DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Enhancing Utilization of Childhood Immunization Client Recall Practices by Private Providers

Announcement Type: New.

Funding Opportunity Number: RFA IP05–088.

Catalog of Federal Domestic Assistance Number: 93.185.

Letter of Intent Deadline: June 10, 2005.

Application Deadline: June 27, 2005.

I. Funding Opportunity Description

Authority: Section 311 [42 U.S.C. 243] and 317 (k)(1) [42 U.S.C. 247b (k)(1)] of the Public Health Service Act, as amended.

Background

Client recall interventions have been strongly recommended by the Task Force of Community Preventive Services as a strategy to increase vaccination coverage among infants and young children who have missed one or more of vaccinations (''Am J Prev Med 2000''; 18 (1S), 97–140). The Task Force has recommended this practice in a range of settings and populations and a range of scales (from individual practice settings to entire communities), either in isolation or as part of a multifaceted program. In addition, studies have been implemented in a range of settings, including academic clinical practice, public health settings, managed care, private practice, and community-wide settings.

However, immunization recall interventions have not been widely adopted by private practitioners. Nationally, fewer than 20 percent of private providers use a recall system (''Pediatrics 2003''; 112:1076–1082). Several barriers include lack of time and funding and the inability to identify children at specific ages. A strong predictor of current use of recall messages is having a key person (champion) to lead the recall effort. Anecdotal evidence suggests that practitioners might have difficulty identifying all age cohorts, but would be more willing to identify a cohort of children of a specified age. Data from the National Immunization Survey suggests that, by seven months, 46 percent of infants have fallen behind the recommended schedule, and by 16 months of age, 31 percent remain behind. These two milestones, increasing 7 and 16 months immunization rates, may represent critical times when recall interventions could be productive.

Purpose

The purpose of the program is to increase the use of immunization recall office procedures among private practitioners who immunize children in a given community. Community is defined as a group of practitioners located within a geographic boundary. This program addresses the ''Healthy People 2010'' focus area of Immunization and Infectious Diseases, specifically the ''Healthy People 2010'' Objective 14–22, which calls for achieving and maintaining effective vaccination coverage levels for universally recommended vaccines among young children, using a target goal of 90 percent up-to-date (UTD) immunization by 2010 for children 19–35 months old.

Measurable outcomes of the program will be in alignment with the performance goal for the Center for Disease Control and Prevention's (CDC) National Immunization Program (NIP) to reduce the number of indigenous vaccine-preventable diseases.

Research Objectives:

- Identify factors that facilitate or impede the use of a recall mechanism among private practitioners in a defined community;
- Develop a community-based program to overcome such barriers and enhance recall practices throughout the entire geographic community; and
- Test how effectively the program results in adoption of recall mechanisms by local private providers.

Activities

Definition: Community-based intervention is defined here as an intervention program provided to all primary care physicians (principally, pediatricians and family practice physicians) in the community. For example, a general education program provided to all such physicians in a community concerning the value of using a client recall program in their practice would qualify. On the other hand, a study involving pre-selection and enrollment of only certain local physicians, followed by an intervention provided only to them, even if designed to provide them with skills or materials suitable to achieve the outcome desired, would not qualify.

Awardee activities for this program are as follows:

1. Identify two geographic communities in which relatively few primary care providers (suggested range, 10–30 percent of practices) use client recall procedures to notify and schedule children in their practice to return for an immunization office visit. One community will serve as the intervention community, the other as the control. The control community should be demographically similar to the intervention community, but will not be exposed to the intervention. The control and intervention communities must be evaluated at the same time intervals and in the same manner during the study.

2. In both communities, determine the knowledge, attitudes, and practices of local private providers and their staff concerning the use of client recall procedures in their office practices.

3. Develop or use existing relationships with university faculty, state and/or local health department personnel, and an immunization coalition to conduct this study. The participation of each of these three groups should be active and substantial. University faculty should be qualified and interested in conducting program evaluation research.

4. Develop (or use an existing) coalition (or alternatively, a partnership, task force, or advisory board) to periodically monitor and provide timely feedback on all programmatic activities. If such a coalition does not presently exist, the applicant must describe how either a broad-based coalition or advisory board will be developed during the first six months. Members should include physicians and nurses who treat children, health educators, and pharmacists; officials from government health departments and social services; administrative representatives from health care organizations, licensed child care centers, health maintenance organizations, insurers, and hospitals; and interested parents, business, and community leaders.

5. Within the intervention community, identify practice-based or physician-based barriers and facilitators to the establishment and/or on-going use of client recall procedures.

6. Use this information to create, develop, and administer a community-based intervention program, as defined above, that is designed to overcome identified barriers or optimize the use of facilitators to the adoption of client recall procedures. Such methods may include the use of education, non-cash incentives, and other, preferably novel methods. Program elements should be readily applicable to many types of practices, or alternatively, have the capacity to be easily tailored to each type of practice. The program may involve, for example, academic detailing, equipment purchase, train-the-trainer, management and training by

the state or local health department or local immunization coalition, incentives by a local professional organization, or other methods. Multifaceted incentive programs are generally preferred over those with only one feature.

7. Recall programs must, at a minimum, target under immunized children at two discrete ages, seven months and 16 months old. Special attention should be paid to children known to have lived at more than one address by their first birthday. At least six cycles should be conducted at each age; that is, each practice should conduct monthly recalls for seven-month-olds and 16 month-olds at least six times during the two-year grant period. Patient recall may be conducted using either mail, e-mail, or telephone methods, which may involve personal calls or auto-dialer techniques.

8. Justification should be shown to demonstrate that any motivators or (non-cash) reward system is low-cost and cost-efficient.

9. Assess the feasibility of providing the proposed intervention program to the entire community before its full institution.

10. Provide the program throughout the intervention community over two years.

11. Measure the actual cost of the intervention program from the provider's perspective.

12. Measure the degree to which the intervention is associated with adoption of recall procedures among all private practices in the intervention community, and compare this with any secular trends in adoption of recall procedures in the control community. Within those practices that conduct any client recall procedures, collect and report key process measures of these functions. For example, measure the number of telephone contacts made, proportion of mailed recall notices returned undeliverable, how many months the office used the recall process, changes in daily functions believed locally to support the continued use of recall, etc. The benchmark of success for this project will be the adoption and on-going use (at 24 months) of recall procedures by 20 percent more practices in the intervention above the corresponding measure in the control community by the end of the two-year period. Alternatively, for relatively populous geographic areas, adoption of recall procedures by at least 10 more practices in the intervention vs. the control community during this period will denote success.

13. At the end of the project period, document changes in vaccination coverage, using 4:3:1:3:3:1 Up to Date (UTD) coverage rates as the standard. (For varicella, history of disease should be taken into account.) Additionally, measure changes in provider's knowledge, attitudes, and practices concerning infant and child immunization that have resulted from the program. All such results should be compared with corresponding findings in the control community.

14. Collaboratively disseminate research findings in peer-reviewed publications and for use in determining national policy.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC activities for this program are as follows:

1. Provide CDC investigator(s) to monitor the cooperative agreement as project officer(s).

2. Participate as active project team members in the development, implementation and conduct of the research project and as coauthors of all scientific publications that result from the project.

3. Provide technical assistance on site selection, data collection instruments, analysis, and evaluation methods.

4. Assist in the development of research protocols for Institutional Review Boards (IRB) review. The CDC IRB will review and approve the project protocol initially and on at least an annual basis until the research project is completed.

5. Contribute subject matter expertise in the areas of epidemiologic and survey methods and statistical analysis.

6. Participate in the analysis and dissemination of information, data and findings from the project to facilitate dissemination of results.

7. Serve as liaisons between the recipients of the project award and other administrative units within the CDC.

8. Facilitate an annual meeting between awardee and CDC to coordinate planned efforts and review progress.

II. Award Information

Type of Award: Cooperative Agreement.

CDC involvement in this program is listed in the Activities Section above.

Mechanism of Support: UO1.

Fiscal Year Funds: 2005.

Approximate Total Funding: $300,000. (Includes direct and indirect costs. This amount is an estimate, and is subject to availability of funds.)

Approximate Number of Awards: One.

Approximate Average Award: $300,000. (Includes direct and indirect costs. This amount is for the first 12-month budget period.)

Floor of Award Range: None.

Ceiling of Award Range: $300,000. (Includes direct and indirect costs. This ceiling is for the first 12-month budget period.)

Anticipated Award Date: August 31, 2005.

Budget Period Length: 12 months.

Project Period Length: Two (2) years.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

III.1. Eligible Applicants

Applications are limited to public and private nonprofit organizations and by governments and their agencies, such as: (For profit organizations are not eligible under Section 317(k)(1) [42 U.S.C. 247b(k)(1)] of the Public Health Service Act, as amended.)

- Public nonprofit organizations.
- Private nonprofit organizations.
- Small, minority, women-owned businesses.
- Universities.
- Colleges.
- Research institutions.
- Hospitals.
- Community-based organizations.
- Faith-based organizations.
- Federally recognized Indian tribal governments.
- Indian tribes.
- Indian tribal organizations.
- State and local governments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau).
- Political subdivisions of States (in consultation with States).

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If you are applying as a bona fide agent of a state or local government, you must provide a letter from the state or local government as documentation of your status. Place this documentation behind the first page of your application form.

III.2. Cost Sharing or Matching

Matching funds are not required for this program.

III.3. Other

If you request a funding amount greater than the ceiling of the award range, your application will be considered non-responsive, and will not be entered into the review process. You will be notified that your application did not meet the submission requirements.

Special Requirements

If your application is incomplete or non-responsive to the requirements listed in this section, it will not be entered into the review process. You will be notified that your application did not meet submission requirements.

- Late applications will be considered non-responsive. See section ''IV.3. Submission Dates and Times'' for more information on deadlines.
- Document in the Appendix that eligibility satisfies the criteria of Section III.1.
- **Note:** Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, or loan.

Individuals Eligible To Become Principal Investigators: Any individual or institution with the skills, knowledge, and resources necessary to carry out the proposed research is invited to work with their institution to develop an application for support. Individuals from underrepresented racial and ethnic groups as well as individuals with disabilities are always encouraged to apply for CDC programs.

IV. Application and Submission Information

IV.1. Address To Request Application Package

To apply for this funding opportunity, use application form PHS 398 (OMB number 0925–0001 rev. 9/2004). Forms and instructions are available in an interactive format on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/forminfo.htm.*

Forms and instructions are also available in an interactive format on the National Institutes of Health (NIH) Web site at the following Internet address: *http://grants.nih.gov/grants/funding/phs398/phs398.html.*

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO–TIM) staff at: 770–488–2700. Application forms can be mailed to you.

IV.2. Content and Form of Application Submission

Letter of Intent (LOI)

Your LOI must be written in the following format:

- Maximum number of pages: Three.
- Font size: 12-point unreduced.
- Double-spaced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Printed only on one side of page.
- Written in plain language, avoid jargon.

Your LOI must contain the following information:

- Descriptive title of the proposed research.
- Name, address, E-mail address, telephone number, and FAX number of the Principal Investigator.
- Names of other key personnel.
- Participating institutions.
- Number and title of this Announcement.

Application: Follow the PHS 398 application instructions for content and formatting of your application. For further assistance with the PHS 398 application form, contact PGO–TIM staff at 770–488–2700, or contact GrantsInfo, Telephone (301) 435–0714, E-mail: *GrantsInfo@nih.gov.*

Your research plan should address activities to be conducted over the entire project period.

You are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. Your DUNS number must be entered on line 11 of the face page of the PHS 398 application form. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *www.dunandbradstreet.com* or call 1–866–705–5711.

For more information, see the CDC Web site at: *http://www.cdc.gov/od/pgo/funding/pubcommt1.htm.*

This announcement uses the non-modular budgeting format.

Additional requirements that may require you to submit additional documentation with your application are listed in section ''VI.2. Administrative and National Policy Requirements.''

IV.3. Submission Dates and Times

LOI Deadline Date: June 10, 2005.

CDC requests that you send a LOI if you intend to apply for this program. Although the LOI is not required, not binding, and does not enter into the review of your subsequent application, the LOI will be used to gauge the level of interest in this program, and to allow CDC to plan the application review.

Application Deadline Date: June 27, 2005.

Explanation of Deadlines: LOIs must be received in the CDC Office of Public Health Research (OPHR) and applications must be received in the CDC Procurement and Grants Office by 4 p.m. Eastern Time on the deadline date. If you submit your LOI or application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery by the closing date and time. If CDC receives your submission after closing due to: (1) Carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, you will be given the opportunity to submit documentation of the carriers guarantee. If the documentation verifies a carrier problem, CDC will consider the submission as having been received by the deadline.

This announcement is the definitive guide on LOI and application content, submission address, and deadline. It supersedes information provided in the application instructions. If your application does not meet the deadline above, it will not be eligible for review, and will be discarded. You will be notified that you did not meet the submission requirements.

CDC will not notify you upon receipt of your submission. If you have a question about the receipt of your LOI or application, first contact your courier. If you still have a question concerning your LOI, contact the OPHR staff at 404–371–5277. If you still have a question concerning your application, contact the PGO–TIM staff at: 770–488–2700. Before calling, please wait two to three days after the submission deadline. This will allow time for submissions to be processed and logged.

IV.4. Intergovernmental Review of Applications

Your application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for state and local governmental review of proposed federal assistance applications. You should contact your state single point of contact (SPOC) as early as possible to alert the SPOC to

prospective applications, and to receive instructions on your state's process. Click on the following link to get the current SPOC list: *http://www.whitehouse.gov/omb/grants/spoc.html.*

IV.5. Funding Restrictions

Restrictions, which must be taken into account while writing your budget, are as follows:

- Funds relating to the conduct of research will not be released until the appropriate assurances and IRB approvals are in place.
- Reimbursement of pre-award costs is not allowed.

If you are requesting indirect costs in your budget, you must include a copy of your indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

IV.6. Other Submission Requirements

LOI Submission Address: Submit your LOI by express mail, delivery service, fax, or E-mail to: Mary Lerchen, DrPH, Scientific Review Administrator, CDC/Office of Public Health Research, One West Court Square, Suite 7000, MS D–72. Telephone: 404–371–5277. Fax: 404–371–5215. E-mail: *MLerchen@cdc.gov.*

Application Submission Address: Submit the original and one hard copy of your application by mail or express delivery service to: Technical Information Management—RFA IP05–088, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

At the time of submission, four additional copies of the application, and all appendices must be sent to: Mary Lerchen, DrPH, Scientific Review Administrator, CDC/Office of Public Health Research, One West Court Square, Suite 7000, MS D–72. Telephone: 404–371–5277. Fax: 404–371–5215. E-mail: *MLerchen@cdc.gov.*

Applications may not be submitted electronically at this time.

V. Application Review Information

V.1. Criteria

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. The benchmark of success for this project will be the adoption of recall procedures by 20 percent more practices in the intervention vs. the control community by the end of the two-year period. Alternatively, for relatively populous geographic areas, adoption of recall procedures by at least 10 practices during this period will denote success. Other measures of effectiveness must relate to the performance goals stated in the ''Purpose'' section of this announcement. Measures must be objective and quantitative, and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation.

The goals of CDC-supported research are to advance the understanding of biological systems, improve the control and prevention of disease and injury, and enhance health. In the written comments, reviewers will be asked to evaluate the application in order to judge the likelihood that the proposed research will have a substantial impact on the pursuit of these goals.

The scientific review group will address and consider each of the following criteria equally in assigning the application's overall score, weighting them as appropriate for each application. The application does not need to be strong in all categories to be judged likely to have major scientific impact and thus deserve a high priority score. For example, an investigator may propose to carry out important work that by its nature is not innovative, but is essential to move a field forward.

The review criteria are as follows:

Significance: Does this study address an important problem in this community? If the aims of the application are achieved, how will scientific knowledge be advanced? What will be the effect of these studies on the concepts or methods that drive this field?

The applicant must address the needs of a community containing at least 50 private provider offices of pediatricians, family practitioners, or doctors of osteopathy where childhood immunizations are given. A separate community of similar size and demographic composition should be used as a control group. In each, recall procedures should be currently in practice in relatively few such offices, preferably 10–30 percent. The application should document in the research plan the approximate number of provider offices and the proportion with recall procedures in place. The cohort of office practices should include relatively large (more than 10 immunizing physicians) as well as small practices with one or two immunizing physicians). If the target audience represents multiple private practices, such practices may not have a single, central administrative authority. No more than half the practices involved should be located in a central county area; the other practices should then be located in one or more outlying counties of the core based statistical area (see *http://www.census.gov/population/www/estimates/aboutmetro.html* for definition of terms). Practices where no broad scale or comprehensive recall program has existed during the past 12 months are less likely to be subjected to confounding by other factors, and are therefore preferred.

Approach: Are the conceptual framework, design, methods, and analyses adequately developed, well-integrated, and appropriate to the aims of the project? Does the applicant acknowledge potential problem areas and consider alternative tactics?

If the proposed intervention involves direct communication with office practice staff, the applicant must include in the Appendix letters of support indicating agreement concerning their access to a variety of types of provider offices, or alternatively, note their experience in conducting on-site interventions in practitioner's offices and discuss ways they intend to overcome such barriers. The applicant should specify their progress to date in identifying both the intervention and control group of physicians/practices. The control group should be one not exposed to the program, yet evaluated at the same time intervals as the intervention group to control for secular changes in office practice procedures.

Innovation: Does the project employ novel concepts, approaches or methods? Are the aims original and innovative? Does the project challenge existing paradigms or develop new methodologies or technologies?

Novel methods that induce system changes by providing non-cash incentives or removing disincentives should be considered.

Investigator: Is the investigator appropriately trained and well suited to carry out this work? Is the work proposed appropriate to the experience level of the principal investigator and other researchers (if any)?

The applicant must develop or use existing relationships with each of three groups—university faculty, state and/or local health department personnel, and an immunization coalition—to conduct this study. University faculty should have experience in conducting program evaluation research. The participation of each of these three groups should be active and substantial, and their agreement to participate documented in letters of support in the Appendix. The applicant should develop (or use an existing) coalition, partnership, task force, or advisory board to provide

timely feedback on all programmatic activities. If such a coalition does not presently exist, the applicant must describe how either a broad-based coalition or advisory board will be developed during the first six months. This coalition should consist of physicians and nurses who treat children, health educators, and pharmacists; officials from government health department and other key health and social services; administrative representatives from health care organizations, licensed child care centers, health maintenance organizations, insurers, and hospitals; and interested parents, business, and community leaders.

Environment: Does the scientific environment in which the work will be done contribute to the probability of success? Do the proposed experiments take advantage of unique features of the scientific environment or employ useful collaborative arrangements? Is there evidence of institutional support? Are letters of support included, if appropriate?

Additional Review Criteria: In addition to the above criteria, the following items will be considered in the determination of scientific merit and priority score:

1. Degree to which the basis of selecting the intervention and control communities is described in the application.

2. Degree of support for the project expressed by immunization providers and key stakeholders in the intervention community.

3. Degree to which the intended program intervention is described, and any preliminary or pilot information that suggests the degree to which it might be effective in this community.

4. Ability of applicant to recruit immunization provider private practices for this or other similar interventions.

5. Degree to which activities are specific, measurable, and appropriately time-framed.

6. Extent to which applicant documents plan to sustain use of recall procedures in the community following the termination of this project.

7. To what extent is each component of the Special Requirements (see Section III.3) met?

Protection of Human Subjects from Research Risks: Does the application adequately address the requirements of Title 45 Part 46 for the protection of human subjects? The involvement of human subjects and protections from research risk relating to their participation in the proposed research will be assessed.

Inclusion of Women and Minorities in Research: Does the application adequately address the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed research? This includes: (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.

Budget: The reasonableness of the proposed budget and the requested period of support in relation to the proposed research. The priority score should not be affected by the evaluation of the budget.

V.2. Review and Selection Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) and for responsiveness by the OPHR. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified that their application did not meet submission requirements.

Applications that are complete and responsive to the announcement will be evaluated for scientific and technical merit by an appropriate peer review group or charter study section convened by the OPHR in accordance with the review criteria listed above. As part of the initial merit review, all applications may:

- Undergo a process in which only those applications deemed to have the highest scientific merit by the review group, generally the top half of the applications under review, will be discussed and assigned a priority score.
- Receive a written critique.
- Receive a second programmatic level review by the Office of Science, National Immunization Program.
- Undergo a peer review by a Special Emphasis Panel (SEP). The SEP will be selected from the NIH pool of scientists or recommendations from the National Immunization Program to serve as reviewers on SEPs. Applications will be ranked for the secondary review according to scores submitted by the SEP. Only those applications deemed to have the highest scientific merit by the review group, generally the top half of the applications under review, will be discussed and assigned a priority score.

Award Criteria: Criteria that will be used to make award decisions during the programmatic review include:

- Scientific merit (as determined by peer review).
- Availability of funds.
- Programmatic priorities.

V.3. Anticipated Announcement and Award Dates

Award Date: August 31, 2005

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer, and mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

45 CFR Part 74 and Part 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: *http://www.access.gpo.gov/nara/cfr/cfr-table-search.html.*

The following additional requirements apply to this project:

- AR–1 Human Subjects Requirements.
- AR–2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research.
- AR–7 Executive Order 12372.
- AR–10 Smoke-Free Workplace Requirements.
- AR–11 Healthy People 2010.
- AR–12 Lobbying Restrictions.
- AR–15 Proof of Non-Profit Status.
- AR–22 Research Integrity.
- AR–24 Health Insurance Portability and Accountability Act Requirements.
- AR–25 Release and Sharing of Data.

Additional information on these requirements can be found on the CDC Web site at the following Internet address: *http://www.cdc.gov/od/pgo/funding/ARs.htm.*

VI.3. Reporting

You must provide CDC with an original, plus two hard copies of the following reports:

1. Interim progress report, (use form PHS 2590, OMB Number 0925–0001,

rev. 9/2004 as posted on the CDC Web site) no less than 90 days before the end of the budget period. The progress report will serve as your non-competing continuation application, and must contain the following additional elements:

a. Progress Toward Measures of Effectiveness.

b. Additional Information Requested by Program.

2. Financial status report, no more than 90 days after the end of the budget period.

3. Final financial and performance reports, no more than 90 days after the end of the project period.

These reports must be mailed to the Grants Management Specialist listed in the ''Agency Contacts'' section of this announcement.

VII. Agency Contacts

We encourage inquiries concerning this announcement.

For general questions, contact: Technical Information Management Section, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770–488–2700.

For scientific/research issues, contact: Susan Chu, PhD, MSPH, Extramural Program Official, Centers for Disease Control and Prevention, National Immunization Program, MS E–05, 1600 Clifton Road NE, Atlanta, GA 30333. Telephone: (404) 639–8727. E-mail: *SChu@cdc.gov.*

For questions about peer review, contact: Mary Lerchen, DrPH, Scientific Review Administrator, CDC/Office of Public Health Research, One West Court Square, Suite 7000, MS D–72, Telephone: 404–371–5277. Fax: 404–371–5215. E-mail: *MLerchencdc.gov.*

For financial, grants management, or budget assistance, contact: Sharron Orum, Grants Management Specialist, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341. Telephone: (770) 488–2716. E-mail: *spo2@cdc.gov.*

VIII. Other Information

This and other CDC funding opportunity announcements can be found on the CDC Web site, Internet address: *http://www.cdc.gov.* Click on ''Funding'' then ''Grants and Cooperative Agreements.''

Dated: May 5, 2005.

William P. Nichols,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 05–9372 Filed 5–10–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Developing Methods and Strategies To Increase Use of Immunization Registries by Private Providers

Announcement Type: New.

Funding Opportunity Number: RFA IP05–096.

Catalog of Federal Domestic Assistance Number: 93.185.

Letter of Intent Deadline: June 10, 2005.

Application Deadline: June 27, 2005.

I. Funding Opportunity Description

Authority: Section 311 [42 U.S.C. 243] and 317 (k)(1) [42 U.S.C. 247b (k)(1)] of the Public Health Service Act, as amended.

Background

Immunization registries are confidential, computerized information systems that collect vaccination histories and help ensure correct and timely immunizations, especially for children. Even though the United States currently enjoys the highest immunization rates and lowest disease levels ever, the growing complexity of the childhood vaccination schedule, as well as the need to vaccinate a new birth cohort of four million infants each year, makes such recordkeeping imperative. Inaccurate vaccination histories could lead to unnecessary immunization or missed opportunities for immunization. Because about 20 percent of children see a second provider during the second year of life and the paper records from the first provider may not be available, there is some risk that toddlers may receive an unnecessary vaccination. This waste increases the cost of medical care and results in an unnecessary injection for the young child. On the other hand, if a provider who sees a child for some but not all immunizations relies on the parent's hand-held vaccination records, a missed opportunity for immunization may occur if the parent forgets to bring in the child's records. The provider may then either (1) remind the parent verbally at the time to bring in the record for review at the next visit, or (2) attempt to obtain all immunization records from other known immunization providers, a time-intensive function. Instead, by electronically combining such records, registries can reduce both the possibility of extra immunizations as well as missed opportunities, as well as enhance other aspects of an immunization program by identifying at-risk and high-risk persons.

Presently 44 states have statewide or regional registries. Nationwide, although about 75 percent of public vaccination providers use them, only an estimated 31 percent of private providers do so. Only seven states have a majority (75 percent) of providers using their central registry. Although studies indicate that providers in general support registry use, several barriers persist. Many providers are not aware of the existence of a registry, despite significant promotion. Many are concerned that the registry available to them is not easily integrated into their other data systems (*e.g.*, appointments, billing, electronic medical records), lacks accuracy compared with hard copy records, or does not already contain the immunization history of patients sufficient to make real-time decisions in the office. Fees and other costs are perceived as a barrier as well. However, published research has refuted the basis of many of these perceptions. CDC has found that the median cost per child younger than six years is $4.71; another recent study estimated the per-shot additional cost at 56¢. Further, where a strong computer record system was put into place, registries were found to be 78 percent sensitive, compared with only 55 percent sensitivity for parental vaccination cards.

Given the presently low use of registries in private office practices, coupled with the high proportion of children (greater than 60 percent according to the 2003 National Immunization Survey) who receive at least some immunizations by private practitioners, a high degree of acceptance and use of registries by private providers is critical to its long-term success.

Purpose

This study is designed to determine methods and strategies to overcome obstacles to full, active participation of a state or county-based immunization registry (''central registry'') by private practitioners. The methods and strategies developed and applied will seek to change procedures in those private practice offices in which county or state based immunization registries are not fully and actively used.

Several definitions apply for the purpose of this Announcement. ''Community-based intervention'' is defined here as an intervention program provided to all primary care physicians (principally, pediatricians and family practice physicians) in the community. For example, a general education