Dated: June 17, 2001.

Thomas A. Scully, Administrator,

Health Care Financing Administration.

[FR Doc. 01–16025 Filed 6–26–01; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Notice of a Cooperative Agreement to Develop and Manage a Program for Faculty Leadership in Interdisciplinary Education to Promote Patient Safety (FLIEPPS)

The Health Resources and Services Administration (HRSA) announces that applications will be accepted for a Cooperative Agreement for fiscal year (FY) 2001 to Develop and Manage a Program for Faculty Leadership in Interdisciplinary Education to Promote Patient Safety (FLIEPPS).

The purpose of this Cooperative Agreement is to develop a ''train the trainers'' program to create nurse and physician faculty leaders in interdisciplinary education specifically directed toward enhancing patient safety. Graduates of the program could then lead in the training of other faculty in curricula and techniques in interdisciplinary education to promote patient safety. The ultimate goal of this program is to bridge the separate cultures of practice in medicine and nursing by expanding numbers of professionals who are trained to work together in teams to improve systems for safe patient care and to prevent errors.

Authorizing Legislation

This Cooperative Agreement is solicited under the following authorities of titles VII and VIII of the Public Health Service (PHS) Act: (1) Section 747, as amended, which authorizes grants for training of physicians who plan to teach in training programs for primary care medicine (family medicine, general internal medicine, general pediatrics, and/or geriatrics); and (2) section 811, as amended, which authorizes grants to strengthen programs that enhance advanced nurse education and practice.

The Federal role in the conduct of this Cooperative Agreement is substantial and will be maintained by the Bureau of Health Professions (BHPr) staff through technical assistance and guidance to the awardee considerably beyond the normal stewardship responsibilities in the administration of grant awards. This Federal role may include any or all of the following:

(a) Technical assistance and participation in the planning, development, and implementation of all phases of the program, including consultation about contracts and agreements developed during the implementation of the program, all curricula developed for the program, content and staffing of training workshops, and the development of an evaluation plan for the project which would be initiated at its inception;

(b) Assistance with identification of Federal and other organizations with whom collaboration is essential in order to further the Cooperative Agreement mission and to develop specific strategies to support the work of these related activities;

(c) Participation in the development of funding projections;

(d) Participation in the development of data collection systems and procedures;

(e) Participation in appropriate meetings, committees, subcommittees, and working groups related to the Cooperative Agreement and its projects as well as site visits.

The successful applicants will be included in the overall program activities of the Department of Health and Human Services (HHS) in patient safety and will participate in the programs and support services that will be offered by the Patient Safety Research Coordinating Center supported under a contract from the Agency for Healthcare Research and Quality (AHRQ). The Cooperative Agreements are part of an overall HHS funding effort to improve patient safety research, demonstration and education through a series of RFAs and Cooperative Agreements (related RFAs are listed at *www.ahrq.gov,* particularly the AHRQ Patient Safety Research Dissemination and Education RFA that was published on April 23, 2001).

Availability of Funds

Up to $400,000 will be available in FY 2001 to fund one award for the first year. Funding may be continued to complete a 3-year total project period. It is expected that the award will be made on or before September 30, 2001. Support beyond the first year of the project period will be based on the achievement of satisfactory progress and the availability of funds.

Background

In September 2000, shortly after the Institute of Medicine (IOM) published its widely discussed report: ''To Err is Human: Building a Safer Health System'' (Kohn, Corrigan and Donaldson, National Academy Press, Washington, DC, 2000), the Council on Graduate Medical Education (COGME) and the National Advisory Council on Nurse Education and Practice (NACNEP) jointly focused on nurse-physician collaboration in a report entitled, ''Collaborative Education Models to Ensure Patient Safety.'' COGME–NACNEP joint recommendations stressed the need for changing the norms of professional education and practice so that physicians and nurses would function as part of collaborative teams to improve patient safety and the overall quality of care. COGME and NACNEP are charged with advising and reporting to the Secretary of HHS and the Congress on workforce, education, and practice improvement policies.

These joint Advisory Council recommendations highlighted the critical importance of developing educational leaders in interdisciplinary education to promote patient safety to effect positive changes toward developing systems of care that stress professional collaboration and teamwork.

This Cooperative Agreement requests the planning, development, and implementation of interdisciplinary educational and training programs for the education of physicians and nurses directed toward improving patient safety. This will involve the development of formal curricula in interdisciplinary leadership and training in interdisciplinary teamwork focused on building safer systems of patient care. Curricula must include both didactic and experiential learning (in both simulations and practice settings) with each team being supported by a mentor. In particular, safety issues must target those areas of care which require physician-nurse communication, especially recognition and elimination of situations which create discontinuities in communication and apparent responsibilities that may increase the likelihood of errors. Curricula must contain elements that emphasize cultural competency, to broaden physicians' and nurses' understanding of how differences in race, ethnicity, language, gender, and sexual orientation may affect communication between physicians, nurses, and patients, interpretations of patients' histories and responses to recommendations and, thereby, affect patient safety.

Educational efforts will be directed at teams of faculty sponsored by health care organizations (universities, teaching hospitals, ambulatory centers or consortia involved in training). Each team to be trained must include at least

several allopathic or osteopathic physicians and nurses, but must include at least one allopathic or osteopathic physician and one nurse. Inclusion of trained medical educators must be encouraged.

Programs may be directed toward developing faculty leaders for undergraduate, graduate, and/or continuing professional education for those who provide clinical care. Faculty leadership development programs must address: (1) The development of curricular design for collaborative education of physicians and nurses, and improvement in leadership and interdisciplinary teaching skills; (2) the development of interdisciplinary collaborative curricula designed to promote patient safety. The emphasis must be on improving communications and teamwork, and identifying and reducing discontinuities in patient care routines and systems, which will eliminate common sources of errors. At the completion of the specified educational and training program, the trainees must be certified by the awardee through a mechanism determined during the initial planning phase as competent faculty to develop and lead collaborative programs in interdisciplinary education to enhance patient safety in their own organizations. The awardee will be expected to perform a comprehensive outcome evaluation of all efforts delivered through this Cooperative Agreement. Evaluations of the individual projects supported by this Cooperative Agreement must be reported along with the evaluation of the overall faculty leadership development program as proposed and implemented through the overall plan.

Applicants must show experience in professional faculty development, physician-nurse collaborative interdisciplinary education, and/or addressing practical patient safety issues, or be able to demonstrate their expertise in these areas.

Eligible Applicants

Eligible applicants are accredited schools of nursing, schools of medicine and osteopathic medicine, academic health centers, public and nonprofit private hospitals, and other public or private nonprofit entities which provide educational programs for undergraduate, graduate, or graduate medical and nursing education.

Applicants should have a demonstrable track record in (1) The design and implementation of training or educational programs for physicians and nurses; (2) inter-disciplinary education and/or training for physicians and nurses; and (3) experience and/or expertise in education to improve patient safety.

Funding Preference

A funding preference is defined as the funding of a specific category or group of approved applications ahead of other categories or groups of applications. The following preferences are available under this Cooperative Agreement:

As provided in section 791(a) of the PHS Act, preference will be given to any qualified applicant that: (a) Has a high rate for placing graduates in practice settings having the principal focus of serving residents of medically underserved communities, or (b) during the 2-year period preceding the fiscal year for which such an award is sought, has achieved a significant increase in the rate of placing graduates in such settings; or (c) qualifies for the funding preference by meeting the criteria for a new program.

Definition of High Rate: At least 20 percent of graduates from academic years 1998, 1999, and 2000 devote at least 50 percent of their time working in clinical practice in medically underserved community (MCH) settings.

Definition of Significant Increase: During the past two years (1999 and 2000), the rate of placing graduates in MUC settings has increased at least 50 percent (with a minimum of 2 graduates) and at least 15 percent from the last year are working in MUC settings.

Established clinical sites identified under the ''medically underserved community'' definition are used as proxies for rural and underserved populations.

The term ''medically underserved community (MUC)'' means an urban or rural area or population that:

(a) Is eligible for designation under section 332 as a Health Professional Shortage Area (HPSA);

(b) Is eligible to be served by a Migrant Health Center under section 330 of the PHS Act, a Community Health Center under section 330 of the Act, a grantee under section 330 of the Act (relating to homeless individuals), or a grantee under section 330 of the Act (relating to residents of public housing);

(c) Is eligible for certification under section 1861(aa)(2) of the Social Security Act (relating to rural health clinics); or

(d) Is designated by a State Governor (in consultation with the medical community) as a shortage area or MUC. (Section 799B(6) of the PHS Act.)

In reference to section 332 (HPSA) listed above, the following instructions apply:

(a) To determine if any applicant fits the standards for eligibility when they are not so designated, the applicant must demonstrate that an application has been submitted for such designation and include proof of acceptance of that application from the designating authority.

(b) The MUC preference will not be applied without proof of approval of that application.

For new programs (those having graduated three or fewer classes), applicant proposals will be evaluated by the criteria in the Act used to define a ''new program'' and a preference will be given to those new programs that meet at least four of the following seven criteria:

(1) The mission statement of the program identifies a specific purpose of the program as being the preparation of health professionals to serve underserved populations.

(2) The curriculum of the program includes content which will help to prepare practitioners to serve underserved populations.

(3) Substantial clinical training experience is required under the program in MUCs.

(4) A minimum of 20 percent of the clinical faculty of the program spend at least 50 percent of their time providing or supervising care in MUCs.

(5) The entire program, or a substantial portion of the program, is physically located in a MUC.

(6) Student assistance, which is linked to service in MUC's following graduation, is available to the students in the program.

(7) The program provides a placement mechanism for deploying graduates to MUCs.

As provided in section 805 of the PHS Act, a funding preference will be applied to approved applications that will substantially benefit rural OR underserved populations, OR help meet public health nursing needs in State or local health departments.

These statutory general preferences will only be applied to applications that rank above the 20th percentile of applications recommended for approval by the peer review group.

Special Consideration

A special consideration is the enhancement of priority scores by individual merit reviewers of approved applications which address special areas of concern.

Section 747(c)(3) provides for a special consideration to be given to projects that prepare practitioners to care for underserved populations and other high risk groups such as the

elderly, individuals with HIV/AIDS, substance abusers, homeless, and victims of domestic violence.

Section 811(f)(3) provides for a special consideration to eligible entities that agree to expend the award to train advanced education nurses who will practice in HPSAs designated under section 332.

Review Criteria

The specific review criteria used to review and rank applications are included in the application guidance that will be provided to each potential applicant. Applicants should pay strict attention to addressing these criteria, as they are the basis upon which applications will be judged by the reviewers.

The following generic review criteria are also applicable to this Cooperative Agreement:

(a) That the estimated cost to the Government of the project is reasonable considering the level and complexity of activity and the anticipated results.

(b) That project personnel are well qualified by training and/or experience for the support sought, and the applicant organization or the organization to provide training has adequate facilities and manpower.

(c) That insofar as practical, the proposed activities, if well executed, are capable of attaining project objectives.

(d) That the project objectives are capable of achieving the specific program objectives defined in the program announcement and the proposed results are measurable.

(e) That the method for evaluating proposed results includes criteria for determining the extent to which the program has achieved its stated objectives and the extent to which the accomplishment of objectives can be attributed to the program.

(f) That, insofar as practical, the proposed activities, when accomplished, are replicable, national in scope, and include plans for broad dissemination.

Letters of Intent and Deadline Date

Applicants are encouraged to submit a letter of intent to apply for this request for applications for a Cooperative Agreement. The letter is requested to assist staff in planning for the review based on anticipated number of applications. The letter of intent is due by July 11, 2001. Simultaneously mail or e-mail one copy of the letter to each of the following representatives from the Division of Medicine and Dentistry and the Division of Nursing within the Bureau:

Dr. Richard D. Diamond, Medical Officer, Policy and Special Projects Branch, Division of Medicine and Dentistry, Bureau of Health Professions, HRSA, Room 9A–27, ParklawnBuilding, 5600 Fishers Lane, Rockville, MD 20867; or e-mail address at *rdiamond@hrsa.gov.* Dr. Diamond's telephone number is (301) 443–1082.

Dr. Madeleine Hess, Deputy Chief, Nursing Special Initiatives and Program Systems Branch,Division of Nursing, Bureau of Health Professions, HRSA, Room 9–35, ParklawnBuilding, 5600 Fishers Lane, Rockville, MD 20867; or e-mail address at *mhess@hrsa.gov.* Dr. Hess' telephone number is (301) 443–6336.

Application Requests, Dates and Address

Federal Register notices and the application form and guidance for this Cooperative Agreement are available on the HRSA web site address at *http://bhpr.hrsa.gov/grants2001/.* Applicants may also request a hard copy of these materials from the HRSA Grants ApplicationCenter (GAC) at 1815 North Fort Myer Drive, Suite 300, Arlington, VA 22209; telephone number 1–877–477–2123. The GAC e-mail address is: *hrsagac@hrsa.gov.*

In order to be considered for competition, applications for this Cooperative Agreement must be received by mail or delivered to the GAC no later than July 27, 2001.

Completed applications must be submitted to the GAC at the above address. Applications received after the deadline date or sent to any address other than the Arlington, Virginia address above will be returned to the applicant and not reviewed.

National Health Objectives for the Year 2010

The PHS urges applicants to submit their work plans that address specific objectives of Healthy People 2010, which potential applicants may obtain through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325 (telephone: (202) 783–3238). Particular attention should focus on Healthy People 2010 Workforce Objectives, such as Objectives 1–8 (achieving minority representation in the health professions) and 23–8 (incorporating specific competencies into the public health workforce).

Smoke-Free Workplace

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

Additional Information

Questions concerning programmatic aspects of the Cooperative Agreement may be directed to the same representatives of the Division of Medicine and Dentistry and the Division of Nursing listed above in the Letters of Intent section of this notice.

Paperwork Reduction Act

The standard application form HRSA–6025–1, the HRSA Competing Training Grant Application, has been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act. The OMB clearance number is 0915–0060. If the methods for developing the proposed comprehensive outcome evaluation of all efforts delivered through thisCooperative Agreement (as described in the Background section of this notice) falls under the purview of the Paperwork Reduction Act, awardees will assist HRSA in seeking OMB clearance for proposed data collection activities.

This program is not subject to the provisions of Executive Order 12372, Intergovernmental Review of Federal Programs (as implemented through 45 CFR part 100). This program is also not subject to the Public Health Systems Reporting Requirements.

Dated: June 19, 2001.

Elizabeth M. Duke,

Acting Administrator.

[FR Doc. 01–16023 Filed 6–26–01; 8:45 am]

BILLING CODE 4160–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Notice of Cooperative Agreements to Develop, Implement and Evaluate Safe Practices at the Patient Care Delivery Level Through Collaborative, Interdisciplinary Education To Prepare Physicians and Advanced Practice Nurses

The Health Resources and Services Administration (HRSA) announces that applications will be accepted for Cooperative Agreements for fiscal year (FY) 2001 to Develop, Implement and Evaluate Safe Practices at the Patient