

organization (if any) the individual will represent, and any requirements for audiovisual equipment (e.g., overhead projector, LCD projector, chalkboard). Oral comments before the HSRB are limited to 5 minutes per individual or organization. Please note that this limit applies to the cumulative time used by all individuals appearing either as part of, or on behalf of an organization. While it is our intent to hear a full range of oral comments on the science and ethics issues under discussion, it is not our intent to permit organizations to expand these time limitations by having numerous individuals sign up separately to speak on their behalf. If additional time is available, there may be flexibility in time for public comments. Each speaker should bring 25 copies of his or her comments and presentation slides for distribution to the HSRB at the meeting.

b. *Written comments.* Although you may submit written comments at any time, for the HSRB to have the best opportunity to review and consider your comments as it deliberates on its report, you should submit your comments at least 5 business days prior to the beginning of the meeting. If you submit comments after this date, those comments will be provided to the Board members, but you should recognize that the Board members may not have adequate time to consider those comments prior to making a decision. Thus, if you plan to submit written comments, the Agency strongly encourages you to submit such comments no later than noon, Eastern Time, June 21, 2006. You should submit your comments using the instructions in Unit 1.C. of this notice. In addition, the Agency also requests that person(s) submitting comments directly to the docket also provide a copy of their comments to the DFO listed under **FOR FURTHER INFORMATION CONTACT**. There is no limit on the length of written comments for consideration by the HSRB.

#### E. Background

EPA will be presenting for HSRB review the results of a completed study involving intentional exposure of human subjects to the pesticide active ingredient, chloropicrin. In addition, EPA will be seeking the Board's advice on: Draft guidelines for conducting research on the efficacy of insect repellent products; insect repellent human studies protocols and pesticide agricultural handler human studies protocols. EPA will also be providing an informational presentation of its proposed workshop on Best Practices for EPA, National Exposure Research

Laboratory Observational Human Exposure Measurement Studies. Finally, the Board may be reviewing draft HSRB reports for subsequent Board approval.

Dated: June 1, 2006.

**George Gray,**

*Science Advisor.*

[FR Doc. E6-8725 Filed 6-5-06; 8:45 am]

**BILLING CODE 6560-50-P**

## FARM CREDIT ADMINISTRATION

### Sunshine Act; Farm Credit Administration Board; Regular Meeting

**AGENCY:** Farm Credit Administration.

**SUMMARY:** Notice is hereby given, pursuant to the Government in the Sunshine Act (5 U.S.C. 552b(e)(3)), of the regular meeting of the Farm Credit Administration Board (Board).

**DATE AND TIME:** The regular meeting of the Board will be held at the offices of the Farm Credit Administration in McLean, Virginia, on June 8, 2006, from 9 a.m. until such time as the Board concludes its business.

**FOR FURTHER INFORMATION CONTACT:**

Roland E. Smith, Secretary to the Farm Credit Administration Board, (703) 883-4009, TTY (703) 883-4056.

**ADDRESSES:** Farm Credit Administration, 1501 Farm Credit Drive, McLean, Virginia 22102-5090.

**SUPPLEMENTARY INFORMATION:** Parts of this meeting of the Board will be open to the public (limited space available), and parts will be closed to the public. In order to increase the accessibility to Board meetings, persons requiring assistance should make arrangements in advance. The matters to be considered at the meeting are:

#### Open Session

##### A. Approval of Minutes

- May 11, 2006 (Open and Closed).

##### B. New Business

- Texas Land Bank, FLCA-ACA Conversion.

##### C. Reports

- Loan Syndications Status Report.
- FCS Building Association Quarterly Report.

#### Closed Session\*

- Office of Secondary Market Oversight.

\* Session Closed—Exempt pursuant to 5 U.S.C. 552b(c)(8) and (9).

Dated: June 1, 2006.

**Roland E. Smith,**

*Secretary, Farm Credit Administration Board.*

[FR Doc. 06-5161 Filed 6-2-06; 9:04 am]

**BILLING CODE 6705-01-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Request for Applications for the National Faith-Based and National Community Cardiovascular Disease Prevention Programs for High-Risk Women

**AGENCY:** Office on Women's Health, Office of Public Health and Science, Office of the Secretary, DHHS.

*Announcement Type:* Competitive Cooperative Agreement FY 2006 Initial announcement.

*Funding Opportunity Number:* Not applicable.

*OMB Catalog of Federal Domestic Assistance:* The OMB Catalog of Federal Domestic Assistance number is pending.

**DATES:** Letter of Intent: June 21, 2006.

Application Deadline: July 6, 2006.

Anticipated Award Date: October 4, 2006.

**SUMMARY:** The Office on Women's Health (OWH) and the Office of Minority Health (OMH) within the Office of Public Health and Science, and the Office of Research on Women's Health (ORWH) within the National Institutes of Health (NIH), Department of Health and Human Services (DHHS), are interested in establishing national faith-based and/or national community cardiovascular disease (CVD) prevention programs.

The purpose of the programs is to reduce CVD mortality and morbidity among high-risk women in the United States through medical screening and risk behavior modification. The CVD prevention programs will be targeted towards high-risk racial and ethnic minority women, aged 40 years and older; however, all high-risk women shall be eligible to participate in the programs regardless of race, religion, or age.

Each grantee shall implement one program in 10 faith-based or community-based sites across the United States, including urban and rural areas. The main goal will be for program participants to increase their level of physical activity and establish or maintain a healthy weight over the course of the program. The educational phase of the program shall consist of eight bi-weekly sessions that shall counsel women on all of the major risk factors for CVD—smoking, Type 2

diabetes, hypertension, cholesterol, obesity, and physical inactivity—while primarily focusing on controlling weight and increasing physical activity. The maintenance phase of the project shall consist of regularly scheduled, interactive maintenance sessions that shall be designed by program participants. During both phases, participants will be screened for all six major CVD risk factors. All counseling and maintenance sessions shall include small group discussions and a physical activity component focused on reducing risk.

These awards focus on President Bush's agenda to broaden Federal efforts to work with faith-based and community organizations. As such, each applicant must either: (1) Be a national faith-based or national community organization that has a network of at least 10 sites across the United States with large populations of high-risk racial and ethnic minority women, aged 40 years and older, or (2) partner with a national faith-based or national community organization that has a network of at least 10 sites across the United States with large populations of high-risk racial and ethnic minority women, aged 40 years and older. Non-profit and for profit organizations that meet the above criteria are eligible to apply. Faith-based organizations, community-based organizations, tribal entities, educational institutions, community health centers, and government entities that meet the above criteria are also eligible and encouraged to apply.

## I. Funding Opportunity Description

### 1. Authority

This program is authorized by 42 U.S.C. 300u-2(a) and 42 U.S.C. 287d.

### 2. Purpose

This cooperative agreement shall fund national faith-based and/or national community cardiovascular disease (CVD) clinical prevention programs to reduce cardiovascular disease mortality and morbidity among high-risk women in the United States through counseling and risk behavior modification. The CVD prevention programs will be targeted towards high-risk racial and ethnic minority women, aged 40 years and older, however, all high-risk women shall be eligible to participate in the programs regardless of race, religion, or age. Each grantee shall implement one program in 10 faith-based or community-based sites across the United States, including urban and rural areas. The main goal will be for program participants to increase their level of

physical activity and establish or maintain a healthy weight over the course of the program.

### 3. Requirements

#### A. Sites and Populations

This cooperative agreement grant announcement focuses on President Bush's agenda to broaden Federal efforts to work with faith-based and community organizations. For more information on the Administration's Faith-Based Initiative, please see the following Web site: <http://www.whitehouse.gov/government/fbci/index.html>.

The grantee shall select 10 faith-based or community-based sites with large populations of high-risk racial and ethnic minority women where the program shall be implemented. The grantees' access to these population(s) through the faith-based or community-based sites should be demonstrated by a history of collaboration or direct programmatic delivery. All sites should be chosen from within the network of the National faith-based or National community organization. Examples of sites include community health centers, retirement centers, group counseling session centers, child care centers, fitness and/or recreation centers, community clinics, and places of worship. The 10 sites must not be located in only one section of the country; they must be geographically dispersed throughout the United States, including urban and rural areas. The grantee shall sign an MOU with each site that describes the expectations and duties of each party.

The grantee shall target high-risk women aged 40 years and older who are members of at least one racial and ethnic minority population; however, all high-risk women shall be eligible to participate in the program, regardless of race, religion, or age.

#### B. Phase I: Program Planning, Development, and Recruitment

##### i. Post-Award Orientation

The grantee shall send two or three representatives to a two-day post-award orientation meeting in Washington, DC. This meeting shall occur within 2 months of grant award. The project manager of the program and a representative who holds a leadership position in the national faith-based or national community organization must attend the meeting. Travel funds for this meeting must come out of the total award funding and should be included in the applicant's cost proposal.

The purpose of the post-award orientation meeting will be to clarify

tasks and requirements and answer any questions that grantees may have. Grantees shall also share their program plans, approaches, and best practices with each other through presentations and round table discussions.

##### ii. Curriculum Development

A multi-disciplinary planning committee shall be formed consisting of representatives from the national faith-based or national community organization, health care professionals and counselors, and high-risk women in the community. The grantee will consult with the planning committee to design eight educational sessions that shall counsel women on all of the major risk factors for CVD (smoking, Type 2 diabetes, hypertension, cholesterol, obesity, and physical inactivity), ways to modify risk, and the benefits associated with risk modification. The prevention of stress and the signs/symptoms of heart attack and stroke in women shall also be addressed. The format of the health sessions will be specified in subsequent sections of this funding opportunity description.

Existing curriculum from successfully tested and evaluated CVD clinical prevention intervention programs should be obtained and adapted for this program. The OWH and ORWH/NIH will not provide the grantee with curriculum. The curriculum and group counseling session materials must be both culturally competent and women-centered (see section VIII.2 for definitions).

##### iii. Site Leaders and Site Leader Training

One site leader from each of the 10 sites will be designated to promote, coordinate, and facilitate the clinical prevention program at his/her particular site. This person will be a faith-based or community leader or a health professional affiliated with the site. Each site shall be given a stipend for their involvement; this stipend shall include compensation for the site leader. The stipend will not exceed \$5,000 per site.

All site leaders shall be required to attend a one-day training course, developed and administered by the grantee. This course must take place in one location and site leaders must attend in person. The training course will introduce site leaders to the goals, structure, and subject matter of the program. The training session will also equip site leaders with the materials, strategies, and resources necessary to implement the program at their sites. Upon completion of training, each site leader will receive a training certificate.

After receiving training, site leaders will coordinate and host all group counseling sessions and maintenance sessions at their specific sites.

#### iv. Recruitment and Retention

Each site leader will be responsible for promoting the prevention program and clinical speakers and participants at her site. Each site shall aim to recruit an average of 20 to 50 participants. High-risk racial and ethnic minority women aged 40 years and older shall be targeted; however, all high-risk women shall be eligible to participate in the program, regardless of race, religion, or age. All participants must read and sign a written consent form before starting the program. The grantee shall prepare the draft consent form in lay-language and the multi-disciplinary planning committee must review and approve this form. The grantee shall also obtain appropriate institutional IRB approval, if applicable. The grantee will also create postcard reminders (or e-mail reminders if participants have easy access to the Internet) for each group counseling session and maintenance session. Each site leader will mail or e-mail the reminders to each participant. The site leader will also make reminder phone calls as necessary.

All counseling sessions and maintenance sessions shall be focused on mutual support for participants in their efforts to reduce the risk associated with increased weight and physical inactivity. Site leaders will obtain and distribute incentives for attendance (e.g., door prizes) and incentives to motivate participants to modify risk factors during the course of the program. Prizes will be offered to the participants who achieve their individualized risk modification goals for each session. Positive reinforcement and open communication as well as a healthy sense of competition must be encouraged. Incentives and prizes may be solicited as donations from private sources.

#### v. Resource Establishment

The grantee must assist site leaders in compiling a local directory of cardiovascular resources (cardiologists, dietitians, Type 2 diabetes experts, weight loss and exercise programs, public health screening and diagnosis information) available in the community of each site, including health care alternatives for the uninsured and under insured women. The grantee shall establish a national Web site or enhance an existing organization's Web site to provide cardiovascular support and information online. These Web sites shall be linked to the OWH's For Your

Heart Web site at <http://www.4women.gov/hhs> and the National Heart, Lung and Blood Institute's Heart Truth Campaign Web site <http://www.nhlbi.nih.gov/health/hearttruth/>.

The grantee shall publish a print and/or Web-based newsletter to promote the program, provide additional cardiovascular disease information, and highlight progress made by individual sites and participants. The newsletter will be distributed to all 10 sites on a monthly basis.

#### C. Phase II: Group Counseling Sessions

##### i. Overview

Each faith-based or community-based site will host eight bi-weekly group counseling sessions over a period of four months. The sessions can be physically located at the faith-based or community-based site or at any other appropriate clinical facility in the community. These sessions shall address the six major risk factors for CVD (smoking, Type 2 diabetes, hypertension, cholesterol, obesity, and physical inactivity), ways to modify risk, and the benefits associated with risk modification. The prevention of stress and the signs/symptoms of heart attack and stroke in women shall also be addressed during at least one of the eight group counseling sessions. Sessions may include medical screening, clinical lectures, health demonstrations, video presentations, activities, etc. Each session must also incorporate some form of low to moderate physical activity (such as walking, yoga, or aerobics). Participants shall be encouraged and organized to meet in groups at least once a week to engage in some form of physical activity.

Additionally, each session shall include a small group counseling discussion component that will focus on encouraging participants to incorporate weight control strategies and physical activity into their daily lives. Participants shall be divided into small counseling groups according to criteria chosen by the grantee. These criteria may be based on Prochaska's Stages of Change model (1), demographics, risk factor profiles, etc. During the group discussion component, participants should discuss self-monitoring efforts and establish risk modification goals. The grantee will consult and utilize qualified cardiologists, endocrinologists, nurses, dietitians, physical exercise and other health professionals in the development and implementation of the curriculum and small group discussions.

##### ii. Group Counseling Sessions—Session #1: Screening and Program Introduction

During the first group counseling session, screening for all six major CVD risk factors shall be conducted for each participant (weight measurements should be kept confidential) to establish baseline measurements. (**Note:** Fasting blood tests must be used to screen for cholesterol and Type 2 diabetes.) The grantee may solicit local health care organizations, drug stores, and/or other private sources to donate or loan screening equipment, giving proper acknowledgment for their assistance. Additionally, health professionals who volunteer to present at counseling sessions can be asked to bring equipment with them and help conduct the screenings. Alternatively, grantees may use grant funds to purchase screening equipment and supplies.

The importance of weight control and physical activity will be introduced and emphasized as the primary goal of the program. Daily weight and physical activity self-monitoring materials (diaries, logs, etc.) will be distributed and explained. The site leader should also discuss the reward system for reaching risk modification goals. Moreover, the first session should include a basic orientation on how to use the Internet. The orientation shall include instruction on how participants who do not own computers can access computers that are available for public use. The format of the orientation may include a hands-on demonstration, pictorial diagrams, and/or written instruction. This award shall not pay for computers.

During the first counseling session, each participant shall also be administered a test to determine baseline knowledge of CVD and its risk factors. Additionally, each participant shall assess her own personal CVD risk profile and Stage of Change (1) for the six major CVD risk factors. One tool that can be used to assess a woman's Stage of Change for each major CVD risk factor can be found on the DHHS/OWH's For Your Heart Web site at <http://www.4women.gov/hhs>. Information from this Web site can also be incorporated into the curriculum for subsequent sessions.

##### iii. Group Counseling Sessions #2–7: Risk Factors

After the first introductory group counseling session, the following six group counseling sessions will be devoted to counseling participants about one CVD risk factor, so that all six of the major risk factors' smoking, Type 2 diabetes, hypertension, cholesterol,

obesity, and physical inactivity are covered. In addition, key lessons learned at previous sessions will be reviewed at each of the following sessions to reinforce risk factor knowledge.

iv. Group Counseling Session #8: Screening and Wrap-up

During the eighth and final group counseling session, participants shall be screened again for all six major CVD risk factors and each participant shall assess her own personal CVD risk profile and Stage of Change. Each participant shall also be administered an intake form to determine knowledge of CVD and its risk factors. Additionally, participants shall be asked to provide feedback regarding their experience in the program and evaluate the program. Responses will be used to aid participants in designing the maintenance phase of the program. Participants will also decide on a plan of action for follow-up maintenance sessions.

D. Phase III—Maintenance Sessions

The maintenance sessions will take place over a period of three months directly following the group counseling sessions (Phase II). With the aid of the site leader, participants shall decide on the number, frequency, and format of the maintenance sessions. These sessions may include any or all of the following: Additional group counseling seminars, screenings, testimonials, personal counseling, field trips (e.g., trips to fitness centers or trips to grocery stores and restaurants to practice selecting healthy foods), etc. However, each session must include a physical activity and a small group discussion component. In addition, participants shall be encouraged and organized to meet in smaller groups at least once a week to engage in some form of physical activity.

At each site, the format of each maintenance session should be clearly outlined and documented by the site leader (what type of activity, duration of activity, material covered, location etc.). During the last maintenance session, participants will be screened again for all six major CVD risk factors and each

participant shall assess her own personal CVD risk profile and Stage of Change. Each participant shall also be administered a test to determine knowledge of CVD and its risk factors. Additionally, participants shall be asked to give feedback and evaluate the program.

E. Phase IV—Program Evaluation/Write-up

Screening, knowledge, Stage of Change (1), and personal health risk profile data shall be obtained from three assessment points the first (baseline) and last group counseling session and the last maintenance session. (**Note:** Fasting blood tests must be used to screen for cholesterol and Type 2 diabetes during these three assessment points.) Data shall also be obtained from self-monitoring materials and from feedback and evaluation forms. Grantees may choose to use any appropriate assessment tools, survey instruments, self-monitoring and evaluation materials to collect data. All data collection materials must be reviewed and approved by the multi-disciplinary planning committee. In addition, grantees shall be required to include a core set of screening and evaluation items that will be prescribed by the OWH. These items will be determined during and after the post-award orientation meeting and will most likely consist of items developed by one or more of the grantees.

The grantee shall design one centralized database, collect all participant data from the site leaders, and enter data into the database. This data shall be kept confidential through use of unique identifying numbers. Baseline and follow-up data must be analyzed to quantitatively evaluate the program's effectiveness at two different intervals—after the end of the group counseling sessions and after the end of the maintenance sessions. The program evaluation must be able to demonstrate, at minimum, the following desired program outcomes:

*Primary Outcome Measures:*

1. Increase the proportion of participants who are aware that heart disease is the #1 killer of women.
2. Increase the proportion of participants who are aware of the early

warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.

3. Increase the proportion of participants who know the major risk factors for CVD and how to modify those risk factors.

4. Increase the participant's knowledge of CVD resources in the community.

5. Decrease the proportion of participants who are obese.

6. Decrease the proportion of participants who are overweight.

7. Increase the proportion of participants who engage regularly in moderate physical activity (outside of program sessions).

8. For each CVD clinical risk factor, move 50% of participants up at least one Stage of Change (1).

*Secondary Outcome Measures:*

1. Decrease the proportion of participants who smoke.

2. Increase the proportion of participants with Type 2 diabetes at baseline whose Type 2 diabetes is under control.

3. Increase the proportion of participants with high blood pressure at baseline whose blood pressure is under control.

4. Decrease the proportion of participants with high total blood cholesterol.

The evaluation should also address the following questions:

1. Did participants evaluate the program favorably?
2. Did the program meet the needs and expectations of the participants?
3. What changes do the participants suggest?

Emphasis should be placed on aligning program outcomes and targets with the objectives and targets of Healthy People 2010. More information on the Healthy People 2010 objectives may be found at <http://www.health.gov/healthypeople>. Each grantee should also take into account the baseline characteristics of the potential program participants when setting outcome targets.

The Time Chart below summaries each phase of the CVD program.

Phases	Activity	Description	Duration (months)
	CVD Program .....	National Faith-Based and National-Community Cardiovascular Disease Prevention Programs for High-Risk Women (CVD).	18

Phases	Activity	Description	Duration (months)
Phase I .....	Program Planning & Recruitment.	Orientation Session, Program Development, Formation of a Multi-disciplinary Planning Committee. Selection of Site Leaders, Site Leader Training, Recruitment and Retention. Resource Establishment, Develop DataBase.	1-8
Phase II .....	Group Counseling Sessions.	Host eight group counseling sessions: Group Counseling Session No. 1—Screening and Program Introduction. CVD Pre-knowledge test administered to all program participants. Group Counseling Session Nos. 2-7—CVD Risk Factors discussion. Group Counseling Session No. 8—Participants screened again for all six CVD risk factors. Participants will assess their own personal CVD risk profile and Stage of Change, Post CVD knowledge test administered to all participants. Participants prepare an evaluation of the program.	9-12
Phase III .....	Maintenance Sessions.	Site leaders will assist participants to design a format for maintenance sessions .....  Screening of all participants for all six CVD risk factors ..... Assessment of risk profile and Stage of Change. CVD post knowledge test administered. Program Evaluation completed.	13-15  (six sessions.)
Phase IV .....	Program Evaluation and Write-Up.	Data entered into centralized database. .... Data analyzed to evaluate the program's effectiveness. Incorporate mutually agreed upon edits from the DHHS/OWH into final copy. Submit second financial status report as an appendix to the final report Participate in a committee with other grantees and DHHS/OWH staff to prepare a joint manuscript. Prepare a draft of the final report.	16-18

OWH shall site visit at least 4 sites per grantee during Phases II and/or Phase III. The grantee shall participate in monthly conference calls with the OWH and other grantees. The grantee shall also host a separate monthly conference call with all site leaders and make additional contact with individual sites as necessary via e-mail and phone calls. The grantee shall prepare a progress report that outlines the status and progression of the project every 3 months (there will be a total of 5 progress reports). The grantee shall prepare a final report that describes the results from the program evaluation and all project activities for the entire 18-month period of the program. OWH shall provide an outline of the final report format and templates for required tables. A draft of the final report must be submitted electronically and in hard copy format six weeks prior to the end date of the award. OWH will review the draft. Suggested revisions will be discussed individually during a conference call with each grantee. The mutually agreed upon revisions must be incorporated into the final report by the end date of the award.

Finally, the grantee shall assign one authorized staff member to participate in a committee with other grantees and OWH to prepare a joint manuscript suitable for publication in a peer-reviewed journal. This manuscript shall combine and summarize data from all programs into one final evaluation.

**II. Award Information**

Under this announcement, OWH and ORWH/NIH anticipate making, through the cooperative agreement grant mechanism, one or two new 18-month awards by October 4, 2006. Approximately \$500,000 in FY 2006 funds is available to make awards up to \$100,000 total cost (direct and indirect) for an 18-month period. The actual number of awards made will depend upon the quality of the applications received and amount of funds available for the program. The government is not obligated to make any awards as a result of this announcement.

Under this cooperative agreement, the duties of the grantee and the Federal Government are described below. The OWH will provide the technical assistance and oversight necessary for the implementation, conduct, and assessment of program activities. This program will be a model; as such, the Federal Government may replicate the clinical prevention program and/or use the intervention materials both during and after the period of performance. The grantee may copyright any work that is developed, or for which ownership was purchased, under the award, but DHHS reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so. In addition, the grantee and the national faith-based or community partner are encouraged to sustain the program after the end of

award and expand it to other sites within its network.

The grantee shall complete the requirements described in the Funding Opportunity Description. Specifically, the grantee will:

- Submit a work plan, task outline, and schedule of activities within one month of award.
- Attend a two-day post-award orientation meeting in Washington, DC within two months of grant award. (Travel funds for this meeting must come out of the total award funding and should be included in the applicant's budget justification.)
- Participate in monthly conference calls with the OWH and other grantees.
- Host a monthly conference call with all site leaders and make additional contact with individual sites as necessary via e-mail and phone calls.
- Prepare and submit progress reports that outline the status and progression of the program every 3 months.
- Form a multi-disciplinary planning committee consisting of representatives from the national faith-based and/or national community organization, health care professionals and counselors, and high-risk women in the community.
- Select 10 faith-based or community-based sites in both urban and rural areas throughout the United States that are willing to participate in the program, and sign an MOU with each site.
- Select site leaders at each site.
- Establish and promote a national Web site or enhance an existing

organization's Web site to provide cardiovascular support and information online.

- Consult with the planning committee to develop eight group counseling sessions that address all of the major risk factors for coronary heart disease and stroke. Curriculum should be adapted from existing models of CVD prevention intervention curriculum that have been successfully tested and evaluated.

- Prepare or obtain group counseling session materials for the eight group counseling sessions (e.g., instructional manual, educational sessions and/or exercise videos, booklets, etc.).

- Develop small group discussion format for each session focusing on encouraging participants to incorporate weight control strategies and physical activity into their daily lives.

- Develop instructional manual for the physical activity component of each educational session and maintenance session.

- Develop self-monitoring risk modification materials (logs, diaries, etc.) that are user-friendly and allow participants to track regular physical activity and weight control behaviors.

- Develop pre- and post-evaluation materials and survey instruments (e.g., knowledge tests, screening data collection forms, risk factor profile assessment tools, and qualitative feedback forms).

- Prepare a draft consent form in lay-language, obtain appropriate institutional IRB approval, if applicable, and obtain consent from all program participants.

- Develop program promotional materials (e.g., flyers, pamphlets, etc.).

- Develop postcard or e-mail reminders for each counseling session and maintenance session.

- Design one-day site leader training course.

- Develop materials for one-day site leader training course (training manual, certificates, etc.).

- Transport site leaders to the training session and execute training session.

- Reproduce all group counseling sessions, self-monitoring, and evaluation materials and deliver copies to each site leader.

- Reproduce reminder postcards/e-mails, consent document and promotional materials and deliver to each site leader.

- Design a print and/or web-based newsletter.

- Distribute newsletter to each site on a monthly basis.

- Assist site leaders in compiling a local directory of cardiovascular

resources available in the community for each site.

- Assist site leaders in scheduling counseling sessions at each site.

- Assist site leaders in obtaining medical screening equipment, obtain clinical personnel, and participation incentives.

- Assist site leaders in coordinating medical screenings and administering evaluation materials.

- Assist site leaders in obtaining clinical speakers for the sessions (e.g., nurses, physicians and other health care professionals) and conducting Web site training.

- Assist site leaders with resources necessary to support the format of the maintenance sessions chosen by the participants.

- Collect all participant data using standard data collection forms.

- Enter all data obtained from each site into centralized database using unique identifiers for each participant.

- Analyze data using appropriate statistical software and submit a draft of the FINAL REPORT six weeks prior to the end date of the grant award.

- Incorporate mutually agreed upon edits from the OWH into FINAL REPORT by the end date of the award.

- Assign one staff member to participate in a committee with other grantees and OWH and prepare a joint manuscript suitable for publication in a peer-reviewed journal.

- Adhere to all program requirements specified in this announcement and the Notice of Grant Award.

- Submit two Financial Status Reports. Financial Status Report number one is to be submitted to the Project Officer on the first anniversary date of the grant award. Financial Status Report number two is to be submitted to the Project Officer as an appendix to the final grant report.

- Adhere to the guidelines under the American with Disabilities Act when planning and implementing seminars. Specifics will be discussed during the one-day course.

The Federal Government will:

- Review and approve work plan, task outline, and schedule of activities.

- Review quarterly progress reports.

- Conduct the monthly conference calls with grantees.

- Conduct the two-day post-award orientation meeting in Washington, DC within two months of award.

- Review and approve list of 10 faith-based and/or community sites and the MOUs with each site.

- Site visit at least 4 sites per program during Phases II and/or Phase III.

- Review, suggest names, and approve membership of the multi-disciplinary planning committee.

- Review and approve all group counseling sessions and instructional materials for the eight group counseling sessions.

- Provide the grantee with government group counseling sessions' materials on CVD, such as *The Heart Truth for Women: A Speaker's Kit*, *The Healthy Heart Handbook for Women* (22), etc.

- Provide all site leaders with guidelines for the Americans with Disabilities Act and ensure that those guidelines are followed during the planning and implementation of the CVD program.

- Review and approve materials for the one-day leader training course; and,

- Review self-monitoring materials, evaluation materials and survey instruments that must be used by each grantee (core set of screening and evaluation items).

- Review and approve informed consent document and program promotional materials to ensure adherence to DHHS policies.

- Review the design and content of program Web site(s).

- Review and provide information for newsletters.

- Provide an outline of the final report format and templates for required tables.

- Review draft of the final report and provide comments and edits to be incorporated into the final document.

- Participate in a committee with grantees to prepare a joint manuscript suitable for a peer-reviewed journal and secure appropriate government publication clearance.

### III. Eligibility Information

#### 1. Eligible Applicants

These awards focus on President Bush's agenda to broaden Federal efforts to work with faith-based and community organizations. As such, each applicant must either: (1) Be a national faith-based or national community organization that has a network of at least 10 sites across the Continental United States and its territories with large populations of high-risk racial and ethnic minority women, aged 40 years and older, or (2) partner with a national faith-based or national community organization that has a network of at least 10 sites across the United States with large populations of high-risk racial and ethnic minority women, aged 40 years and older. If a partnership is established, the applicant and the national faith-based or national community organization must sign a Memorandum of Understanding (MOU) that describes the partnership, including

the expectations and duties of each partner. This MOU must be included in the application. If the document is not provided, the application may not be considered. Please see section VIII.2 for a definition of partnership, national faith-based organization, and national community organization. For more information on the Administration's Faith-Based and Community Initiatives please see the following Web site: <http://www.whitehouse.gov/government/fbci/index.html>.

Non-profit and for-profit organizations that meet the above criteria are eligible to apply. Faith-based organizations, community-based organizations, tribal entities, educational institutions, community health centers, and government entities that meet the above criteria are also eligible and encouraged to apply.

Any organization currently receiving funding or support from the Centers for Disease Control and Prevention's (CDC) WISEWOMAN program is not eligible to apply to this grant announcement. These organizations have been deemed ineligible to prevent the overlapping of the OWH and the CDC's cardiovascular disease prevention programs and the possible contamination of current WISEWOMAN program results.

If funding is requested in an amount greater than the ceiling of the award range (\$100,000 total cost for an 18-month period), 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 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 program announced in this notice of funding availability. Organizations submitting more than one proposal will be deemed ineligible. The proposal will be returned without comment.

## 2. Cost Sharing or Matching Funds

Cost sharing and matching funds are not a requirement of this grant; however applicants may solicit private sources for donations and/or loans of screening equipment, screening personnel, and participation incentives.

## IV. Application and Submission Information

### 1. Address To Request Application Package

Application kits may be requested by calling (240) 453-8822 or writing to: OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Requests may also be submitted by fax at (240) 453-8823. Application kits are also available online through the OPHS electronic grants management Web site at <https://egrants.osophs.dhhs.gov> and Grants.gov at <http://www.grants.gov>.

### 2. Content and Form of Application Submission

#### A. Letter of Intent

A Letter of Intent (LOI) is encouraged from all potential applicants for the purpose of planning the competitive review process. The LOI should be no more than one page, double-spaced, printed on one side, with one-inch margins, and 12-point font. LOIs should include the following information: (1) Program announcement title and number; (2) 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 (3) name and address of the partnering national faith-based or national community organization if the applicant is not a national faith-based or national community organization. Do not include a description of your proposed project.

#### B. Application

Applications must be submitted using the Form OPHS-1 (Revised 8/04) and in the manner prescribed in the application kit. Applicants are required to submit an original ink-signed and dated application and 2 photocopies. The application should be organized in accordance with the format presented in the Program Guidelines. The original and each copy must be stapled and/or otherwise securely bound. All pages must be numbered clearly and sequentially. The application must be typed on plain 8½" × 11" white paper, using a 12 point font, and contain 1" margins all around. The Project Narrative, excluding the appendices, is limited to a total of 50 pages, the fronts and backs of 10 pieces of paper. The first 50 pages of the proposal will be considered; any pages exceeding this length will be removed from the proposal and will not be evaluated. Staff resumes, letters of support, memorandums of understanding (MOUs), budget justifications, samples

of existing curriculum, samples of survey instruments and data collection forms, and research results and references may be included as part of an appendix and will not count toward the 50 pages limit. The application must also include a detailed budget justification, including a narrative and computation of expenditures for one year. The budget justification does not count toward the 50 pages limit.

An outline for the minimum information to be included in the "Project Narrative" section is presented below.

#### i. Program Plan

The applicant must describe, in detail, its approach for accomplishing each of the requirements identified in the funding opportunity description. The program plan must reference each requirement, and the material should be presented in the order in which it appears in the funding opportunity description. The applicant should demonstrate a full understanding of the need for the program, anticipating, prioritizing, and presenting likely components that will achieve overall goals and desired outcomes. The applicant should also identify potential problems and intended solutions. The applicant is free to recommend and describe other procedures that it believes will more effectively achieve the stated objectives, but needs to carefully relate alternatives and rationales to the approach recommended in the funding opportunity description.

The proposal should include curriculum outlines and sample agendas for one or more of the group counseling sessions described in the funding opportunity description. The applicant must provide a detailed description of the existing curriculum that will be adapted and used for the group counseling sessions. In addition, samples of the existing curriculum and results from any pilot or demonstration projects that used the curriculum should be provided. These samples and results may be included as part of the appendices.

The proposal should describe the criteria for selecting sites and provide a potential list of sites or locations of sites. The proposal should describe its plan for maintaining contact with each site on a regular basis. The proposal should also include letters of support from each site selected, if possible. Letters of support may be included as part of the appendices.

### C. Experience and Commitment of Key Personnel

The applicant must identify key personnel involved in the project based on the requirements described in funding opportunity description and other personnel adequate to support the administrative, logistical, financial, and scientific coordination aspects of the project within the time limits of the grant. The applicant must provide information on which task(s) each of the key personnel will perform and the rationale for that assignment. Resumes for all proposed personnel must be submitted with the application in the appendices.

### D. Management Plan

The applicant should develop and propose a Management Plan. This plan includes a program schedule that lays out tasks and a time-line and identifies significant milestones for the accomplishment of the project. Specific staff responsibilities must be detailed in this schedule along with the number of hours that each person will devote to each task. The plan must provide, at a minimum, details pertaining to the four program phases (Phase I: Program Planning, Development, and Recruitment; Phase II: Group Counseling Sessions; Phase III: Maintenance Sessions; Phase IV: Program Evaluation/Write-Up) as they are outlined in the funding opportunity description.

### E. Past Performance

Each applicant should describe its organization's relevant experience and success in managing this type of project. The applicant should also include a description of itself, the experience of its support personnel, and information about grantees, partners, and quality of cooperation between organization, staff, key personnel, and clients. Specific descriptions of relevant previous experience that the organization has performed within the past five years must be included. Include period of performance, dollar amount, name of program sponsor, and a letter of support from at least three different program sponsors. Letters of support may be included as part of the appendices.

Relevant previous experience may include, but is not limited to, the development of: Comprehensive interventions or group counseling sessions programs aimed at improving the health of women and/or men, health behavior modification programs, programs delivered in faith-based or community settings, cardiovascular disease prevention and risk

modification programs, and previous collaborations with a national faith-based or national community organization.

### F. Appendices

Include documentation and other supporting information in this section, including staff resumes, letters of support, memorandums of understanding (MOUs), samples of existing curriculum, samples of survey instruments and data collection forms, and research results and references. If the applicant is not a national faith-based or national community organization, an MOU between the applicant and a national faith-based or national community organization confirming that a partnership has been established must be included in the appendices. The applicant should also include an MOU between the applicant and any other organization or entity with which it intends to collaborate/partner.

#### 3. Submission Dates and Times

The LOI must be received by the OPHS Office of Grants Management by 5 p.m. Eastern Time on the deadline date specified in the **DATES** section of the announcement. If an applicant does not submit an LOI by the established due date and time, the application will not be eligible for the review process. Submit the LOI to: OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852.

#### Submission Mechanisms

The OPHS provides multiple mechanisms for the submission of applications, as described in the following sections. Applicants will receive notification via mail from the OPHS Office of Grants Management confirming the receipt of applications submitted using any of these mechanisms. Applications submitted to the OPHS Office of Grants Management after the deadlines described below will not be accepted for review. Applications which do not conform to the requirements of the grant announcement will not be accepted for review and will be returned to the applicant.

Applications may only be submitted electronically via the electronic submission mechanisms specified below. Any applications submitted via any other means of electronic communication, including facsimile or electronic mail, will not be accepted for review. While applications are accepted in hard copy, the use of the electronic application submission capabilities provided by the OPHS eGrants system

or the Grants.gov Web site Portal is encouraged.

Electronic grant application submissions must be submitted no later than 5 p.m. Eastern Time on the deadline date specified in the **DATES** section of the announcement using one of the electronic submission mechanisms specified below. All required hardcopy original signatures and mail-in items must be received by the OPHS Office of Grants Management no later than 5 p.m. Eastern Time on the next business day after the deadline date specified in the **DATES** section of the announcement.

Applications will not be considered valid until all electronic application components, hard copy original signatures, and mail-in items are received by the OPHS Office of Grants Management according to the deadlines specified above. Application submissions that do not adhere to the due date requirements will be considered late and will be deemed ineligible.

Applicants are encouraged to initiate electronic applications early in the application development process, and to submit early on the due date or before. This will aid in addressing any problems with submissions prior to the application deadline.

#### Electronic Submissions via the Grants.gov Web Site Portal

The Grants.gov Web site Portal provides organizations with the ability to submit applications for OPHS grant opportunities. Organizations must successfully complete the necessary registration processes in order to submit an application. Information about this system is available on the Grants.gov Web site, <http://www.grants.gov>.

In addition to electronically submitted materials, applicants may be required to submit hard copy signatures for certain program related forms, or original materials as required by the announcement. It is imperative that the applicant review both the grant announcement, as well as the application guidance provided within the Grants.gov application package, to determine such requirements. Any required hard copy materials, or documents that require a signature, must be submitted separately via mail to the OPHS Office of Grants Management, and, if required, must contain the original signature of an individual authorized to act for the applicant agency and the obligations imposed by the terms and conditions of the grant award.

Electronic applications submitted via the Grants.gov Web site Portal must



contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative and any appendices or exhibits. All required mail-in items must be received by the due date requirements specified above. Mail-In items may only include publications, resumes, or organizational documentation.

Upon completion of a successful electronic application submission via the Grants.gov Web site Portal, the applicant will be provided with a confirmation page from Grants.gov indicating the date and time (Eastern Time) of the electronic application submission, as well as the Grants.gov Receipt Number. It is critical that the applicant print and retain this confirmation for their records, as well as a copy of the entire application package.

All applications submitted via the Grants.gov Web site Portal will be validated by Grants.gov. Any applications deemed "Invalid" by the Grants.gov Web site Portal will not be transferred to the OPHS eGrants system, and OPHS has no responsibility for any application that is not validated and transferred to OPHS from the Grants.gov Web site Portal. Grants.gov will notify the applicant regarding the application validation status. Once the application is successfully validated by the Grants.gov Web site Portal, applicants should immediately mail all required hard copy materials to the OPHS Office of Grants Management to be received by the deadlines specified above. It is critical that the applicant clearly identify the organization name and Grants.gov Application Receipt Number on all hard copy materials.

Once the application is validated by Grants.gov, it will be electronically transferred to the OPHS eGrants system for processing. Upon receipt of both the electronic application from the Grants.gov Web site Portal, and the required hardcopy mail-in items, applicants will receive notification via mail from the OPHS Office of Grants Management confirming the receipt of the application submitted using the Grants.gov Web site Portal.

Applicants should contact Grants.gov regarding any questions or concerns regarding the electronic application process conducted through the Grants.gov Web site Portal.

#### Electronic Submissions via the OPHS eGrants System

The OPHS electronic grants management system, eGrants, provides for applications to be submitted electronically. Information about this system is available on the OPHS eGrants Web site, <https://>

[grants.osophs.dhhs.gov](https://grants.osophs.dhhs.gov), or may be requested from the OPHS Office of Grants Management at (240) 453-8822.

When submitting applications via the OPHS eGrants system, applicants are required to submit a hard copy of the application face page (Standard Form 424) with the original signature of an individual authorized to act for the applicant agency and assume the obligations imposed by the terms and conditions of the grant award. If required, applicants will also need to submit a hard copy of the Standard Form LLL and/or certain Program related forms (e.g., Program Certifications) with the original signature of an individual authorized to act for the applicant agency.

Electronic applications submitted via the OPHS eGrants system must contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative and any appendices or exhibits. The applicant may identify specific mail-in items to be sent to the Office of Grants Management separate from the electronic submission; however these mail-in items must be entered on the eGrants Application Checklist at the time of electronic submission, and must be received by the due date requirements specified above. Mail-In items may only include publications, resumes, or organizational documentation.

Upon completion of a successful electronic application submission, the OPHS eGrants system will provide the applicant with a confirmation page indicating the date and time (Eastern Time) of the electronic application submission. This confirmation page will also provide a listing of all items that constitute the final application submission including all electronic application components, required hardcopy original signatures, and mail-in items, as well as the mailing address of the OPHS Office of Grants Management where all required hard copy materials must be submitted.

As items are received by the OPHS Office of Grants Management, the electronic application status will be updated to reflect the receipt of mail-in items. It is recommended that the applicant monitor the status of their application in the OPHS eGrants system to ensure that all signatures and mail-in items are received.

#### Mailed or Hand-Delivered Hard Copy Applications

Applicants who submit applications in hard copy (via mail or hand-delivered) are required to submit an original and two copies of the application. The original application

must be signed by an individual authorized to act for the applicant agency or organization and to assume for the organization the obligations imposed by the terms and conditions of the grant award.

Mailed or hand-delivered applications will be considered as meeting the deadline if they are received by the OPHS Office of Grant Management on or before 5 p.m. Eastern Time on the deadline date specified in the **DATES** section of the announcement. The application deadline date requirement specified in this announcement supersedes the instructions in the OPHS-1. Applications that do not meet the deadline will be returned to the applicant unread.

#### 4. Intergovernmental Review

This program is subject to the Public Health Systems Reporting Requirements. Under these requirements, community-based and faith-based, non-governmental applicants must prepare and submit a Public Health System Impact Statement (PHSIS). Applicants shall submit a copy of the application face page (SF-424) and a one-page summary of the project, called the Public Health System Impact Statement. 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 or faith-based, non-governmental organizations within their jurisdictions.

Community-based and faith-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), (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 OWH.

This program is also subject to the requirements of Executive Order 12372 that 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 to be made available under this notice will contain a listing of States that 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 in each affected State. A complete list of SPOCs may be found at the following Web site: <http://www.whitehouse.gov/omb/grants/spoc.html>. The due date for State process recommendations is 60 days after the application deadline. The OWH 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.)

#### 5. Funding Restrictions

Grant funds may be used to cover costs of:

- Personnel.
- Consultants.
- Office supplies and software.
- Group counseling sessions,

promotional and evaluation materials.

- Screening supplies and equipment.
- Grant related travel (domestic only).
- Other grant related costs.

Grant funds may not be used for:

- Building alterations or renovations.
- Computers.
- Construction.
- Food.
- Fund raising activities.
- Medical treatment or therapy.
- Political education and lobbying.
- Other activities that are not grant related.

Guidance for completing the budget can be found in the Program Guidelines, which are included with the complete application kits. The allowability, allocability, reasonableness and necessity of direct and indirect costs that may be charged to OPHS grants are outlined in the following documents: OMB Circular A-21 (Institutions of Higher Counseling); OMB Circular A-87 (State and Local Governments); OMB Circular A-122 (Nonprofit Organizations); and 45 CFR part 74, Appendix E (Hospitals). Copies of the Office of Management and Budget (OMB) Circulars are available on the Internet at [http://www.whitehouse.gov/omb/grants/grants\\_circulars.html](http://www.whitehouse.gov/omb/grants/grants_circulars.html). In order to claim indirect costs as part of a budget request, an applicant organization must have an indirect cost rate, which has been negotiated with the Federal government. The Health and

Human Services Division of Cost Allocation (DCA) Regional Office that is applicable to your State can provide information on how to receive such a rate. A list of DCA Regional Offices is included in the application kit for this announcement. Guidance for completing the budget can be found in the Program Guidelines, which are included with the complete application kits.

#### 6. Other Submission Requirements

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 OWH 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: <https://www.dnb.com/product/eupdate/requestOptions.html>.

Be sure to click on the link that reads, "DUNS Number Only" at the right 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.

#### V. Application Review Information

##### 1. Criteria

The technical review of applications will consider the following 5 factors:

##### A. Factor 1: Program Plan (40 Points)

This factor will be evaluated by rating the applicant's approach to accomplishing each of the requirements identified in the funding opportunity description as demonstrated by the following:

- Demonstrated understanding of the scope, goals, and objectives of the work required and the applicability and clarity of the overall approach.
- Discussions detailing how each of the requirements will be performed and the appropriateness of all proposed methodologies and analyses.
- Identification of potential problems and intended solutions.
- Discussions detailing the criteria used for selecting sites, list of selected sites or locations of sites, and letters of support from each site, if possible.
- Discussions of curriculum, including samples of the existing

curriculum that will adapted for the program and preliminary outlines and sample agendas for one or more of the group counseling sessions described in the funding opportunity description.

- Potential for the success of the proposed program plan to improve the cardiovascular health status of the targeted population.

##### B. Factor 2: Management Plan (30 Points)

The applicant's staffing, scheduling, and logistics plans will be evaluated for their effectiveness in committing personnel and resources to provide high-quality service and products within the time frames set-forth. This evaluation is based on the following:

- Realism of the proposed time line and the personnel and resources assigned to complete each requirement.
- Appropriateness of the proposed number of hours estimated for each requirement and each staff member.
- Adequacy of organizational structure.
- Adequacy of proposed plan to identify and solve potential problems.
- Adequacy of proposed plan to monitor and report on program progress and ensure effective communication between program staff members and the OWH.

##### C. Factor 3: Experience and Commitment of Key Personnel (20 Points)

This factor covers the qualifications of key personnel proposed to perform the work assigned to them and the amount of effort estimated for each person. This evaluation is based on the following:

- Experience, counseling, and professional credentials of proposed key personnel on similar projects and in related fields (similar projects must convey similarity in topic, dollar value, workload, duration, and complexity).
- Appropriateness of each person's skills and experience for performing the requirements in the funding opportunity description.

##### D. Factor 4: Past Performance (10 Points)

This factor will evaluate the applicant's experiences and success in implementing and managing similar projects in number, size, complexity. The applicant should describe its experiences and successes that will reflect the following:

- Relevant previous experience may include, but is not limited to, the development and implementation of a comprehensive campaign or group counseling program aimed at improving the health of women and/or men, or

health behavior modification program, a cardiovascular disease prevention and risk modification program delivered in a national faith-based or national community organization.

- Training received by its staff members on how to implement a cardiovascular program for minority women with high-risk for heart disease.
- Applicant's adherence to schedules and budgets, effectiveness of program management, willingness to cooperate when difficulties arise, general compliance with the terms of the grants, and acceptability of delivered products.

## 2. Review and Selection Process

Applications will be screened upon receipt. Those that are judged to be incomplete or arrive after the deadline will be returned without review or comment. If funding is requested in an amount greater than the ceiling of the award range (\$100,000 for an 18-month budget period), 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.

The OPHS Office of Grants Management will notify applicants that are judged to be in compliance. Accepted applications will be evaluated based on the criteria listed in Section V.1 and reviewed for technical merit in accordance with DHHS policies. Applicants are advised to pay close attention to the specific program requirements and general instructions in the application kit and to the definitions provided in this notice.

Applications will be evaluated by a technical review panel composed of experts in the fields of program management, cardiovascular disease, minority community outreach and health counseling, and community-based research. Consideration for award will be given to applicants that best demonstrate the potential to design a program that achieves the program goals stated in this announcement.

The Federal government may conduct pre-award site visits of applicants with scores in the funding range prior to final selection. References may also be requested from these applicants and contacted to better evaluate prior relevant experience. Any applicant who believes the Government will find derogatory information as a result of checking the past performance record may provide an explanation and any remedial action taken by its company to address the problem. Funding decisions will be made by the OWH, and will take into consideration the recommendations and ratings of the review panel, pre-

award site visits and references, program needs, geographic location, and stated preferences.

## VI. Award Administration Information

1. *Award Notices:* The OWH does not release information about individual applications during the review process until final funding decisions have been made. When final funding decisions have been made, the applicant's authorized representative will be notified of the outcome of their application electronically via the eGrants system and followed up by postal mail. The official document notifying an applicant that an application has been approved for funding is the Notice of Grant Award signed by the Grants Management Officer, which specifies to the grantee the amount of money awarded, the purposes of the grant, the length of the project period, terms and conditions of the grant award, and the amount of funding to be contributed by the grantee to project costs.

2. *Administrative and National Policy Requirements:* The regulations set out at 45 CFR parts 74 and 92 are the Department of Health and Human Services (DHHS) rules and requirements that govern the administration of grants. Part 74 is applicable to all recipients except those covered by part 92, which governs awards to state and local governments. Applicants funded under this announcement must be aware of and comply with these regulations. The CFR volume that includes parts 74 and 92 may be downloaded from [http://www.access.gpo.gov/nara/cfr/waisidx\\_03/45cfrv1\\_03.html](http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfrv1_03.html).

The DHHS 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:* Grantees will submit five progress reports, a final report, and two final Financial Status Reports in the format established by the OWH, in accordance with provisions of the general regulations which apply under "Monitoring and Reporting Program Performance", 45 CFR parts 74 and 92. The purpose of the progress reports and final report is to provide accurate and timely program information to program managers and to respond to

Congressional, Departmental, and public requests for information about the program. Grantees shall prepare a progress report that outlines the status and progression of the project every 3 months. Grantees will be informed of the exact progress report due dates and means of submission after the award is made. The final report must describe all project activities for the entire 18-month period of the program including data analysis and program evaluation. The financial reports will be submitted to the Project Officer by the first anniversary date of the award and the final financial report will be included as an appendix to the grant's final report no later than 90 days after the close of the Project Period. OWH shall provide an outline of the final report format and templates for required tables. A draft of the final report must be submitted six weeks prior to the end date of the award. OWH will review the draft. Suggested revisions will be discussed individually during a conference call with each grantee. The mutually agreed upon revisions must be incorporated into the final report by the end date of the award.

The grantee shall assign one staff member to participate in a committee with other grantees and OWH to prepare a joint manuscript suitable for a peer-reviewed journal. This manuscript shall combine and summarize data from all programs into one final evaluation. The jointly prepared manuscript must be submitted two weeks prior to the end date of award.

## VII. Agency Contact(s)

For application kits and information on budget and business aspects of the application, please contact: Office of Grants Management, Office of Public Health and Science, Department of Health and Human Services, 1101 Wootton Parkway, Suite 550, Rockville, MD 20857. Telephone: 240-453-8822.

Questions regarding programmatic information and/or requests for technical assistance in the preparation of the "Project Narrative" should be directed in writing to: Dr. Suzanne Haynes, Senior Science Advisor, Office on Women's Health, Office of Public Health and Science, Department of Health and Human Services, 200 Independence Avenue, SW., Rm 719E, Washington, DC 20201. Telephone: 202-205-2623. E-mail: [shaynes@osophs.dhhs.gov](mailto:shaynes@osophs.dhhs.gov).

## VIII. Other Information

### 1. Background

#### A. Agencies

The OWH coordinates the efforts of all the DHHS agencies and offices involved in women's health. OWH works to improve the health and well being of women and girls in the United States through its innovative programs by educating health professionals and motivating behavior change in consumers through the dissemination of health information. To that end, the OWH has established public/private partnerships that address the major killer of women—cardiovascular disease (CVD). One such partnership is with the National Heart, Lung, and Blood Institutes (NHLBI), which is targeting women aged 40–60 years and their health care providers, through a national educational campaign called the Heart Truth Campaign.

The Office of Research on Women's Health at the National Institutes of Health (ORWH/NIH) promotes, stimulates, and supports efforts to improve the health of women through biomedical and behavioral research. ORWH/NIH works in partnership with the NIH institutes and centers to ensure that women's health research is part of the scientific framework at NIH and throughout the scientific community. Both the OWH and the ORWH/NIH are committed to reducing the death and disability due to heart disease and stroke.

The Office of Minority Health (OMH) mission is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. The OMH will provide expert and technical support to the OWH during the performance of this grant.

#### B. Women and Cardiovascular Disease

Cardiovascular disease (CVD), which includes both heart disease and stroke, is the leading cause of death for women in the United States (2). Compared to men, women have higher CVD mortality, higher morbidity following a heart attack or stroke, lower awareness of CVD, and a higher prevalence of most major risk factors for CVD.

- Since 1984, the number of CVD deaths for females has exceeded those for males in the United States (3).
- In 2002, about 60,000 more U.S. women died of CVD than men (3).
- Each year about 40,000 more women than men have a stroke (3).
- Thirty-eight percent of women die within one year of having a heart attack

compared to 10% of men who have heart attacks (2).

- About 35% of women and 18% of men heart attack survivors will have another heart attack within six years (2).

• About 46% of women become disabled with heart failure within 6 years of having a heart attack compared to 22% of men (2).

• Some evidence indicates that women suffer more short and long-term disability after having a stroke than men (4, 5).

• Perioperative complications and mortality after percutaneous angioplasty and coronary artery bypass surgery are also higher in women than in men (6).

• More women than men in the United States have the following five major risk factors for CVD: high blood pressure, high cholesterol, Type 2 diabetes, physical inactivity, and obesity (3).

Some experts speculate that the difference in CVD outcomes and risk factor prevalence between women and men may be due, in part, to a lack of awareness among women and their physicians of the risks for CVD in women (6, 7).

• A 2003 national survey conducted by the American Heart Association found that 35% of women cite breast cancer as their greatest health threat while only 13% of women believe that their greatest health threat is heart disease (8). However, more women die of heart disease than of all cancers combined.

• The majority of women fail to identify the risk factors for heart disease, such as high blood pressure and high cholesterol (8).

• Physicians tend to rate women as being at lower risk for heart disease than men even when the men and women have very similar risk profiles (9).

• A study of over 29,000 routine physician office visits found that women were counseled less often than men about exercise, nutrition, and weight reduction (10).

• The results of the 2003 national survey found that only 38% of women reported that their doctors had ever discussed heart disease with them (8).

Women and health care providers are often ill informed about the differences between male and female signs, symptoms, and risk factors for heart disease (7, 8, 11, 12).

• The most common heart attack symptoms in women are different than those in men; women are more likely than men to experience "atypical" symptoms such as nausea, indigestion, palpitations, dyspnea and fatigue, and they are less likely than men to experience chest pain (13).

• The association between Type 2 diabetes and heart disease is stronger in women than in men; Type 2 diabetes increases a woman's risk of developing heart disease by 3 to 7 times, compared to 2 to 3 times in men (14).

• New evidence indicates that C-reactive protein may be a stronger risk factor in men than in women (15).

• The Women's Health Initiative study found that a common menopausal hormone therapy offered to women—estrogen plus progestin—increased the risk of heart disease in postmenopausal women (16).

#### C. High-Risk Groups

Some groups of women have higher rates of CVD mortality than other women and/or a higher prevalence of factors that increase the risk of CVD mortality and morbidity. These high-risk groups of women include women aged 40 years and older and racial and ethnic minority women.

##### i. Women Aged 40 Years and Older

A woman's risk of CVD starts to rise between the ages of 40 and 60; thus, behavioral modification programs that target women aged 40 years and older have the potential to prevent CVD from developing.

• The incidence of CVD increases with age, and over 97% of people who die of CVD are age 40 years or older (17).

• CVD risk factors including obesity, high blood pressure, high LDL cholesterol levels and Type 2 diabetes often develop around the ages of 40 to 60 (17).

• After menopause, heart disease rates in women are 2 to 3 times that of women the same age before menopause (3).

• The risk of high blood pressure also increases with age; women age 45–54 years have double the risk of high blood pressure as women under age 45 years (17).

• About 80% of women age 65 years and older have high blood pressure (18).

• Only 18% of women age 65 years and older report engaging in regular leisure time physical activity compared to 59% of the total population of women (19).

##### ii. Racial and Ethnic Minority Women

African American women have the highest age-adjusted heart disease and stroke death rates of any female race/ethnicity group in the United States. Compared to white women, racial and ethnic minority women have a higher prevalence of many major risk factors for CVD. CVD awareness is also lower among racial and ethnic minority

groups of women than among white women.

- In 2002, the heart disease death rate was 263.2 per 100,000 for African American women compared to 192.1 per 100,000 for white women and 197.2 per 100,000 for all women combined (17).

- In 2002, the stroke death rate was 71.8 per 100,000 for African American women compared to 53.4 per 100,000 for white women and 55.2 per 100,000 for all women combined (17).

- About 57% of Hispanic/Latino women, 56% of American Indians/Alaska Native women, 42.6% of Asian/Pacific Islander women and 55% of African American women do not exercise, compared to 38% of white women (3, 20–22).

- About 72% of Mexican-American women, 77% of African American women and 61% of American Indians/Alaska Native women are overweight or obese, compared to 57% of white women (3, 20, 21).

- About 37% of American Indians/Alaska Native women smoke compared to 21% of white women (3, 21).

- Other CVD risk factors such as Type 2 diabetes mellitus and high blood pressure are also more prevalent among minority women than among white women (3, 20, 21).

- About 26% of Hispanic/Latino women and 27% of Asian American women have not had a blood pressure screening in the past 12 months, compared to 20% of white women (23).

- In the 2003 national survey conducted by the American Heart Association, fewer African-American and Hispanic women than white women correctly cited heart disease as the leading cause of death among women (8).

- The survey also showed that white women were more likely than women in other racial/ethnic groups to correctly identify the major risk factors and warning signs of heart attack and stroke (8, 24).

#### D. Cardiovascular Disease Interventions

Cardiovascular disease (CVD) prevention programs that target high-risk women, particularly racial/ethnic minority women age 40 years and older, have the potential to reduce CVD incidence and mortality in the United States. Counseling is an essential component of cardiovascular health promotion efforts, and many programs aiming to prevent CVD focus on counseling as their primary goal. However, risk behavior modification, the process of translating knowledge into practice, is pivotal to achieving improved health outcomes. In

particular, interventions that encourage women to establish a healthy weight and increase their levels of physical activity could dramatically affect CVD rates in the United States.

Targeted CVD behavioral modification interventions have been successful in modifying cardiovascular risk behaviors in women. Such CVD interventions have been administered at various venues, including churches, community health centers, community health clinics, YMCAs and other health clubs, schools, Head Start facilities, etc (10–33). Studies indicate that several aspects of targeted CVD intervention programs are particularly effective in modifying the CVD risk behaviors of women (1, 10, 26, 34–39). These include:

- Personalized risk assessment and screening.
- Daily self-monitoring (log-sheets, exercise diaries, etc.).
- Program and group counseling sessions materials tailored to a woman's stage of the lifecycle, readiness to change, needs and subgroup affiliation (e.g. racial group, low socioeconomic status, obese, etc.).
- Behavioral reinforcement strategies such as contracts, verification procedures, incentives, lotteries and team building.
- Group sessions that incorporate physical activity.
- Frequent contact via mail and phone.
- CVD resource library.

#### E. Faith-Based and Community Organizations

Faith-based and community organizations have a long history of providing an array of clinical information and screening to people and communities in the United States. These groups have unique strengths that government cannot duplicate. They hold the trust of their community neighbors and leaders and have great understanding of the needs of the community and its systems. Furthermore, the sense of mission from which these organizations work often translates into a unique approach to service delivery, a dedication of service to others, and a cultural awareness specific to their surrounding communities.

In recognition of this history and ability, President Bush believes it is in the public's interest to broaden Federal efforts to work with faith-based and community organizations, and he has made improving funding opportunities for such organizations a priority. The program described in this announcement is a part of this effort to enhance and expand the participation of

faith-based and community groups in serving racial and ethnic minority women who do not regularly receive clinical information and screening.

#### 2. Definitions

For the purposes of this cooperative agreement program, the following definitions are provided:

*Community-based:* The locus of control and decision-making powers is located at the community level, representing the service area of the community or a significant segment of the community.

*Culturally competent:* Information and services provided at the educational level and in the language and cultural context that are most appropriate for the individuals for whom the information and services are intended.

*High-risk women:* Groups of women that have higher rates of heart disease mortality than other women and/or a higher prevalence of factors that increase the risk of heart disease mortality and morbidity. Major risk factors for heart disease include smoking, high blood pressure, high LDL cholesterol, obesity, Type 2 diabetes, physical inactivity, age, and family history of heart disease. Information on high risk or risks for heart disease can be found online at <http://circ.ahajournals.org/cgi/content/full/109/5/672> and [http://www.guidelines.gov/summary/summary.aspx.doc\\_id=3487&nr=2713&string=lipid](http://www.guidelines.gov/summary/summary.aspx.doc_id=3487&nr=2713&string=lipid).

*Partnership:* A collaboration where both parties (the grantee and the national faith-based or national community organization) play a substantive role during all stages of the program including development, implementation and evaluation. Both parties must also be included and consulted when decisions are made on all aspects of the program.

*National faith-based organization:* The national organizing, representational, policy making or leadership entity for several faith-based member units/sites (e.g., churches, synagogues, etc.) that are located in communities in multiple states across the United States. It is a non-profit organization that has a grassroots network of contributing members.

*National community organization:* The national organizing, representational, policy making or leadership entity for several community-based member units/sites (e.g., health centers, recreational centers, sorority chapters, etc.) that are located in communities in multiple states across the United States. It is also a non-profit organization that has a

grassroots network of contributing members.

*Racial and Ethnic Minority Women:* American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander. (Revision to the Standards for the Classification of Federal Data on Race and Ethnicity, **Federal Register**, Vol. 62, No. 210, pg. 58782, October 30, 1997.)

*Target:* Put forth effort to ensure that members of a specific group of women are aware of the program and that components of the program are designed to be effective in reaching those populations. This includes creating program materials that are culturally competent for that specific group of women. This also includes training staff and health professionals to understand the unique needs, behaviors, cultures and concerns of members of the specific group of women. Targeting does not mean excluding other groups of women from the program.

*Women-centered:* (1) Taking into account the differences between heart disease in men and women and (2) addressing the needs and concerns of women in a way that is welcoming to women, fosters a commitment to women, treats women with dignity, and empowers women through respect and counseling.

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Disease Control and Prevention**

[30Day-06-0298]

**Agency Forms Undergoing Paperwork Reduction Act Review**

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639-5960 or send an e-mail to *omb@cdc.gov*. Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395-6974. Written comments should be received within 30 days of this notice.

**Proposed Project**

National Home and Hospice Care Survey (NHHCS)(OMB No. 0920-0298)—Reinstatement with Change—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention.

*Background and Brief Description*

The NHHCS was conducted in 1992, 1993, 1994, 1996, 1998, and 2000. NHHCS data describe a major segment of the long-term care system and are used extensively for health care research, health planning and public policy. NHHCS provides data on the characteristics of home health and hospice agencies (e.g. Medicare and Medicaid certification, ownership, membership in chains, nursing home, or hospital systems); patients (e.g. demographics, functional status, services received, diagnoses, or sources of payment); and staff (e.g. staffing mix, turnover, benefits, training, or education).

The survey provides detailed information on utilization and staffing patterns, and quality of care variables that are needed to make accurate assessments of the need for and effects of changes in the provision and financing of long-term care for the elderly and disabled. The availability and use of long-term care services are becoming an increasingly important issue as the number of elderly increases and persons with disabilities live longer. Equally as important is ensuring the adequacy and availability of the long-term care workforce. The 2007 NHHCS will include a supplement on home health aides. The upcoming survey has been redesigned and expanded to better meet the data needs of researchers and health care planners working to ensure that quality long-term care will be available for the nation's growing senior population. The survey will utilize both computer-assisted personal interviewing (CAPI) and

computer-assisted telephone interviewing (CATI) systems. These computerized systems speed the flow of data, making it possible to release information on a timelier basis and easier for respondents to participate in the survey.

Users of NHHCS data include the National Immunization Program, and the National Center for Injury Prevention and Control CDC; the Congressional Research Office; the Bureau of Health Professions, Health Resources and Services Administration; the Office of the Assistant Secretary for Planning and Evaluation; the Agency for Healthcare Research and Quality; the National Association for Health Care; the National Hospice and Palliative Care Organization; American Health Care Association; Centers for Medicare and Medicaid Services; Bureau of the Census, and the American Association for Retired People. Other users of these data include universities, many in the private sector, foundations, and a variety of users in the print media.

NCHS plans to conduct the next NHHCS in August-December 2007 and during the same months in 2008. These two national surveys follow a pretest of the forms and procedures in August-September 2006. The data collection procedures and content have been extensively revised from those of the previous NHHCS. There is no cost to respondents other than their time to participate. The burden tables below include the average annual burden for the pretest and the national survey. The total estimated annualized burden hours are 6,088.

**ESTIMATED ANNUALIZED BURDEN HOURS—PRETEST**

Respondents	Number of respondents	Number of responses/respondent	Average burden/response (in hours)
Agency level data collection (CAPI) .....	17	1	30/60
Agency Staff Questionnaire .....	17	1	50/60
Current or Discharge Patient Sampling (CAPI) .....	17	1	20/60
Current Home Health Patient Data Collection (CAPI) .....	8	4	25/60
Hospice Discharge Patient Data Collection (CAPI) .....	9	4	25/60
Home Health Aide Sampling (CAPI) .....	17	1	15/60
Home Health Aide Data Collection (CATI) .....	133	1	40/60

**ESTIMATED ANNUALIZED BURDEN HOURS—NATIONAL SURVEY**

Respondents	Number of respondents	Number of responses/respondent	Average burden/response (in hours)
Agency level data collection (CAPI) .....	820	1	30/60
Agency Staff Questionnaire .....	820	1	50/60
Current or Discharge Patient Sampling (CAPI) .....	820	1	20/60
Current Home Health Patient Data Collection (CAPI) .....	410	8	25/60
Hospice Discharge Patient Data Collection (CAPI) .....	410	8	25/60