FOR MORE INFORMATION PLEASE CONTACT: Michelle A. Smith, Assistant to the Board; 202–452–2955.

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.federalreserve.gov* for an electronic announcement that not only lists applications, but also indicates procedural and other information about the meeting.

Dated: February 22, 2002.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 02–4641 Filed 2–22–02 2:15 pm]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

[Docket No. R–1098]

Pro Forma Financial Statements for Federal Reserve Priced Services

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Notice.

SUMMARY: After considering comments received in response to its requests for comment on a proposal to discontinue the quarterly publication of interim pro forma financial statements for Federal Reserve priced services in March 2001, the Board has determined that the priced-services pro forma financial statements will only be produced annually.

EFFECTIVE DATE: February 19, 2002.

FOR FURTHER INFORMATION CONTACT: For questions regarding the priced-services pro forma financial statements contact Gregory L. Evans, Manager (202/452–3945); or Elizabeth Miyagi, Financial Analyst (202/452–2222), Division of Reserve Bank Operations and Payment Systems. For users of Telecommunication Device for the Deaf (TDD) only, please contact 202/263–4869.

SUPPLEMENTARY INFORMATION: The Board has published pro forma financial statements for Federal Reserve priced services (pro formas) quarterly and annually since 1984. Essentially, the purpose of the pro formas is to provide information to the public regarding the financial results of Reserve Bank priced services activities and to allow the public to assess Federal Reserve compliance with the Monetary Control Act (MCA).

The MCA requires the Federal Reserve to set fees for priced services to recover total costs over the long run. The Federal Reserve reviews cost recovery over a ten-year period to assess compliance with the MCA requirement. The Board believes that the ten-year historical recovery rate, together with the annual pro formas published in the Board's Annual Report and the additional cost-recovery information included in the annual repricing **Federal Register** notice, provides the relevant information to enable Congress and the public to evaluate the Federal Reserve's performance under MCA. The Board believes the information in the quarterly pro formas is of little value to parties interested in priced-services financial results because it does not provide a relevant long-term cost-recovery assessment. Given the staff resources required to produce, document, and review the pro formas, the Board believes the cost of producing quarterly pro formas exceeds the benefit.

The Board requested public comment on discontinuing quarterly pro formas in March 2001 (66 FR 16945, March 28, 2001). The Board received only two comments on the proposal to discontinue publication of the quarterly pro formas, both disagreeing with the Board's recommendation. The comment letters, one from the National Clearinghouse Association (NCHA) and one from the Electronic Check Clearing House Organization (ECCHO) were essentially identical and indicated that the quarterly pro formas were the only source of current information that could provide early warning of trends and developments for Federal Reserve priced services specifically and for payments more generally. The commenters believed that such information is particularly important in the current environment of rapid changes in the payment system. The commenters also expressed surprise with the proposal to provide less information to the public given a recent GAO report on potential conflicts of interest, which concluded that the System should provide more information to the payments industry about its services and product enhancements.

Although these comments clearly expressed a desire for the continuation of the quarterly pro formas, they were not responsive with regard to identifying which elements of the current pro formas provide the most relevant information. The Board continues to believe that the information provided in the quarterly pro formas is of little value to parties interested in the Federal Reserve's priced-services financial results when compared with the costs to produce them. Quarterly pro formas present data for priced services activities at an aggregate level and do not provide information such as volume trends that the commenters had indicated in their comment letters. The Board recently, however, started providing more useful quarterly payment system information including volume trends on the Board's public website. This information is more relevant to the public and the payment system industry.

Because of the limited interest expressed in retaining the quarterly pro formas, the availability of more relevant information on the Board's website, and the Board's continued belief that quarterly pro formas do not provide sufficient useful information to warrant the preparation costs, the Board is changing the publication frequency of pro formas to annually.

By order of the Board of Governors of the Federal Reserve System, February 20, 2002.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 02–4489 Filed 2–25–02; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Applications for the National Community Centers of Excellence in Women's Health Program

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

ACTION: Notice.

Authority: This program is authorized by 42 U.S.C. 300u–2(a)(1), 300u–3, and 300u–6(e).

Purpose

To provide recognition and funding to community-based programs that unite promising approaches in women's health through the integration of the following six components: (1) Comprehensive health service delivery; (2) training for lay and professional health providers; (3) community-based research; (4) public education and outreach; (5) leadership development for women as health care consumers and providers; and (6) technical assistance to ensure the replication of promising models and strategies that coordinate and integrate women's health activities at the community level and improve health outcomes for

underserved women. The National Community Centers of Excellence in Women's Health (CCOE) program is not for the development of new programs or to fund direct service but rather to integrate, coordinate, and strengthen linkages between activities/programs that are already underway in the community in order to reduce fragmentation in women's health services and activities.

The proposed CCOE program must address women's health from a women-centered, women-friendly, women-relevant, holistic, multi-disciplinary, cultural and community-based perspective. Information and services provided must be at the educational level and within the language and cultural context that are most appropriate for the individuals for whom the information and services are intended. Women's health issues are defined in the context of women's lives, including their multiple social roles and the importance of relationships with other people in their lives. This definition of women's health encompasses both mental and physical health (including oral health) and spans the life course.

The CCOE program will be supported through the cooperative agreement mechanism, to allow a collaborative relationship between CCOEs and the Department of Health and Human Services (DHHS) offices. The DHHS funding offices include the Office on Women's Health (OWH), the Office of Minority and Women's Health in the Bureau of Primary Health Care of the Health Resources and Services Administration, and the Office of Minority Health. These offices will provide the technical assistance and oversight necessary for the implementation, conduct, and assessment of program activities. Specifically, the Federal Government will:

1. Participate in at least two annual meetings with the CCOE Center Directors in the Washington, DC area.

2. Participate in the development of a comprehensive national CCOE ''how-to'' manual.

3. Review and approve the CCOE's local evaluations.

4. Participate in a national evaluation of the CCOE programs using guidance/measurements provided by the OWH contractor.

5. Review and concur with project modifications.

6. Review the design of CCOE Web pages.

7. Make site visits to the CCOE facilities.

8. Review all quarterly and final progress reports.

9. Conduct an orientation meeting for the new CCOEs within the first month of funding.

The DHHS is committed to achieving the health promotion and disease prevention objectives of *Healthy People 2010.* Emphasis will be placed on aligning CCOE activities and programs with the *Healthy People 2010:* Goal 2—eliminating health disparities due to age, gender, race/ethnicity, education, income, disability, living in rural localities, or sexual orientation. More information on the Healthy People 2010 objectives may be found on the Healthy People 2010 Web site: *http://www.health.gov/healthypeople.* Another reference is the *Healthy People 2010 Review—1998–99.* One free copy may be obtained from the National Center for Health Statistics (NCHS), 6525 Belcrest Road, Room 1064, Hyattsville, MD 20782 or telephone (301) 458–4636 [DHHS Publication No. (PHS) 99–1256]. This document may also be downloaded from the NCHS Web site: *http://www.cdc.gov/nchs.*

DATES: To be considered for review, applications must be Received by May 1, 2002. Applications will be considered as meeting the deadline if they are: (1) received on or before the deadline date or (2) postmarked on or before the deadline date and received in time for orderly processing. A legibly dated receipt from a commercial carrier or U.S. Postal Service will be accepted in lieu of a postmark. Private metered postmarks will not be accepted as proof of timely mailing. Applications submitted by facsimile transmission (FAX) or any other electronic format will not be accepted. Applications that do not meet the deadline will be considered late and will be returned to the applicant unread.

ADDRESSES: Applications must be prepared using Form PHS 5161–1 (revised July 2000). This form is available in Adobe Acrobat format at the following Web site: *http://www.cdc.gov/od/pgo/forminfo.htm.* Complete applications should be submitted to: Ms. Karen Campbell, Grants Management Officer, Division of Management Operations, Office of Minority Health, Office of Public Health and Science, Rockwall II Building, Room 1000, 5515 Security Lane, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Questions regarding programmatic information and/or requests for technical assistance in the preparation of grant applications should be directed in writing to Ms. Barbara James, CCOE Program Director, Division of Program Management, Office on Women's Health, Parklawn Building, Room 16A–55, 5600 Fishers Lane, Rockville, MD 20857, e-mail: *bjames1@osophs.dhhs.gov.* Technical assistance on budget and business aspects of the application may be obtained from Ms. Karen Campbell, Grants Management Officer, Division of Management Operations, Office of Minority Health, Office of Public Health and Science, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, MD 20852, telephone: (301) 594–0758.

SUPPLEMENTARY INFORMATION:

Availability of Funds

The Office on Women's Health anticipates making up to 7 new awards in FY 2002. Awards of up to $150,000 total costs (direct and indirect) for a 12-month period will be made to up to 7 competing applicants. However, the actual number of awards made will depend upon the amount of funds available for the CCOE program.

Period of Support

The start date for the cooperative agreement will be September 30, 2002. Support may be requested for a total project period not to exceed 5 years. Noncompeting continuation awards of up to $150,000 (total cost) per year will be made subject to satisfactory performance by the grantee and the availability of funds.

Eligible Applicants

The CCOE applicant must be a public or private nonprofit community-based hospital, community health center, or community-based organization serving underserved women. Community health centers funded under Section 330 of the Public Health Service Act are encouraged to apply. All applicants receiving Section 330 funding must identify themselves as recipients of these funds in the Background section of the application and by checking the appropriate response on the OWH Project Profile form. Community entities/organizations, including faith-based organizations, that have alliances, partnerships, networks with, or have other affiliations with an academic health center are also eligible to apply for a CCOE grant as long as the community entity/organization has a leading management role in the activity and maintains control of all funding. Organizations that have previously submitted CCOE applications, but were not funded, are also eligible to reapply for this award. Academic health centers and state, county, and local health

departments are not eligible for this program.

To ensure a wide geographic distribution of the Centers of Excellence in Women's Health model, applications will be accepted from organizations in all of the American States and Territories except those that already have a National Center of Excellence in Women's Health (CoE) program or a National Community Center of Excellence in Women's Health (CCOE) program. Thus, applications will not be accepted from programs in the following states: AZ, CA, IL, IN, LA, MA, MI, MO, MN, NM, NY, OH, PA, PR, VT, WA, and WI. Preference will be given to DHHS regions that do not have a CCOE or a CoE program and to programs proposed to be implemented in medically underserved areas, enterprise communities, and empowerment zones. We encourage the submission of applications from eligible organizations in DHHS Regions IV and VIII.

Program Goals

The goals of the CCOE program are to:

1. Reduce the fragmentation of services and access barriers that women encounter using a framework that coordinates and integrates comprehensive health services with research, training, education, and leadership activities in the community to advance women's health.

2. Create healthier communities with a more integrated and coordinated women's health delivery system targeted to underserved women.

3. Empower underserved women as health care consumers and decision-makers.

4. Increase the women's health knowledge base using community-based research that involves the community in identifying research areas that address the health needs, and respond to, issues of concern to underserved women.

5. Increase the number of health professionals trained to work with underserved communities and increase their leadership and advocacy skills.

6. Increase the number of young women who pursue health careers and also increase the leadership skills and opportunities for women in the community.

7. Spread the successes, through technical assistance, of model women's health program strategies and new innovations to communities across the country that may be interested in replicating the model.

8. Eliminate health disparities for women who are underserved due to age, gender, race/ethnicity, education, income, disability, living in rural localities, or sexual orientation.

Project Requirements

A CCOE program must: (1) Develop and/or strengthen a framework to bring together a comprehensive array of services for women; (2) develop promising strategies to train a cadre of health care providers capable of addressing issues at the community level that impact underserved women's health needs; (3) develop strategies to prevent and/or reduce illness or injuries that appear controllable through individual knowledge and behavior; (4) conduct community-based research in women's health; (5) enhance public education and outreach activities in women's health with an emphasis on prevention and/or reduction of illness or injuries that appear controllable through increased knowledge that leads to a modification of behavior; (6) promote leadership/career development for women in the health professions and women/girls in the community; (7) demonstrate an ability to foster the transfer of lessons learned to other communities interested in improvements in women's health; (8) evaluate their program; and (9) participate in a national evaluation of the CCOE program. A CCOE program may develop outreach and education materials, training programs, and leadership development activities/materials. Award recipients must also, with input from community representatives, put into place and track a set of measurable objectives for improving health outcomes and decreasing health disparities for underserved women in the community. In addition, the CCOE program must contribute to the development of a comprehensive national CCOE ''how-to'' manual by submitting, as part of their annual report, a section on steps taken to implement each component of the CCOE program, a discussion of the effectiveness of the implementation strategy(s) and how measured, and the impact of the program on the targeted community/population. A draft manual will be developed and made available to other organizations interested in establishing a CCOE program. The OWH plans to publish a final ''how-to'' manual near the end of the third cycle of funding for the CCOE program.

At a minimum, each CCOE clinical care center must be a physically-identifiable space, within the CCOE facility(s), for the delivery of comprehensive health care for women only. The CCOE clinical care center must have permanent signage and, at least 50 percent of the facility's space and 50 percent of the operational hours must be devoted to women-friendly, women-centered, women-relevant care delivered from a multidiscliplinary, holistic, and culturally and linguistically appropriate perspective. The CCOE clinical care center must also have a schedule and procedures for identifying and counting the women served by the CCOE and for tracking the cost of services provided to women who receive care through the CCOE program.

Application Requirements

Each applicant for a cooperative agreement funded under this CCOE announcement must, at a minimum:

1. Present a plan to integrate all six components of the CCOE program by the end of the first year of funding, although only four components have to be in place at the time the application is submitted. The challenge of the CCOE model is to stretch the ''medical health care model'' and ''think out of the box'' about ways to improve the health status of underserved women. Applicant are encouraged to be creative in suggesting ways to increase integration among the CCOE components.

2. Develop a CCOE advisory board or ensure that their already established advisory board is included in the decision-making process for CCOE program development, identification of community-based research questions, and formulation of CCOE policies. Applicants should also ensure that the advisory board includes representative(s) from their community partner organizations.

3. Be a sustainable organization with an established network of partners capable of providing coordinated and integrated women's health services in the targeted community. The network of partner organizations must have the capability to coordinate and provide comprehensive, seamless health services for women and empower them with community-based women's health research information that addresses issues of particular concern to the women, teaching/training opportunities in women's health, leadership opportunities for community women in health, and community outreach/education activities in women's health to improve the health status of women in the community. The applicant will need to define the components of comprehensive care, demonstrate that they are culturally, linguistically, and gender appropriate, and show that they have a clear and sustainable framework for providing those services.

4. Have an established clinical care center/facility, an operating public educational/outreach program, and a community identified as the recipient of technical assistance at the time the

application is submitted. A time line and plans for phasing in the remaining CCOE components by the end of Year 1 must be described in detail in the application.

5. Demonstrate the ways in which the organization and the care that are coordinated through its partners are women-focused, women-friendly, women-relevant, and sensitive to the importance of patient/provider communication/relationships for medically underserved women of all ages. The care that is coordinated through this organization must be focused on health promotion, disease prevention, and treatment.

6. Detail/specify the roles and resources/services that each partner organization brings to the program, the duration and terms of agreement as confirmed by a signed agreement between the applicant organization and each partner, and describe how the partner organizations will operate within the CCOE structure. The partnership agreement(s) must name the individual who will work with the CCOE program, describe their function, and state their qualifications. The documents, specific to each organization (form letters are not acceptable), must be signed by individuals with the authority to represent the organization (e.g., president, chief executive officer, executive director) and submitted as part of the grant application.

7. Describe in detail plans for the local evaluation of the CCOE program and when and how information obtained from the evaluation will be used to enhance the CCOE program. The applicant must also indicate their willingness to participate in a national evaluation of the CCOE program to be conducted under the leadership of the OWH contractor.

8. Describe in detail the planned community-based research and the research methodology/procedure. Applicants may: (a) Propose original patient-oriented research; (b) enter into a formal agreement with institutions conducting population-based research to facilitate women's entry into clinical trial(s)/patient-oriented research; (c) participate in the national evaluation of the CCOE program (required of all awardees); (d) link with organizations conducting community-based research; and/or (e) propose other original/creative research projects. To satisfy the community-based research component of the CCOE program, all applicants must undertake at least two of the research activities listed above, in addition to the required participation in the national CCOE evaluation. However, if a CCOE proposes to conduct original research and participate in the national evaluation of the CCOE program, these activities will satisfy the community-based research component.

Use of Grant Funds

A majority of the funds from the CCOE award must be used to support staff and efforts aimed at coordinating and integrating the major components of the CCOE program. The Center Director, or the person responsible for the day-to-day management of the CCOE program, must devote at least a 75 percent level of effort to the program. Additionally, 25 percent of the funds must target efforts to foster the transfer of lessons learned/successful strategies from the CCOE program (technical assistance). These may include either process-based lessons (*i.e.,* How to bring multiple community partners together) or outcomes-based lessons (*i.e.,* How to increase diabetes screening and control through improved outreach, education, and treatment). The CCOEs must foster the replication of the entire integrated CCOE model through activities such as showcasing them at meetings and workshops; providing direct technical assistance to other communities; participating in the development of national replication guidelines/materials; and providing technical assistance to health professionals, directly or through their professional organizations, interested in working with underserved women in the community. Applicants must provide a plan for how they will provide technical assistance in the first year. They will be expected to identify at least one community that they will work closely with to help them replicate all the components of the CCOE model, beginning no later than 6 months after receipt of the CCOE award, and provide materials for the development of a manual that describes how to link, coordinate, and partner within the community to form the CCOE infrastructure. The CCOEs must help the technical assistance community implement all components of the CCOE program (the entire integrated CCOE model) except technical assistance.

Funds may be used for personnel, consultants, supplies (including screening, education, and outreach supplies), and grant related travel. Items costing less than $5,000 are considered to be supplies. Funds may not be used for construction, building alterations, equipment, medical treatment, or renovations. All budget requests must be justified fully in terms of the proposed CCOE goals and objectives and include a computational explanation of how costs were determined.

The CCOE Center Directors will meet twice a year in the Washington metropolitan area. The CCOE's budget should include a request for funds to pay for the travel, lodging, and meals for the first Center Directors' meeting of each year. The first meeting is usually held between mid-November and mid-December. The OWH will pay the travel and other expenses associated with the second annual CCOE meeting which is usually held in May. Center Directors are encouraged to bring their Program Manager/Coordinators to these meetings.

In the first year of the award, the new CCOE Center Directors and Program Managers are required to attend an orientation meeting that will be held in the Washington metropolitan area in October 2002. Funds to attend this meeting should also be included as part of the CCOE budget request.

Review of Applications

Applications will be screened upon receipt. Those that are judged to be incomplete, arrive after the deadline, or are from states that already have a CCOE or a CoE program will be returned without review or comment. Accepted applications will be reviewed for technical merit in accordance with DHHS policies. Applications will be evaluated by a technical review panel composed of experts in the fields of program management, community service delivery, community outreach, health education, community-based research, and community leadership development. Consideration for award will be given to applicants that best demonstrate progress and/or plausible strategies for eliminating health disparities through the integration of services, community-based research, education, training, leadership/career development, and technical assistance to other communities. Applicants are advised to pay close attention to the specific program guidelines and general instructions in the application kit and to the definitions provided.

Organization of Application

Applicants are required to submit an original ink-signed and dated application and 15 photocopies. All pages must be numbered clearly and sequentially beginning with the Project Profile. The application must be typed double-spaced on one side of plain 8½″x11″ white paper, using at least a 12 point font, and contain 1″ margins all around.

The Project Summary and Project Narrative must not exceed a total of 25

double-spaced pages, excluding the appendices. The original and each copy must be stapled and/or otherwise securely bound. The application should be organized in accordance with the format presented in the Program Guidelines. An outline for the minimum information to be included in the ''Project Narrative'' section is presented below. Applications not adhering to these guidelines may not be reviewed.

I. Background
A. Local CCOE purpose(s) and goals
B. Section 330 funding
C. Local CCOE program objectives
1. Tied to program goal(s)
2. Measurable with time frame
3. Elements identified in Factor 5: Objectives
D. CCOE organization charts that include partners and a discussion of the resource being contributed to the CCOE, partners, personnel and their expertise and how their involvement will help achieve the CCOE program goals
II. Implementation Plan (Approach to the establishment of the CCOE program)
A. Components in place and plans with a timetable for phasing in the other CCOE components
B. Partnerships and referral system/follow up
C. Community-based research
D. National CCOE ''how-to'' manual
E. Elements identified in Factor 1: Implementation Plan
III. Management Plan
A. Key project staff
B. To-be-hired staff and their qualifications
C. Staff responsibilities
D. Management experience of the lead agency and partners as related to their role in the CCOE program
E. Advisory board
F. Elements identified in Factor 2: Management Plan
IV. Local CCOE Evaluation Plan
A. Purpose
B. Design/methodology
C. Use of results to enhance programs
D. Elements identified in Factor 3: Evaluation Plan
V. Technical Assistance/Replication Strategy
A. Identification of Technical Assistance community
B. Reason for selection of Technical Assistance community
C. Technical Assistance plans/strategies/time line
D. Plans for sustaining Technical Assistance
E. Elements identified in Factor 4: Technical Assistance
Appendices
A. Memorandums of Agreement/Understanding/Partnership Letters
B. Required Forms (Assurance of Compliance Form, etc.)
C. Other Attachments

Application Review Criteria

The technical review of applications will consider the following factors:

Factor 1: Implementation Plan—45%

This section must discuss:

1. Appropriateness of the existing community resources and linkages established to deliver coordinated women's services to meet the requirements of the CCOE program.

2. Appropriateness of proposed approach, component integration, and specific activities described to address each element of the National Community Center of Excellence in Women's Health program including: (a) Comprehensive women's health services, (b) outreach and education, (c) training for professional and lay health care workers serving underserved women, (d) community-based research that involves the community in substantive roles/ways, (e) leadership/career development for women providers, and women/girls in the community across the life span, and (f) technical assistance-the ability to train others in lessons learned and replication of successful strategies. Although all components of the CCOE do not have to be in place/operational at the time the application is submitted, the applicant must discuss/describe the resources available to support each component, time lines and plans for phasing in each component, and the relationship of each component to the overall goals and objectives of the CCOE program.

3. Soundness of evaluation objectives for measuring program effectiveness and changes in health outcomes.

4. Willingness to participate in the national CCOE evaluation.

5. Willingness to contribute to the development of a comprehensive national CCOE ''how-to'' manual.

Factor 2: Management Plan—15%

Applicant organization's capability to manage the project as determined by the qualifications of the proposed staff or requirements for ''to be hired'' staff, proposed staff level of effort, management experience of the lead agency and the experience, resources and role of each partner organization as it relates to the needs and programs/activities of the CCOE program, diversity of the CCOE staff as it relates to and reflects the community and populations served, and integration of the advisory board into the CCOE activities.

Factor 3: Evaluation Plan—10%

A clear statement of program goal(s) and thoroughness, feasibility and appropriateness of the local CCOE evaluation design, data collection plan, analysis of results, and procedures to determine if program goals are met. A clear statement of willingness to be involved actively in the national CCOE evaluation.

Factor 4: Technical Assistance—10%

Plans for the provision of technical assistance and the potential for replication of the CCOE model in similar populations and communities. The plan must include the name of and justification for the community selected and a detailed discussion of how the applicant will sustain interaction with the community. Technical assistance to the selected community must begin no later than 6 months after receipt of the CCOE award.

Factor 5: Objectives—10%

Merit of the objectives outlined by the applicant to address the CCOE program discussed in the program goals section in a way relevant to the targeted community needs and available resources. Objectives must be measurable and attainable within a stated time frame.

Factor 6: Background—10%

Adequacy of demonstrated knowledge of systems of health care for underserved women at the local level; demonstrated need within the proposed local community and target population of underserved women; demonstrated support and established linkages in place to operate a fully functional CCOE program; demonstrated access to medically underserved women; and documented past efforts/activities outcome with underserved women.

Award Criteria

Funding decisions will be made by the Office on Women's Health, and will take into consideration the recommendations and ratings of the review panel, program needs, geographic location, stated preferences, and the recommendations of DHHS Regional Women's Health Coordinators (RWHC). A pre-site visit, conducted by DHHS RWHCs will be scheduled prior to the award of a grant with all applicants with scores in the funding range. The purpose of the visit will be to assess the applicants' readiness to implement a CCOE program. The OWH plans to conduct the pre-site visits during the week of July 22, 2002.

Reporting (Other Requirements)

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

DHHS strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. In addition,

Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children.

Public Health System Reporting Requirements

This program is subject to the Public Health Systems Reporting Requirements. Under these requirements, a community-based non-governmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprized on proposed health services grant applications submitted by community-based non-governmental organizations within their jurisdictions.

State Reviews

This program is subject to the requirements of Executive Order 12372 which allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. The application kit to be made available under this notice will contain a listing of States which have chosen to set up a review system and will include a State Single Point of Contact (SPOC) in the State for review. Applicants (other than federally recognized Indian tribes) should contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC in each affected State. The due date for State process recommendations is 60 days after the application deadline. The Office on Women's Health does not guarantee that it will accommodate or explain its responses to State process recommendations received after that date. (See ''Intergovernmental Review of Federal Programs,'' Executive Order 12372, and 45 CFR part 100 for a description of the review process and requirements.)

General Reporting Requirements

In addition to those listed above, a successful applicant will submit an annual progress report that includes a summary of the local CCOE evaluation and a discussion of steps taken to implement each component of the CCOE program and the impact of the program on the targeted community/population, an annual Financial Status Report, a final Progress Report, a final Financial Status Report, an Audit Report, and a Technical Assistance Documentation Report in the format established by the Office on Women's Health, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program Performance,'' 45 CFR part 74, subpart J and part 92.

Additionally, a successful applicant will submit quarterly progress reports. An original and two copies of the quarterly progress report must be submitted by January 1, April 1, July 1, and September 15. The last quarterly report will serve as the annual progress report and will describe all project activities for the entire year. The annual progress report must be submitted by September 15 of each year.

Definitions

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

Clinical Care Center: At a minimum, each CCOE clinical care center must be a physically-identifiable space, within the CCOE facility(s), for the delivery of comprehensive health care for women only. The CCOE clinical care center must have permanent signage and at least 50 percent of the facility's space and 50 percent of the operational hours must be devoted to women-friendly, women-centered, women-relevant care delivered from a multidisciplinary, holistic, and culturally and linguistically appropriate perspective. The CCOE clinical care center must also have a schedule and procedures for identifying and counting the women served by the CCOE and for tracking the cost of services provided to women who receive care through the CCOE program.

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

Community-based organization: Public and private, nonprofit organizations that are representative of communities or significant segments of communities.

Community-based research: Community members work with researchers to help determine research issues, shape the research process/objectives, and bring research results back to the community. Community members' participation maximizes the potential for exchange in knowledge and implementation of research findings. The shared goal is to maintain scientific integrity in the research methods, while also incorporating the skills, knowledge, and strengths of the participants/beneficiaries of the research. There is an emphasis on ensuring that research results are translated into practice and communicated back to the community.

Community health center: A community-based organization that provides comprehensive primary care and preventive services to medically underserved populations. This includes, but is not limited to, programs reimbursed through the Federally Qualified Health Centers mechanism, Migrant Health Centers, Primary Care Public Housing Health Centers, Healthcare for the Homeless Centers, and other community-based health centers.

Comprehensive women's health services: Services including, but going beyond traditional reproductive health services to address the health needs of underserved women in the context of their lives, including a recognition of the importance of relationships in women's lives, and the fact that women play the role of health providers and decision-makers for the family. Services include basic primary care services; acute, chronic, and preventive services; mental and dental health services; patient education and counseling; promotion of healthy behaviors (like nutrition, smoking cessation, substance abuse services, and physical activity); and enabling services. Ancillary services are also provided such as laboratory tests, X-ray, environmental, social services referral, and pharmacy services.

Coordinated care: The formal linkages, case management services, partnering arrangements, and patient advocate support that enable better coordination of women's health resources and help underserved women to navigate systems to obtain the comprehensive health services they need. Community-based organizations are expected to coordinate with State and local health departments, nonprofit organizations, academic institutions, or other local organizations in the community as appropriate.

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

Cultural perspective: Recognizes that culture, language, and country of origin have an important and significant impact on the health perceptions and health behaviors that produce a variety of health outcomes.

Enabling services: Services that help women access health care, such as

transportation, translation, child care, and case management.

Healthy People 2010: A set of national health objectives that outlines the prevention agenda for the Nation. *Healthy People 2010* identifies the most significant preventable threats to health and establishes national goals for the next ten years. Individuals, groups, and organizations are encouraged to integrate *Healthy People 2010* into current programs, special events, publications, and meetings. Businesses can use the framework, for example, to guide worksite health promotion activities as well as community-based initiatives. Schools, colleges, and civic and faith-based organizations can undertake activities to further the health of all members of their community. Health care providers can encourage their patients to pursue healthier lifestyles and to participate in community-based programs. By selecting from among the national objectives, individuals and organizations can build an agenda for community health improvement and can monitor results over time.

Holistic: Looking at women's health from the perspective of the whole person and not as a group of different body parts. It includes mental as well as physical health.

Integrated: In the CCOE context, the bringing together of the numerous spheres of activity (6 CCOE components) that touch women's health, including clinical services, research, health training, public health outreach and education, leadership development for women, and technical assistance. The goal of this approach is to unite the strengths of each of these areas, and create a more informed, less fragmented, and efficient system of women's health for underserved women that can be replicated in other populations and communities.

Lifespan: Recognizes that women have different health and psycho-social needs as they encounter transitions across their lives and that the positive and negative effects of health and health behaviors are cumulative across a woman's life.

Multi-disciplinary: An approach that is based on the recognition that women's health crosses many disciplines, and that women's health issues need to be addressed across multiple disciplines, such as adolescent health, geriatrics, cardiology, mental health, reproductive health, nutrition, dermatology, endocrinology, immunology, rheumatology, dental health, etc.

Social Role: Recognizes that women routinely perform multiple, overlapping social roles that require continuous multi-tasking.

Sustainability: An organization's or program's staying power: the capacity to maintain both the financial resources and the partnerships/linkages needed to provide the services demanded by the CCOE program. It also involves the ability to survive change, incorporate needed changes, and seize opportunities provided by a changing environment.

Underserved Women: In the context of the CCOE model, women who encounter barriers to health care that result from any combination of the following characteristics: poverty, ethnicity and culture, mental or physical state, housing status, geographic location, language, sexual orientation, age, and lack of health insurance/under-insured.

Women-centered/women-focused: Addressing the needs and concerns of women (women-relevant) in an environment that is welcoming to women, fosters a commitment to women, treats women with dignity, and empowers women through respect and education. The emphasis is on working with women, not for women. Women clients are considered active partners in their own health and wellness.

Dated: February 8, 2002.

Wanda K. Jones,

Deputy Assistant Secretary for Health.

[FR Doc. 02–4470 Filed 2–25–02; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel: State Fatality Surveillance and Field Investigations of Occupational Injuries: Fatality Assessment and Control Evaluation, RFA CC–02–012

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Public Law 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting:

Name: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): State Fatality Surveillance and Field Investigations of Occupational Injuries: Fatality Assessment and Control Evaluation (FACE), RFA CC–02–012.

Times and Dates: 8:30 a.m.-8:30 a.m., March 15, 2002 (Open), 9 a.m.-5 p.m., March 15, 2002 (Closed).

Place: Hotel Washington, 515 15th Street, NW., Washington DC 20004–2099.

Status: Portions of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office CDC, pursuant to Public Law 92–463.

Matters to be Discussed: The meeting will include the review, discussion, and evaluation of applications received in response to RFA CC–02–012.

FOR MORE INFORMATION CONTACT: Gwendolyn H. Cattledge, Ph.D., Health Science Administrator, National Institute for Occupational Safety and Health, CDC, 1600 Clifton Road, NE, M/S E74, telephone (404) 498–2508.

The Director, Management Analysis and Services Office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: February 20, 2002.

Alvin Hall,

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

[FR Doc. 02–4507 Filed 2–25–02; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel: Musculoskeletal Disorders: Prevention and Treatment, RFA OH–02–004

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting:

Name: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Musculoskeletal Disorders: Prevention and Treatment, RFA OH–02–004.

Times and Dates: 8 a.m.–8:30 a.m., March 12, 2002 (Open), 8:40 a.m.–5 p.m., March 12, 2002 (Closed), 8 a.m.–5 p.m., March 13, 2002 (Closed).

Place: Harbor Court Hotel, 550 Light Street, Baltimore MD 21202.

Status: Portions of the meeting will be closed to the public in accordance with