6803, INTERNET address phs3@cdc.gov.

For programmatic technical assistance contact: Sharon Conley, Financial Acquisition Specialist, Office of Program Operations & Management (OPOM), Agency for Toxic Substances and Disease Registry (ATSDR), 1600 Clifton Road, NE., Mailstop E–60, Atlanta, Georgia 30333, Telephone (404) 639–0559, INTERNET address sac7@cdc.gov.

Also, the CDC home-page on the Internet: *http://www.cdc.gov* is available for copies of this Announcement and funding documents as well as application forms.

Dated: June 3, 1998.

Georgi Jones,

Director, Office of Policy and External Affairs, Agency for Toxic Substances and Disease Registry.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR–135]

Availability of ATSDR Decision Document Regarding the Bunker Hill, Idaho, Medical Monitoring Program

AGENCY: Agency for Toxic Substances and Disease Registry (ATSDR), Department of Health and Human Services (HHS).

ACTION: Notice of availability for public review and comment of draft Decision Document Regarding the Bunker Hill, Idaho, Medical Monitoring Program.

SUMMARY: ATSDR has reviewed scientific literature and clinical information in order to assess the need for medical monitoring at Bunker Hill, Idaho. ATSDR has determined that there is a definable population at significantly increased risk of disease that will benefit from a medical monitoring program. ATSDR has judged that the medical monitoring program is appropriate to provide periodic medical evaluation and referrals to improve the public health status of the affected population. The current literature and expert panel workshop held by ATSDR reflect that medical monitoring at Bunker Hill would be good public health practice and of medical benefit to the affected populations. This notice is announcing the availability of the draft report documenting ATSDR's justification for implementing a medical monitoring program for the population at the Bunker Hill Site: the ''ATSDR Decision Document Regarding the Bunker Hill, Idaho, Medical Monitoring Program'', is available for public review and comment.

DATES: Comments must be received by July 9, 1998.

ADDRESSES: The report is available through Dr. Vivian Rush, MD, Medical Officer, ATSDR-Division of Health Education and Promotion, 1600 Clifton Road, NE., Mailstop E–33, Atlanta, Georgia 30333, E-mail address vcr1@cdc.gov and telephone (404) 639–5080.

FOR FURTHER INFORMATION CONTACT: Dr. Vivian Rush, Medical Officer, ATSDR; telephone (404) 639–5080.

SUPPLEMENTARY INFORMATION: Section 104 (i)(9) of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), as amended [42 U.S.C. 9604 (i)(9)], provides for the Administrator of ATSDR to initiate a health surveillance program for populations at a significant increased risk of adverse health effects as a result of exposure to hazardous substances released from a facility. A program ATSDR includes under health surveillance is referred to as ''Medical Monitoring or Screening'' and is defined, as published in the **Federal Register** on July 28, 1995 (60 FR 38840), in ''ATSDR's Final Criteria for Determining the Appropriateness of a Medical Monitoring Program under CERCLA'' as ''the periodic medical testing to screen people at significant increased risk for disease.'' There are 7 Medical Monitoring criteria associated with this program and they are as follows:

(1) There should be evidence of contaminant levels in environmental media that would suggest the high likelihood of environmental exposure to a hazardous substance and subsequent adverse health outcomes.

(2) There should be a well-defined, identifiable target population of concern in which exposure to a hazardous substance at a sufficient level has occurred.

(3) There should be documented human health research that demonstrates a scientific basis for a reasonable association between an exposure to a hazardous substance and a specific adverse health effect (such as an illness or change in a biological marker of effect).

(4) The monitoring should be directed at detecting adverse health effects that are consistent with the existing body of knowledge and amenable to prevention or intervention measures.

(5) The general requirements for a medical screening program should be satisfied. Those requirements are:

- The natural history of the disease process should be understood sufficiently for screening.
- The early detection through screening should be known to have an impact on the natural history of that disease process.
- There should be an accepted screening test that meets the requirements for validity, reliability, estimates of yield, sensitivity, specificity, and acceptable cost.

(6) An accepted treatment, intervention or both for the condition (outcome or marker of exposure) must exist and a referral system should be in place prior to the initiation of a medical monitoring program.

(7) The logistics of the system must be resolved before the program can be initiated.

Background

The 21-square-mile Bunker Hill Superfund site includes the Bunker Hill mining and smelting complexes and the communities of Pinehurst, Page, Smelterville, Kellogg and Wardner in Shoshone county, in Silver Valley of northern Idaho. Mining and mineral refining has been the dominant industry in the Silver Valley for more than 100 years. The mining and mineral refining activities have severely impacted the landscape, vegetation, and the quality of the air, and soils in the area. A population of workers and residents who have worked in and lived surrounding the former Bunker Hill lead and zinc smelting facility have been exposed to lead (and probably other heavy metals) in the past at levels of public health concern (i.e., at levels where health effects could be expected to occur). The most serious exposures took place during the 1970's after a baghouse fire resulted in large amounts of lead to be released into the air of towns surrounding the smelter. Epidemiologic studies have shown adverse health effects in the populations that were present during the past high exposure periods. Since the smelter's closure in 1981, the exposures have markedly decreased. In addition, the Panhandle Health District has implemented a program to detect excess exposure in the community and provides information and education on preventing harmful exposures and scientific literature supports these findings.

Dated: June 3, 1998.

Georgi Jones,

Director, Office of Policy and External Affairs, Agency for Toxic Substances and Disease Registry.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30DAY–15–98]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7090. Send written comments to CDC, Desk Officer; Human Resources and Housing Branch, New Executive Office Building, Room 10235; Washington, DC 20503. Written comments should be received within 30 days of this notice.

Proposed Projects

1. *Prostate and Colorectal Cancer Screening in the Managed Care Environment—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).* Prostate and colorectal cancer are among the leading causes of cancer deaths in the U.S. Prostate cancer screening has increased rapidly during the past few years; however, little is known about actual rates of screening, or the proportion of men screened who present with symptoms or who are at high risk for prostate cancer. Evidence suggests that colorectal cancer screening can save lives and efforts are under way to increase participation in screening. However, little information is available to monitor screening rates. It is also unknown how well self-reported prostate and colorectal cancer screening rates, which are often used in population surveys, compare to actual screening rates. Therefore, the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control, intends to conduct a survey of prostate and colorectal cancer screening test utilization. As an increasing number of people are served by managed care organizations where they may receive cancer screening tests, the proposed study population are members of managed care organizations.

A sample of members (men aged 40 years and older and women 50 years and older) of 3 managed care organizations will be interviewed over the telephone, and the medical charts of the participants will be abstracted. The information collected will include demographic information, prostate and colorectal cancer screening tests received within the past 5 years, and the reasons and outcomes of the tests. The total annual burden hours are 530.

Respondents	No. of respondents	No. of responses/respondent	Average burden of response (in hrs.)	Total burden (in hrs.)
Survey	2120	1	0.25	530

2. *Weekly and Annual Morbidity and Mortality Reports—(0920–0007)—Extension—Epidemiology Program Office*—In 1878, Congress authorized the U.S. Marine Hospital Service (later re-named the U.S. Public Health Service) to collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas. This information was to be used for instituting quarantine measures to prevent the introduction and spread of these diseases in the United States. In 1879, a specific Congressional appropriation was made for the collection and publication of reports of these notifiable diseases. The authority for weekly reporting and publication was expanded by Congress in 1893 to include data from state and municipal authorities throughout the U.S. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General of the Public Health Service to provide forms for the collection and compilation of data and for the publication of reports at the national level.

In 1961, responsibility for the collection of data on nationally notifiable diseases and deaths in 121 U.S. cities was transferred from the National Office of Vital Statistics to CDC. For 37 years, the MMWR has consistently served as CDC's main communication mode for disease outbreaks and trends in health and health behavior. In collaboration with the Council of State and Territorial Epidemiologists (CSTE), CDC has demonstrated the efficiency and effectiveness of computer transmission of data.

The data collected electronically for publication in the MMWR provides information which CDC and State epidemiologists use to detail and more effectively interrupt outbreaks. Reporting also provides the timely information needed to measure and demonstrate the impact of changed immunization laws or a new therapeutic measure. Users of data include, but are not limited to, congressional offices, state and local health agencies, health care providers, and other health related groups.

The dissemination of public health information is accomplished through the MMWR series of publications. The publications consist of the MMWR, the CDC Surveillance Summaries, the Recommendations and Reports, and the Annual Summary of Notifiable Diseases. The total annual burden hours are 4,927.