percentage multiple of the guidelines such as 125 percent or 185 percent.

While many programs use the guidelines to classify persons or families as either eligible or ineligible, some other programs use the guidelines for the purpose of giving priority to lower-income persons or families in the provision of assistance or services.

In some cases, these poverty guidelines may not become effective for a particular program until a regulation or notice specifically applying to the program in question has been issued.

The poverty guidelines given above should be used for both farm and non-farm families. Similarly, these guidelines should be used for both aged and non-aged units. The poverty guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Definitions

There is no universal administrative definition of ''family,'' ''family unit,'' or ''household'' that is valid for all programs that use the poverty guidelines. Federal programs in some cases use administrative definitions that differ somewhat from the statistical definitions given below; the Federal office which administers a program has the responsibility for making decisions about its administrative definitions. Similarly, non-Federal organizations which use the poverty guidelines in non-Federally-funded activities may use administrative definitions that differ from the statistical definitions given below. In either case, to find out the precise definitions used by a particular program, please consult the office or organization administering the program in question.

The following statistical definitions (derived for the most part from language used in U.S. Bureau of the Census, Current Population Reports, Series P60–185 and earlier reports in the same series) are made available for illustrative purposes only; in other words, these statistical definitions are not binding for administrative purposes.

(a) Family

A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment, they would all be considered members of a single family.

(b) Unrelated Individual

An unrelated individual is a person 15 years old or over (other than an inmate of an institution) who is not living with any relatives. An unrelated individual may be the only person living in a house or apartment, or may be living in a house or apartment (or in group quarters such as a rooming house) in which one or more persons also live who are not related to the individual in question by birth, marriage, or adoption. Examples of unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.

(c) Household

As defined by the Census Bureau for statistical purposes, a household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units (see next item), but only one household. Some programs, such as the Food Stamp Program and the Low-Income Home Energy Assistance Program, employ administrative variations of the ''household'' concept in determining income eligibility. A number of other programs use administrative variations of the ''family'' concept in determining income eligibility. Depending on the precise program definition used, programs using a ''family'' concept would generally apply the poverty guidelines separately to each family and/or unrelated individual within a household if the household includes more than one family and/or unrelated individual.

(d) Family Unit

''Family unit'' is not an official U.S. Census Bureau term, although it has been used in the poverty guidelines **Federal Register** notice since 1978. As used here, either an unrelated individual or a family (as defined above) constitutes a family unit. In other words, a family unit of size one is an unrelated individual, while a family unit of two/three/etc. is the same as a family of two/three/etc.

Note that this notice no longer provides a definition of ''income.'' This is for two reasons. First, there is no universal administrative definition of ''income'' that is valid for all programs that use the poverty guidelines. Second, in the past there has been confusion regarding important differences between the statistical definition of income and various administrative definitions of ''income'' or ''countable income.'' The precise definition of ''income'' for a particular program is very sensitive to the specific needs and purposes of that program. To determine, for example, whether or not taxes, college scholarships, or other particular types of income should be counted as ''income'' in determining eligibility for a specific program, one must consult the office or organization administering the program in question; that office or organization has the responsibility for making decisions about the definition of ''income'' used by the program (to the extent that the definition is not already contained in legislation or regulations).

Dated: February 6, 2002.

Tommy G. Thompson,

Secretary of Health and Human Services.

[FR Doc. 02–3627 Filed 2–13–02; 8:45 am]

BILLING CODE 4154–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Nominations of Topics for EAvidence-based Practice Centers

AGENCY: Agency for Healthcare Research and Quality (AHRQ), DHHS.

ACTION: Nominations of topics for evidence reports and technology assessments.

SUMMARY: AHRQ invites nominations of topics for evidence reports and technology assessments relating to the prevention, diagnosis, treatment and management of common diseases and clinical conditions, as well as topics relating to organization and financing of health care. AHRQ's previous requests for topic nominations were published in the **Federal Register** on December 23, 1996, November 28, 1997, May 4, 1999, and November 13, 2000.

DATES: Topic nominations should be submitted by April 15, 2002, in order to be considered for the next group of evidence reports and technology assessments. In addition to timely responses to this request for nominations, AHRQ also accepts topic nominations on an ongoing basis. AHRQ will not reply to individual responses, but will consider all nominations during the selection process. Topics selected will be announced from time to time in the **Federal Register** and through AHRQ press releases.

ADDRESSES: Topics nominations should be submitted to Jacqueline Besteman, J.D., M.A., Director, Evidence-based Practice Centers (EPC) Program, Center

for Practice and Technology Assessment, AHRQ, 6010 Executive Boulevard, Suite 300, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Jacqueline Besteman, J.D., M.A., Center for Practice and Technology Assessment, AHRQ, 6010 Executive Blvd., Suite 300, Rockville, MD 20852; Phone: (301) 594–4017; Fax: (301) 594–4027; E-mail: *jbestema@ahrq.gov*

Arrangement for Public Inspection: All nominations will be available for public inspections at the Center for Practice and Technology Assessment, telephone (301) 594–4015, weekdays between 8:30 a.m. and 5 p.m. (Eastern time).

SUPPLEMENTARY INFORMATION:

1. Background

Under Title IX of the Public Health Service Act (42 U.S.C. 299a–299c) as amended by Public Law 106–129 (1999), AHRQ is charged with enhancing the quality, appropriateness, and effectiveness of health care services and access to such services. AHRQ accomplishes these goals through scientific research and through promotion of improvements in clinical practice and health systems practices including the prevention of diseases and other health conditions.

2. Purpose

The purpose of this **Federal Register** notice is to encourage participation and collaboration of professional societies, health systems, payors, and providers, with AHRQ as it carries out its mission to promote the practice of evidence-based health care. AHRQ serves as the science partner with private-sector and public organizations in their efforts to improve the quality, effectiveness, and appropriateness of health care delivery in the United States, and to expedite the translation of evidence-based research findings into improved health care services. AHRQ awards takes order contracts to its Evidence-based Practice Centers (EPCs) to undertake scientific analysis and evidence syntheses on high-priority topics. The EPCs produce science syntheses—evidence reports and technology assessments—that provide to public and private organizations the foundation for developing and implementing their own practice guidelines, performance measures, educational programs, and other strategies to improve the quality of health care and decision-making related to the effectiveness and appropriateness of specific health care technologies and services. The evidence reports and technology assessments also may be used to inform coverage and reimbursement policies.

In addition to clinical and behavioral research, as the body of scientific studies related to organization and financing of health care grows, systematic review and analysis of these studies can provide health system organizations with a scientific foundation for developing system-wide policies and practices. These reports may address and evaluate topics such as risk adjustment methodologies, market performance measures, provider payment mechanisms, and insurance purchasing tools, as well as provider integration of new scientific findings regarding health care and delivery innovations. To review topics that have been assigned to the EPCs between FY 1997 and FY 2001, visit AHRQ's Web site at *http://www.ahrq.gov/clinic/epc/#centers.*

3. Evidence-based Practice Centers (EPCs)

The EPCs prepare evidence reports and technology assessments on topics for which there is significant demand for information by health care providers, insurers, purchasers, health-related societies, and patient advocacy organizations. Such topics may include the prevention, diagnosis and/or treatment of particular clinical and behavioral conditions, use of alternative or complementary therapies, and appropriate use of commonly provided services, procedures, or technologies. Topics also may include issues related to the organization and financing of care. AHRQ widely disseminates the EPC evidence reports and technology assessments, both electronically and in print. The EPC evidence reports and technology assessments do not include clinical recommendations or recommendations or reimbursement and coverage policies.

4. Role/Responsibilities of Partners

Nominators of topics selected for development of an EPC evidence report or technology assessment assume the role of Partners of AHRQ and the EPCs. Partners have defined roles and responsibilities. AHRQ places high value on these relationships, and plans to review Partners' past performance of these responsibilities at such time as AHRQ is considering whether to accept additional topics nominated by an organization, in subsequent years. Specifically, Partners are expected to serve as resources to EPCs and they develop the evidence reports and technology assessments related to their nominated topic; serve as members of external peer reviewers of relevant draft evidence report and assessment; and commit to (a) timely translation of the EPC reports and assessments into their own quality improvement tools (*i.e.,* clinical practice guidelines, performance measures), educational programs, and reimbursement policies; and (b) dissemination of these derivative products to their membership. AHRQ also is interested in members' use of these derivative products and the products' impact on enhanced healthcare. AHRQ will look to the Partners to provide these use and impact data on products that are based on EPC evidence reports and technology assessments.

The AHRQ will review topic nominations and supporting information and determine final topics; seeking additional information as appropriate. AHRQ is very interested in receiving topic nominations from professional societies and organizations comprised of members of minority populations, as well as nomination of topics that have significant impact on the health status of women, children, ethnic and racial populations.

5. Topic Nomination and Selection Process

The processes that AHRQ employs a select topics nominated for analyses by the EPCs is described below. Section A addresses AHRQ's nomination process and selection criteria for clinical and behavioral topics. Section B addresses AHRQ's nomination process and selection criteria for organization and financing topics.

A. Section A: Clinical and Behavioral Topics

(a) Nomination Process for Clinical and Behavioral Topics

Nominations of clinical and behavioral topics for AHRQ evidence reports and technology assessments should focus on specific aspects of prevention, diagnosis, treatment and/or management of a particular condition, or on an individual procedure, treatment, or technology. Potential topics should be carefully defined and circumscribed so that the relevant published literature and other databases can be searched, evidence systematically reviewed, supplemental analyses performed, draft reports and assessments circulated for external peer review, and final evidence reports or technology assessments produced. Some reports and assessments can be completed within six months, if there is a small volume of literature to be systematically reviewed and analyzed. Other evidence reports and technology

assessments may required up to 12 months for completion due to complexity of the topic, the volume of literature to be searched, abstracted, and analyzed, and completion of the external peer review process. Topics selected will not duplicate current and widely available syntheses, unless new evidence is available that suggests the need for revisions or updates.

For each topic, the nominating organization must provide the following information: (a) Rationale and supporting evidence on the clinical relevance and importance of the topic; and (b) plans for rapid translation of the evidence reports and technology assessments into clinical guidelines, performance measures, educational programs, or other strategies for strengthening the quality of health care services, or plans to inform development of reimbursement or coverage policies; (c) plans for dissemination of these derivative products to their membership; and (d) process by which the nominating organization will measure the use of these products by their members, and impact of such use. Specifically, nomination information should include:

- Defined condition and target population.
- Three to five very focused questions to be answered.
- Incidence or prevalence, and indication of the disease burden (*e.g.,* mortality, morbidity, functional impairment) in the U.S. general population or in subpopulations (*e.g.,* Medicare and Medicaid populations). For prevalence, the number of cases in the U.S. and the number of affected persons per 1,000 persons in the general U.S. population should be provided. For incidence, the number of new cases per 100,000 a year should be provided.
- Costs associated with the clinical or behavioral condition, including average reimbursed amounts for diagnosis and therapeutic interventions (*e.g.,* average U.S. costs and number of persons who receive care for diagnosis or treatment in a year, citing ICD9–CM and CPT codes, if possible).
- Impact potential of the evidence report or technology assessment to decrease health care costs or to improve health status or clinical outcomes.
- Availability of scientific data and bibliographies of studies on the topic.
- References to significant differences in practice patterns and/or results; alternative therapies and controversies.
- Plans of the nominating organization to incorporate the report into its managerial or policy decision making (*i.e.,* rapid translation of the report or assessment into derivative products such as clinical practice guidelines or other quality improvement tools, or to inform reimbursement or coverage about a particular technology or service).
- Plans of the nominating organization for disseminating of these derivative products to its membership.
- Process by which the nominating organization will measure members' use of the derivative products, and measure the impact of such use, on clinical practice.

(b) Selection Criteria for Clinical Topics

Factors that will be considered in the selection of clinical topics for AHRQ evidence report and technology assessment topics include: (1) High incidence or prevalence in the general population and in special populations, including women, racial and ethnic minorities, pediatric and elderly populations, and those of low socieconomic status; (2) significance for the needs of the Medicare, Medicaid and other Federal health programs; (3) high costs associated with a condition, procedure, treatment, or technology, whether due to the number of people needing care, high unit cost of care, or high indirect costs; (4) controversy or uncertainty about the effectiveness or relative effectiveness of available clinical strategies or technologies; (5) impact potential for informing and improving patient or provider decision making; (6) impact potential for reducing clinically significant variations in the prevention, diagnosis, treatment, or management of a disease or condition, or in the use of a procedure or technology, or in the health outcomes achieved; (7) availability of scientific data to support the systematic review and analysis of the topic; (8) submission of nominating organization's plan to incorporate the report into its managerial or policy decision making, as defined above; and (9) submission of nominating organization's plan to disseminate derivative products to it members, and plan to measure members' use of these products, and the resultant impact of these products on clinical practice.

B. Section B: Organization and Financing Topics

(a) Nomination Process for Organization and Financing Topics

Nominations of organization and financing topics for AHRQ evidence reports should focus on specific aspects of health care organization and finance. Topics should be carefully defined and circumscribed so that relevant databases may be searched, the evidence systematically reviewed, supplemented analyses performed, draft reports circulated for external peer review, and final evidence reports produced. Reports can be completed within six months if there is a small volume of literature for systematic review and analysis. Some evidence reports may require up to 12 months for completion due to the complexity to the topic and the volume of literature to be searched, abstracted, analyzed. Topics selected will not duplicate current and widely available research syntheses, unless new evidence is available that suggests the need for revisions or updates.

For each topic, nominators should provide a rationale and supporting evidence on the importance and relevance of the topic. Nominators must also state their plans for use of the evidence report and indicate how the report could be used by public and private decision makers. Nomination information should include:

- Defined organizational/financial arrangement or structure impacting quality, outcomes, cost, access or use.
- Three to five focused questions to be answered.
- If appropriate, description of how the organizational/financial arrangement or structure is particularly relevant to delivery of care for specific vulnerable populations (*e.g.,* children, persons with chronic disease) or certain communities (*e.g.,* rural markets).
- Costs potentially affected by the organizational/financial arrangement, to the extent they can be quantified.
- Impact potential of the evidence report to decrease health care costs or to improve health status or outcomes.
- Availability of scientific and/or administrative data and bibliographies of studies on the topic.
- References to significant variation in delivery and financing patterns and/or results, and related controversies.
- Nominator's plan for use of an evidence report on the topic.
- Nominator's plan for measuring the impact of the report on practice.

(b) Selection Criteria for Organization and Financing Topics

Factors that will be considered in the selection of topics related to the organization and financing of care include the following: (1) Uncertainty about the impact of the subject organizational or financing strategy; (2) potential for the subject organizational or financing strategy or the proposed research synthesis to significantly impact aggregate health care costs; (3) policy-relevant to Medicare, Medicaid, and/or other Federal and State health programs; (4) relevant to vulnerable

populations, including racial and ethnic minorities, and particular communities, such as rural markets; (5) available scientific data to support systematic review and analysis of the topic; (6) plans of the nominating organization to incorporate the report into its managerial or policy decision-making; and (7) plans by the nominating organization to measure the impact of the report on practice.

Dated: February 8, 2002.

John M. Eisenberg,

Director.

[FR Doc. 02–3566 Filed 2–13–02; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality Notice of Meeting

In accordance with section 10(d) of the Federal Advisory Committee Act (5 U.S.C., Appendix 2), announcement is made of a Health Care Policy and Research Special Emphasis Panel (SEP) meeting.

The Health Care Policy and Research Special Emphasis Panel is a list of experts in fields related to health care research who are invited by the Agency for Healthcare Research and Quality (AHRQ) and agree to be available, to conduct, on an as needed basis, scientific reviews of applications for AHRQ support. Individual members of the Panel do not meet regularly and do not serve for fixed or long terms. Rather, they are asked to serve for particular review meetings which require their type of expertise.

Substantial segments of the upcoming SEP meeting listed below will be closed to the public in accordance with the Federal Advisory Committee Act, section 10(d) of 5 U.S.C., Appendix 2 and 5 U.S.C. 552b(c)(6). Grant applications for Cooperative Agreement Awards are to be reviewed and discussed at this meeting. These discussions are likely to include personnel information concerning individuals associated with these applications. This information is exempt from mandatory disclosure under the above-cited statutes.

1. *SEP Meeting on:* Consumer Assessments of Health Plans Study, Phase II (CAHPS).

Date: March 11, 2002 (Open on March 11, from 8:00 a.m. to 8:15 a.m. and closed for remainder of the meeting).

Place: Hyatt Regency, Susquehanna Room, One Bethesda Metro Center, Bethesda, MD 20814.

Contact Person: Anyone wishing to obtain a roster of members or minutes of this meeting should contact Mrs. Bonnie Campbell, Committee Management Officer, Office of Research Review, Education and Policy, AHRQ, 2101 East Jefferson Street, Suite 400, Rockville, Maryland 20852, Telephone (301) 594–1846.

Agenda items for this meeting are subject to change as priorities dictate.

Dated: February 11, 2002.

John M. Eisenberg,

Director.

[FR Doc. 02–3678 Filed 2–13–02; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 02025]

Cooperative Agreement for Epidemiologic Studies of Birth Defects and Developmental Disabilities, and the Promotion of Optimal Birth Outcomes in China; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2002 funds for a cooperative agreement program for epidemiologic studies of birth defects and other reproductive and developmental outcomes in China.

B. Eligible Applicant

Assistance will be provided only to the National Center for Maternal and Infant Health, Peking University Health Science Center, Beijing, People's Republic of China. No other applications are solicited.

The People's Republic of China (PRC) is the most appropriate country, and the Peking University Health Science Center (PUHSC) (formerly Beijing Medical University [BMU]) is the most appropriate institution to conduct the work under this cooperative agreement.

The National Center for Maternal and Infant Health (NCMIH) at PUHSC.

Scientists at PUHSC have successfully collaborated with CDC on a large community intervention program of folic acid supplementation to prevent neural tube defects, including almost 250,000 women; and currently maintain surveillance of four large cohorts. These scientists have experience in all areas of birth defects research including clinical pediatrics and dysmorphology, epidemiology, public health, statistics, and laboratory science. Extensive data sets on perinatal health, birth outcome, and birth defects surveillance are maintained at PUHSC.

NCMIH functions as the national research center on health care, clinical epidemiology, and public health; and the national laboratory for reproductive health research. In addition, it is a national training center for professional technical personnel in medical epidemiological research and public health; an information management center for birth outcomes and reproductive health, and a consulting and advising center for the promotion of international academic exchange and cooperation.

Population Characteristics and Childbearing Practices in China.

China has a large, stable, and relatively homogeneous population, registration for marriage is required, and virtually all pregnancies are planned. Women who may be eligible to participate in clinical trials or other birth defects prevention programs can therefore be identified early, at the time of registration for marriage.

Approximately 80 percent of women in China become pregnant within one year of marriage. In accordance with family planning practices, most women, particularly in urban areas, have only one child. Thus, the PRC is well-suited for evaluating interventions directed toward the prevention of birth defects and adverse pregnancy outcomes, or for studying varying doses and schedules of nutritional supplements without interfering with national recommendations for women who are newly married or planning a pregnancy.

China Public Health Priorities.

Ensuring an optimal birth outcome is a national health priority in the PRC. In June 2001, the implementation procedure for the Maternal and Child Health Law (enacted July 1, 1995) was signed by Premier Zhu Rongji. Under the provisions of this law, all women are entitled to receive reproductive health services to ensure a healthy pregnancy and a healthy baby. As a result of the capabilities of the PUHSC, the Ministry of Health is expected to identify the NCMIH as the main technical unit for implementation of the law.

One of the major components of the implementation plan is the prevention of birth defects and reduction of infant mortality.

In addition, the Ministry of Science and Technology has taken responsibility for a number of projects to prevent birth defects and disabilities. Among these are (1) determining risk factors for congenital cardiac defects in China, (2)