performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: New Collection, Regular;

Title of Information Collection: Adolescent Family Life Pregnancy Prevention Core Evaluation;

Form/OMB No.: OS–0990–New;

Use: The Office of Adolescent Pregnancy Programs (OAPP) has developed core data collection tools to assist programs that have received Adolescent Family Life (AFL) demonstration grants with evaluating the programs and services provided as a part of their grant activies. These would be available to support both its prevention and care demonstration projects. The data collection tool for AFL prevention grantees will provide information on grantee progress in three areas: Reducing sexual risk behaviors, strengthening parents and families, and strengthening school and community supports.

Frequency: Reporting, Annually;

Affected Public: Individuals or households, Not-for-profit institutions;

Annual Number of Respondents: 41,500;

Total Annual Responses: 83,000;

Average Burden Per Response: 30 minutes;

Total Annual Hours: 41,500;

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the HHS Web site address at *http://www.hhs.gov/oirm/infocollect/pending/* or e-mail your request, including your address, phone number, OMB number, and OS document identifier, to *naomi.cook@hhs.gov,* or call the Reports Clearance Office on (202) 690–6162. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the Desk Officer at the address below: OMB Desk Officer: John Kraemer, OMB Human Resources and Housing Branch, Attention: (OMB #0990–NEW), New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: June 17, 2005.

Robert E. Polson,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. 05–12489 Filed 6–23–05; 8:45 am]

BILLING CODE 4168–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[Document Identifier: OS–0990–New]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Office of the Secretary, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: New Collection, Regular;

Title of Information Collection: Adolescent Family Life Care Core Evaluation;

Form/OMB No.: OS–0990–New;

Use: The Office of Adolescent Pregnancy Programs (OAPP) provide services to pregnant and parenting adolescents. The proposed instruments developed for this evaluation permit measurement of standardized core outcomes for parents and their children across sites.

Frequency: Reporting, Annually;

Affected Public: Individuals or households, Not-for-profit institutions;

Annual Number of Respondents: 6,300;

Total Annual Responses: 12,600;

Average Burden Per Response: 30 minutes;

Total Annual Hours: 12,600;

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the HHS Web site address at *http://www.hhs.gov/oirm/infocollect/pending/* or e-mail your request, including your address, phone number, OMB number, and OS document identifier, to *naomi.cook@hhs.gov,* or call the Reports Clearance Office on (202) 690–6162. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the Desk Officer at the address below: OMB Desk Officer: John Kraemer, OMB Human Resources and Housing Branch, Attention: (OMB #0990–NEW), New Executive Office Building, Room 10235, Washington DC 20503.

Dated: June 17, 2005.

Robert E. Polson,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. 05–12490 Filed 6–23–05; 8:45 am]

BILLING CODE 4168–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Grants and Cooperative Agreements; Notice of Availability

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

ACTION: Notice.

Funding Opportunity: Request for Applications for Improving, Enhancing, and Evaluating Outcomes of Comprehensive Heart Health Care Programs for High-Risk Women.

Announcement Type: Competitive Cooperative Agreement—FY 2005 Initial announcement.

Funding Opportunity Number: Not applicable.

OMB Catalog of Federal Domestic Assistance: The OMB Catalog of Federal Domestic Assistance number is 93.012.

DATES: *Application Deadline:* July 25, 2005.

Anticipated Award Date: September 1, 2005.

SUMMARY: The Office on Women's Health (OWH) within the United States Department of Health and Human Services (DHHS) is interested in improving, enhancing, and evaluating outcomes of comprehensive heart health care programs for high-risk women. Under this announcement, OWH anticipates making up to five new awards, through the cooperative agreement grant mechanism, to provide funding to improve and enhance existing women's heart health care programs in hospitals, clinics, and/or health centers and to enable the programs to track and evaluate outcome data. Each grantee shall enhance an existing women's heart health care program so that it provides a continuum of heart health care services through the integration of the following five interrelated components: Education and Awareness, Screening and Risk

Assessment, Diagnostic Testing and Treatment, Lifestyle Modification and Rehabilitation, and Tracking and Evaluation. Grantees shall also target high-risk women in at least one of the following groups: Women aged 60 years or older, racial and ethnic minority women, and/or women who live in rural communities (particularly rural communities in the South and Appalachian region).

The goal of these programs will be to reduce heart disease mortality and morbidity among women and to increase the number of high-risk women who receive quality heart health care services, including education, prevention, screening, diagnosis, treatment and rehabilitation. These programs will offer comprehensive heart health care services that are women-centered, culturally competent, multi-disciplinary, continuous and integrated.

I. Funding Opportunity Description

1. Authority

This program is authorized by section 1703(a) of the Public Health Service Act.

2. Purpose

Through the cooperative agreement grant mechanism, OWH is interested in improving and enhancing existing women's heart health care programs and enabling the programs to track and evaluate outcome data. The goal of these programs will be to reduce heart disease mortality and morbidity among women and to increase the number of high-risk women who receive quality heart health care, including education, prevention, screening, diagnosis, treatment and rehabilitation. These programs will be demonstration projects; as such, they will provide the evidence necessary to evaluate whether comprehensive women's heart health care programs are effective in improving heart disease outcomes in high-risk women.

3. Project Outcomes

At minimum, grantees must be able to demonstrate the following desired program outcomes among women who participate in the program or among the community served:

Education/Knowledge

- Increase the proportion of women who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911 (Target = 50%)
- Increase the proportion of women with diabetes who receive formal diabetes education (Target = 60%)
- Increase the proportion of women appropriately counseled about health behaviors (Target for physical activity = 58%; Target for diet and nutrition = 56%; Target for smoking cessation = 72%)
- Increase the proportion of women who are aware that heart disease is the #1 killer of women (Target = 75%)

Prevention/Risk Factors

- Increase the proportion of women with high blood pressure whose blood pressure is under control (Target = 50%)
- Reduce the proportion of women with high total blood cholesterol (Target = 17%)
- Increase the proportion of women with diabetes whose condition has been diagnosed (Target = 80%)
- Reduce the proportion of women who are obese (Target = 15%)
- Increase the proportion of women who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day. (Target = 30%)

Treatment

- Increase the proportion of eligible women with heart attacks who receive fibrinolytics within an hour of symptom onset (Target = 6%)
- Increase the proportion of eligible women with heart attacks who receive percutaneous intervention (PCI) within 90 minutes of symptom onset (Target = 0.67%)
- Increase the proportion of women with coronary heart disease who have their LDL-cholesterol level treated to a goal of less than or equal to 100 mg/dL (Target pending)

The targets for these outcomes are based on the targets set for the objectives of Healthy People 2010. More information on the Healthy People 2010 objectives may be found at *http://www.health.gov/healthypeople*.

4. Requirements

In order to apply for the award, applicants must already have a basic women's heart health care program in place. The award shall not be used to fund direct health care services or equipment for patients (e.g., diagnostic tests, screening equipment, treatment, etc.). Rather, funds should be used to strengthen infrastructure, track and evaluate outcome data, conduct community outreach and educational activities, improve the coordination and continuity of care, and reduce fragmentation of heart health care services that already exist within the health care facility. For example, funds can be used to hire a program coordinator, set up a data tracking system, acquire or produce educational materials, etc.

The grantee shall enhance the existing women's heart health care program so that it provides a continuum of quality heart health care services to all women in the community, while specifically targeting high-risk women in at least one of the following groups: Women aged 60 years or older, racial and ethnic minority women, and/or women who live in rural communities (particularly rural communities in the South and Appalachian region). Each program must also be enhanced to offer comprehensive heart health care services that are women-centered, culturally competent, multi-disciplinary, continuous and integrated.

The women's heart health care program must be identifiable to patients and health professionals. Key staff and health care providers involved in the program must be knowledgeable about the differences between heart disease prevention, diagnosis and treatment in women and men. The grantee should use the award to train other health care providers affiliated with the program to understand these differences. Adult high-risk women shall be the primary focus of this program; however, family members who request services through the program must also be accommodated. All high-risk women shall be eligible to participate in the program, regardless of race, religion, or age.

In order to apply for the award, applicants must have the framework for at least three of the following five components already in place: Education and Awareness, Screening and Risk Assessment, Diagnostic Testing and Treatment, Lifestyle Modification and Rehabilitation, and Tracking and Evaluation. The award should be used to implement the other two components and to enhance the components that are already in place. The framework for all five components must be in place by the third month of funding. After the initial three months, each component must become a continuous, ongoing process throughout the entire period of funding.

Component #1—Education and Awareness

Education and awareness activities must be conducted in the community and/or at the health care facility several times throughout the year. Activities may include health fairs, seminars, CME courses, etc. The goal of these activities will be to educate women and their health care providers about heart disease in women and in the targeted group(s) of high-risk women. During these activities, participants must receive educational materials that contain information on statistics, risk factors, prevention and healthy lifestyle changes, warning signs and symptoms,

diagnosis, screening, treatment, and rehabilitation. The prevention information in these materials must be based on the latest AHA/ACA Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women (1). Grantees may also use or adapt materials from the National Heart, Lung, and Blood Institute's (NHLBI) Heart Truth Campaign (*http://www.nhlbi.nih.gov/health/hearttruth/*) and other NHLBI materials.

The OWH will provide the grantee with materials from the Heart Truth Professional Education Campaign, which can be used or adapted for the health professional educational activities. These materials will be available for use in the Fall of 2005. They will include (1) curriculum materials for medical students and allied health professional students, (2) grand round presentations (traditional slides and a web-based interactive version) for cardiologists, primary care physicians, and allied health professionals, and (3) web-based interactive multiple unit learning modules for training and self study.

Component #2—Screening and Risk Assessment

Women who participate in the educational activities must be encouraged to complete a self-administered heart disease risk and knowledge assessment tool, which will be distributed and collected by the grantee. Each woman who completes the risk and knowledge assessment tool must receive a summary report with personalized heart disease risk information and a follow-up phone call. During the phone call, women must be invited to a follow-up consultation at the women's heart health care program or encouraged to make an appointment with their own primary care doctor. During the consultation, each woman should receive a more detailed risk assessment including appropriate screening tests, as indicated by the latest evidence-based practice guidelines.

Component #3—Diagnostic Testing and Treatment

A follow-up appointment must be scheduled for women requiring diagnostic testing and women requiring interventions, as indicated by the latest evidence-based practice guidelines. Women who attend a follow-up appointment shall undergo a physical examination and diagnostic tests, if necessary. Those women needing interventions should receive prescriptions for appropriate medication, counseling on appropriate heart healthy lifestyle changes, and follow-up appointments with specialists, if necessary.

Component #4—Lifestyle Modification and Rehabilitation

Follow-up of women requiring risk factor modification interventions is required. Group or individual classes on such topics as hypertension, diabetes, nutrition, exercise, and smoking cessation can be offered as part of the program. The program must also include comprehensive cardiac rehabilitation services specifically for high-risk women who are diagnosed with coronary heart disease. Women requiring cardiac rehabilitation services should be actively encouraged to take advantage of the services, including monitored physical exercise and activity, education, counseling, and risk factor management. The program must also address the barriers to participation and compliance experienced by women (2, 3).

Component #5—Tracking and Evaluation

The program must track, evaluate and report on data from Components 1–4. Baseline and follow-up data from risk and knowledge assessments, screenings, diagnostic tests, treatment plans, and interventions must be collected, entered into a central database, and analyzed. The data collected must be able to demonstrate, at minimum, the desired program outcomes listed above in section I.3.

II. Award Information

Under this announcement OWH anticipates making, through the cooperative agreement grant mechanism, up to five new 12-month awards by September 1, 2005. Approximately $750,000 is available to make awards of up to $150,000 total cost (direct and indirect) for the initial 12-month period. Cost sharing and matching funds is not a requirement of this grant. The actual number of awards made will depend upon the quality of the applications received and amount of funds available for the program. The government is not obligated to make any awards as a result of this announcement. The anticipated start date for new awards is September 1, 2005 and the anticipated period of performance is September 1, 2005 through August 31, 2006.

Under the cooperative agreement, the duties of the grantee and the federal government are described below. The OWH will provide the technical assistance and oversight necessary for the implementation, conduct, and assessment of program activities. The federal government shall be free to use program materials both during and after the period of performance. The grantee may copyright any work that is developed, or for which ownership was purchased, under the award, but DHHS reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so.

The grantee shall complete all requirements described in the Funding Opportunity Description. The grantee shall also:

- Prepare a work plan, task outline, and schedule of activities within one month of award.
- Prepare quarterly progress reports that outline the status and progression of the program.
- Participate in monthly conference calls with OWH and other awardees of this grant.
- Attend a post-award orientation meeting in Washington, DC within two months of award. (Travel funds for this meeting must come out of the total award funding and should be included in the applicant's budget justification.)
- Develop materials (*e.g.* flyers, pamphlets, Web site, etc.) to promote the program within the community.
- Prepare or obtain culturally competent educational materials on heart disease in women, including information on statistics, risk factors, prevention, warning signs and symptoms, diagnosis, screening, treatment, and rehabilitation.
- Prepare a directory of local heart resources available in the community, including cardiologists, dieticians, diabetes experts, weight loss and exercise programs, and health care alternatives for uninsured and underinsured women.
- Prepare a draft consent form in lay-language, obtain appropriate institutional IRB approval, if applicable, and obtain consent from all program participants.
- Develop or obtain a self-administered heart disease risk and knowledge assessment tool and a summary report format.
- Develop or obtain tracking and evaluation materials, including tools and surveys for collecting data on heart disease risk factors, screenings, diagnostic tests, treatment plans, interventions, and health outcomes.
- Develop or obtain a centralized database for storing and analyzing the tracking and evaluation data.
- Prepare a draft of the final report six weeks prior to the end date of award. The report should describe all project activities for the entire year and include

an analysis of the tracking and evaluation data.

• Incorporate mutually agreed upon edits from the OWH into the final report by the end date of award.

• Adhere to all program requirements specified in this announcement and the Notice of Grant Award.

• Submit a final Financial Status Report.

The Federal Government will:

• Conduct pre-award site visits of applicants with scores in the funding range prior to final selection of awardees, as needed.

• Conduct site visits of the funded programs, as needed.

• Review and approve work plan, task outline, and schedule of activities.

• Review quarterly progress reports.

• Conduct the monthly conference calls with grantees.

• Conduct a post-award orientation meeting in Washington, DC within two months of award.

• Review and approve materials to promote the program within the community.

• Review and approve the educational brochures and materials on heart disease in women.

• Provide the grantee with the Heart Truth Professional Education Campaign materials.

• Review the directory of local heart resources available in the community.

• Review and approve the self-administered heart disease risk and knowledge assessment tool and summary report format.

• Participate in the development of tracking and evaluation materials.

• Review draft of the final report and provide comments and edits to be incorporated into the final document.

III. Eligibility Information

1. Eligible Applicants

Applicants must be a public or private hospital, clinic, or health center providing heart health care services to women. Academic health centers and State, county, and local health departments are eligible for funding under this announcement. Programs that will be implemented in medically underserved areas, enterprise communities, and empowerment zones as well as community health centers funded under Section 330 of the Public Health Service Act are encouraged to apply. Native American tribal organizations, faith-based organizations, and organizations serving rural or frontier communities are also encouraged to apply.

In order to apply for the award, applicants must already have a basic women's heart health care program in place. Applicants must also have the framework for three of the five components described in the funding opportunity description (Education and Awareness, Screening and Risk Assessment, Diagnostic Testing and Treatment, Lifestyle Modification and Rehabilitation, Tracking and Evaluation) already in place.

If funding is requested in an amount greater than the ceiling of the award range ($150,000 for a 12-month budget period), the application will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements. Applications that are not complete or do not conform to or address the criteria of this announcement will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements. An organization may submit no more than one proposal for the program announced in this notice of funding availability. Organizations submitting more than one proposal will be deemed ineligible. The proposal will be returned without comment.

2. Cost Sharing or Matching Funds

Cost sharing, matching funds, and cost participation is not a requirement of this grant.

3. Other

Preference will be given to organizations serving rural or frontier communities and/or Native American tribal organizations. To increase the likelihood of funding organizations serving rural or frontier communities and/or Native American tribal organizations, OWH will award 5 bonus points to applicants meeting these criteria.

IV. Application and Submission Information

1. Address To Request Application Package

Application kits may be requested by calling (301) 594–0758 or writing to: Ms. Karen Campbell, Director, Office of Public Health and Science (OPHS) Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Applications must be prepared using Form OPHS–1.

2. Content and Form of Application Submission

Applicants are required to submit an original ink-signed and dated application and two photocopies. The application should be organized in accordance with the format presented in the Program Guidelines. The original and each copy must be stapled and/or otherwise securely bound. All pages must be numbered clearly and sequentially. The application must be typed on plain 8 ½″ x 11″ white paper, using a 12 point font, and contain 1″ margins all around. The Project Narrative, excluding the appendices, is limited to a total of thirty (30) pages—the fronts and backs of 15 pieces of paper. The first 30 pages of the proposal will be considered; any pages exceeding this length will be removed from the proposal and will not be evaluated. Staff resumes, letters of support, budget justifications, samples of educational materials, samples of survey instruments and data collection forms, and research results and references may be included as part of an appendix and will not count toward the thirty pages limit. The application must also include a detailed budget justification, including a narrative and computation of expenditures for one year. The budget justification does not count toward the 30 pages limit.

An outline for the minimum information to be included in the ''Project Narrative'' section is presented below.

A. Statement of Need

The applicant should demonstrate the need for improving, enhancing, and evaluating outcomes of the women's heart health care program. The statement of need should include a description of the population served by the applicant, including relevant demographic and risk factor information. The applicant should also describe the group(s) of high-risk women that will be targeted and the rationale for choosing the group(s).

B. Program Plan

The applicant must describe, in detail, its approach for accomplishing each of the requirements identified in the funding opportunity description. The program plan must discuss each component (Education and Awareness, Screening and Risk Assessment, Diagnostic Testing and Treatment, Lifestyle Modification and Rehabilitation, and Tracking and Evaluation) of the program in the order in which it appears in the funding opportunity description. The proposal should describe the three components of the program that are already in place as well as the components that will be added and/or strengthened using the award. The applicant should discuss how all five components will be

integrated to improve the coordination and continuity of care and reduce fragmentation of heart health care services. The applicant should also discuss how barriers to receiving and utilizing health care will be addressed in each component of the program, including options available for underinsured and uninsured women, transportation issues, child care, etc.

The applicant should identify potential problems and intended solutions. The applicant is free to recommend and describe other procedures that it believes will more effectively achieve the stated objectives, but needs to carefully relate alternatives and rationales to the approach recommended in the funding opportunity description.

C. Experience and Commitment of Key Personnel

The applicant must identify key personnel involved in the project based on the requirements described in funding opportunity description and other personnel adequate to support the administrative, logistical, financial, and scientific coordination aspects of the project within the time limits of the grant. The applicant must provide information on which task(s) each of the key personnel will perform and the rationale for that assignment. Resumes for all proposed personnel must be submitted with the application in the appendices. The applicant should also describe the network of multi-disciplinary health care providers that will be available to provide the services required in the funding opportunity description, including any partnerships established with specialists in the community. The applicant must demonstrate that key staff and health care providers involved in the program are knowledgeable on (1) the differences between heart disease prevention, screening, diagnosis, treatment and rehabilitation in men and women and (2) heart disease in the targeted high-risk group(s).

D. Management Plan

The applicant should develop and propose a Management Plan. This plan includes a program schedule that lays out tasks and a time-line and identifies significant milestones for the accomplishment of the project. Specific staff responsibilities must be detailed in this schedule along with the number of hours that each person will devote to each task. The plan must provide, at a minimum, details pertaining to the five program components as they are outlined in the funding description. The applicant should keep in mind that the framework for all five components must be in place by the third month of funding. After the initial three months, each component must become a continuous, ongoing process throughout the entire period of funding.

E. Past Performance

Each applicant should describe its experience and success in implementing and managing the existing women's heart health care program, including any tracking and evaluation data already collected and analyzed. Each applicant should also describe any other relevant previous experience, which may include, but is not limited to, the implementation of (1) a similar comprehensive women's or men's health program in any health area (e.g. heart disease, cancer, osteoporosis, etc.), (2) educational activities aimed at improving the awareness of health issues in women and men, and (3) any health programs targeting the chosen group(s) of high-risk women. The applicant should also include a description of itself, its support personnel, contractors, and partners, and the quality of cooperation between organization, staff, key personnel, and clients. Finally, the applicant should describe any training received by its staff members on how to implement and evaluation a women's heart health care program.

F. Appendices

Include documentation and other supporting information in this section, including staff resumes, letters of support, samples of survey instruments and data collection forms, and research results and references.

3. Submission Dates and Times

To be considered eligible for review, applications must be received by the Office of Public Health and Science (OPHS), Office of Grants Management by 5 p.m. EST on July 25, 2005. Applications will be considered as meeting the deadline if they are received on or before the deadline date. The application due date requirement in this announcement supersedes the instructions in the OPHS–1. Electronic submissions through the Grants.gov Website Portal provides for applications to be submitted electronically. Information about the system is available on the Grants.gov Web Site, *http://www.grants.gov.* Applications submitted by facsimile transmission (FAX) or any other electronic format are ineligible for review and will not be accepted. Applications that do not meet the deadline will be considered ineligible and will be returned to the applicant unread.

4. Intergovernmental Review

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). Applicants shall submit a copy of the application face page (SF–424) and a one page summary of the project, called the Public Health System Impact Statement. The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based, non-governmental organizations within their jurisdictions.

Community-based, non-governmental applicants are required to submit, no later than the Federal due date for receipt of the application, the following information to the head of the appropriate state and local health agencies in the area(s) to be impacted: (a) a copy of the face page of the application (SF 424), (b) a summary of the project (PHSIS), not to exceed one page, which provides: (1) A description of the population to be served, (2) a summary of the services to be provided, and (3) a description of the coordination planned with the appropriate state or local health agencies. Copies of the letters forwarding the PHSIS to these authorities must be contained in the application materials submitted to the DHHS/OWH.

This program is also subject to the requirements of Executive Order 12372 that 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 that 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. A complete list of SPOCs may be found at the following Web site: *www.whitehouse.gov/omb/grants/spoc.html.* The due date for State process recommendations is 60 days after the application deadline. The OWH 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.)

5. Funding Restrictions

The award shall not be used to fund direct health care services or equipment for patients (e.g. diagnostic tests, screening equipment, treatment, etc.). Rather, funds should be used to strengthen infrastructure, track and evaluate outcome data, improve the coordination and continuity of care, and reduce fragmentation of heart health care services that already exist within the health care facility.

Grant funds may be used to cover costs of:

- Personnel
- Consultants
- Grant related office supplies and software
- Grant related travel (domestic only)
- Educational, promotional and evaluation materials
- Other grant related costs

Grant funds may not be used for:

- Building alterations or renovations
- Construction
- Screening supplies or equipment
- Incentives and prizes
- Food
- Fund raising activities
- Medical care, diagnostic tests, treatment or therapy
- Political education and lobbying
- Other activities that are not grant related

Guidance for completing the budget can be found in the Program Guidelines, which are included with the complete application kits.

6. Other Submission Requirements

All applicants are required to obtain a Data Universal Numbering System (DUNS) number as preparation for doing business electronically with the Federal Government. The DUNS number must be obtained prior to applying for OWH funds. The DUNS number is a nine-character identification code provided by the commercial company Dun & Bradstreet, and serves as a unique identifier of business entities. There is no charge for requesting a DUNS number, and you may register and obtain a DUNS number by either of the following methods:

Telephone: 1–866–705–5711.

Web site: *https://www.dnb.com/product/eupdate/requestOptions.html.*

Be sure to click on the link that reads, ''DUNS Number Only'' at the right hand, bottom corner of the screen to access the free registration page. Please note that registration via the web site may take up to 30 business days to complete.

V. Application Review Information

1. Criteria

The technical review of applications will consider the following 5 factors:

A. Factor 1: Program Plan (30 Points)

This factor will be evaluated by rating the applicant's approach to accomplishing each of the requirements identified in the funding opportunity description as demonstrated by the following:

- Demonstrated understanding of the scope, goals, and objectives of the work required and the applicability and clarity of the overall approach
- Discussions detailing how each of the requirements will be performed and the appropriateness of all proposed methodologies and analyses
- Discussions detailing how each of the five program components will be implemented (or enhanced) and integrated to provide continuity of care
- Discussions detailing how the program will be women-centered, culturally competent, and multi-disciplinary
- Discuss describing how barriers to receiving and utilizing health care will be addressed in each component of the program, including options available for underinsured and uninsured women, transportation issues, child care, etc.
- Identification of potential problems and intended solutions
- Potential for the success of the proposed program plan to achieve and demonstrate the program outcomes described in the funding opportunity description.

B. Factor 2: Statement of Need (20 Points)

The evaluation of this factor will be based on the following:

- Demonstrated need for improving, enhancing, and evaluating outcomes of the women's heart health care program
- Clarity of description of the population served by the applicant including total population, percent women, race/ethnicity data, age distribution, incidence of heart disease morbidity and mortality, prevalence of heart disease risk factors, and current utilization of heart health care services
- Clarity of the description of the group(s) of high-risk women that will be targeted and the rationale for choosing the group(s)
- Demonstrated understanding of the unique issues and concerns of women and of the targeted group(s) of high-risk women
- Demonstrated understanding of the differences between heart disease prevention, screening, diagnosis, treatment and rehabilitation in men and women.

C. Factor 3: Experience and Commitment of Key Personnel (20 Points)

This factor covers the qualifications of key personnel proposed to perform the work and the amount of effort estimated for each person. This evaluation is based on the following:

- Experience, education, and professional credentials of proposed key personnel on similar projects and in related fields
- Appropriateness of each person's skills for performing the requirements in the funding opportunity description
- Adequacy of the multi-disciplinary network of health care providers that will be available to provide the required services
- Degree to which key staff and health care providers involved in the program are knowledgeable on the differences between heart disease prevention, screening, diagnosis, treatment, and rehabilitation in men and women
- Degree to which key staff and health care providers involved in the program are knowledgeable on heart disease in the targeted high-risk group(s).

D. Factor 4: Management Plan (20 Points)

The applicant's staffing, scheduling, and logistics plans will be evaluated for their effectiveness in committing personnel and resources to achieve the program goals within the time frames set-forth. This evaluation is based on the following:

- Realism of the proposed timeline and the personnel and resources assigned to complete each requirement
- Appropriateness of the proposed number of hours estimated for each requirement and each staff member
- Adequacy of organizational structure
- Adequacy of proposed plan to identify and solve potential problems
- Adequacy of proposed plan to monitor and report on program progress and ensure effective communication between program staff members and the OWH.

E. Factor 5: Past Performance (10 Points)

This factor will be evaluated by considering the number, size, complexity, and success of similar

projects that the applicant has previously successfully implemented. The applicant should describe its experience and success in implementing and managing the existing women's heart health care program, including any tracking and evaluation data already collected and analyzed. Other relevant previous experience may include, but is not limited to, the implementation of (1) A similar comprehensive women's or men's health program in any health area (*e.g.* heart disease, cancer, osteoporosis, etc.), (2) educational activities aimed at improving the awareness of health issues in women and men, and (3) any health programs targeting the chosen group(s) of high-risk women. Finally, the applicant should describe any training received by its staff members on how to implement a women's heart health care program.

Also evaluated will be the applicant's past adherence to schedules and budgets, effectiveness of program management, willingness to cooperate when difficulties arise, and general compliance with the terms of grants.

2. Review and Selection Process

Applications should be submitted to: Ms. Karen Campbell, Director, Office of Public Health and Science (OPHS) Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Technical assistance on budget and business aspects of the application may be obtained from the Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852, telephone: (301) 594–0758.

Questions regarding programmatic information and/or requests for technical assistance in the preparation of the Project Narrative should be directed in writing to Dr. Suzanne Haynes, Senior Science Advisor, Office on Women's Health, U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Rm 719E, Washington, DC 20201, e-mail: *shaynes@osophs.dhhs.gov*.

Applications will be screened upon receipt. Those that are judged to be incomplete or arrive after the deadline will be returned without review or comment. If funding is requested in an amount greater than the ceiling of the award range ($150,000 for a 12-month budget period), the application will be considered nonresponsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

Applicants that are judged to be in compliance will be notified by the Office of Grants Management. Accepted applications will be reviewed for technical merit in accordance with DHHS policies. Applications will be evaluated by a technical review panel. Applicants are advised to pay close attention to the specific program requirements and general instructions in the application kit and to the definitions provided in this notice.

Applications will be evaluated by a technical review panel composed of experts in the fields of program management, heart disease and health care, community outreach and health education, and community-based research. Consideration for award will be given to applicants that best demonstrate the potential to design a program that achieves the program goals stated in this announcement. The Federal Government may conduct pre-award site visits of applicants with scores in the funding range prior to final selection.

Funding decisions will be made by the OWH, and will take into consideration the recommendations and ratings of the review panel, pre-award site visits, program needs, geographic location, and stated preferences. To increase the likelihood of funding organizations serving rural or frontier communities and/or Native American tribal organizations, OWH will award 5 bonus points to applicants meeting these criteria.

VI. Award Administration Information

1. *Award Notices:* Within two weeks of the review of all applications, all applicants will receive a letter from the OWH stating whether they are likely to be or have not been approved for funding. For those likely to be funded, the letter is not an authorization to begin performance of grant activities. Applicants selected for funding support will receive a Notice of Grant Award signed by the Director of the OPHS Office of Grants Management. This is the authorizing document and it will be sent electronically and followed up with a mailed copy.

2. *Administrative and National Policy Requirements:* (1) In accepting this award, the grantee stipulates that the award and any activities thereunder are subject to all provisions of 45 CFR parts 74 and 92, currently in effect or implemented during the period of this grant. (2) Requests that require prior approval from the awarding office (See Chapter 8, PHS Grants Policy Statement) must be submitted in writing to the OPHS Grants Management Officer. Only responses signed by the OPHS Grants Management Officer are to be considered valid. Grantees who take action on the basis of responses from other officials do so at their own risk. Such responses will not be considered binding by or upon the OWH. (3) Responses to reporting requirements, conditions, and requests for postaward amendments must be mailed to the attention and address of the Grants Management Officer indicated below in ''Contacts.'' All correspondence should include the Federal grant number (item 4 on the Notice of Grant Award) and requires the signature of an authorized business official and/or the project director. Failure to follow this guidance will result in a delay in responding to your correspondence. (4) The DHHS Appropriations Act requires that, when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees shall clearly state the percentage and dollar amount of the total costs of the program or project which will be financed with Federal money and the percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources. (5) A notice in response to the President's Welfare-to-Work Initiative was published in the **Federal Register** on 5/16/97. This initiative is designed to facilitate and encourage grantees to hire welfare recipients and to provide additional training and/or mentoring as needed. The text of the notice is available electronically on the OMB home page at *http://www.whitehouse.gov/wh/eop/omb*.

3. *Reporting:* A successful applicant will submit quarterly progress reports, a final report, and a final Financial Status Report in the format established by the OWH, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program Performance,'' 45 CFR parts 74 and 92. The purpose of the quarterly and final reports is to provide accurate and timely program information to program managers and to respond to Congressional, Departmental, and public requests for information about the program. An original and two copies of the quarterly progress reports must be submitted by December 2, March 2, and June 2. A draft of the final report must be submitted by July 24. The report should describe all project activities for the entire year and include an analysis of the tracking and evaluation data. OWH will review the draft. Suggested revisions will be discussed individually during a conference call with each grantee. The mutually agreed upon revisions must be incorporated into the final report by the end date of the award.

VII. Agency Contact(s)

For application kits and information on budget and business aspects of the application, please contact: Ms. Karen Campbell, Director, OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20857. Telephone: 301–594–0758. E-mail: *kcampbell@osophs.dhhs.gov*.

Questions regarding programmatic information and/or requests for technical assistance in the preparation of the ''Project Narrative'' should be directed in writing to: Dr. Suzanne Haynes, Senior Science Advisor, Office on Women's Health, U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Rm 719E, Washington, DC 20201. E-mail: *shaynes@osophs.dhhs.gov*.

VIII. Other information

1. Background

A. OWH

The Office on Women's Health (OWH) in the United States Department of Health and Human Services (DHHS) coordinates the efforts of all the DHHS agencies and offices involved in women's health. OWH works to improve the health and well-being of women and girls in the United States through its innovative programs by educating health professionals and motivating behavior change in consumers through the dissemination of health information. To that end, the OWH has established public/private partnerships that address the major killer of women—cardiovascular disease. One such partnership is with the National Heart, Lung, and Blood Institute's (NHLBI) Heart Truth Campaign, which is targeting women aged 40–60 years and their health care providers, through a national educational campaign.

B. Women and Heart Disease

Heart disease is the leading cause of death for women in the United States (4). Compared to men, women have higher heart disease mortality, higher morbidity following a heart attack, lower awareness of heart disease, and have a higher prevalence of most major risk factors for heart disease.

- In 2002, about 15,000 more women died of heart disease than men in the United Sates (5).
- Thirty-eight percent of women die within one year of having a heart attack compared to 25% of men who have heart attacks (4).
- About 35% of women and 18% of men heart attack survivors will have another heart attack within six years (4).
- About 46% of women become disabled with heart failure within 6 years of having a heart attack compared to 22% of men (4).
- Perioperative complications and mortality after percutaneous angioplasty and coronary artery bypass surgery are also higher in women than in men (6).
- More women than men in the United States have the following five major risk factors for heart disease: High blood pressure, high cholesterol, diabetes, physical inactivity, and obesity (7).

Some experts speculate that the difference in heart disease outcomes and risk factor prevalence between women and men may be due, in part, to a lack of awareness among women and their physicians of the risks for heart disease in women, and less aggressive use of treatments and preventive therapies for women than for men (6, 8).

- A 2003 national survey conducted by the American Heart Association found that 35% of women cite breast cancer as their greatest health threat while only 13% of women believe that their greatest health threat is heart disease (9).
- Women often fail to make the connection between risk factors, such as high blood pressure and high cholesterol, and their own chance of developing heart disease.
- Physicians tend to rate women as being at lower risk for heart disease than men even when the men and women have very similar risk profiles (10).
- A study of over 29,000 routine physician office visits found that women were counseled less often than men about exercise, nutrition, and weight reduction (11).
- The results of the 2003 national survey found that only 38% of women reported that their doctors had ever discussed heart disease with them (9).

Women and health care providers are often ill-informed about the differences between male and female signs, symptoms, and risk factors for heart disease (8, 9, 12, 13).

- The most common heart attack symptoms in women are different than those in men; women are more likely than men to experience ''atypical'' symptoms such as nausea, indigestion, palpitations, dyspnea and fatigue, and they are less likely than men to experience chest pain (14).
- The association between diabetes and heart disease is stronger in women than in men; diabetes increases a woman's risk of developing heart disease by 3 to 7 times, compared to 2 to 3 times in men (15).
- New evidence indicates that C-reactive protein may be a stronger risk factor in men than in women (16).
- The Women's Health Initiative study found that a common menopausal hormone therapy offered to women—estrogen plus progestin—increased the risk of heart disease in postmenopausal women (17).

There are also differences among men and women in heart disease prevention, diagnosis and treatment options and recommendations.

- The American Heart Association (AHA) and the American College of Cardiology (ACA) now recommend that women keep their HDL level at 50 mg/dL, compared with a recommended level of 40 mg/dL for men (1).
- New evidence indicates that aspirin therapy does not have the same heart protective effect in women as it does in men (18).
- The accuracy of exercise EKG and exercise thallium (with either conventional or SPECT imaging) for the diagnosis of heart disease is lower in women than in men due to both poor sensitivity and specificity (6).
- Some evidence indicates that clopidogrel is more effective in men than in women at reducing the risk of cardiovascular events and death among patients with acute coronary syndromes (6).
- For a comprehensive summary of prevention recommendations in women, see the Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women recently published by the AHA and the ACA (1).
- For a comprehensive summary of diagnosis and treatment options in women, see the Evidence Report/Technology Assessment: Results of a Systematic Review of Research on Diagnosis and Treatment of Coronary Heart Disease in Women published in 2003 by the Agency for Healthcare Research and Quality (6).

Recent research has shown disparities in prevention, diagnosis and treatment for heart disease among women as compared to men.

- In one study, men were more likely than women to undergo noninvasive cardiac tests as well as invasive cardiac procedures after being diagnosed with unstable angina (19).
- A recent prospective cohort study of 8353 high-risk women from the southeastern U.S. found that only about one-third of women with high lipids received lipid-lowering drugs (20).
- Women are also less likely than men to receive appropriate drug therapy after a heart attack such as acute heparin, angiotensin-converting enzyme

inhibitors, and glycoprotein IIb/IIIa inhibitors (13, 21).

• In another study conducted in the UK, women were 39% less likely than men to be correctly diagnosed with a heart attack (22).

• Women are significantly less likely than men to be referred to a cardiac rehabilitation program once they have been diagnosed with heart disease; women are also less likely to enroll in and complete cardiac rehabilitation programs (23–26).

C. High-Risk Groups

Some groups of women have higher rates of heart disease mortality than other women and/or a higher prevalence of factors that increase the risk of heart disease mortality and morbidity. These high-risk groups of women include women aged 60 years or older, racial and ethnic minority women, and/or women who live in some rural communities (particularly rural communities in the South and Appalachian region) (5, 7, 9, 23, 24, 27–48).

i. Older Women

• The incidence of heart disease increases with age, and over 83% of people who die of heart disease are age 65 years or older (27).

• The risk of high blood pressure also increases with age; about 80% of women age 65 years and older have high blood pressure (27).

• After menopause, heart disease rates in women are 2 to 3 times that of women the same age before menopause (7).

• In addition, levels of HDL cholesterol decrease after menopause while levels of LDL cholesterol increase, which increases the risk of developing coronary artery disease.

• Only 18% of women age 65 years and older report engaging in regular leisure time physical activity compared to 59% of the total population of women (28).

• Older heart disease patients are less likely to receive guideline-recommended medical therapies such as beta-blockers, thrombolysis, statins, and angiotensin-converting enzyme inhibitors (29–32).

• Older women are also less likely than younger women to participate in cardiac rehabilitation programs after having a heart attack (23, 24).

ii. Racial and Ethnic Minority Women

African American women have the highest age-adjusted heart disease death rate of any female race/ethnicity group in the United State. Compared to white women, racial and ethnic minority women have a higher prevalence of many major risk factors for heart disease.

• In 2002, the heart disease death rate was 263.2 per 100,000 for African American women compared to 192.1 per 100,000 for white women and 197.2 per 100,000 for all women combined (5).

• About 57% of Hispanic/Latino women, 56% of American Indians/Alaska Native women, 42.6% of Asian/Pacific Islander women and 55% of African American women do not exercise, compared to 38% of white women (7, 33–35).

• About 72% of Mexican-American women, 77% of African American women and 61% of American Indians/Alaska Native women are overweight or obese, compared to 57% of white women (7, 33, 34).

• About 37% of American Indians/Alaska Native women smoke compared to 21% of white women (7, 34).

• Other CVD risk factors such as diabetes mellitus and high blood pressure are also more prevalent among minority women than among white women (7, 33, 34).

• About 26% of Hispanic/Latino women and 27% of Asian American women have not had a blood pressure screening in the past 12 months, compared to 20% of white women (36).

Disparities also exist in prevention, screening and treatment for heart disease among certain racial and ethnic minority women compared to white women.

• Studies have shown that African American women are less likely than white women to receive statin therapy even though African American women have higher rates of high cholesterol (37, 38).

• In one study of 700,000 elderly Medicare beneficiaries with ischemic heart disease, African American and Native American underwent invasive diagnostic and surgical revascularization far less often than whites, and Asian Americans were 50% less likely to be admitted to a hospital than whites (39).

• In another recent study of patients hospitalized with heart attack, the time it took for African Americans, Asian/Pacific Islanders and Hispanics to receive both fibrinolytic therapy and percutaneous coronary intervention was significantly longer compared with white patients (40).

• Several studies of heart attack patients have shown that African Americans, Asian Americans and Hispanics are less likely than whites to undergo angioplasty, cardiac catheterization, and bypass surgery (41–44).

• African American women are also significantly less likely than white women to be referred to a cardiac rehabilitation program once they have had a heart attack (45).

Heart disease awareness is also lower among certain racial and ethnic minority groups of women than among white women.

• In the 2003 national survey conducted by the American Heart Association, fewer African-American and Hispanic women than white women correctly cited heart disease as the leading cause of death among women (9).

• The survey also showed that white women were more likely than women in other racial/ethnic groups to correctly identify the major risk factors for heart disease.

iii. Rural Populations: South and Appalachian Region

According to the Rural Healthy People 2010 Companion Document to Healthy People 2010, rural populations ''are faced with certain behaviors, attitudes, and access challenges that may contribute to their heightened risks of coronary heart disease and stroke (46).''

• Access challenges cited in the document include ''long travel distances to comprehensive post discharge care for heart failure, limited access to screening services, variances in utilization of antithrombolytic therapy, availability of technology and specialists, and limited access to cardiac rehabilitation services (46).''

• Other challenges include a decreased awareness of heart disease risk, particularly among older rural women, and an increased prevalence of heart disease risk factors. Women who live in rural counties in the South and Appalachian region have higher rates of heart disease mortality than any other counties in the United States (47, 48).

• Women living in rural areas have higher rates of smoking and obesity than women living in urban areas (48).

D. Women's Heart Health Programs

Clearly there is much improvement needed at all levels of women's heart health care, particularly for high-risk groups of women (*e.g.* women aged 60 years or older, racial and ethnic minority women, and women who live in rural communities). OWH believes that implementing comprehensive women's heart health programs within hospitals, clinics, and other health care centers may help to improve heart disease prevention, diagnosis, and treatment in women. Such programs address the unique issues and concerns

of women and take into account the differences between heart disease in women and men. While there is limited data to date on the ability of these programs to improve heart disease awareness and care in women, some promising results have been reported.

- After the Women's Heart Program was implemented at Our Lady of Lourdes Regional Medical Center in Lafayette, Louisiana, non-invasive heart disease testing increased by 32% (49).
- In addition, 38% of patients increased their physical activity and 24% lost weight.
- Prior to the program's existence, Lafayette women identified cancer as their greatest health risk. In 2001, they identified heart disease as their greatest risk.

2. Definitions

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

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

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.

Continuous: An ongoing set of services that include a complete array of heart health care, from education to screening to diagnosis to treatment and rehabilitation, without interruption.

Frontier community: Community or area with low population density that is usually fewer than 6–7 persons per square mile.

High-risk women: Groups of women that have higher rates of heart disease mortality than other women and/or a higher prevalence of factors that increase the risk of heart disease mortality and morbidity. Major risk factors for heart disease include smoking, high blood pressure, high LDL cholesterol, obesity, diabetes, physical inactivity, age, and family history of heart disease. Information on high risk or risks for heart disease can be found online at *http://circ.ahajournals.org/cgi/content/full/109/5/672* and *http://www.guidelines.gov/summary/summary.aspx?doc_id=3487&nbr=2713&string=lipid*.

Integrated: The goal of this approach is to unite the strengths of the various areas of women's health care, and create a more informed, less fragmented, and efficient system of care for women that can be replicated in other populations and communities.

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, geriatrics, cardiology, mental health, reproductive health, nutrition, endocrinology, physiology, immunology, rheumatology, dental health, etc.

Racial and Ethnic Minority Women: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander. (Revision to the Standards for the Classification of Federal Data on Race and Ethnicity, **Federal Register**, Vol. 62, No. 210, pg. 58782, October 30, 1997.)

Rural community: All territory, population, and housing units located outside of urban areas and urban cluster.

Target: Put forth effort to ensure that members of a specific group of women are aware of the program and that components of the program are designed to be effective in reaching those populations. This includes creating program materials that are culturally competent for that specific group of women. This also includes training staff and health professionals to understand the unique needs, behaviors, cultures and concerns of members of the specific group of women. Targeting does not mean excluding other groups of women from the program.

Women-centered heart health care services: Services and health care providers that (1) take into account the differences between heart disease in men and women, prevention, screening, diagnosis, treatment and rehabilitation and (2) address the needs and concerns of women in an environment that is welcoming to women, fosters a commitment to women, treats women with dignity, and empowers women through respect and education.

3. References

1. Mosca L, Appel LJ, Benjamin EJ, et al. Evidence-based guidelines for cardiovascular disease prevention in women. Circulation 2004;109(5):672–93.

2. Gallagher R, McKinley S, Dracup K. Predictors of women's attendance at cardiac rehabilitation programs. Prog Cardiovasc Nurs 2003;18(3):121–6.

3. Heid HG, Schmelzer M. Influences on women's participation in cardiac rehabilitation. Rehabil Nurs 2004;29(4):116–21.

4. American Heart Association. Heart Disease and Stroke Statistics—2005 Update. Dallas, Texas: American Heart Association; 2005.

5. Center for Disease Control and Prevention (CDC). National Center for Health Statistics. Health, United States, 2004 With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland: 2004.

6. Grady D, Chaput L, Kristof M. Results of Systematic Review of Research on Diagnosis and Treatment of Coronary Heart Disease in Women. Evidence Report/Technology Assessment No. 80. AHRQ Publication No. 03–0035. Rockville, MD: Agency for Healthcare Research and Quality. May 2003.

7. American Heart Association. Women and Cardiovascular Diseases—Statistics. Dallas, Texas: American Heart Association; 2005.

8. Practice News. Red Dress Attracts New Attention to Heart Disease in Women. Cardiology 2003;32(7):1–4.

9. Mosca L, Ferris A, Fabunmi R, Robertson RM; American Heart Association. Tracking women's awareness of heart disease: an American Heart Association national study. Circulation 2004;109(5):573–9.

10. Mosca L, Linfante AH, Benjamin EJ, et al. National study of physician awareness and adherence to cardiovascular disease prevention guidelines. Circulation 2005;111(4):499–510.

11. Missed opportunities in preventive counseling for cardiovascular disease: United States, 1995. Morbidity and Mortality Weekly Report 1998;47:91–95.

12. McSweeney JC, Cody M, Crane PB. Do you know them when you see them? Women's prodromal and acute symptoms of myocardial infarction. J Cardiovasc Nurs 2001;15(3):26–38.

13. National Institutes of Health. National Heart Lung and Blood Institute. Women's Heart Health: Developing a National Health Education Action Plan. Strategy Development Workshop Report. March 26–27, 2001. NIH Publication No.01–2963. September 2001.

14. Patel H, Rosengren A, Ekman I. Symptoms in acute coronary syndromes: does sex make a difference? Am Heart J 2004;148(1):27–33.

15. Mosca L, Grundy SM, Judelson D, et al. Guide to Preventive Cardiology for Women. AHA/ACC Scientific Statement Consensus panel statement. Circulation 1999;99:2480–2484.

16. Pai JK, Pischon T, Ma J, et al. Inflammatory markers and the risk of coronary heart disease in men and women. N Engl J Med 2004;351(25):2599–610.

17. Rossouw JE, Anderson GL, Prentice RL, et al. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results From the Women's Health

Initiative randomized controlled trial. JAMA 2002;288:321–333.

18. Ridker PM, Cook NR, Lee IM, et al. A Randomized Trial of Low-Dose Aspirin in the Primary Prevention of Cardiovascular Disease in Women. N Engl J Med 2005 Mar 7; [Epub ahead of print].

19. Roger VL, Farkouh ME, Weston SA, et al. Sex differences in evaluation and outcome of unstable angina. JAMA 2000;283(5):646–52.

20. Mosca L, Merz NB, Blumenthal RS, *et al.* Opportunity for intervention to achieve American Heart Association guidelines for optimal lipid levels in high-risk women in a managed care setting. Circulation 2005;111(4):488–93.

21. Blomkalns AL, Chen AY, Hochman JS, *et al.* Gender disparities in the diagnosis and treatment of non-ST-segment elevation acute coronary syndromes: large-scale observations from the CRUSADE (Can Rapid Risk Stratification of Unstable Angina Patients Suppress Adverse Outcomes With Early Implementation of the American College of Cardiology/American Heart Association Guidelines) National Quality Improvement Initiative. J Am Coll Cardiol 2005;45(6):832–7.

22. Willingham SA, Kilpatrick. Evidence of gender bias when applying the new diagnostic criteria for myocardial infarction. Heart 2005;91(2):237–8.

23. Spencer FA, Salami B, Yarzebski J, *et al.* Temporal trends and associated factors of inpatient cardiac rehabilitation in patients with acute myocardial infarction: a community-wide perspective. J Cardiopulm Rehabil 2001;21(6):377–84.

24. Witt BJ, Jacobsen SJ, Weston SA, *et al.* Cardiac rehabilitation after myocardial infarction in the community. J Am Coll Cardiol 2004;44(5):988–96.

25. Halm M, Penque S, Doll N, Beahrs M. Women and cardiac rehabilitation: Referral and compliance patterns. J Cardiovasc Nurs 1999 Apr;13(3):83–92.

26. Caulin-Glaser T, Blum M, Schmeizl R, *et al.* Gender differences in referral to cardiac rehabilitation programs after revascularization. J Cardiopulm Rehabil 2001;21(1):24–30.

27. American Heart Association. Older Americans and Cardiovascular Diseases—Statistics. Dallas, Texas: American Heart Association; 2005.

28. Federal Interagency Forum on Aging-Related Statistics. Older Americans 2004: Key Indicators of Well-Being. Federal Interagency Forum on Aging-Related Statistics, Washington, DC: U.S. Government Printing Office. November 2004.

29. Tran CT, Laupacis A, Mamdani MM, Tu JV. Effect of age on the use of evidence-based therapies for acute myocardial infarction. Am Heart J 2004;148(5):834–41.

30. Rathore SS, Mehta RH, Wang Y, *et al.* Effects of age on the quality of care provided to older patients with acute myocardial infarction. Am J Med 2003;114(4):307–15.

31. McLaughlin TJ, Soumerai SB, Willison DJ, *et al.* Adherence to national guidelines for drug treatment of suspected acute myocardial infarction: Evidence for undertreatment in women and the elderly. Arch Intern Med 1996;156(7):799–805.

32. Safford M, Eaton L, Hawley G, *et al.* Disparities in use of lipid-lowering medications among people with type 2 diabetes mellitus. Arch Intern Med 2003;163(8):922–8.

33. American Heart Association. Hispanics/Latinos and Cardiovascular Diseases—Statistics. Dallas, Texas: American Heart Association; 2005.

34. American Heart Association. American Indians/Alaska Natives and Cardiovascular Diseases—Statistics. Dallas, Texas: American Heart Association; 2005.

35. American Heart Association. Asian/Pacific Islanders and Cardiovascular Diseases—Statistics. Dallas, Texas: American Heart Association; 2005.

36. National Institutes of Health. National Heart Lung and Blood Institute. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) Express. NIH Publication No. 03–5233. December 2003.

37. Jha AK, Varosy PD, Kanaya AM, *et al.* Differences in medical care and disease outcomes among African American and white women with heart disease. Circulation 2003;108(9):1089–94.

38. Massing MW, Foley KA, Carter-Edwards L, *et al.* Disparities in lipid management for African Americans and Caucasians with coronary artery disease: a national cross-sectional study. BMC Cardiovasc Disord 2004;4(1):15.

39. Cromwell J, McCall NT, Burton J, Urato C. Race/Ethnic disparities in utilization of lifesaving technologies by medicare ischemic heart disease beneficiaries. Med Care 2005;43(4):330–7.

40. Bradley EH, Herrin J, Wang Y, *et al.* Racial and ethnic differences in time to acute reperfusion therapy for patients hospitalized with myocardial infarction. JAMA 2004;292(13):1563–72.

41. Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB. Racial variation in the use of coronary-revascularization procedures. Are the differences real? Do they matter? N Engl J Med 1997;336(7):480–6.

42. Shen JJ. Severity of illness, treatment environments, and outcomes of treating acute myocardial infarction for Hispanic Americans. Ethn Dis 2002;12(4):488–98.

43. Yarzebski J, Bujor CF, Lessard D, *et al.* Recent and temporal trends (1975 to 1999) in the treatment, hospital, and long-term outcomes of Hispanic and non-Hispanic white patients hospitalized with acute myocardial infarction: a population-based perspective. Am Heart J 2004;147(4):690–7.

44. Kressin NR, Petersen LA. Racial differences in the use of invasive cardiovascular procedures: Review of the literature and prescription for future research. Ann Intern Med. 2001;135(5):352–66.

45. Allen JK, Scott LB, Stewart KJ, Young DR. Disparities in women's referral to and enrollment in outpatient cardiac rehabilitation. J Gen Intern Med 2004;19(7):747–53.

46. Gamm LD, Hutchison LL, Dabney BJ, Dorsey, AM., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 1.* College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center. 2003.

47. Halverson JA, Barnett E, Casper M. Geographic disparities in heart disease and stroke mortality among African American and white populations in the Appalachian region. Ethn Dis 2002;12(4):S3–82–91.

48. Center for Disease Control and Prevention (CDC). National Center for Health Statistics. Health, United States, 2001 With Urban and Rural Health Chartbook. Hyattsville, Maryland: 2001.

49. Montgomery K. Tracking Your Way to Success: Women's Heart Program Justifies Its Existence. The Ireland Report (From the Snowmass Institute—www.snowinst.com) on Succeeding in Women's Health. May/June 2002.

Dated: June 16, 2005.

Wanda K. Jones,

Deputy Assistant Secretary for Health (Women's Health).

[FR Doc. 05–12519 Filed 6–23–05; 8:45 am]

BILLING CODE 4130–33–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Applications for the National Centers of Excellence in Women's Health (CoE) and the National Community Centers of Excellence in Women's Health (CCOE)—Ambassadors for Change Program

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of Public Health and Science.

ACTION: Notice.

Announcement Type: Competitive Cooperative Agreement—FY 2005 Initial announcement.

Funding Opportunity Number: Not applicable.

Catalog of Federal Domestic Assistance: The Catalog of Federal Domestic Assistance number is 93.013.

Authority: This program is authorized by 42 U.S.C. 300u–2(a).

DATES: To receive consideration applications must be received by the Office of Grants Management, Office of Public Health and Science (OPHS), Department of Health and Human Services (DHHS), no later than 5 p.m. eastern daylight time no later than July 25, 2005.

SUMMARY: The National Centers of Excellence in Women's Health and the National Community Centers of Excellence in Women's Health programs provide funding to academic health centers and community-based organizations to enhance their women's health program through the integration