(TDD) users may contact Diane Jenkins, 202-452-3544.

Board of Governors of the Federal Reserve System, February 25, 1998.

William W. Wiles

Secretary of the Board

[FR Doc. 98–5382 Filed 3–2–98; 8:45 am]

BILLING CODE 6210–01–F

FEDERAL RESERVE SYSTEM

Sunshine Act Meeting

TIME AND DATE: 11:00 a.m., Monday, March 9, 1998.

PLACE: Marriner S. Eccles Federal Reserve Board Building, 20th and C 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: Joseph R. Coyne, Assistant to the Board; 202–452–3204.

SUPPLEMENTARY INFORMATION: You may call 202–452–3206, beginning at approximately 5 p.m., two business days before the meeting for a recorded announcement of bank and bank holding company applications scheduled for the meeting; or you may contact the Board's Web site at http://www.bog.frb.fed.us for an electronic announcement that not only lists applications, but also indicates procedural and other information about the meeting.

Dated: February 27, 1998.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 98–5636 Filed 2–27–98; 3:49 pm]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration on Aging

[Program Announcement No. AoA–98–3]

Fiscal Year 1998 Program Announcement; Availability of Funds and Notice Regarding Applications

AGENCY: Administration on Aging, HHS.

ACTION: Announcement of availability of funds and request for applications to establish, or expand and improve, Statewide Senior Legal Hotlines whose purpose is to advance the quality and accessibility of the legal assistance provided to older people.

SUMMARY: The Administration on Aging announces that under this program announcement it will hold a competition for grant awards for four (4) to five (5) projects that establish, or expand and improve, Statewide Senior Legal Hotlines aimed at advancing the quality and accessibility of the legal assistance provided to older people.

The deadline date for the submission of applications is May 11, 1998. Eligibility for grant awards is limited to public and/or nonprofit agencies, organizations, and institutions experienced in providing legal assistance to older persons.

Application kits are available by writing to the Department of Health and Human Services, Administration on Aging, Office of Program Development, 330 Independence Avenue, SW, Room 4264, Washington, DC 20201, or by calling 202/619–2987.

Dated: February 24, 1998.

Jeanette C. Takamura,

Assistant Secretary for Aging.

[FR Doc. 98–5332 Filed 3–2–98; 8:45 am]

BILLING CODE 4150–40–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement 98022]

Traumatic Brain Injury Surveillance and Traumatic Brain Injury Follow-up Registries

Introduction

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1998 funds for a cooperative agreement program for population-based data systems for Traumatic Brain Injury (TBI). The program will serve two purposes:

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

Part II—To develop or enhance population-based registries of persons sustaining TBI to better define the outcomes and secondary conditions associated with the injury.

CDC is committed to achieving the health promotion and disease prevention objectives of ''Healthy People 2000,'' a national activity to reduce morbidity and mortality and to improve the quality of life. This announcement is related to the priority areas of Unintentional Injuries, Violent and Abusive Behavior, and Surveillance and Data Systems. (For ordering a copy of ''Healthy People 2000,'' see the section **Where to Obtain Additional Information.**)

Authority

This program is authorized under sections 301, 317, 391–394a, of the Public Health Service Act (42 U.S.C. 241, 247b, 280b-1 and 280b-2) as amended, and supported by Public Law 104–166.

Smoke-Free Workplace

CDC strongly encourages all grant recipients to provide a smoke-free workplace and to promote the nonuse of all tobacco products, and Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, and early childhood development services are provided to children.

Eligible Applicants

Eligible applicants are the official public health agencies of States or their bona fide agents. This includes the District of Columbia, American Samoa, the Commonwealth of Puerto Rico, the Virgin Islands, the Federated States of Micronesia, Guam, the Northern Mariana Islands, the Republic of the Marshall Islands and the Republic of Palau.

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

For each part of this announcement, only one application per Part, from each State, may enter the review process and be considered for an award under this program.

Applicants may apply for Part I only or for Part I and Part II or for Part II only.

Priority preferences for Part I will be given to competing-continuation applicants who were funded under Announcement 526, who currently participate in CDC's multi-State TBI surveillance system, i.e., States that have provided population-based TBI data to CDC for cases incident in years 1994 or later.

Note: Public Law 104–65, dated December 19, 1995, states that an organization described in section 501(c)(4) of the IRS Code of 1986, which engages in lobbying activities, shall not be eligible for the receipt of Federal funds constituting an award, a grant, contract, loan, or any other form.

Availability of Funds

Approximately $1,310,000 is available in FY 1998 to fund approximately six awards under Parts I and II of this announcement:

Part I—Up to $550,000 is available in FY 1998 to fund up to four awards to support or enhance existing State surveillance systems for TBI. It is expected that the average award will be in the range of $125,000—$135,000.

Part II—Up to $760,000 is available in FY 1998 to fund two awards to develop or enhance population-based registries of persons with TBI, including initial efforts addressing persons treated in emergency departments for TBI but not hospitalized. It is expected that the average award will be $380,000.

Both Part I and Part II projects are expected to begin on or about August 1, 1998, and will be made for a 12-month budget period within a project period of up to three years. Funding estimates may vary and are subject to change. Cooperative agreement funds cannot be used to replace other existing funds for TBI surveillance or registry activities.

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

Use of Funds

Restriction on Lobbying

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying Congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition, the FY 1998 Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act (Pub. L. 105–78) states in section 503 (a) and (b) that no part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself. No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

Prohibition on Use of CDC Funds for Certain Gun Control Activities

The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1998 specifies that: ''None of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control.'' Anti-Lobbying Act requirements prohibit lobbying Congress with appropriated Federal monies. Specifically, this Act prohibits the use of Federal funds for direct or indirect communications intended or designed to influence a member of Congress with regard to specific Federal legislation. This prohibition includes the funding and assistance of public grassroots campaigns intended or designed to influence members of Congress with regard to specific legislation or appropriation by Congress.

In addition to the restrictions in the Anti-Lobbying Act, CDC interprets the new language in the CDC's 1998 Appropriations Act to mean that CDC's funds may not be spent on political action or other activities designed to affect the passage of specific Federal, State, or local legislation intended to restrict or control the purchase or use of firearms.

Background & Definitions

Background

Among all types of injury, traumatic brain injury is most likely to result in death or permanent disability. The incidence and prevalence, severity, and cost of TBI indicate its importance as a public health problem.

A. Some estimates and studies of incidence have indicated that traumatic brain injuries may result in more than 500,000 emergency department visits, 260,000 hospitalizations and more than 51,000 deaths each year in the United States.

B. The severity of the nonfatal injuries is shown by estimates that each year 70,000 to 90,000 people sustain TBI resulting in permanent disability.

C. The costs of TBI—acute care, rehabilitation, chronic care, and indirect costs—are unknown but certainly enormous. One estimate suggests that head injuries impose an annual economic burden of $37 billion in direct and indirect costs. These estimates of cost fail to account for the extraordinary losses experienced by the families and friends of those who have died or sustained disability from TBI.

D. TBI is largely preventable. The leading causes of TBI are motor-vehicle crashes, falls, and violence.

State-based Surveillance. Over the past several years, many States have responded to the need for better TBI data by developing public health surveillance systems. These data systems are beginning to provide ongoing population-based incidence and etiologic information that is useful to plan and evaluate public health programs. Building on these efforts, CDC funded four States in 1995 (Announcement 526) and eleven more States in 1997 (Announcement 526) to conduct ongoing population-based TBI surveillance.

Methods of data collection vary among these surveillance systems. All obtain mortality data from State vital records or multiple-cause-of-death data files. Data on hospitalizations for TBI are obtained by several mechanisms: Employing legal reporting requirements for CNS injuries similar to reporting requirements for certain communicable diseases, using existing hospital discharge data systems or trauma registries, or relying on a combination of these methods. Changes in health care practices in the United States in recent years have resulted in a smaller proportion of persons with TBI being admitted to hospitals after evaluation in emergency departments. To assess the public health importance of TBIs increasingly being treated only in emergency departments, a few States are developing methods to expand TBI surveillance to include emergency department-based care.

Lack of information about outcomes of TBI. Although there are increasing data to describe the current incidence and etiology of TBI, little is known, on a population basis, about the outcomes experienced by persons who survive traumatic brain injury. These outcomes include: their impairments, disabilities (functional limitations), and handicaps (e.g., limits in ability to return to full social participation including major roles such as work or school); the occurrence of secondary conditions; and the need for and use of post-acute

medical, rehabilitation, and social services. In fact, most of what is known about outcomes is based on studies that rely on case series methodology, small regional samples, and anecdotal reports. Greater understanding of these issues is important for several reasons: First, a better understanding of outcomes will add to our knowledge about the public health impact and societal costs associated with disabling injuries. Second, a better understanding of specific impairments associated with disabling injuries could lead to improving acute care and rehabilitation interventions aimed at reducing the severity of impairment and related disabilities. Third, little is known about barriers to receiving needed rehabilitation and other health-related services following TBI. In 1995, under Announcement 526—Part II, CDC funded one State (Colorado) to develop a population-based registry of persons with TBI to assess the outcomes they experience and their need for services in the year following injury.

Additionally, there is a critical lack of information about outcomes experienced by persons who experience a TBI which does not result in hospitalization. Critical work is needed to evaluate the quality of emergency department data for TBI surveillance, to define relevant public health outcome measures for persons with TBI who are not hospitalized, and to develop methods to collect outcome data among this group.

Definitions

Traumatic Brain Injury (TBI) and essential data elements for TBI surveillance are fully defined in CDC's **"Guidelines for Surveillance of Central Nervous System Injury."** For ordering a copy of the Guidelines, see the sections: **Where to Obtain Additional Information** and **Traumatic Brain Injury Surveillance References.**

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

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

Hospital emergency departments (ED's) are defined as facilities offering 24-hour emergency medical services affiliated with an acute care hospital of six or more beds.

Impairment refers to loss or abnormality of an organ, extremity, tissue, or other body part such as an amputated or paralyzed extremity.

Disability (functional limitation) refers to a restriction or lack of ability to perform an action or activity considered normal for a human being, such as walking.

Handicap refers to a disadvantage for a given individual, resulting from impairment or disability, that limits or prevents the fulfilment of a role that is considered normal for that individual. See World Health Organization, International Classification of Impairments, Disabilities, and Handicaps, Geneva, 1980.

A secondary condition is a disease, impairment, or disability that occurs at an increased frequency among people with a primary disabling condition. See Institute of Medicine, Disability in America—Toward a National Agenda for Prevention, National Academy Press, Washington 1991.

Timeliness refers to the promptness with which surveillance systems gather, analyze, and report information gathered. For purposes of the multi State TBI surveillance system related to this program, TBI case-level data should be submitted to CDC in less than 18 months from the end of each calendar year under surveillance.

A population-based *registry* is defined as a system of ongoing registration of all or a representative sample of all cases of a condition in a defined population, such that cases can be related to the population base. (adapted from Last JM. A Dictionary of Epidemiology, Oxford University Press, New York, 1988.)

Purpose

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

Part I—To support or enhance existing State TBI surveillance systems, in order to promote a multi-State surveillance system that uses common case definitions and data elements according to CDC's Guidelines for Central Nervous System Injury Surveillance. This multi-State surveillance system is defining the magnitude of TBI at a national level, defining the spectrum of severity of injury, helping to identify populations at high risk, and defining the distribution of external causes of injury, in order to plan injury control programs addressing prevention and service provision.

Part II—To develop or enhance population-based data collection methods to define the longer term public health impacts of TBI—examining the outcomes of TBI (impairments, disabilities, and handicaps). Part II is intended to support the development or enhancement of pilot registries that assess persons six to 12 months following hospitalization for TBI. It is expected that Part II recipients will build on experience gained and methods developed by the Colorado Department of Health and Environment/Craig Hospital Project, funded under P.A. 526. Part II. Additionally, Part II funding will support activities to evaluate the quality of emergency department data for TBI surveillance and initiate the development of methods to assess outcomes among persons treated for TBI in hospital EDs but not hospitalized.

Application Requirements

Part I—Eligible applicants must:

1. Demonstrate the existence of a population-based TBI surveillance system Statewide *or* a population-based TBI surveillance system in a geopolitical jurisdiction of the State of 1.5 million people or more.

2. Demonstrate the availability of at least one year of TBI data from the TBI surveillance system (either calendar year 1995 or 1996 data).

3. Document that legislation and/or regulations are in place that support current collection of TBI data, and that confidentiality is protected.

Part II—Eligible applicants must:

1. Apply for funding under Part I of this announcement, or currently be funded under Announcement 716.

2. Demonstrate that data are collected with personal identifiers including names.

3. Document that legislation and/or regulations are in place that allow follow-up of persons with TBI.

4. Demonstrate that the population targeted for follow-up is either Statewide or in a geopolitical jurisdiction of the State of 1.5 million people or more.

An affirmative response to each requirement is necessary for the full objective review of applications under Part I or II. The applicant must provide this documentation on a separate page

to be included as the first page of the application, entitled: ''Application Requirements Declaration.''

Cooperative Activities

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

Part I

Recipients of awards under Part I of this announcement will conduct population-based TBI surveillance Statewide or in a population defined by a geopolitical jurisdiction of the State of 1.5 million or more.

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

1. Conduct Statewide surveillance of TBI using the definitions, data elements, and methods described in the CDC Guidelines for Central Nervous System Injury Surveillance. Recipients will collect information addressing diagnosis, demographics, etiology, severity, and outcome as defined in section **Application Content** of this announcement. Recipients are expected to link data obtained from State vital records (death certificates and/or multiple-cause-of-death data) and hospital discharge data, to produce a non-duplicative data set for the population under surveillance. Since hospital discharge data and vital records may not contain complete information describing injury cause, circumstances, severity, and outcome, recipients are expected to obtain additional data from hospital medical records and/or medical examiner/coroner reports in either all cases or a representative sample of cases.

2. Evaluate the surveillance system for completeness and validity of data collected.

3. Develop and submit an annual report to CDC on the analysis of surveillance data.

4. Compile case-level and summary surveillance data each year and submit these data to CDC in a timely (see Definitions:Timeliness) manner for use in a multi-State TBI surveillance data base. Case level data must be formatted according the CDC Guidelines for Surveillance of Central Nervous System Injury.

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

B. CDC Activities:

1. Provide technical assistance for effective surveillance program planning and management.

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

3. Maintain and analyze multi-State data and regularly report analysis findings.

4. Conduct site visits to assess program progress and mutually resolve problems, as needed.

5. Facilitate communication/coordination among States to improve efficiency of activities and quality of surveillance data.

Part II

Recipients of funds for Part II are expected to develop or enhance—and evaluate—a population-based registry to collect follow-up data on persons hospitalized with TBI Statewide or in a population defined by a geopolitical jurisdiction of the State of 1.5 million or more. It is expected that recipients of these funds will build on the experience gained and methods developed by the project funded in 1995 under Announcement 526—Part II (Colorado). It is also expected recipients of these funds will collaborate with one another in order to develop their projects.

A. Recipient Activities include but are not limited to:

1. Define the target population.

2. Develop tracking mechanisms to facilitate follow up of persons with TBI; i.e., develop and maintain access to persons who have been hospitalized for TBI.

3. Define the minimal data set for follow-up, and interview and/or other methods of follow-up and data collection. The data set should include information about primary and secondary conditions, injury severity, motor and sensory impairments, disability, handicap, recommended use and actual use of post-acute care services (so cost estimates can be generated), community integration, and demographic information.

4. Collect follow up data from a representative sample of the population of persons sustaining TBI. It is expected that a sample representing persons with mild, moderate, and severe TBI can be developed to adequately define the parameters in item three, above.

5. Analyze follow-up data.

6. Evaluate the usefulness of hospital emergency department data for TBI in a variety of hospital settings (e.g., urban public hospitals, rural hospitals, level I, II, and III trauma centers, large community hospitals, etc.). It is expected that ED records from a variety of hospital settings will be selected in order to evaluate the accuracy—including sensitivity and predictive value positive—of ED data for TBI surveillance. Applicants are not expected to define the incidence of TBI treated in the ED, but are expected to evaluate the quality, and therefore the usefulness, of ED data for TBI surveillance.

7. In collaboration with the other funded project, convene two meetings of experts to address outcomes associated with TBI treated in EDs but not hospitalized. These meetings should address relevant public health outcome measures and methods to collect these data.

8. Produce yearly reports of analyses and of project progress; document the costs of maintaining the registry.

9. Evaluate project progress, and evaluate the completeness and accuracy of the data.

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

11. Collaborate with the other recipient of Part II funding.

12. Share project case level and summary data with CDC.

B. CDC Activities:

1. Provide ongoing consultation with funded recipients in areas outlined under Part II, Activities A.2., A.3., A.4., A.6., A.7., and A.9., above.

2. Provide technical assistance in establishing or endorsing criteria for completeness, timeliness, and accuracy of data, and monitor to ensure compliance with program (recipient) activities.

3. Analyze and provide technical assistance for analysis of TBI follow-up data, for the evaluation of ED data for TBI surveillance, and for convening meetings of experts to address outcomes associated with non-hospitalized TBI.

4. Conduct site visits to assess program progress and mutually resolve problems, as needed.

5. Facilitate the IRB review process at CDC.

6. Facilitate coordination between recipients of Part II funds.

Technical Reporting Requirements

An original and two copies of semi-annual progress reports are required of all grantees. Time lines for the semi-annual reports will be established at the time of award. Final financial status and performance reports are required no later than 90 days after the end of the project period. All reports are submitted to the Grants Management Branch, CDC.

Semiannual progress reports should include:

A. A brief program description.

B. A Statement of the goals and objectives, followed by comparisons with the actual accomplishments for the period.

C. If established goals and objectives were not accomplished or were delayed, describe both the reason for the deviation and anticipated corrective action or deletion of the activity from the project.

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

Application Content

A separate application must be submitted for each part (Part I and/or Part II) of this announcement for which funding is requested. Applicants are required to submit an original and two copies of their application. The application, including appendices, should not exceed 55 pages for Part I and 65 pages for Part II.

Competing continuation applicants (Parts I & II) may include up to five additional pages to describe outcomes from the previously funded program.

The first page of the application should contain the response to requirements as indicated in the **Application Requirements** section of this announcement.

Pages should be clearly numbered and a complete index to the application and any appendices included. The project narrative section must be double-spaced. The original and each copy of the application must be submitted unstapled and unbound. All materials must be typewritten, double-spaced where noted, with unreduced type (font size 10 point or greater) on 8–1/2'' by 11'' paper, with at least 1'' margins, headers and footers, and printed on one side only.

The applicant should provide a detailed description of first-year activities and briefly describe future-year objectives and activities.

For TBI surveillance applications (Part I), the application must include:

A. Application Requirements Declaration (see **Application Requirements**).

B. Executive Summary (one page, may be single spaced): This section should include:

1. Type of federal assistance requested: Part I, support of an existing population-based TBI surveillance system.

2. Existing resources for the program.

3. Major objectives and components for the proposed program.

4. The amount of federal assistance requested.

C. Proposal Narrative (not to exceed 25 double-spaced pages excluding the budget narrative and appendices, 30 double-spaced pages for competing continuations): This section should include:

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

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

a. Existing staff and brief summary of their qualifications.

b. A description of the applicant's capacity for data entry, data processing, and data analysis.

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

(1) Case definition.

(2) Data elements collected.

(3) Sources of data used to ascertain cases.

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

d. Legal authority to conduct surveillance (e.g., TBI reporting legislation or regulation), and legal authority and methods to ensure data confidentiality.

e. A brief summary of any data analyses completed.

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

g. A progress narrative (not to exceed five pages) documenting project outcomes (competing continuations only).

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

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

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

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

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

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

(4) All other sources of data that are used to provide additional information on cases. At a minimum this should include hospital medical records, which may be reviewed in a representative sample of cases.

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

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

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

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

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

6. A description of the schedule by which annual case-level data will be submitted to the CDC.

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

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

9. Human Subjects: Indicate whether human subjects will be involved, and if so, how will they be protected, and describe the review process which will govern their participation (see also **Other Requirements** Section, **Human Subjects**).

For Population-Based Registries applications (Part II)—The application must include:

A. Application Requirements Declaration (see **Application Requirements**).

B. Executive Summary (one page, may be single spaced): This section should include:

1. Type of federal assistance requested: Part II, development of a TBI follow-up registry based on an existing population-based surveillance program.

2. Existing resources for the program.

3. Major objectives and components for the proposed program.

4. The amount of federal assistance requested.

C. Proposal Narrative (not to exceed 35 double-spaced pages excluding the budget narrative and appendices, 40 double-spaced pages for a competing continuation project). This Section should include:

1. A description of the need for a TBI registry and the objectives for the registry. Describe the purpose of the TBI registry data including:

a. A description of how the data will contribute to the applicant's public health mission and fit with other activities in the organization.

b. A description of how the data will contribute to current TBI prevention and service activities as well as a description of potential intervention activities.

2. A description of existing TBI surveillance capacity, including a summary of current surveillance data (i.e., 1995 or 1996).

3. A characterization of the target population including: a. A description of the target population under surveillance, including how it constitutes a discrete geopolitical jurisdiction; and the size and demographic features such as age, sex, and race/ethnicity. Demonstration of population characteristics that may reflect the disability status of the population, such as employment status, educational attainment, and income, is desirable. This includes the extent to which the applicant has met the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed project, including:

(1) The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation; (2) The proposed justification when representation is limited or absent; (3) A statement as to whether the design of the study is adequate to measure differences when warranted; and (4) A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with community(ies) and recognition of mutual benefits.

4. A description of the applicant's ability to track persons who have sustained TBI and collect health data. High follow-up rates are vital to the success of a registry. Describe the attributes enhancing and impeding follow-up of incident TBI cases, including: a. The applicant's legislative or regulatory authority to collect and maintain health data with identifying information for members of the target population who have had a TBI. This description should include the language currently in place which supports the legal authority of the health department to develop or enhance a central TBI registry.

b. Prior experience conducting follow-up studies or running other registries that would be pertinent to the applicant's capacity to develop or enhance a TBI registry. A discussion of the relevance of these prior endeavors to proposed efforts should be included.

c. Plans to locate registry participants, anticipated barriers to follow-up, and plans to address the barriers.

d. Legal authority and methods to maintain data confidentiality.

5. A description of the applicant's methodologic capacity--specifically, management capacity for planning and maintaining the registry, and scientific resources for data management and analysis of data collected through the TBI registry, including:

a. Organization chart(s) to establish relationships between the registry and support resources.

b. Experience with data management, analysis and use of registry-type (for example, follow-up) data.

c. If appropriate, describe plans for and evidence of collaborative relationships with agencies (including universities and non-governmental entities) that will provide needed expertise.

6. A description of planned data collection. For a newly funded project, sufficient time in the first budget year should be devoted to planning, establishing infrastructure, and developing data collection instruments in collaboration with CDC and the other recipient of Part II funds. Familiarity should be demonstrated with data needs and data collection issues of a TBI registry, including:

a. A demonstration of familiarity with concepts of impairment, disability, handicap, and secondary conditions.

b. A description of potentially useful public health outcome measures of disability, including relevant published data collection instruments.

c. A description of methods to be employed at follow up that will assess disability and handicap, and a description of methods to be employed to assess pre-TBI baseline function.

d. A description of other existing computerized health data systems that might be useful for the ongoing monitoring of registry participants, and a description of the applicant's authority and experience in linking such data systems.

e. A description of existing computer hardware and software resources and anticipated needs to maintain the registry, including for the purposes of data linkage, analysis and transmission to the CDC.

7. Describe the overall operational plan for development, implementation, and ongoing management of the TBI registry including:

a. A realistic time line with measurable milestones.

b. A management and staffing plan describing qualifications and experience of existing and proposed staff, and responsibilities of each position.

c. The methods for registry participant enrollment, for data collection (e.g.,

telephone versus in-person interview, record abstraction), and for confidentiality. A description of the TBI severity and care spectrum of registry participants to be enrolled and followed should be included.

d. A description of analysis plans for data collected through the registry.

e. If applicable, plans for and evidence of collaborative relationships with agencies (including universities and non-governmental entities) relevant to the surveillance of TBI and the monitoring of the health, service needs, and community integration of injured persons.

f. If the applicant has an established follow-up registry for TBI, a description of how methods will be shared and how technical support may be given to the other recipient of Part II funding.

g. Plans to share project case level and summary data with the CDC.

8. A description of methods to evaluate the usefulness of hospital emergency department data for surveillance of non-hospitalized TBI. This must include the following:

a. Proposed methods of case ascertainment, including case definition(s), data collected, and sources of data within the hospital to identify cases and to provide additional information about the TBI (e.g., administrative and clinical emergency department data sources, radiology reports, emergency medical service data).

b. A description of how ED cases will be selected, including a description of which hospitals will participate (or will be selected to participate), the characteristics of those hospitals, the proposed number of cases needed from each hospital, and the rationale for how cases will be identified.

c. A description of methods to evaluate sensitivity, predictive value positive and the quality of data collected in the ED.

9. In collaboration with CDC and the other funded project, an agreement to convene two meetings of experts to address outcomes associated with TBI treated in emergency departments but not hospitalized. These meetings should address relevant public health outcome measures for TBIs treated in emergency departments and methodologies to collect data among this group.

10. A description of plans to evaluate the attainment of proposed objectives, including (where applicable) plans to evaluate the quality of the registry and ED data collected (e.g., completeness and validity).

11. As applicable, a progress narrative (not to exceed five double-spaced pages) to address progress and outcomes from the prior-funded project.

12. Human Subjects: Indicate how human subjects will be protected, and describe the review process which will govern their participation (see **Other Requirements** Section, **Human Subjects**).

Evaluation Criteria

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

An objective review of the applications which are successful in the preliminary review will then be conducted according to the following criteria:

Part I—Evaluation Criteria

Evaluation criteria are based on the responsiveness to and quality of specific information requested in section **Application Content.**

1. Needs Assessment (5 points). The extent to which the applicant describes the impact of TBI in the applicant's jurisdiction and the need for TBI data for public health programs.

2. Existing Surveillance Program and Resources (40 points total). The status of the applicant's existing TBI surveillance program, and the degree to which it currently serves the requirements and purposes of this cooperative agreement. Priority will be given to:

a. programs including in this application a summary of current (i.e., 1995 or 1996) TBI morbidity and mortality data analyzed by age, sex, and cause, [5 points];

b. programs that have evaluated the quality of their data (e.g., predictive value positive, completeness, timeliness), [5 points];

c. programs that have abstracted records of a population-based sample to characterize the external cause, severity, and outcome of TBI (e.g., by abstracting data from medical records in a representative sample of reported cases), [10 points];

d. programs providing a progress report that details participation in CDC's multi-State TBI surveillance system, addressing progress and outcomes from the previous three-year funding period, [20 points].

3. Goals and Objectives (10 points). The extent to which objectives are specific, achievable, practical, measurable, time-linked, and consistent with the overall purposes described in this announcement.

4. Methods and Activities (20 points). The application will be scored according to the extent that the proposed methods and activities can achieve the proposed objectives, consistent with the purposes of this announcement. The extent to which clear explanations of appropriate methods addressing case ascertainment and data collection, TBI case definition(s), data elements, sources and availability of data, sampling methods, legal authority for surveillance activities, protection of confidentiality, and data processing and analysis are provided. The applicant should also describe methods for sharing project data with the CDC.

5. Staffing and Management (15 points). The extent to which proposed staffing, organizational structure, staff qualifications and experience, identified training needs or plan, and job descriptions and curricula vitae for both proposed and current staff indicate the applicant's ability to carry out the objectives of the program.

6. Evaluation (10 points). The degree to which the applicant includes plans to evaluate the attainment of proposed objectives, including plans to evaluate the sensitivity and predictive value positive of case ascertainment and the completeness and quality of data.

7. Budget (not scored). The extent to which the budget is reasonable, clearly justified, and consistent with stated objectives and proposed activities.

8. Human Subjects Review (not scored). The applicant must clearly state what precautions exist to protect human subjects.

Part II—Evaluation Criteria

Evaluation criteria are based on the responsiveness to, and quality of, specific information requested in this section. See also **Application Content** Section in this announcement.

1. Statement of Need for TBI Follow-up Data, and Registry Goals and Objectives: (5 points). The extent to which the applicant describes plans for using a TBI registry that respond to public health needs and are linked with prevention and service activities; the extent to which the project goals and objectives are specific, achievable, measurable, time-linked, and consistent with the overall purposes described in this announcement.

2. Existing TBI Surveillance Capacity: (10 points). The extent to which the applicant describes an effective incidence surveillance system for TBI and addresses the following issues: The objectives for incidence surveillance,

the case definitions for TBI, the sources of TBI case reporting, the timeliness of case ascertainment, the completeness of case ascertainment and other qualitative attributes of the system, a summary of current surveillance data (i.e., 1995 or 1996), and a description of the prior usefulness of the system.

3. Definition and Scope of the Target Population: (10 points). The extent to which a discrete, geopolitical jurisdiction can be established and the following issues are addressed: Demonstrated access to descriptive data concerning the target population, including measures relevant to the disability status of the target population, and a thorough justification and description of sampling or restricting the target population for participation in the registry. Breadth of socio-demographic representation in the target population and relevance to the national population will be scored favorably.

This includes the extent to which the applicant has met the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed project including: (a) The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation; (b) The proposed justification when representation is limited or absent; (c) A statement as to whether the design of the study is adequate to measure differences when warranted; and (d) A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with community(ies) and recognition of mutual benefits.

4. Ability to Track TBI Patients and Collect Health Data: (15 points). While authority to collect and maintain personal identifiers from TBI incidence surveillance is a requirement for Part II eligibility, the ability to track participants and collect follow-up information is so important to the success of the registry that scoring will reflect the extent to which the applicant demonstrates legislative and/or regulatory authority to conduct a TBI registry, shows prior successful experience following a population and collecting health information at prospective intervals, understands the barriers to locating registry participants for follow-up data collection and presents appropriate plans to overcome those barriers, and demonstrates proper authority and methods to maintain confidentiality of health information with personal identifiers.

5. Methodologic Capacity, Project Management and Staffing: (15 points). The extent to which the scientific resources for planning and data management/analysis of a TBI registry are demonstrated within the applicant's organization or through collaboration with universities or other agencies. The extent to which proposed staffing, staff qualifications and experience, and project organization indicates ability to accomplish the objectives of the program.

6. Data Collection: (15 points). For a newly funded project, planning, establishing infrastructure, and developing data collection instruments are expected to occur during the first year. Under these circumstances the application will be scored according to the extent to which familiarity with data needs and data collection issues is demonstrated in the proposal, including the concepts of impairment, disability, handicap, and secondary conditions. Awareness of published data collection instruments used to measure outcome measures of disability and handicap and assess health status prior to injury should be demonstrated, as well as awareness of the technical resources necessary to conduct the registry.

Applicants with established TBI registry projects should describe experience with—and proposed changes involving—data collection instruments and methods.

All applicants should describe implemented or proposed methods to conduct follow-up interviews and link pertinent health data systems to enhance data collection.

7. Operational Plan: (10 points). The extent to which the registry methods and timetable are realistic, milestones are measurable, and proposed products are commensurate with the size of the cooperative agreement award. The spectrum of TBI severity addressed within the registry should be as broad as possible, and the data collection methods should be appropriate for the type of data proposed for collection.

8. Evaluation of Hospital Emergency Department Data for TBI Surveillance and Developing Outcome Measures for Non-hospitalized TBI: (10 points). The extent to which the applicant's proposed methods and activities will evaluate the quality of hospital ED data relevant to TBI surveillance. The extent to which clear explanations of appropriate, achievable methods are presented demonstrating access to hospital ED data, demonstrating access to other data sources within the hospital, and to evaluate sensitivity, predictive value positive, and the quality of ED data for TBI surveillance. In addition, the extent to which the applicant demonstrates a willingness to collaborate with CDC and the other funded project to address outcomes issues among persons treated in EDs for TBI.

9. Evaluation Plan: (10 points). The degree to which the applicant includes plans to evaluate the attainment of proposed objectives, including plans to evaluate the quality of the data collected through the registry.

10. Budget (not scored). The extent to which the budget is reasonable, clearly justified, and consistent with stated objectives and proposed activities described in this announcement.

11. Human Subjects (not scored). The applicant must clearly state what precautions are in place to protect human subjects. Activities under Part II of this announcement are subject to an IRB review at CDC. An IRB must also review this project at the State level. The State review should occur after the project has been reviewed at CDC (see also Human Subjects).

Funding Preferences: During the selection process CDC will attempt to ensure a balanced geographic distribution of funded TBI surveillance and registry projects.

Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs as governed by Executive Order (E.O.) 12372. E.O. 12372 sets up a system for State and local government review of proposed Federal assistance applications. Applicants should contact their State Single Point of Contact (SPOC) as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each affected State. A current list of SPOCs is included in the application kit. If SPOCs have any State process recommendations on applications submitted to CDC, they should send them to Ron Van Duyne, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Mailstop E–13, Atlanta, GA 30305. The receipt date for SPOC comments will be 60 days after publication in the **Federal Register**. The Program Announcement Number and Program Title should be referenced on the document. The granting agency does not guarantee to ''accommodate or explain'' the State process recommendations it receives after that date.

Public Health System Reporting Requirements

This program is not subject to the Public Health System Reporting Requirements.

Catalog of Federal Domestic Assistance Number

The Catalog of Federal Domestic Assistance number is 93.136.

Other Requirements

Paperwork Reduction Act

Projects that involve the collection of information from 10 or more individuals and funded by the cooperative agreement will be subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Human Subjects

If the proposed project involves research on human subjects, the applicant must comply with the Department of Health and Human Services Regulations, 45 CFR part 46, regarding the protection of human subjects (see Application Contents, parts I and II). Assurance must be provided to demonstrate that the project will be subject to initial and continuing review by an appropriate institutional review committee. The applicant will be responsible for providing assurance in accordance with the appropriate guidelines and form(s) provided in the application kit. Applicants under Part II of this announcement *are* subject to an IRB review at CDC. The CDC IRB review should occur before an IRB reviews the project at the State level. Additional information and forms will be available as part of the application package mentioned under **Where to Obtain Additional Information** Section.

Women and Racial and Ethnic Minorities

It is the policy of the CDC to ensure that women and racial and ethnic groups will be included in CDC-supported research projects involving human subjects, whenever feasible and appropriate. Racial and ethnic groups are those defined in OMB Directive No. 15 and include American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and Hispanic or Latino. Applicants shall ensure that women and racial and ethnic minority populations are appropriately represented in applications for research involving human subjects. Where clear and compelling rationale exist that inclusion is not feasible, this situation must be explained as part of the application. In conducting the review of applications for scientific merit, review groups will evaluate proposed plans for inclusion of minorities and both sexes as part of the scientific assessment and assigned score. This policy does not apply to research studies when the investigator cannot control the race, ethnicity and/or sex of subjects. Further guidance to this policy is contained in the **Federal Register**, Vol. 60, No. 179, Friday, September 15, 1995, pages 47947–47951.

Application Submission and Deadline

The original and two copies of the application PHS Form 5161–1 (OMB Number 0937–0189) must be submitted to Joanne Wojcik, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 300, Mailstop E–13, Atlanta, GA 30305, on or before May 7, 1998.

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

a. Received on or before the deadline date; or

b. Sent on or before the deadline date and received in time for submission to the objective review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks will not be acceptable as proof of timely mailing.)

2. Late Applications: Applications that do not meet the criteria in 1.a. or 1.b. above are considered late applications. Late applications will not be considered in the current competition and will be returned to the applicant.

Where to Obtain Additional Information

To receive additional written information call 1–888-GRANTS4 (1–888–472–6874). You will be asked your name and address and will need to refer to Announcement 98022. You will receive a complete program description, information on application procedures, and application forms. In addition, this announcement is also available through the CDC Home Page on the Internet. The address for the CDC Home Page is (http://www.cdc.gov).

If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from Joanne Wojcik, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Mailstop E–13, Atlanta, GA 30305, telephone (404) 842–6535, or Internet address jcw6@cdc.gov.

Programmatic technical assistance, including additional information developed by the existing registry project, may be obtained from Joseph Sniezek, M.D., Division of Acute Care, Rehabilitation Research and Disability Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop F–41, Atlanta, GA 30341–3724, telephone (404) 488–4244 or Internet address jes6@cdc.gov.

Please refer to Announcement 98022 when requesting information and submitting an application.

Potential applicants may obtain a copy of ''Healthy People 2000'' (Full Report, Stock No. 017–001–00474–0) or ''Healthy People 2000'' (Summary Report, Stock No. 017–001–00473–1) referenced in the **Introduction** Section through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325, telephone (202) 512–1800.

Dated: February 25, 1998.

Joseph R. Carter,

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

TRAUMATIC BRAIN INJURY SURVEILLANCE REFERENCES

Methods and Key Resources

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

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

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

Brooks CA, Gabella B, Hoffman R, Sosin D, Whiteneck G. Traumatic brain injury: designing and implementing a population-based follow-up system. Arch Phys Med Rehabil 1997; 78:S26–S30.

Epidemiologic Studies and Reviews

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

Kraus JF, McArthur DL. Epidemiologic aspects of brain injury. Neurologic Clinics 1996; 14(2):435–50.

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

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

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

A copy of these Guidelines can be obtained either by calling 770-488–4031, by submitting the ''NCIPC Publications Order Form'' through the Internet website of the National Center for Injury Prevention and Control <http://www.cdc.gov/ncipc/pub-res/pubsav.htm>, or by writing to the Division of Acute Care, Rehabilitation Research, and Disability Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop F–41, Atlanta, GA 30341–3724.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement Number 98029]

Grants for Violence-Related Injury Prevention Research; Notice of Availability of Funds for Fiscal Year 1998

Introduction

The Centers for Disease Control and Prevention (CDC) announces applications are being accepted for Violence-Related Injury Prevention Research Grants for fiscal year (FY) 1998.

The CDC is committed to achieving the health promotion and disease prevention objectives of Healthy People 2000, a national activity to reduce morbidity and mortality and improve the quality of life. This announcement is related to the priority area of Violent and Abusive Behavior (To order a copy of Healthy People 2000, see the Section Where to Obtain Additional Information.)

Authority

This program is authorized under sections 301, 391, 392 and 394 of the Public Health Service Act (42 U.S.C. 241, 280b, 280b–1 and 280b–2) as amended. Program regulations are set forth in Title 42 CFR, part 52.

Eligible Applicants

Eligible applicants include all nonprofit and for-profit organizations. Thus State and local health departments, State and local governmental agencies, universities, colleges, research institutions, and other public and private organizations, including small, minority and/or woman-owned businesses are eligible for these research grants. Current holders of CDC injury control research projects are eligible to apply.

Note: An organization described in section 501(c)(4) of the Internal Revenue Code of 1986 which engages in lobbying activities shall not be eligible to receive Federal funds constituting an award, grant, contract, loan, or any other form.

Smoke-Free Workplace

CDC strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products, and Pub. L. 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, child care, health care, and early childhood development services are provided to children.

Availability of Funds

Approximately $2.0 million is expected to be available for injury research grants in the areas of suicidal behavior, firearm-related injury, sexual violence, and intimate partner violence. The specific program priorities for these funding opportunities are outlined with examples in this announcement under the section, ''Programmatic Priorities.'' It is expected that the awards will begin on or about September 1, 1998, and will be made for 12-month budget periods within the appropriate (see below) project period. Funding estimated may vary and is subject to change.

For research projects targeting the areas of suicidal behavior and firearm-related injury, approximately $1,000,000 is available to fund 3–4 grants. Each grant will be supported for a maximum project period of three years at $300,000 per year (including both direct and indirect costs).

For research projects targeting sexual violence or intimate partner violence, approximately $1,000,000 is available to fund 3–4 grants. Each grant will be supported for a maximum project period of three years at $300,000 per year (including both direct and indirect costs). Applicants who are awarded grants targeting sexual violence or intimate partner violence and who collect data will be required to archive the data (minus any personal identifiers) and secure a privacy certificate (see the following section, Other Requirements).

Grant applications that exceed the $300,000 per year caps will be returned to the investigator as non-responsive.

Continuation awards within the project period will be made based on satisfactory progress demonstrated by investigators at work-in-progress monitoring workshops (travel expenses for this annual one day meeting should be included in the applicant's proposed budget), the achievement of workplan milestones reflected in the continuation application, and the availability of Federal funds. In addition, if funds are available, continuation awards may be eligible for increased funding to offset inflationary costs.

Use of Funds—Restrictions on Lobbying

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying Congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition, the FY 1998 HHS Appropriations Act expressly prohibits the use of 1998 appropriated funds for indirect or ''grass roots'' lobbying efforts that are designed to support or defeat legislation pending before State legislatures. Section 503 of Public Law 105–78, provides as follows:

(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, or any State legislature, except in presentation to the Congress or any State legislative body itself.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

Use of Funds—Prohibition on Use of CDC Funds for Certain Gun Control Activities

The Departments of Labor, Health and Human Services, and Education, and