entrance between 20th and 2lst Streets, N.W., Washington, D.C. 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452–3204. You may call (202) 452–3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: February 10, 1997.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 97–3587 Filed 2–10–97; 10:17 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary, Office of Minority Health; Availability of Funds for Grants for the Bilingual/Bicultural Service Demonstration Program (Managed Care)

AGENCY: Office of the Secretary.

ACTION: Notice of availability of funds and request for applications.

AUTHORITY: This program is authorized under section 1707(d)(1) of the Public Health Service Act, as amended in Public Law 101–527, the Disadvantaged Minority Health Improvement Act of 1990.

PURPOSE: The purpose of this Fiscal Year 1997 Bilingual/Bicultural Service Demonstration Grant Program (Managed Care) is to:

(1) provide support to improve and expand the capacity and ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to limited-English-proficient populations; and

(2) increase the limited-English-proficient populations' knowledge and understanding about managed care and its implications, including the different managed care models/plans that exist, so they can make informed decisions about their health care.

These grants are intended to demonstrate the merit of programs that involve partnerships between minority community-based organizations and health care facilities in a collaborative effort to address cultural and linguistic barriers to effective health care service delivery and to increase access to effective health care for the limited-English-proficient populations living in the United States.

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of Healthy People 2000, a PHS-led national activity to reduce morbidity and mortality and to improve the quality of life. Potential applicants may obtain a copy of *Healthy People 2000* (Full Report: Stock No. 017–001–00474–0) or *Healthy People 2000: Midcourse Review and 1995 Revisions* (Stock No. 017–001–00526–6) through the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402–9325 or telephone (202) 783–8238.

ELIGIBLE APPLICANTS: Public and private, nonprofit minority community-based organizations which have an established linkage with a health care facility serving a targeted minority community with limited-English-proficient populations. Applicants must be located within one of the following top 15 Metropolitan Statistical Areas identified from the 1990 U.S. Census as having the highest number of limited-English-proficient households experiencing linguistic isolation:

- Phoenix, AZ.
- Fresno, CA.
- Los Angeles/Anaheim/Riverside, CA.
- Sacramento, CA.
- Honolulu, HI.
- Boston/Lawrence/Salem, MA–NH.
- Detroit/Ann Arbor, MI.
- New York/North New Jersey/Long Island, NY–NJ–CT.
- Philadelphia/Wilmington/Trenton, PA–NJ–DE–MD.
- Dallas/Ft. Worth, TX.
- El Paso, TX.
- Houston/Galveston/Brazoria, TX.
- McAllen/Edinburg/Mission, TX.
- Seattle/Tacoma, WA.
- Washington, DC Metropolitan Statistical Area.

National organizations are not eligible to apply; however, local affiliates of national organizations which have an established link with a health care facility are eligible to apply. Currently funded OMH Bilingual/Bicultural Service Demonstration Program grantees are not eligible to apply.

DEADLINE: To receive consideration, grant applications must be received by the OMH Grants Management Office by April 11, 1997. Applications will be considered as meeting the deadline if they are: (1) received on or before the established deadline date and received in time for orderly processing. Applicants should request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing. Applications submitted by facsimile transmission (FAX) or any other electronic format will not be accepted. Applications which do not meet the deadline will be considered late and will be returned to the applicant unread.

ADDRESSES/CONTACTS: Applications must be prepared using Form PHS 5161–1 (Revised July 1992 and approved by OMB under control Number 0937–0189). Application kits and technical assistance on budget and business aspects of the application may be obtained from Ms. Carolyn A. Williams, Grants Management Officer, Division of Management Operations, Office of Minority Health, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, MD 20852, telephone (301) 594–0758. Completed applications are to be submitted to the same address.

Questions regarding programmatic information and/or requests for technical assistance in the preparation of grant applications should be directed to Ms. Cynthia Amis, Director, Division of Program Operations, Office of Minority Health, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, Maryland 20852, telephone number (301) 594–0769.

The OMH Regional Minority Health Consultants (RMHCs) are also available to provide technical assistance. A listing of the RMHCs and how they may be contacted will be provided in the grant application kit. Applicants can contact the OMH Resource Center (OMH–RC) at 1–800–444–6472 for health information.

AVAILABILITY OF FUNDS: Approximately $1.17 million is available for award in FY 1997. It is projected that awards of up to $100,000 total costs (direct and indirect) for a 12-month period will be made to approximately 10 to 12 competing applicants.

PERIOD OF SUPPORT: The start date for the Bilingual/Bicultural Service Demonstration Program (Managed Care) grants is September 30, 1997. Support may be requested for a total project period not to exceed 3 years. Noncompeting continuation awards of up to $100,000 will be made subject to satisfactory performance and availability of funds.

BACKGROUND: Large numbers of minorities in the United States are

linguistically isolated. According to the 1990 U.S. Census, 31.8 million persons or 13 percent of the total U.S. population (ages 5 and above) speak a language other than English at home. Almost 2 million people do not speak English at all and 4.8 million people do not speak English well. The 1990 U.S. Census also found that various minority populations and subgroups are linguistically isolated: approximately 4 million Hispanics; approximately 1.6 million Asian and Pacific Islanders; approximately 282,000 Blacks; and approximately 77,000 Native Americans. Based on the review of the statistics regarding linguistically isolated households across the United States, it has been determined that this announcement will focus on those top 15 Metropolitan Statistical Areas in which the largest concentration of limited-English-proficient minority populations reside.

In 1993, the Office of Minority Health launched its Bilingual/Bicultural Service Demonstration Grant Program to specifically address the barriers that limited-English-proficient minority populations encounter when accessing health services. Besides the social, cultural and linguistic barriers, which significantly affect the delivery of adequate health care, there are other factors that contribute to the poor health status of limited-English-proficient minorities. These factors include:

- Inadequate number of health care providers and other health care professionals skilled in culturally competent and linguistically appropriate delivery of services;
- Scarcity of trained interpreters at the community level;
- Deficiency of knowledge about appropriate mechanisms to address language barriers in health care settings;
- Lack of culturally appropriate community health prevention programs;
- Absence of effective partnerships between major mainstream provider organizations and limited-English-proficient minority communities;
- Low economic status;
- Lack of health insurance; and
- Organizational barriers.

Today, more and more people are receiving their health services through managed care—the integration of financing, management, and the delivery of health services, with providers taking on financial risk (OMH, Closing The Gap, Mar/Apr 1996). The Health Care Financing Administration (HCFA) is the largest purchaser of managed care in the country. According to HCFA's 1995 Medicaid Managed Care Enrollment Report, more than 11.6 million Medicaid beneficiaries are enrolled in Medicaid managed care plans. With this increased focus on providing health care service delivery via managed care, it is essential that limited-English-proficient minority populations adequately understand the intricacies of the managed care system.

To make informed decisions, the target population will need to understand various concepts: for example, what managed care means, what are managed care entities, what types of managed care plans exist and what are the differences, what are the pros and cons of a managed care system, how to access services in a managed care setting, what is a provider network, and what are the rights of the client. For this information to be effective, it will need to be provided in linguistic and culturally sensitive and comprehensive formats appropriate for diverse populations.

It is essential that health care providers, health care professionals and other staff (managed care or non-managed care) become informed about their diverse clientele from a linguistic, cultural, and medical perspective. By becoming culturally competent, health care providers can encourage this vulnerable population to more confidently access and receive appropriate health care.

Definitions

For purposes of this grant announcement, the following definitions apply:

Cultural Competency—A set of interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable persons of and from the community in developing focused interventions, communications and other supports. (Orlandi, Mario A., 1992.)

Health Care Facility—A public nonprofit facility that has an established record for providing a full range of health care services to a targeted, limited-English-proficient, racial and ethnic minority community. Facilities providing only screening and referral activities are not included in this definition. A health care facility may be a hospital, outpatient medical facility, community health center, migrant health center, or a mental health center. (Federal Register, Vol. 60, No. 71, pg 18935, April 13, 1995.)

Limited-English-Proficient Populations—Individuals (as defined in Minority Populations below) with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in and benefit from any aid, service or benefit provided by the health provider.

Metropolitan Statistical Area—Comprises one or more counties containing either a place with at least 50,000 inhabitants, or an urbanized area and a metropolitan area of at least 100,000 (75,000 in New England). Contiguous counties are included if they have close social and economic links with the area's population nucleus. (U.S. Bureau of the Census, Factfinder for the Nation, CFF No. 8, March 1991.)

Minority Community-Based Organization—A public or private nonprofit community-based minority organization or a local affiliate of a national minority organization that has: a governing board composed of 51 percent or more racial/ethnic minority members, a significant number of minorities in key program positions, and an established record of service to a racial and ethnic minority community.

Minority Populations—Asian/Pacific Islanders, Blacks, Hispanics, and American Indians/Alaska Natives. (OMB Statistical Policy Directive No. 15)

Project Requirements

Each project funded under this demonstration grant is to:

1. Carry out activities to improve the ability of health care providers and other health care professionals to delivery linguistically and culturally competent health care services to the target population. Potential activities may include: language and cultural competency training and curricula development using traditional and innovative training models, such as CD–ROMs, on-line formats for continuing education; bilingual health access or health promotion information in the native language; and on-site interpretation services.

2. Carry out activities to educate the target population on the basic principles of managed care plans and services available within the targeted region. Potential activities may include: utilizing culturally and linguistically appropriate informational/communication technologies, such as mass media, public service announcements and neighborhood outreach and electronic systems including kiosks, as an educational tool; and conducting forums/seminars to promote information exchange among managed care organizations, health care

providers, advocacy groups, and consumers.

3. Have an established, formal linkage with a health care facility, prior to submission of an application, for the purpose of ensuring that the target population is provided with a continuum of support for receiving appropriate health care services. Evidence of an established linkage should include signed letters of agreement written specifically to address the proposed projects and relevant activities.

4. Have clearly defined and documented roles for the applicant (minority community-based organization), the health care facility and any other primary entity relevant to the proposed model.

5. Develop an evaluation plan to assess process and outcome data.

Use of Grant Funds

Budgets of up to $100,000 total costs (direct and indirect) per year may be requested to cover costs of: personnel, consultants, supplies, equipment, and grant-related travel. Funds may not be used for medical treatment, construction, building alterations, or renovations. All budget requests must be fully justified in terms of the proposed goals and objectives and include a computational explanation of how costs were determined.

Criteria for Evaluating Applications

Review of Applications: Applications will be screened upon receipt. Those that are judged to be incomplete, nonresponsive to the announcement or nonconforming will be returned without comment. Each organization may submit no more than one proposal under this announcement. If an organization submits more than one proposal all will be deemed ineligible and returned without comment. Accepted applications will be reviewed for technical merit in accordance with PHS policies. Applications will be evaluated by an Objective Review Panel chosen for their expertise in minority health and managed care, and their understanding of the unique health problems and related issues confronted by the limited-English-proficient, racial and ethnic populations in the United States.

Applicants are advised to pay close attention to the specific program guidelines and general and supplemental instructions provided in the application kit.

Application Review Criteria: The technical review of applications will consider the following generic factors:

Factor 1: Background (15%)

Adequacy of: demonstrated knowledge of the problem at the local level; demonstrated need within the proposed community and target population; demonstrated support and established linkages in order to conduct proposed model; and extent and documented outcome of past efforts/activities with the target population.

Factor 2: Goals and Objectives (15%)

Delineation of specific objectives which are consistent with the goals of the program, and are measurable and outcome-oriented.

Factor 3: Methodology (35%)

Comprehensiveness of proposed work plan and specific activities for each objective. Adequacy of the time line in relation to the objectives and program evaluation. Extent to which the applicant demonstrates access to the target population. Adequacy of the established linkages to provide the services. Delineation and clarity of defined roles for the applicant and the linked health care facility.

Factor 4: Evaluation (20%)

Thoroughness, feasibility and appropriateness of the evaluation design from a methodological and data collection perspective. Extent to which the design allows a generalized conclusion regarding the outcomes in achieving the goals and objectives of the project. Potential for replication in other health care settings for the target population.

Factor 5: Management Plan (15%)

Capability of the applicant organization for program management and evaluation of the project. Evidence of capabilities would be adequacy of: proposed management, frontline and evaluation staff qualifications or requirements of ''to be hired'' staff; proposed staff level of effort; and background and experience of proposed staff relevant to proposed activities.

Award Criteria

Funding decisions will be determined by the Deputy Assistant Secretary of Minority Health, Office of Minority Health and will take under consideration: the recommendations/ratings of the review panels, geographic and race/ethnicity distribution, and health problem areas having the greatest impact on minority health. Consistent with the Congressional intent of Public Law 101–527, section 1707(c)3, special consideration will be given to projects targeting Asian, American Samoan, and other Pacific Islander populations. Special consideration will also be given to projects proposed to be implemented in Empowerment Zones/Empowerment Communities.

Reporting and Other Requirements

General Reporting Requirements

A successful applicant under this notice will submit: (1) an annual progress report and Financial Status Report, and (2) a final project report and Financial Status Report in the format established by the Office of Minority Health, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program Performance,'' 45 CFR Part 74, Subpart J, with the exception of State and local governments to which 45 CFR Part 92, Subpart C reporting requirements apply.

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

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

Public Health System Reporting Requirements

This program is subject to Public Health Systems Reporting Requirements which have been approved by the Office of Management and Budget under No. 0937–0195. Under these requirements, a community-based nongovernmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based nongovernmental organizations within their jurisdictions.

Community-based, nongovernmental 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 applications (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,

(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 Office of Minority Health.

State Reviews

This program is subject to the requirements of EO 12372. Executive Order 12372 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 which have chosen to set up a review system and will include a State Single Point of Contact (SPOC) in the State for review. Applications (other than federally recognized Indian tribes) should contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the application deadline by the Office of Minority Health's Grants Management Officer. The Office of Minority Health 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.)

OMB Catalog of Federal Domestic Assistance

The OMB Catalog of Federal Domestic Assistance Number for the Bilingual and Bicultural Service Demonstration Program is 93.105.

Dated: January 23, 1997.

Clay E. Simpson, Jr.,

Deputy Assistant Secretary for Minority Health.

[FR Doc. 97–3522 Filed 2–11–97; 8:45 am]

BILLING CODE 4160–17–M

Agency for Toxic Substances and Disease Registry

Citizens Advisory Committee on Public Health Service Activities and Research at Department of Energy (DOE) Sites: Hanford Health Effects Subcommittee

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Agency for Toxic Substances and Disease Registry (ATSDR) and the Centers for Disease Control and Prevention (CDC) announce the following five meetings.

Name: Citizens Advisory Committee on Public Health Service Activities and Research at DOE Sites: Hanford Health Effects Subcommittee (HHES).

Dates: February 20, 1997. February 21, 1997, 9:30 a.m.–12:30 p.m.

Times: 9 a.m.–5 p.m.; 6:30 p.m.–8:30 p.m.

Place: Red Lion Hotel/Jantzen Beach, 909 N. Hayden Island Drive, Portland, Oregon 97217. Same Location.

Tel: 503/283–4466.

Fax: 503/283–4743.

Dates: May 8, 1997, May 9, 1997, 9:30 a.m.–3:30 p.m.

Times: 9 a.m.–5 p.m., 6:30 p.m.–8:30 p.m.

Place: Cavanaugh's at Columbia Center, 1101 Columbia Center Boulevard, Kennewick, Washington 99336. Same Location.

Tel: 509/783–0611.

Fax: 509/735–3087.

Dates: July 24, 1997. July 25, 1997, 9:30 a.m.–3:30 p.m.

Times: 9 a.m.–5 p.m., 6:30 p.m.–8:30 p.m.

Place: Marines' Memorial Club, 609 Sutter Street (at Mason), San Francisco, California 94102.

Tel: 415/673–6672.

Fax: 415/441–3649.

Dates: October 9, 1997. October 10, 1997, 9:30 a.m.–3:30 p.m.

Times: 9 a.m.–5 p.m., 6:30 p.m.–8:30 p.m.

Place: Coeur d'Alene Inn, West 414 Appleway, Coeur d'Alene, Idaho 83814. Same Location.

Tel: 208/765–3200.

Fax: 208/664–1962.

Dates: December 11, 1997. December 12, 1997, 9:30 a.m.–3:30 p.m.

Times: 9 a.m.–5 p.m., 6:30 p.m.–8:30 p.m.

Place: Madison Hotel, 515 Madison Street, Seattle, Washington 98104. Same Location

Tel: 206/583–0300.

Fax: 206/624–8125.

Status: Open to the public, limited only by the space available. The meeting rooms accommodate approximately 150 people.

Background

A Memorandum of Understanding (MOU) was signed in October 1990 and renewed in November 1992 between ATSDR and DOE. The MOU delineates the responsibilities and procedures for ATSDR's public health activities at DOE sites required under sections 104, 105, 107, and 120 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA or ''Superfund''). These activities include health consultations and public health assessments at DOE sites listed on, or proposed for, the Superfund National Priorities List and at sites that are the subject of petitions from the public; and other health-related activities such as epidemiologic studies, health surveillance, exposure and disease registries, health education, substance-specific applied research, emergency response, and preparation of toxicological profiles.

In addition, under an MOU signed in December 1990 with DOE, the Department of Health and Human Services (HHS) has been given the responsibility and resources for conducting analytic epidemiologic investigations of residents of communities in the vicinity of DOE facilities, workers at DOE facilities, and other persons potentially exposed to radiation or to potential hazards from non-nuclear energy production and use. HHS has delegated program responsibility to CDC.

Purpose

This subcommittee is charged with providing advice and recommendations to the Director, CDC, and the Administrator, ATSDR, regarding community, American Indian tribes, and labor concerns pertaining to CDC's and ATSDR's public health activities and research at this DOE site. Activities shall focus on providing a forum for community, American Indian Tribal, and labor interaction and serve as a vehicle for community concern to be expressed as advice and recommendations to CDC and ATSDR.

Matters To Be Discussed

Agenda items include: ATSDR's proposed medical monitoring program, ATSDR's planning for an exposure subregistry program, and solicitations of subcommittee concerns to be addressed by ATSDR and CDC. There will also be updates from the Inter-tribal Council on Hanford Health Projects, and reports from the following Work Groups: Outreach/Special Populations, Public Health Activities, and Health Studies.

This notice is being published less than 15 days prior to the meeting due to an administrative delay.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Linda A. Carnes, Health Council Advisor, ATSDR, E–28, 1600 Clifton Road, NE., Atlanta, Georgia 30333, telephone 404/639–0730, FAX 404/639–0759.

Dated: February 5, 1997.

Carolyn J. Russell,

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

[FR Doc. 97–3472 Filed 2–11–97; 8:45 am]

BILLING CODE 4163–70–P