.

Partners must include, but are not limited to, local and State health departments; community-based health centers and other health care offices, clinics, systems or providers identified to provide care to medically insured, under insured and uninsured people identified with high blood pressure through activities of this or other initiatives; key community, health care, voluntary, and professional organizations; business, community, and faith-based leaders; and at least one lay representative of the population to be served. Other partners may include, but are not limited to, existing community coalitions or entities (especially those already focusing on stroke and high blood pressure), local education agencies; worksite wellness programs, health care purchasers, health plans, unions, health care providers for farm and migrant workers and their families, primary care associations, social service providers, health maintenance organizations, private providers, hospitals, universities, schools of public health, academic health centers, State Medicaid officials, community service organizations, aging services organizations, senior centers, community action groups, consumer groups, and the media.

Partnerships will operate in accordance to the core collaboration process and Enabling ring framework described above.

ii. *Establish or Designate, and Coordinate a Leadership Team.* This team will consist of a subset of SBCAT members who function as a steering or executive committee. The Leadership team will be responsible for overseeing project activities, establishing and maintaining an organizational structure and governance for the SBCAT (including decisionmaking procedures), determining the project budget and subcontracts, and participating in project-related local and national meetings. The leadership team should include, but is not limited to, the local health department, key community leaders, and others who have experience working in community health promotion and addressing stroke, high blood pressure, and high-risk populations.

iii. *Establish or Designate and Support a SBCAT Coordinator or other Project Staff as Required.* Project staff must include a full-time SBCAT Coordinator with a strong background in community-based projects, communications and health data evaluation, and experience in coordination of community-wide initiatives. The Coordinator will function as the program manager, coordinate community activities, help to facilitate the SBCAT, and effectively collaborate with the Stroke Belt Regional Action Team (SBRAT) Coordinator and the HHS Action Team. Other part-time, full-time, or in-kind staff, contractors, and consultants must be sufficient in number and expertise to ensure project success and have demonstrated skills and experience in coalition and partnership development, community mobilization, health care systems, public health, program evaluation, epidemiology, data management, health promotion, policy and environmental interventions, health care quality improvement, communications, resource development, and the prevention and control of stroke and high blood pressure.

iv. *Rapidly Develop a Stroke Belt Community Action Plan and Implement Community-Based Interventions.* Identify and implement high priority, intervention strategies proven to prevent and control hypertension and stroke. Communities must examine their stroke and hypertension burdens, higher-risk populations, current services and resources, and partnership capabilities to develop a comprehensive community action plan that effectively addresses required activities including coordination among SBCAT members, its leadership team, coordinator, community, State or sub-regional, regional, and national resources and activities via application of an Enabling ring model.

v. *Project Management.* The SBCAT Coordinator, in collaboration with other project staff and the leadership team, should:

a. Encourage active participation of SBCAT in project activities and decisions, through regular meetings and other proactive methods of communication.

b. Actively oversee all project activities during their planning, development, implementation, and evaluation phases.

c. Track performance in relationship to the achievement of short-term and intermediate goals and objectives as well as budgetary expenditures.

d. Collaborate with the SBRAT Coordinator to seek technical assistance from the State, region, HHS and other Federal agencies, other recipients, national voluntary organizations, universities, or other sources (*see* Core Collaboration Process section).

e. Collaborate with the SBRAT Coordinator to keep the Project Officer informed and seek Project Officer input and assistance.

f. When necessary, take corrective action promptly to ensure project success.

g. Participate in program evaluation and use evaluation data for program improvement.

C. Core Objectives

Core Objective 1—Increase community awareness and knowledge of hypertension and stroke.

Communities are required to implement coordinated interventions

designed to educate the community about stroke and high blood pressure. Such interventions might include:

i. Conducting community-wide campaigns about the signs and symptoms of stroke and recommended action steps; facilitating and coordinating prevention messages including collaborating with existing educational campaigns such as those occurring in May related to National Stroke Awareness Month, National High Blood Pressure Education Month, and National Physical Fitness and Sports Month.

ii. Coordinating with organizations and specific community settings via a community Enabling ring and a core collaboration process to increase the knowledge of people about prevention and control of stroke and high blood pressure. These include but are not limited to worksites, schools, health care settings, media outlets, and other community organizations such as faith-based organizations and senior centers.

Core Objective 2—Enhance early detection of high blood pressure and stroke with early referral to care.

Such interventions might include:

i. Working with community-based health centers, health care providers, health systems and plans, and employer/purchasers to increase the use of evidence-based preventive care practices for enhancing prevention and control of stroke and hypertension.

ii. Providing access to training for health care professionals on implementation of effective guideline-based care plans, including guidance on effective self-management for patients, employees, and other individuals with hypertension or stroke.

iii. Ensuring that mechanisms are in place in the community for networked notification about the when and where of free blood pressure checks and referrals to care. This might be done through increased collaborations with community-based health centers, clinics, medical offices, systems, plans, worksites, faith-based sites, volunteer health professionals, and others.

iv. Enhancing access to and utilization of quality health care services for prevention and control of stroke and hypertension.

Core Objective 3—Increase the community's adoption and use of lifestyle behaviors known to promote prevention and control of hypertension and stroke.

Promote lifestyle behaviors aimed at preventing or reducing risk of high blood pressure and stroke at the individual/patient, health professional/provider, health system or plan, and other organizational levels as well as in other community sectors.

Such interventions might include:

i. Improving community environmental/ecological policies and systems to manage strokes during the acute phase and decrease deaths and disability related to stroke. For example, enhancing 911 coverage, EMS and other first responder stroke training and protocols, and hospital stroke protocols.

ii. Working with health professionals and health professional organizations to more effectively counsel individuals regarding adoption and continued use of stroke- and hypertension-prevention and control health behaviors.

iii. Working with commercial, Medicaid, and Medicare health plans to more effectively counsel patients to use stroke- and hypertension-prevention and control health behaviors.

iv. Working with health systems to develop and implement policy-level incentives for providers and staff to more effectively counsel patients as regards use of stroke- and hypertension-prevention and control health behaviors.

v. Working with other community sectors to encourage students, employees, members, clients, local media, and others to use stroke- and hypertension-prevention and control health behaviors.

Core Objective 4—Enhance blood pressure control rates among community persons who are known to have hypertension and who are members of a health plan or otherwise visit health systems, clinics, or medical offices.

It is expected that activities will be undertaken to facilitate incorporation of clinical practice guideline-based approaches into organizational programmatic and system-wide policies and procedures that will improve high blood pressure control rates in health plans, health systems, and medical practice.

Such interventions might include:

i. Working with health care providers and in other settings to ensure effectiveness of systems designed to support appropriate and timely monitoring and care of persons with hypertension and sharing verbal and written BP readings and BP goals with them. For example, identification and effective management of patients with hypertension, including referrals to care, follow-up on visits, and use of patient as well as provider reminder systems.

ii. Working with community, state, and national partners to enhance hypertension and stroke training and continuing education for health professionals.

iii. Working with health professionals and health professional organizations to increase the percentage of community residents with hypertension whose blood pressure is controlled to guideline-recommended levels.

iv. Working with commercial, Medicaid, and Medicare health plans to meet or exceed the national average for controlling high blood pressure reported annually by the National Committee for Quality Assurance (NCQA).

v. Collaborating with health systems to develop and implement effective policy-level incentives for providers and staff to meet or exceed the national average for controlling high blood pressure reported annually by the NCQA.

vi. Partnering with pharmacists, pharmaceutical companies, and others to enhance access to basic anti-hypertensive medications for persons with hypertension who lack sufficient drug coverage.

vii. Increasing medical self-management skills of persons with hypertension or stroke, including better adherence to medication and other health regimens.

2. HHS Activities

A. Leadership and Coordination

i. *HHS Stroke Belt Action Team.* An HHS-level Stroke Belt Action Team (HHSAT) has been established to coordinate and organize the Stroke Belt Elimination Initiative at the national level. The HHSAT is comprised of high-level representatives of participating HHS entities. The team will provide SBEI policy oversight and direction. In addition, the HHSAT will develop agreements with HHS entities as well as national partners specifying how each will assist the SBRAT and SBCAT and coordinate technical assistance in support of achievement of the goals and objectives described in this program announcement.

ii. *Regional Stroke Belt Action Team.* An SBRAT will be formally established and an SBRAT Coordinator hired to facilitate and coordinate activities among the funding communities. The action team will work with representatives from funded communities; States; and sub-regional, regional, and national partners to ensure effective use of an enabling ring-based collaboration process by SBCATs, funded under this program announcement, and their key partners. This action team should: 1) anticipate priority needs of recipients and help to meet such needs collaboratively and on

a timely basis so that the SBEI is implemented efficiently and effectively; and 2) assist in organizing and facilitating approaches to sharing experiences, lessons-learned, results, outcomes, and resources among recipients and existing community and state chronic disease programs.

B. Technical Assistance

HHS will provide technical assistance training and support to funded communities in the areas of surveillance and epidemiology, community assessment and planning, evidence-based interventions, community mobilization and partnership development, monitoring of program performance outcomes, baseline data acquisition and data management, program sustainability, and other areas as deemed necessary by SBCATs and approved by HHS.

C. Baseline Mean Community Blood Pressure and Follow-up

Because of the importance of external baseline determination of average community blood pressure using representative cross-sampling methodologies, HHS will provide this critical element.

D. Evaluation Oversight and Coordination

HHS will separately fund and direct an independent, external evaluation of the SBEI. However, recipients are expected to budget for their full participation in the data collection associated with this external review. Additionally, HHS will work with recipients to finalize the evaluation plan based upon the initial plan included with the recipient's application.

II. Award Information

Estimated Funds Available for Competition: $2,000,000.

Anticipated Number of Awards: 3 to 4.

Range of Awards: $500,000 to $650,000 per year.

Anticipated Start Date: Friday, July 30, 2004.

Budget Period Length: 12 months.

Period of Performance: 4 Years.

Continuation awards and level of funding within an approved project period will be based on the availability of funds and satisfactory progress in achieving performance measures as evidenced by required progress reports. It is expected that projects will begin to implement interventions within Year One of funding. It is also expected that assessment and evaluation will require special emphasis during the first two years of funding. It is anticipated that additional FY 2004 resources may enable HHS to fund additional prevention initiatives based on this announcement or a separate announcement.

Pending availability of funds, beginning in FY 2004 and each of the remaining years of this program announcement, there may be an open season for new competitive applications. Specific guidance will be provided with application due dates and funding levels each year.

Type of Award: Cooperative Agreement.

Type of Application Accepted: New.

Applicants funded for the first time will be required to submit a revised work plan and budget to address issues identified in the objective review of applications in order to receive their first year of funding. For subsequent years of funding, the applicants may be required to submit a revised work plan and budget to address issues identified in the technical review of their continuation applications.

III. Eligibility Information

1. Eligible Applicants

This announcement only requests qualified applicants from communities in each of the contiguous Seven Core Stroke Belt States (Alabama, Arkansas, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee). These States are part of the original 11 Stroke Belt States and either have a long history of ranking high in terms of stroke death rates or rank first in the 2001 analysis (*see* Attachment B). That these states are also contiguous provides opportunity to truly regionalize this initiative, assuring enhanced ability to form an Enabling ring around the priority condition (stroke) and priority risk factor (hypertension) in a contiguous region of significant need.

Applicants must meet the following additional criteria:

A. Must be a public or non-profit organization, including faith-based organizations;

B. Have been in the community for at least five years to enhance likelihood of familiarity with and recognition by other community entities and individuals; and

C. Have an agreement (*e.g.*, Memorandum of Understanding, contract, written agreement) or document that an agreement is being developed with one or more community health centers and/or other health providers, systems or plans to offer care to uninsured people identified as having high blood pressure through the activities of this initiative to assure availability of followup care of hypertension.

For this announcement, the term "community'' is defined as any contiguous geographic area (including counties). Applicants can specify an intervention area that is smaller than the entire city or county, or includes multiple counties, but the intervention area must be geographically contiguous. The area must include a population of at least 100,000 residents for an urban community and 60,000 residents for a rural community. Although multiple applications may be submitted from an eligible community, only one award will be made to a community that is selected as part of this SBEI.

Communities with substantial expertise and infrastructure for the design, delivery, and evaluation of chronic disease prevention and control interventions and are able to begin intervention activities under the program announcement in year one of funding are encouraged to apply under this announcement.

2. Cost Sharing or Matching

Matching funds, that is, a specific percentage of program costs that must be contributed by a recipient in order to be eligible for this announcement, are not required. Applicants are encouraged, however, to identify financial and in-kind contributions from their own organization and their partners to support and sustain the activities of this program announcement. Applicants are encouraged to seek partnerships and in-kind support from a variety of partners including (1) private partners (*e.g.*, health care providers or systems, businesses), (2) regional and State partners (*e.g.*, regional stroke networks, the State Health Department Heart Disease and Stroke Prevention Program), and (3) federally funded partners (*e.g.*, Federally Funded Health Centers).

3. Other

Organizations must submit documentation of nonprofit status with their applications. If documentation is not provided, the application will be considered non-responsive and will not be entered into the review process. The organization will be notified that the application did not meet the submission requirements.

Any of following serves as acceptable proof of nonprofit status:

- A reference to the applicant organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

• A copy of a currently valid IRS tax exemption certificate.

• A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

• A certified copy of the organization's certificate of incorporation or similar document that clearly establishes nonprofit status.

• Any of the above proof for a State or national organization and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If funding is requested in an amount greater than the ceiling of the award range, the application will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

Applications that are not complete or that do not conform to or address the criteria of this announcement will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

An organization may submit no more than one proposal for the Stroke Belt Elimination Initiative. Organizations submitting more than one proposal for the same grant program will be deemed ineligible. The proposals will be returned without comment.

Organizations are not eligible to receive funding from more than one OMH grant program to carry out the same project and/or activities.

IV. Application and Submission Information

1. Address To Request Application Package

To obtain an application kit, write to: Ms. Karen Campbell, Director, OPHS Office of Grants Management, Office of Public Health and Science, Department of Health and Human Services, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852, or telephone (301) 594–0758, e-mail *kcampbell@osophs.dhhs.gov.*

2. Content and Form of Application

A. Letter of Intent

A Letter of Intent (LOI) is required from all potential applicants for the purpose of planning the competitive review process. The narrative should be no more than two pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. LOIs should include the following information: (1) The program announcement title and number; (2) whether the application will be from an urban or rural community; (3) the exact boundaries and total population size of the contiguous geographic area with population that qualifies the applicant as eligible for this program announcement; and (4) the name of the applicant agency or organization, the official contact person and that person's telephone number, fax number, and mailing and e-mail addresses. If an applicant does not submit an LOI prior to submitting an application, the application will not be entered into the review process.

Submit the LOI to: Ms. Karen Campbell, Director, OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Letters of intent must be received by the OPHS Office of Grants Management by 5 p.m. e.d.t. on Wednesday, May 12, 2004.

B. Application

Applications must be prepared using Form PHS 5161–1 (revised July 2000 and approved by OMB under Control Number 0348–0043). This form is available in Adobe Acrobat format at the following Web site: http://www.cdc.gov/od/pgo/forminfo/htm.

The narrative (excluding attachments) should be no more than 50 pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. In addition to the application forms, the application must contain the following in this order:

A. Table of Contents

Include a Table of Contents with page numbers for each of the following sections:

B. Executive Summary

An Executive Summary should be included that provides specific evidence that the applicant is eligible to apply (*see* section on Eligible Applicants). It should also briefly describe the overall project; intervention area and population size; and partnerships, intervention strategies, and predicted major short-term and intermediate outcomes.

C. Community Lead Agency

A description of the lead agency should be provided, including fiduciary and programmatic capabilities, length of time in community, as well as an inventory of current agency activities and partnerships related to this announcement and confirmation of relevant agreements. For example, include a Memorandum of Understanding or other written agreement with appropriate partners to provide health care services to uninsured people identified to have high blood pressure as a result of activities of this initiative.

D. Intervention Area

Provide a description of the community intervention area, including its demographic, geographic and political boundaries, target populations to receive special focus under the SBEI, as well as evidence of the burden of disease, and disparities in hypertension and stroke, and access to and use of proven prevention and control interventions. Description of current local, State, and already-active private-sector activities that focus on chronic conditions, especially hypertension and stroke, and each relevant HHS agency and national partner. Include a description of related assets and needs of the intervention area including a description of findings from any community assessments or asset mapping done in the past three years.

E. Staffing

Provide a description of proposed program staff including resumes or job descriptions for full-time project coordinator and other key staff, the qualifications and responsibilities of each staff member, and percent of time each is committing to the program.

F. Stroke Belt Community Action Team

Include a description of the proposed SBCAT including a list of key partners and documentation of their capabilities; their commitment to specific functions, responsibilities, and resources; and evidence of prior successful collaborations. The structure, decision making processes, and methods for accountability of the members should be described as well as how coordination and linkage with existing programs and interventions with similar focus will be maintained.

G. Community Action Plan

Include a detailed plan for year one and a preliminary plan for years two through four. The community action plan for year one should include goals, objectives, a work plan, and timeline for carrying out the Required Activities (*see* section 1). The community action plan objectives should be time-phased, specific, measurable, and realistic and should clearly relate to attaining specific short-term and intermediate outcomes that are based on the needs of the community and gaps in current prevention and control activities. The

community action plan should identify likely approaches, strategies, and interventions to be used in year one and over the four-year project period to address stroke and high blood pressure. The organizations responsible for the interventions should be identified as well as the target populations to be addressed. The preliminary plan for years two though four should include the community interventions to be employed as well as a plan to ensure long-term sustainability of project efforts and outcomes.

H. Financial Contributions

Provide a description of financial and in-kind resources, if any, that will be contributed toward activities initiated as part of the SBEI. Also discuss how these will enhance the likelihood of achieving sustainability of activities within the community.

I. Evaluation and Monitoring

Include a plan for data identification, collection, and use for program planning and monitoring for the community that includes a commitment to work with HHS on baseline and subsequent data collection. Describe any additional efforts to obtain data and sources to better understand the burden and trends in stroke and high blood pressure and the effects of this initiative. Provide specific assurance that the community will track common performance measures and participate fully in an independent, external evaluation of initiative outcomes. Describe how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

J. Communication Plan

Provide a plan for the community to communicate and share information with the members of its SBCAT, other key partners, and its own community broadly, as well as with other communities funded under this initiative. This plan should describe the proposed exchange of information, proposed means and timing of communication, with an emphasis on communications innovations such as electronic formats or web forums.

K. Budget and Budget Justification/ Narrative

Provide a One-Year and Four-Year Budget. In support of the four-year community action plans, provide a detailed budget and budget justification/ narrative for the first budget year and a budget estimate for years two through four.

i. Provide a detailed budget for the first budget year in support of each activity that must be completed in the first year of program operations to accomplish the short-term and intermediate outcomes specified in the five-year community action plan.

This detailed budget must include:

a. Community expenditures. A budget justification and narrative that describe all requested funds for the 501(c)(3) and other key community partners by category in support of first-year activities in the four-year community action plan. As part of the request for travel funds in FY 2004, applicants should budget for two trips to workshops and/or conferences for key community members. For planning purposes, use Atlanta and Washington, DC, as the travel destinations.

b. The information above should be consistent with the first year budget information entered in Section B of Standard Form 424A (Budget Information—-Non-Construction Programs).

ii. Provide estimated budgets for funding years two to four that are linked to accomplishment of intermediate community outcomes. For each budget year, include budget estimates for two trips to workshops and/or conferences for key staff members of the lead/ fiduciary organization and its key partners. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Provide the estimated total budget for each year for each object class category in Section B of Standard Form 424A (Budget Information—Non-Construction Programs).

L. Letters of Support

Provide letters of support and Memoranda of Understanding, as appropriate, from the local health departments, community-based health centers and other health care partners, and additional key members of the SBCAT, specifying their specific roles, responsibilities, and resources.

DUNS Number Requirement

Beginning October 1, 2003, all applicants are required to obtain a Data Universal Numbering System (DUNS) number as preparation for doing business electronically with the Federal Government. The DUNS number must be obtained prior to applying for OMH funds. The DUNS number is a nine-character identification code provided by the commercial company Dun & Bradstreet, and serves as a unique identifier of business entities. There is no charge for requesting a DUNS number, and you may register and obtain a DUNS number by either of the following methods: Telephone: 1–866–705–5711; Web site: *http://eupdate.dnb.com/requestoptions.html.* Be sure to click on the link that reads, "DUNS Number Only'' at the left hand bottom corner of the screen to access the free registration page. Please note that registration via the web site may take up to 30 business days to complete.

3. Submission Dates and Times

Letter of Intent Deadline Date: Wednesday, May 12, 2004, by 4 p.m.

Application Deadline Date: Thursday, June 17, 2004, by 4 p.m.

Explanation of Deadlines: Applications must be received by the Office of Public Health and Science, Office of Grants Management by 4 p.m. on Thursday, June 17, 2004, by 4 p.m. Applications will be considered as meeting the deadline if they are received on or before the deadline date. The application due date requirement in this announcement supercedes the instructions in the PHS 5161–1. Applications submitted by facsimile transmission (FAX) or any other electronic format will not be accepted. Applications that do not meet the deadline will be considered late and will be returned to the applicant unread.

Applications must be submitted to Ms. Karen Campbell, Director, OPHS Office of Grants Management, Office of Public Health and Science, Department of Health and Human Services, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852.

Applications will be screened upon receipt. Applications that are not complete or that do not conform to or address the criteria of the announcement will be returned without comment.

Each organization may submit no more than one proposal under this announcement.

Organizations submitting more than one proposal will be deemed ineligible. The proposals will be returned without comment.

Accepted applications will be reviewed for technical merit in accordance with PHS policies.

4. Intergovernmental Review

This program is subject to the requirements of Executive Order 12372 which allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. The application kit available under this notice will contain a list of States which have chosen to set up a review system and will include a State Single Point of Contact (SPOC) in the State for review.

Applicants (other than federally recognized Indian tribes) should contact their SPOCs 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 of each affected State. The due date for State process recommendations is 60 days after the application deadline established by the Office of Public Health and Science Grants Management Officer. The OMH does not guarantee that it will accommodate or explain its responses to State process recommendations received after that date. (*See* ''Intergovernmental Review of Federal Programs'' Executive Order 12372 and 45 CFR part 100 for a description of the review process and requirements).

This program is subject to Public Health Systems Reporting Requirements. Under these requirements, a community-based non-governmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based organizations within their jurisdictions.

Community-based non-governmental applicants are required to submit, no later than the Federal due date for receipt of the application, the following information to the head of the appropriate State and local health agencies in the area(s) to be impacted: (a) A copy of the face page of the application (SF 424), and (b) a summary of the project (PHSIS), not to exceed one page, which provides: (1) A description of the population to be served; (2) a summary of the services to be provided; and (3) a description of the coordination planned with the appropriate State or local health agencies. Copies of the letters forwarding the PHSIS to these authorities must be contained in the application materials submitted to the OMH.

5. Funding Restrictions

Cooperative agreement funds may be used to expand, enhance, or complement existing activities to accomplish the objectives of this program announcement. Funds may be used to pay for, but are not limited to: staffing, consultants, contractors, materials, resources, travel, and associated expenses to implement and evaluate intervention activities related to addressing stroke and high blood pressure. Activities might relate to such things as: Helping health care centers, worksites, schools, senior centers, faith-based organizations and other community locations educate people about stroke and high blood pressure, and making environmental changes to support prevention and control of stroke and high blood pressure in the community and among higher risk populations; educating health plans, purchasers, and providers regarding guidelines for preventive health care practices related to stroke and high blood pressure and how to fully implement them; enhancing office-based systems to ensure that persons with stroke and high blood pressure are called for routine exams and other follow-up; using information technology (such as the web and email) to communicate with people with stroke and high blood pressure; developing community support groups for persons with stroke and high blood pressure; conducting awareness and media campaigns tied to prevention and outreach programs to educate persons about their risk of stroke and high blood pressure, the signs and symptoms of stroke and what actions to take; conducting community-based outreach to high-risk populations, encouraging them to seek appropriate care and increasing knowledge of self-management of high blood pressure; and training lay health workers to conduct health promotion programs and outreach into the community.

Cooperative agreement funds may not be used for direct patient care, diagnostic medical testing, patient rehabilitation, pharmaceutical purchases, facilities construction, lobbying, basic research, or controlled trials. Applicants may not use these funds to supplant funds from State sources or the Preventive Health and Health Services Block Grant dedicated to stroke, high blood pressure, or the related risk factors of tobacco use, physical inactivity, overweight, and excessive salt intake.

Although program funds under this Program Announcement are to be used to address stroke and high blood pressure, resources to address related risk factors (*i.e.*, tobacco use, physical inactivity, overweight, and excessive salt intake) are important and can be reported as in-kind support.

6. Other Submission Requirements

Applications may only be submitted in hard copy. Send an original, signed in blue ink, and two copies of the complete grant application to Ms. Karen Campbell, Grants Management Officer, Office of Grants Management, Office of Public Health and Science, Tower Building, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Applications submitted by e-mail, Facsimile transmission (FAX) or any other electronic format will not be accepted.

V. Application Review Information

1. Criteria

A. *Strength of Technical Approach (25 points).* (1) Overall strength and creativity of proposed SBCAT technical approach in relation to stroke and high blood pressure; and (2) innovation of approach; extent to which the HHS Core Framework shapes the SBCAT's plan which must include goals, objectives, and measures; and commitment of partners to employ the enabling ring concept and to share existing or add new resources to help achieve goals/objectives and obtain measures to evaluate impact. In addition, likelihood that the proposed SBCAT plan, if implemented, will reduce mean high blood pressure as well as stroke mortality rate; and likelihood that efforts will be institutionalized within the community. The evaluation plan contains appropriate performance measures/indicators (of success) and data collection and analysis methodologies.

B. *Understanding of the Problem (20 points).* Demonstrated understanding of: (1) Stroke (condition) and high blood pressure (risk factor) and their differential geographic and racial/ethnic impact in the Stroke Belt and within the target community; (2) local community health needs related to management and control of stroke and high blood pressure; (3) issues related to the underutilization of proven/science-based modalities (*e.g.*, guideline-based and case or disease management-based interventions), both clinical and behavioral; and (4) relevance to eliminating disparities in stroke deaths and high blood pressure prevalence.

C. *Capacity and Commitment of Organization (20 points).* Demonstrated capacity and documented past program success; existing infrastructure and strength of partnerships; evidence of past collaboration within the community and substantiated commitment to participate in the project via an ''enabling ring of collaborators'' who may already be involved in local activities. These may be representatives from the community sectors (*i.e.*, government, education, business, faith, health care, media, and voluntary agencies); and documented commitment of resources to the proposed project in terms of dollars, staff, and/or administrative support.

D. *Staff Capability (20 points).* Capacity and skills of proposed staff, including, but not limited to, project management experience, familiarity with stroke and high blood pressure activities and issues, understanding of cultural diversity, competence and sensitivity, knowledge of evaluation methodology, and understanding of and access to information technologies. The respondent must demonstrate existing and sufficient computer hardware and software capabilities, including the technical ability to access the Internet, and submit reports electronically.

E. *Understanding of Core SBEI Concept (15 points).* Demonstrated understanding of core goals, core framework, and collaborative enabling ring concept of the SBEI.

2. Review and Selection Process

Applications will be evaluated by an independent Objective Review Committee (ORC) appointed by HHS against specific criteria. The ORC members are chosen for their expertise in minority health and their understanding of the unique health problems and related issues confronted by the racial/ethnic minority populations in the United States. Funding decisions will be determined by the Deputy Assistant Secretary for Minority Health will take under consideration the recommendations and ratings of the ORC, and geographic and racial/ethnic distribution.

Funding Preferences: Preference in funding may be given to ensure:

- Geographic distribution of programs.
- Inclusion of geographic areas with high, age-adjusted rates of stroke and high blood pressure.
- Inclusion of populations disproportionately affected by stroke and high blood pressure.
- Inclusion of communities of varying sizes, including rural and urban communities.

3. Anticipated Award Date

Friday, July 30, 2004.

VI. Award Administration Information

1. Award Notices

Successful applicants will receive a notification letter from the Deputy Assistant Secretary for Minority Health and a Notice of Grant Award (NGA), signed by the OPHS Grants Management Officer. The NGA shall be the only binding, authorizing document between the recipient and the Office of Minority Health. Notification will be mailed to the Program Director/Principal Investigator identified in the application.

Unsuccessful applicants will receive a notification letter with the results of the review of their application from the Deputy Assistant Secretary for Minority Health.

2. Administrative and National Policy Requirements

In accepting this award, the grantee stipulates that the award and any activities thereunder are subject to all provisions of 45 CFR parts 74 and 92, currently in effect or implemented during the period of the grant.

The Buy American Act of 1933, as amended (41 U.S.C. 10a–10d), requires that Government agencies give priority to domestic products when making purchasing decisions. Therefore, to the greatest extent practicable, all equipment and products purchased with grant funds should be American-made.

A Notice providing information and guidance regarding the ''Government-wide Implementation of the President's Welfare-to-Work Initiative for Federal Grant Programs'' was published in the **Federal Register** on May 16, 1997. This initiative was designated to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the notice is available electronically on the OMB home page at *http://www.whitehouse.gov/omb.*

The HHS Appropriations Act requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, grantees shall clearly state the percentage and dollar amount of the total costs of the program or project which will be financed with Federal money and the percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

3. Reporting Requirements

A successful applicant under this notice will submit: (1) Progress reports; (2) an annual Financial Status Report; and (3) a final progress report and Financial Status Report in the format established by the OMH, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program Performance,'' 45 CFR part 74.51–74.52, with the exception of State and local governments to which 45 CFR part 92, subpart C reporting requirements apply.

Provision of Smoke-Free Workplace and Non-Use of Tobacco Products by Recipients of PHS Grants

The PHS strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children.

VII. Agency Contacts

Questions regarding programmatic information and/or requests for technical assistance in the preparation of the grant application should be directed to Ms. Cynthia H. Amis, Director, Division of Program Operations, Office of Minority Health, 1101 Wootton Parkway, Suite 600, Rockville, MD 20852, telephone (301) 594–0769. Technical assistance on budget and business aspects of the application may be obtained from the OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852, telephone (301) 594–0758.

For health information call the OMH Resource Center at 1–800–444–6472.

Special Guidelines for Technical Assistance Conference Call. A conference call will be held on *Tuesday, April 27, 2004* to provide technical assistance to potential applicants. Interested parties must register for the conference call by calling (301) 594–0769, e-mail *kcampbell@osophs.dhhs.gov.* Information will be provided at that time on the date and time of the conference call, the call-in number and the access code.

The purpose of the conference call is to help potential applicants to:

1. Understand the scope and intent of the program; and

2. Review application and evaluation procedures.

Participation in this conference call is not mandatory.

HHS ''One-Department'' Participating Entities: These include, but are not limited to, the Administration on Aging, Administration for Children and Families, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, the Substance

Abuse and Mental Health Services Administration, and the Office of Disease Prevention and Health Promotion.

VIII. Other Information

1. Rationale

The Stroke Belt is located in the southeastern region of the United States (U.S.) and primarily consists of contiguous states where rates of stroke death have exceeded the U.S. national average by more than 10 percent since its initial identification in the 1980s. Accordingly, the Stroke Belt represents a long-standing geographic disparity. In addition, demographic disparities exist within many areas, including the Stroke Belt. The Stroke Belt Elimination Initiative is undertaken by the Department to complement and, where indicated, enhance existing local, regional, and national activities designed to contribute to reducing and ultimately eliminating excessive rates of stroke death in this geographic area. Where necessary, the SBEI will seek to encourage effective and innovative approaches to this problem. *Focus on the Stroke Belt* provides a unique opportunity to leverage and coordinate resources within a well-defined and contiguous region, with an opportunity to expand efforts at a later time should effectiveness be demonstrated. *Focus on communities within the Stroke Belt* recognizes the importance of identifying, enhancing, allocating, and coordinating resources at the level where individuals live, work, and play in efforts to further enable communities to more fully encircle or form a collaborative ring around the problem and ultimately reduce or eliminate excess stroke death rates. *Focus on formation of an enabling ring of collaborative activities* addressing the community's stroke problem is a required core component of this announcement. This is undertaken in view of the need for enhanced coordination of existing as well as newly developed stroke-reducing activities that typically occur concurrently with single communities. *Focus on hypertension* recognizes that (1) this is one of the most prevalent and significant modifiable risk factors contributing to stroke, (2) the risk of stroke death doubles as blood pressure rises 20 mm Hg and very importantly, it falls in a similar doubling-fashion as blood pressure is reduced, and (3) the need to provide simpler messages for lay individuals to build upon over time.

Essential core components of the overall SBEI are detailed below.

Core Goals: Short-term (by month 4)—to begin implementing core framework, including establishment of an effective enabling ring of collaborative activities around the problem of stroke death in the community. *Mid-Term (by month 18)*—to begin to reduce mean community blood pressure (BP) among adults ≥18 years of age living within the community and to begin to reduce mean subpopulation BP among at least one demographic subpopulation considered to be a higher risk for hypertension. Mean community and subpopulation BPs will be obtained via a representative cross-sectional sampling methodology under guidance and funding by HHS (*see below,* core framework component 6). *Long-term (by month 36)*—to begin to reduce mean community stroke death rate (SDR) among adults ≥18 years of age living within the community and to begin to reduce mean population SDR among at least one demographic subpopulation considered to be a higher risk for stroke death. The community may set other measurable goals; however, core goals must be included and additional ones approved by HHS. Mean community and subpopulation SDRs will be obtained under guidance from HHS using a process that includes a modified health behaviors and blood pressure readings survey.

Core Framework: Each selected community is required to make use of a core framework for action. Additional activities may be pursued as determined by the community's Stroke Belt Community Action Team (SBCAT). *Core framework component 1 (pre-award)*—an SBCAT is being formed or designated and is comprised of representation from entities that formally agree to work collaboratively toward goals, submits application for funding, and is responsible for receiving and allocating funding under a cooperative agreement with HHS. *Core framework component 2 (by month 3)*—following notification of selection, the SBCAT will designate attendees of an orientation conference to be attended by national and regional members of a Stroke Belt Regional Action Team (SBRAT) (defined in section Core Collaboration Process, Regional Level). *Core framework component 3 (by month 3)*—the SBCAT reviews and adopts core goals, objectives, and process and creatively adapts them to their specific community. Other goals, objectives, and processes may be added by the SBCAT upon approval under terms of the cooperative agreement with HHS. *Core framework component 4 (by month 3)*—a full-time SBCAT Coordinator is hired or designated, whose experience includes leading effective community action interventions and has familiarity with health data, and who works directly and daily on the community's goals under the direction of the leadership of the SBCAT and in coordination with the SBRAT Coordinator. *Core framework component 5 (by month 4)*—an Enabling ring of collaborative activities is being formed or designated, including formal statements of the specific activity or activities that each enabling ring participant will coordinate or be responsible for in a collective effort to manage the priority condition (stroke) and priority risk factor (hypertension). *Core framework component 6 (by month 6)*—the HHS will work directly with the SBCAT to obtain baseline data on mean community blood pressure and basic health behaviors that impact hypertension and stroke. This step will consist of performing a representative sampling and will be technically coordinated and funded by HHS and performed in collaboration with the SBCAT. This survey includes an assessment of basic health behaviors and blood pressure and will be repeated at months 18 and 36. *Core framework component 7 (by month 6)*—the SBCAT coordinates with HHS to approve a framework for action and specific measures for evaluation of activities.

Enabling Ring of Collaborative Activities: The need for enhanced systemic coordination of activities designed to improve health results and outcomes is well recognized. This announcement emphasizes the requirement that selected communities will identify existing activities at local, State, regional, and national levels that have direct or indirect impact on prevention and control of hypertension (priority risk factor) and stroke (priority condition) within the community.

Once these activities and resources are identified, the community, via their SBCAT and SBCAT Coordinator, will work collaboratively with entities and individuals leading those activities to collaboratively encircle the problem, enabling the community to more effectively solve it (*see Core Collaboration Process*).

Core Objectives: The SBCAT is required to review, adopt, and adapt the following core objectives in order to enhance the likelihood for reducing hypertension and stroke locally. *Core objective 1*—increase community awareness and knowledge of hypertension and stroke. This requires use of an educational campaign (HHS to make electronic templates available) and, in the month of May (beginning in 2005), annual recognition of National

Stroke Awareness Month, National High Blood Pressure Education Month, and National Physical Fitness and Sports Month. *Core objective 2*—enhance early detection of hypertension and stroke with early referral to care. Formation of a volunteer information/notification network whereby community members are informed of when and where free blood pressure checks will be available. *Core objective 3*—increase the community's adoption and use of lifestyle behaviors known to promote prevention and control of hypertension and stroke. Strategically, these behaviors should be adopted by individuals/patients, families, health professionals/providers, health systems or plans, and by other community organizations and leaders including but not limited to schools, faith-based institutions, and work sites. *Core objective 4*—enhance blood pressure control rates (the percentage of persons with hypertension whose blood pressure is treated and controlled to levels that are recommended by accepted clinical practice guidelines) among community persons who are known to have hypertension and who are members of a health plan or otherwise visit health systems, clinics, or medical offices. This objective requires inclusion of representatives of these health-related organizations in the SBCAT. Other objectives may be added by the SBCAT upon approval under terms of the cooperative agreement with HHS.

Core Collaboration Process: to facilitate coordination of effort at local, State, regional, and national levels, and to achieve establishment of the community's Enabling ring, a core process for multi-level partnering will be utilized. *National Level*—HHS will be responsible for establishing and maintaining formal agreements of collaboration with non-Federal national organizations and other Federal entities for the purposes of this announcement and coordinating communications with entities at this level. The SBCAT will be required to coordinate with HHS to avoid multiple contacts from multiple communities to a single national entity. *Regional Level*—HHS will establish a SBRAT that includes appropriate HHS Regional Health Administrators and Regional Directors, pre-existing stroke consortia or networks as well as other national, regional, sub-regional, and local representatives. The SBRAT will be responsible for maintaining formal agreements of collaboration with regional entities for the purposes of this announcement and coordinating communications with entities at this level. The SBCAT will be required to coordinate with the SBRAT to avoid multiple contacts from multiple communities to a single regional entity. *State and Local Levels*—The SBCAT will be responsible for coordinating communications with entities at this level while keeping SBRAT and HHS point of contacts up to date as per final agreement. The key roles and responsibilities of partners and their specific enabling ring of activities must be clearly delineated.

Core Measures for Evaluation and Process Improvement: While community-specific measures are important, a core set of measures is required to enhance opportunities to share insights and lessons-learned as well as facilitate assessment of progress across multiple communities. *Core Process Measures*—These are required to include documentation of (a) an effective SBCAT, (b) evidence of attendance at the initial awardees orientation meeting, (c) SBCAT Coordinator, (d) membership in the SBRAT, (e) an effective enabling ring of collaboration within the community, (f) an effective educational campaign that also makes use of existing efforts and materials by participating entities as well as SBEI-specific ones to be provided by HHS, (g) evidence of annual recognition in the Month of May of National Stroke Awareness Month, National High Blood pressure Education Month, and National Physical Fitness and Sports Month, (h) evidence from SBCAT-participating health professionals, medical societies, health systems and health plans, and other SBCAT-member community organizations of efforts to incorporate guideline-based hypertension and stroke reducing behaviors into their policies and practices, (i) evidence of an information network, formal or informal, that notifies the community of when and where blood pressure checks are available, (j) evidence of activities undertaken that are designed to increase BP control rates in community persons with hypertension, and (k) approval of an evaluation plan. *Core Results Measures*—Requirements include documentation of (a) SBCAT-facilitated and HHS coordinated and funded baseline and follow-up data on a timeline-appropriate basis (mean community adult BP and mean BP for at least one demographic subpopulation at higher risk for hypertension or stroke; mean community adult stroke death rate and SDR for at least one demographic subpopulation at higher risk for hypertension or stroke; and simple questionnaire-based survey of lifestyle behaviors; for example, self-reported physical activity, weight control, salt use, smoking, consumption of fruits and vegetables, and other hypertension and stroke-related questions), (b) a summary of traditional metrics for the education campaign (*e.g.*, extent and frequency of multi-media paid advertisements and public service announcements, and estimated number and demographics of community persons reached), and (c) estimated number of blood pressure screenings performed by participants in the volunteer informational blood pressure check network. *Core Outcomes Measures*—These include estimation by SBCAT, in collaboration with HHS, of the degree of change, if any, in: (a) Mean community adult BP and mean BP for at least one demographic subpopulation at higher risk for hypertension or stroke; (b) mean community adult SDR and SDR for at least one demographic subpopulation at higher risk for hypertension or stroke; and (c) surveyed hypertension and stroke-reducing lifestyle behaviors.

2. Background

The Stroke Belt is an Important Geographic Disparity: The original Stroke Belt region was designated in 1980 by the National Heart, Lung, and Blood Institute and consisted of eleven States mainly in the southeast where the rate of death due to stroke was at least 10 percent higher than the U.S. national average. The original 11 Stroke Belt States are Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. A review of earlier statistical evidence indicates that excess rates of stroke-deaths have been present in this general region for a long period of time. As of 2001, the top seven of the original 11 Stroke Belt States, in terms of stroke death rates, are contiguous within the southeastern U.S. and include Alabama, Arkansas, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee (the Seven Core Stroke Belt States).

Stroke Burden: The overall burden of stroke is significant. Stroke is the third leading cause of death in the U.S., and, on average, someone living in the U.S. has a stroke about every 45 seconds. There are over 700,000 new strokes annually and about 29 percent of these are recurrent strokes. There are at least 4.7 million U.S. persons living with stroke. Stroke accounts for over 981,000 hospital discharges and over $51.2 billion in costs annually. Reductions in stroke mortality account for about 1 of 6 years gained in life expectancy from 1970–2000. In 2001, approximately 163,538 U.S. deaths were directly

attributable to stroke. As of 2001, the average stroke death rate for the Seven Core Stroke Belt States was significantly higher than the U.S. national average or that for the remaining 43 states and the District of Columbia (about 22 percent and 26 percent higher, respectively).

Stroke Risk Factors: Risk factors for stroke include high blood pressure, excess weight, and heart disorders such as atrial fibrillation, an irregular heart rhythm, or a large area of heart wall damage due to a heart attack. High cholesterol, smoking, significant carotid artery disease, markedly high red blood cell count, and sleep apnea are also risk factors. The risk of stroke increases with age, being over 25-times higher for persons 75 years and older, and over 11-times higher for persons 65 to 74 years-old, compared to persons 35 to 44 years of age. Men 75 years and older have a 16 percent higher risk of stroke compared to women. A history of a prior stroke or mini-stroke (transient ischemic attack, TIA) or a family history of stroke are associated with increased stroke risk. The presence of diabetes increases the risk of stroke by over 150 percent. The importance of risk factors is underscored by the fact that persons with a low risk profile for heart disease or stroke are almost 60 percent less likely to die prematurely. These persons are also estimated to live up to 9.5 years longer. Accordingly, clinical practice guidelines for early intervention exist and have been recently updated.

The Demographic Disparity of Death from Stroke: As of 2001, Latino/Hispanic persons had the lowest stroke death rate (44.9 deaths per 100,000, age-adjusted). Rates for non-Latino/Hispanic blacks, whites, and others were 74 percent, 25 percent and 29 percent higher, respectively. Lack of early clinical management of ischemic stroke increases the risk of disability and death.

Hypertension Defined: Adult hypertension is currently defined as present when systolic blood pressure is ≥ 140 mm Hg , or diastolic BP ≥ 90 mm Hg on multiple readings over several different days, or when a person is taking anti-hypertensive medication to control BP over time. Blood pressure normally varies over time. Accordingly, a high blood pressure reading does not always constitute hypertension in a individual; the time element is an important component of the diagnosis. This is why referral to care for formal assessment and management is recommended following detection of elevated BP during a screening event.

Hypertension Is a Potent Stroke Risk Factor: Hypertension is one of the most prevalent and powerful risk factors for stroke. The risk of dying from stroke rises rapidly as blood pressure increases above 115/75 mm Hg. Stroke mortality doubles for every 20 mm Hg rise in systolic BP or for every 10 mm Hg rise in diastolic BP. Very importantly, the risk of stroke falls exponentially as high blood pressure is controlled to guideline-recommended levels in persons with hypertension. For this reason, the SBEI focuses on hypertension as the priority risk factor while facilitating activities that will also favorably impact other stroke risk factors. Hypertension is both preventable and treatable using a combination of lifestyle changes and medication.

Hypertension Burden: The public health, health care, and economic burdens of hypertension are substantial. Hypertension is the most common cardiovascular disease and the most common primary care clinical diagnosis in the U.S. It is estimated that not fewer than 50 million U.S. adults have hypertension. The burden of hypertension rises with age; over 80 percent of U.S. adults with hypertension are ≥ 45 years of age. A person with normal blood pressure at 55 years of age has a 90 percent risk of developing hypertension over their remaining lifetime. Health care costs for patients with hypertension and complications due to high blood pressure are estimated at $109 billion for 1998 (over $120 billion in U.S. 2002 dollars). About $22 billion of the total estimate was spent for anti-hypertensive treatment alone (over $24 billion in U.S. 2002 dollars). The average amount spent annually per person with a hypertensive condition was about $3,787 and about $4,180 in U.S. 2002 dollars when hypertensive complications and co-morbid conditions are included. Carving out complications and hypertensive co-morbidities yielded an estimated total 2004 cost of $55.5 billion for hypertensive disease alone (at least $1,110 per person for hypertension alone).

Why Hypertension Prevention and Control and Key Goals: It is estimated that almost 50,000 strokes could be prevented and more than 28,000 U.S. lives saved each year if about 90 percent of persons with hypertension had their blood pressure controlled to guideline-recommended levels. Intensified hypertension control was very cost-effective in a recent cost-effectiveness analysis of patients with type 2 diabetes. Nationally, in spite of notable successes over the years, only about 59 percent of adults with hypertension were being treated and only about 34 percent of adults with hypertension had their blood pressure controlled to guideline-recommended levels in 1999–2000. Mean high blood pressure control rates for the year 2002 for commercial health plans, Medicare and Medicaid were 58.4 percent, 56.9 percent and 53.4 percent, respectively. These values represent significant improvements over year 2000 values and thus, serve as a basis for encouragement toward continued performance improvement. A recent analysis of data from the third National Health and Nutrition Examination Survey (NHANES III; 1988–1994) indicates that although there were some differences in health care access and utilization, about 92 percent of adults with uncontrolled hypertension reported having health insurance and 86 percent of them had a usual source of care. It was also found that U.S. adults with hypertension not controlled to guideline-recommended levels reported an average of over four visits per year to physicians. About 75 percent of U.S. adults in the NHANES III survey who were not aware that they had hypertension, had their blood pressure checked by a health professional at some time within the prior 12 months.

3. Healthy People 2010

The PHS is committed to achieving the health promotion and disease prevention objectives of Healthy People 2010, a PHS-led national activity announced in January 2000 to eliminate health disparities and improve years and quality of life. More information may be found on the Healthy People 2010 Web site: *http://www.healthypeople.gov*. Copies of the *Healthy People 2010: Volumes I and II* can be purchased by calling (202) 512–1800 (cost $70.00 for printed version; $20.00 for CD–ROM). Another reference is the *Healthy People 2000 Final Review 2001*. For one free copy of *Healthy People 2010*, contact: The National Center for Health Statistics (NCHS), Division of Data Services, 3311 Toledo Road, Hyattsville, MD 20782; or, telephone (301) 458–4636. Ask for DHHS Publication No. (PHS) 99–1256. This document may also be downloaded from the *http://www.healthypeople.gov*.

4. Resources

The following are Web sites from various Federal and non-Federal sources that may serve as resources as you develop your proposals related to stroke and/or high blood pressure prevention and control:

Agency for Healthcare Research & Quality

Put Prevention Into Practice, *http://www.ahrq.gov/clinic/ppipix.htm*.

Guide to Clinical Preventive Services, Chapters 19 & 21, *http://hstat.nlm.nih.gov/hq*.

Centers for Disease Control and Prevention

Guide to Community Preventive Services, *http://www.thecommunityguide.org*.

Promising Practices in Chronic Disease Prevention and Control, Chapter on Achieving a Heart-Healthy and Stroke-Free Nation, *http://www.cdc.gov/nccdphp/promising_practices/index.htm*.

Overweight and Obesity, *http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm*.

Centers for Excellence—Exemplary State Programs, *http://www.cdc.gov/nccdphp/exemplary/heart_disease.htm* and *http://www.cdc.gov/nccdphp/exemplary/diabetes.htm*.

State Heart Disease and Stroke Prevention Program *http://www.cdc.gov/cvh/stateprogram.htm*.

State-Based Nutrition and Physical Activity Program; Obesity; 5 A-Day; Active Community Environments; Kids Walk to School; Physical Activity, *http://www.cdc.gov/nccdphp/dnpa*.

Atlas of Stroke Mortality (county-level data), Cardiovascular Health Program, CDC, *http://www.cdc.gov/cvh*.

WISEWOMAN (Well Integrated Screening & Evaluation for Women Across the Nation): Screening and Lifestyle Interventions for Many Low-Income, Uninsured Women, *http://www.cdc.gov/wisewoman*.

Surgeon General's Report on Physical Activity, *http://www.cdc.gov/nccdphp/sgr/sgr.htm*.

National Health and Nutrition Examination Survey, *http://www.cdc.gov/nchs/nhanes.htm*.

Behavioral Risk Factor Surveillance System—State, city and county data, *http://apps.nccd.cdc.gov/brfss/index.asp*.

Centers for Medicare & Medicaid Services

Quality Initiatives (main page summary), *http://cms.hhs.gov/quality/*.

Quality Fact, Sheet *http://cms.hhs.gov/quality/QualityFactSheet.pdf*.

Hospital Quality Initiative (National Voluntary Hospital Reporting Initiative), *http://cms.hhs.gov/quality/hospital/*.

Medicaid Quality in Home and Community Based Services, *http://cms.hhs.gov/medicaid/waivers/quality.asp*.

Quality in Managed Care, *http://cms.hhs.gov/healthplans/quality/*.

Demonstration Projects and Evaluation Reports, *http://cms.hhs.gov/researchers/demos/*.

Medicare Physician Group Practice Demonstration, *http://cms.hhs.gov/researchers/demos/PGP.asp*.

CMS Research Activities: The Active Projects Report, 2003 Edition, Theme 7: Outcomes, Quality and Performance, *http://cms.hhs.gov/researchers/projects/apr/* (complete report), *http://cms.hhs.gov/researchers/projects/APR/2003/theme7.pdf*.

Quality Improvement Organizations (QIOs), *http://cms.hhs.gov/qio/*.

Statistics and Data, *http://cms.hhs.gov/researchers/*.

Health Resources and Services Administration

Find a Health Center; people looking for low cost health care, *http://bphc.hrsa.gov/*.

Area Health Education Centers; Health Education Training Centers, *http://bhpr.hrsa.gov/interdisciplinary/hetc.html*.

Indian Health Service

IHS National Diabetes Program; Diabetes topics; Nutrition topics; Pediatric Height and Weight Study; IHS Best Practice Model; Type 2 Diabetes in Youth; School Health-Physical Activity and Nutrition; Pathways; Cardiovascular Disease, *http://www.ihs.gov/MedicalPrograms/Medical_index.asp*.

National Institutes of Health

Evidence-Based Health Information for the Public, *http://medlineplus.gov*.

NIDA Nicotine Information Page, *http://www.drugabuse.gov/drugpages/nicotine.html*.

Evidence-Based Approaches for Implementation of 5 A Day for Better Health, *http://dccps.nci.nih.gov/5ad_6_eval.html*.

Obesity Education Initiative, *http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/index.htm*.

Hearts N' Parks, *http://www.nhlbi.nih.gov/health/prof/heart/obesity/hrt_n_pk/index.htm*.

Heart Healthy Recipes, *http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/recipes.htm*.

National High Blood Pressure Education Program, *http://www.nhlbi.nih.gov/hbp/index.html*.

National Cholesterol Education Program, *http://www.nhlbi.nih.gov/chd/index.htm*.

Information for Patients & General Public, *http://www.nhlbi.nih.gov/health/public/heart/index.htm*.

Enhanced Dissemination & Utilization Centers (EDUCs) in communities, *http://hin.nhlbi.nih.gov/educs/awardees.htm*.

The Heart Truth Campaign, *http://www.nhlbi.nih.gov/health/hearttruth/index.htm*.

Act in Time to Heart Attack Signs, *http://www.nhlbi.nih.gov/actintime/index.htm*.

Healthy People 2010 Cardiovascular Gateway, *http://hin.nhlbi.nih.gov/cvd_frameset.htm*.

Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report, *http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm*.

Body Mass Index Calculator, *http://www.nhlbisupport.com/bmi/bmicalc.htm*.

National Diabetes Education Program; Small Steps, Big Rewards—Prevent Type 2 Diabetes, *http://www.ndep.nih.gov*.

Diabetes Research and Training Centers Demonstration and Education Divisions; The Pima Indians—Pathfinders for Health; Diabetes Prevention Program Prevention Trial—Type 1 (DPT–1); Look Ahead (Action in Health for Diabetes), *http://www.niddk.nih.gov/patient/show/lookahead.htm*.

Stroke Awareness, *http://www.ninds.nih.gov/news_and_events/pressrelease_may_stroke_050801.htm*.

Weight Control Information Network, *http://www.niddk.nih.gov/health/nutrit/win.htm*.

Exercise: A Guide from the National Institute on Aging, *http://nia.nih.gov/exercisebook/*.

Office of the Secretary

HealthierUS, *http://www.healthierus.gov/, http://www.whitehouse.gov/infocus/fitness/*.

Healthy People 2010, *http://www.health.gov/healthypeople/document/html*.

Best Practices Initiative—Comprehensive Diabetes Control Program, *http://www.osophs.dhhs.gov/ophs/BestPractice/MI.htm*.

Nutrition Guidelines (Developed by HHS and United States Department of Agriculture), *http://www.health.gov/dietaryguidelines/*.

The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, *http://www.surgeongeneral.gov/topics/obesity*.

Girls and Obesity Initiative, *http://www.4woman.gov/owh/education.htm*.

Non-Federal Resources

Tri-state Stroke Network, *http://www.tristatestrokenetwork.org*.

State Heart Disease and Stroke Prevention Programs, *http://www.cdc.gov/cvh/stateprogram.htm*.

American Heart Association, *http://www.americanheart.org*.

American Heart Association's Guide for Community-Wide Cardiovascular

Health, *http://www.americanheart.org/presenter.jhtml?identifier=3008344.*

American Stroke Association, *http://www.strokeassociation.org.*

Comprehensive resource, for patients and families, *http://www.medlineplus.org.*

Health Disparities Collaborative, *http://www.healthdisparities.net/.*

National Stroke Association, *http://www.stroke.org.*

National training program using community mobilization model, *http://www.diabetestodayntc.org.*

University of Michigan's Mfit Community Nutrition Program, *http://www.mfitnutrition.com/supermarketprogram.asp.*

Web-based training program on how to provide tobacco cessation counseling, *http://oralhealth.dent.umich.edu/VODI/html/index.html.*

Writing in plain language, *http://www.plainlanguage.gov/handbook/index.htm.*

Evaluation and Logic Models

CDC Office on Smoking and Health, *http://www.cdc.gov/tobacco/evaluation_manual/app_b.html.*

CDC Division of Nutrition and Physical Activity, *http://www.cdc.gov/nccdphp/dnpa/physical/handbook/step2.htm#logic.*

Kellogg Foundation Logic Model Development Guide (under "Tools'', "Evaluation''), *http://www.wkkf.org/.*

Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action, *http://www.cdc.gov/nccdphp/promising_practices/pdfs/Heart.pdf.*

University of Wisconsin-Extension, *http://www1.uwex.edu/ces/lmcourse.*

Kansas University Community Tool Box, *http://ctb.ku.edu.*

5. Basis for Focus on the Seven Core Stroke Belt States

Using 1930–2001 age-adjusted stroke mortality rate data from the National Center for Health Statistics, South Carolina has ranked second or first in 8 of 8 decades (100 percent of the time), Georgia first or second in 6 of 8 decades (75 percent of the time), North Carolina seventh or higher in 8 of 8 decades (100 percent of the time), Alabama sixth or higher in 6 of 8 decades (75 percent of the time), Mississippi seventh or higher in 7 of 8 decades (97 percent of the time), Tennessee seventh or higher in 6 of 8 decades (75 percent of the time), and Arkansas ranks first as of the most recent 2001 analysis, demonstrating the most rapid increase of all states and the District of Columbia over the study period. Arkansas' stroke mortality rate ranking has moved dramatically from a rank of 36th in 1940 and 1950 to 15th in 1960, to 7th or 8th in 1970–1980, to 3rd in 1990, and to 1st in 2001.

Dated: April 15, 2004.

Nathan Stinson, Jr.,

Deputy Assistant Secretary for Minority Health.

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BILLING CODE 4150–29–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2004N–0166]

Agency Information Collection Activities; Proposed Collection; Comment Request; Infant Feeding Practices Study II

AGENCY: Food and Drug Administration, HHS

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on a voluntary consumer survey about infant feeding and diet of pregnant women and new mothers.

DATES: Submit written or electronic comments on the collection of information by June 21, 2004.

ADDRESSES: Submit electronic comments on the collection of information to: *http://www.fda.gov/dockets/ecomments.* Submit written comments on the collection of information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane., rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Peggy Robbins, Office of Management Programs (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1223.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of a collection of information, before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Infant Feeding Practices Study II

Under section 903(d)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 393(d)(2)), FDA is authorized to conduct research and educational and public information programs relating to foods and devices. Under this authority, FDA is planning to conduct a consumer study about infant feeding and the diet of pregnant women and new mothers. The study will provide detailed information about foods fed to infants, including breast milk and infant formula; factors that may contribute to infant feeding choices and to breastfeeding success, including intrapartum hospital experiences, mother's employment status, mother's self confidence, postpartum depression, infant sleeping arrangements; and other issues of interest to FDA, including infant food allergy, and experiences with breast pumps. The study will measure dietary intake of pregnant women and new mothers. It will also be used as one component of an evaluation of the Department of Health and Human