D

Indian Health Service

Addressing Dementia in Indian Country: Models of Care

Announcement Type: New

Funding Announcement Number: HHS-2023-IHS-ALZ-0001

Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.933

Key Dates

Application Deadline Date: [INSERT DATE 90 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]

Earliest Anticipated Start Date: [INSERT DATE 135 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for cooperative agreements for Addressing Dementia in Indian Country. This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the Indian Health Care Improvement Act, 25 U.S.C. 1665a(c)(5)(F) and 1660e. This program is described in the Assistance Listings located at https://sam.gov/content/home (formerly known as the CFDA) under 93.933.

Background

Alzheimer's disease and Alzheimer's disease-related dementias affect lives in every Tribal and Urban Indian community. Alzheimer's disease is the most common cause of dementia – a progressive cognitive impairment that adversely affects function. Other

forms of dementia include vascular dementia, Lewy-Body Disease, Fronto-Temporal Dementia, alcohol-related dementia, dementia related to traumatic brain injury, and mixed dementia (attributable to more than one cause of cognitive impairment). Age is the most significant risk factor for Alzheimer's disease. Although the average age of the American Indian and Alaska Native (AI/AN) population is younger than the United States (U.S.) average population as a whole, the AI/AN group ages 65 and older is growing more rapidly than the U.S. population. The Centers for Disease Control and Prevention (CDC) notes that the number of AI/AN aged 65 and older is expected to triple in the next 30 years, with the oldest – those 85 years and older – increasing even more rapidly. While age is the most substantial risk factor for Alzheimer's disease, early-onset occurs in younger populations and in persons with Down Syndrome or Trisomy 21, who are at markedly increased risk for Alzheimer's Disease. Conditions such as diabetes, cardiovascular disease, chronic kidney disease, chronic liver disease, and traumatic brain injury increase the risk of dementia and can lead to a more rapid worsening.

Dementia of all types is under-recognized, underdiagnosed, and undertreated in all populations in the U.S., and anecdotal evidence suggests this is very much true for the AI/AN population. Many individuals go unrecognized in the community, never seeking care and living with impaired cognition that puts them at risk for financial exploitation, poor health outcomes, and accidental injury. Individuals and their families may not recognize the cognitive changes that dementia brings. They may think the changes are due to normal aging or may accept the changes and not seek care out of concern for the elder's dignity. Failure to recognize dementia may also stem from the stigma associated with dementia and from a lack of awareness of the resources available. Often it takes a crisis or illness to bring attention to the condition. Diagnosis of dementia is most often made in the primary care office or clinic, with specialty referral needed when the presentation is not typical or apparent. But primary care providers may lack the

confidence or knowledge to make the diagnosis or plan effective care. They also may not have access to an interdisciplinary team to support care or specialists through consultation or referral to support diagnosis and management decisions. Effective management of dementia crosses many boundaries, involving medical care, personal care, social services, legal and financial services, and housing. Management of dementia requires coordination between clinical services and community-based services. Those living with dementia and their caregivers are too often left to coordinate this complex care themselves. Most persons living with dementia receive some care and assistance from caregivers and sometimes from family members. Care for the person living with dementia should include consideration for their caregivers; unfortunately, this is not common.

Effective models for addressing dementia in Tribal and Urban Indian communities will be supported by evidence and will emerge through development or adaptation and evaluation from those communities. A recent report by the Agency for Healthcare Research and Quality and the National Academies of Science, Engineering, and Medicine points to the Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) caregiver support intervention and models of coordinated care as interventions that have evidence for benefit and are ready for implementation and further evaluation.[1] The REACH into Indian Country initiative successfully trained public and community health nurses to provide the REACH intervention in Tribal communities. Communities across the country, including some Tribal communities, use the Dementia-Friendly Communities approach to building community-based efforts to improve care for persons living with dementia and their families.[2] A large number of evidence-based programs

---

1 National Academies of Sciences, Engineering, and Medicine. 2021. Meeting the challenge of caring for persons living with dementia and their care partners and caregivers: A way forward. Washington, DC: The National Academies Press. https://doi.org/10.17226/26026.

2 Dementia Friendly America https://www.dfamerica.org https://iasquared.org/news-release-ia2-is-now-a-national-dementia-friends-sub-licensee-for-american-indian-and-alaska-native-tribal-communities/.

have been cataloged online.[3] The Alzheimer's and Dementia Care Program is one example of an evidence-based program that works with primary care providers to provide comprehensive and coordinated care to persons living with dementia and their caregivers.[4] The Healthy Brain Initiative Roadmap for Indian Country, developed by the CDC and the Alzheimer's Association, is designed to support discussion about dementia and caregiving with Tribal communities and encourage a public health approach as part of a larger holistic response.[5] These and other models and resources can help inform the design of Tribal and Urban Indian health models.

Purpose

The purpose of this program is to support the development of models of comprehensive and sustainable dementia care and services in Tribal and Urban Indian communities that are responsive to the needs of persons living with dementia and their caregivers. Awardees will:

1. Plan and implement a comprehensive approach to care and services for persons living with dementia and their caregivers that addresses:
    a. Awareness and Recognition. Enhance awareness and early recognition of dementia in the community and increase referral to clinical care for evaluation leading to diagnosis. The U.S. Preventive Services Task Force has concluded that "current evidence is insufficient to assess the benefits and harms of screening for cognitive impairment in older adults." Still, there is broad consensus supporting case finding to promote early recognition and diagnosis of dementia.

3 Best Practice Caregiving online database. https://bpc.caregiver.org/#searchPrograms
4 The Alzheimer's and Dementia Care Program. https://www.adcprogram.org/
5 Centers for Disease Control and Prevention. Road Map for Indian Country. https://www.cdc.gov/aging/healthybrain/indian-country-roadmap.html

b. Accurate and Timely Diagnosis. Individuals and their families should have confidence that concerns about potential cognitive impairment will be evaluated thoroughly and lead to an accurate and timely diagnosis. Most diagnoses of dementia can be made in primary care, but clinical programs should have referral and consultation mechanisms in place (either in person or via telehealth) to support diagnosis when needed.

c. Interdisciplinary Assessment. Persons living with dementia will have complex and evolving care needs. An interdisciplinary assessment helps identify goals of care and gaps in services and sets the stage for appropriate care and services. In best practice, this assessment includes an attempt to understand the cultural, religious, and personal values that will guide goals and preferences for care. It assesses family and other caregiving resources, the needs and capabilities of those partners in care, and housing security and safety risks.

d. Management and Referral. Care for the person living with dementia is guided by the assessment and most often requires coordination of health care and social services to meet their needs and support caregivers. Those living with dementia and their caregivers often need support and assistance navigating the various systems providing this care.

e. Support for Caregivers. Care for persons living with dementia includes care for their caregivers. Families and other caregivers need help navigating services and mobilizing respite care, help in understanding what to expect and how to respond to the challenges of living with dementia, and support for self-care. Interventions that provide that care and support (e.g., REACH) and provide education and training (e.g., Savvy Caregiver) have been adapted for use in Tribal communities.

2. Develop, in collaboration with the IHS Alzheimer's Grant Program, best and promising practices to include tools, resources, reports, and presentations accessible to Federal, Tribal, and Urban Indian health programs as they plan and implement their own programs.
3. Identify and implement reimbursement and funding streams that will support service delivery and facilitate sustainability. Opportunities for reimbursement and funding streams are dependent on the specific interventions planned, but potential sources might include:
    a. Medicare reimbursement through the Physician Fee Schedule, including Cognitive Assessment and Planning codes and Chronic and Complex Care Management codes.
    b. Medicaid and other state programs.
    c. Purchased and Referred Care resources.
    d. IHS and Third Party Revenue.

The IHS Alzheimer's Grant Program in the IHS Division of Clinical and Community Services (DCCS) will provide technical assistance to grantees in the development of a plan for sustainability.

Required, Optional, and Allowable Activities

Awardees must plan to participate in regular (not more than monthly) web-based opportunities to share their experience and expertise with other awardees and to participate in at least one annual, one to two day in-person meeting in a location to be determined. In addition, optional training and technical assistance opportunities will be provided.

II. Award Information

Funding Instrument – Cooperative Agreement

Estimated Funds Available

The total funding identified for fiscal year (FY) 2023 is approximately $1.2 million. Individual award amounts for the first budget year are anticipated to be between $100,000 and $200,000. The funding available for competing and subsequent continuation awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. The IHS is under no obligation to make awards that are selected for funding under this announcement.

Anticipated Number of Awards

Approximately six awards will be issued under this program announcement.

Period of Performance

The period of performance is for 2 years.

Cooperative Agreement

Cooperative agreements awarded by the Department of Health and Human Services (HHS) are administered under the same policies as grants. However, the funding agency, IHS, is anticipated to have substantial programmatic involvement in the project during the entire period of performance. Below is a detailed description of the level of involvement required of the IHS.

Substantial Agency Involvement Description for Cooperative Agreement

1. The IHS DCCS Alzheimer's Grant Program, will collaborate with recipients throughout the process of project planning and implementation and assist in the identification of tools, resources, reports, and presentations for dissemination to other Tribal, IHS, and Urban Indian health programs. The IHS will also provide technical assistance in evaluation plan implementation and developing a sustainability plan, as needed.
2. The IHS will convene recipients periodically, not more often than monthly, to share ideas, strategies, and tools to accelerate design and implementation progress.

3. The IHS will link recipients with Federal agencies and non-governmental organizations working to improve the care of persons living with dementia and their caregivers.
4. The IHS will coordinate reporting (e.g., identified metrics utilized, achieved goals, identified best practices, etc.) and technical assistance (e.g., programmatic support to Tribal communities) as required.

III. Eligibility Information

1. Eligibility

To be eligible for this funding opportunity, an applicant cannot be an existing awardee under the Addressing Dementia in Indian Country program. Also, under this announcement, an applicant must be one of the following as defined under 25 U.S.C. 1603:

- A federally recognized Indian Tribe as defined by 25 U.S.C. 1603(14). The term "Indian Tribe" means any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation, as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the U.S. to Indians because of their status as Indians.
- A Tribal organization as defined by 25 U.S.C. 1603(26). The term "Tribal organization" has the meaning given the term in Section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304(l)): "Tribal organization" means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is

democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: provided that, in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant. Applicant shall submit letters of support and/or Tribal Resolutions from the Tribes to be served.

- An Urban Indian organization, as defined by 25 U.S.C. 1603(29). The term "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an Urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a). Applicants must provide proof of nonprofit status with the application, e.g., 501(c)(3).

The Division of Grants Management (DGM) will notify any applicants deemed ineligible.

Note: Please refer to Section IV.2 (Application and Submission Information/Subsection 2, Content and Form of Application Submission) for additional proof of applicant status documents required, such as Tribal Resolutions, proof of nonprofit status, etc.

2. Cost Sharing or Matching

The IHS does not require matching funds or cost sharing for grants or cooperative agreements.

3. Other Requirements

Applications with budget requests that exceed the highest dollar amount outlined under Section II Award Information, Estimated Funds Available, or exceed the period of performance outlined under Section II Award Information, Period of Performance, are considered not responsive and will not be reviewed. The DGM will notify the applicant.

Additional Required Documentation

Tribal Resolution

The DGM must receive an official, signed Tribal Resolution prior to issuing a Notice of Award (NoA) to any Tribe or Tribal organization selected for funding. An applicant that is proposing a project affecting another Indian Tribe must include Tribal Resolutions from all affected Tribes to be served. However, if an official signed Tribal Resolution cannot be submitted with the application prior to the application deadline date, a draft Tribal Resolution must be submitted with the application by the deadline date in order for the application to be considered complete and eligible for review. The draft Tribal Resolution is not in lieu of the required signed resolution but is acceptable until a signed resolution is received. If an application without a signed Tribal Resolution is selected for funding, the applicant will be contacted by the Grants Management Specialist (GMS) listed in this funding announcement and given 90 days to submit an official signed Tribal Resolution to the GMS. If the signed Tribal Resolution is not received within 90 days, the award will be forfeited.

Applicants organized with a governing structure other than a Tribal council may submit an equivalent document commensurate with their governing organization.

Proof of Nonprofit Status

Organizations claiming nonprofit status must submit a current copy of the 501(c)(3) Certificate with the application.

IV. Application and Submission Information

Grants.gov uses a Workspace model for accepting applications. The Workspace consists of several online forms and three forms in which to upload documents – Project Narrative, Budget Narrative, and Other Documents. Give your files brief descriptive names. The filenames are key in finding specific documents during the objective review and in processing awards. Upload all requested and optional documents individually, rather than combining them into a single file. Creating a single file creates confusion when trying to find specific documents. Such confusion can contribute to delays in processing awards and could lead to lower scores during the objective review.

1. Obtaining Application Materials

The application package and detailed instructions for this announcement are available at https://www.Grants.gov.

Please direct questions regarding the application process to DGM@ihs.gov.

2. Content and Form Application Submission

Mandatory documents for all applicants include:

- Application forms:
    1. SF-424, Application for Federal Assistance.
    2. SF-424A, Budget Information – Non-Construction Programs.
    3. SF-424B, Assurances – Non-Construction Programs.
    4. Project Abstract Summary form (one page).
- Project Narrative (not to exceed 10 pages). See Section IV.2.A, Project Narrative for instructions.
- Budget Narrative (not to exceed five pages). See Section IV.2.B, Budget Narrative for instructions.
- Work plan chart.

- Tribal Resolution(s) as described in Section III, Eligibility, if applicable.
- Letters of Support from organization's Board of Directors (optional).
- 501(c)(3) Certificate, if applicable.
- Biographical sketches for all Key Personnel.
- Contractor/Consultant resumes or qualifications and scope of work.
- Disclosure of Lobbying Activities (SF-LLL), if applicant conducts reportable lobbying.
- Certification Regarding Lobbying (GG-Lobbying Form).
- Copy of current Negotiated Indirect Cost (IDC) rate agreement (required in order to receive IDC).
- Organizational Chart.
- Documentation of current Office of Management and Budget (OMB) Financial Audit (if applicable).

  Acceptable forms of documentation include:

  1. E-mail confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or
  2. Face sheets from audit reports. Applicants can find these on the FAC web site at https://facdissem.census.gov/.

Public Policy Requirements

All Federal public policies apply to IHS grants and cooperative agreements. Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by Federal law to individuals eligible for benefits and services from the IHS. See https://www.hhs.gov/grants/grants/grants-policies-regulations/index.html.

Requirements for Project and Budget Narratives

A. Project Narrative: This narrative should be a separate document that is no

more than 10 pages and must: 1) have consecutively numbered pages; 2) use black font 12 points or larger (applicants may use 10 point font for tables); 3) be single-spaced; and 4) be formatted to fit standard letter paper (8-1/2 x 11 inches). Do not combine this document with any others.

Be sure to succinctly answer all questions listed under the evaluation criteria (refer to Section V.1, Evaluation Criteria) and place all responses and required information in the correct section noted below or they will not be considered or scored. If the narrative exceeds the overall page limit, the reviewers will be directed to ignore any content beyond the page limit. The 10-page limit for the project narrative does not include the accompanying work plan, standard forms, Tribal Resolutions, budget, budget narratives, and/or other items. Page limits for each section within the project narrative are guidelines, not hard limits.

There are three parts to the project narrative: Part 1 – Program Information; Part 2 – Program Planning and Evaluation; and Part 3 – Program Report. See below for additional details about what must be included in the narrative.

The page limits below are for each narrative and budget submitted.

Part 1: Program Information (limit – 4 pages)

Section 1: Tribal or Organizational Overview

Provide a brief description of the Tribe, Tribal organization, or Urban Indian health program, health care delivery system and resources, elderly services and resources, long-term services and supports, and other Tribal or community-based services that might be involved.

Section 2: Needs

Provide any data available about the number of persons living with dementia, their needs, and the needs of their caregivers. If data is not currently available, indicate this here and in Part 2 below, and describe in

detail how the applicant will obtain or develop this data in the first year of the program.

Section 3: Other Funded Initiatives

Provide information about other funded initiatives addressing dementia that the applicant is or will be participating in that are relevant to this proposal. Indicate any HHS grants addressing dementia (e.g., Dementia Capability in Indian Country Grant program of the Administration for Community Living) the applicant has been awarded whose period of performance may overlap the period of performance of this grant opportunity.

Part 2: Program Planning and Evaluation (limit – 4 pages)

Section 1: Program Plans

Describe fully and clearly the applicant's plan to implement a comprehensive approach to care and services for persons living with dementia and their caregivers and identify funding streams that will support service delivery. State the purpose, goals, and objectives of your proposed project. The plan should include a vision for a comprehensive approach to care, recognizing that achieving the fully implemented approach may not be feasible within the period of performance.

Section 2: Program Evaluation

Describe fully and clearly the methods, data sources, and measures that will be used to monitor the progress of the proposed activities and determine effectiveness in implementing the plan and progress towards achieving goals as described in Section 1. The evaluation plan should include the specific measures, e.g., outputs and outcomes that will be used to assess achievement. The evaluation plan should, at a minimum, include

performance measures about the number of persons newly diagnosed with dementia, the number of persons living with a pre-existing dementia diagnosis, screening measures, and case finding efforts among their patient population. If the applicant intends to obtain or develop data about the needs of persons living with dementia and the needs of their caregivers as an element of this award, the applicant should indicate those data elements and describe how that data will be developed or acquired in the first year.

Part 3: Program Report (limit – 2 pages)

Section 1: Identify and describe your organization's significant program activities and accomplishments within the past five years associated with developing and implementing clinical or community care and support services for people living with dementia and their caregivers, if any. Provide a comparison of actual accomplishments to the established goals, where relevant. If applicable, provide justification for the lack of or limited progress.

Section 2: Sharing with Other Tribes, Tribal Organizations, and Urban Indian Organizations

Describe how your program will develop and share, in collaboration with the IHS, best and promising practices that include tools, resources, reports, and presentations accessible to stakeholders across the Tribal health system including Tribal and Urban Indian health partners.

B. Budget Narrative (limit – 5 pages)

Provide a budget narrative table that explains the amounts requested for each line item of the budget from the SF-424A (Budget Information for Non-Construction Programs) for the first year of the project. The applicant can submit with the

budget narrative a more detailed spreadsheet than is provided by the SF-424A (the spreadsheet will not be considered part of the budget narrative). The budget narrative should specifically describe how each item would support the achievement of proposed objectives. Be very careful about showing how each item in the "Other" category is justified. Do NOT use the budget narrative to expand the project narrative.

3. Submission Dates and Times

Applications must be submitted through Grants.gov by 11:59 p.m. Eastern Time on the Application Deadline Date. Any application received after the application deadline will not be accepted for review. Grants.gov will notify the applicant via e-mail if the application is rejected.

If technical challenges arise and assistance is required with the application process, contact Grants.gov Customer Support (see contact information at https://www.Grants.gov). If problems persist, contact Mr. Paul Gettys (DGM@ihs.gov), Deputy Director, DGM, by telephone at (301) 443-2114. Please be sure to contact Mr. Gettys at least 10 days prior to the application deadline. Please do not contact the DGM until you have received a Grants.gov tracking number. In the event you are not able to obtain a tracking number, call the DGM as soon as possible.

The IHS will not acknowledge receipt of applications.

4. Intergovernmental Review

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions

- Pre-award costs are allowable up to 90 days before the start date of the award provided the costs are otherwise allowable if awarded. Pre-award

costs are incurred at the risk of the applicant.

- The available funds are inclusive of direct and indirect costs.
- Only one cooperative agreement may be awarded per applicant.

6. Electronic Submission Requirements

All applications must be submitted via Grants.gov. Please use the https://www.Grants.gov web site to submit an application. Find the application by selecting the "Search Grants" link on the homepage. Follow the instructions for submitting an application under the Package tab. No other method of application submission is acceptable.

If you cannot submit an application through Grants.gov, you must request a waiver prior to the application due date. You must submit your waiver request by e-mail to DGM@ihs.gov. Your waiver request must include clear justification for the need to deviate from the required application submission process. The IHS will not accept any applications submitted through any means outside of Grants.gov without an approved waiver.

If the DGM approves your waiver request, you will receive a confirmation of approval e-mail containing submission instructions. You must include a copy of the written approval with the application submitted to the DGM. Applications that do not include a copy of the signed waiver from the Deputy Director of the DGM will not be reviewed. The Grants Management Officer of the DGM will notify the applicant via e-mail of this decision. Applications submitted under waiver must be received by the DGM no later than 5:00 p.m. Eastern Time on the Application Deadline Date. Late applications will not be accepted for processing. Applicants that do not register for both the System for Award Management (SAM) and Grants.gov and/or fail to request timely assistance with technical issues will not be considered for a waiver to submit an application via alternative method.

Please be aware of the following:

- Please search for the application package in https://www.Grants.gov by entering the Assistance Listing (CFDA) number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- If you experience technical challenges while submitting your application, please contact Grants.gov Customer Support (see contact information at https://www.Grants.gov).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.
- Applicants are strongly encouraged not to wait until the deadline date to begin the application process through Grants.gov as the registration process for SAM and Grants.gov could take up to 20 working days.
- Please follow the instructions on Grants.gov to include additional documentation that may be requested by this funding announcement.
- Applicants must comply with any page limits described in this funding announcement.
- After submitting the application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The IHS will not notify you that the application has been received.

System for Award Management

Organizations that are not registered with SAM must access the SAM online registration through the SAM home page at https://sam.gov. Organizations based in the U.S. will also need to provide an Employer Identification Number from the

Internal Revenue Service that may take an additional two to five weeks to become active. Please see SAM.gov for details on the registration process and timeline. Registration with the SAM is free of charge but can take several weeks to process. Applicants may register online at https://sam.gov.

Unique Entity Identifier

Your SAM.gov registration now includes a Unique Entity Identifier (UEI), generated by SAM.gov, which replaces the DUNS number obtained from Dun and Bradstreet. SAM.gov registration no longer requires a DUNS number.

Check your organization's SAM.gov registration as soon as you decide to apply for this program. If your SAM.gov registration is expired, you will not be able to submit an application. It can take several weeks to renew it or resolve any issues with your registration, so do not wait.

Check your Grants.gov registration. Registration and role assignments in Grants.gov are self-serve functions. One user for your organization will have the authority to approve role assignments, and these must be approved for active users in order to ensure someone in your organization has the necessary access to submit an application.

The Federal Funding Accountability and Transparency Act of 2006, as amended ("Transparency Act"), requires all HHS awardees to report information on sub-awards. Accordingly, all IHS awardees must notify potential first-tier sub-awardees that no entity may receive a first-tier sub-award unless the entity has provided its UEI number to the prime awardee organization. This requirement ensures the use of a universal identifier to enhance the quality of information available to the public pursuant to the Transparency Act.

Additional information on implementing the Transparency Act, including the specific requirements for SAM, are available on the DGM Grants Management,

Policy Topics web page at https://www.ihs.gov/dgm/policytopics/.

V. Application Review Information

Possible points assigned to each section are noted in parentheses. The project narrative and budget narrative should include only the first year of activities. The project narrative should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the applicant. It should be well organized, succinct, and contain all information necessary for reviewers to fully understand the project. Attachments requested in the criteria do not count toward the page limit for the narratives. Points will be assigned to each evaluation criteria adding up to a total of 100 possible points. Points are assigned as follows:

1. Evaluation Criteria

   A. Introduction and Need for Assistance (10 points)

      1. Description of the clinical services, elder services and resources, long-term care services, and supports available through the applicant's organization, either as a direct service or through agreement, contract, or Purchased and Referred Care (PRC). Applicants must be able to provide ambulatory care services directly or through coordination with IHS Direct Services and must be able to coordinate with elder services.
      2. Description of the number of individuals living with dementia to be served, any data available about the prevalence of risk factors for dementia (including age as reflected in the population's demographics), and any limitations of the data available.
      3. Identification of the most urgent and pressing gaps in availability or quality of care and services for persons living with dementia and their families. If this information is not available, the acquisition of this information should be a detailed part of the Project Objective(s), Work

Plan, and Approach.

4. If the applicant is the recipient of other HHS grants that will provide funding to address dementia over the same time period (e.g., Dementia Capability in Indian Country Grant program of the Administration for Community Living), address how funding under this opportunity will address the need without overlapping the activities of other funded awards, if applicable.

B. Project Objective(s), Work Plan, and Approach (30 points)

1. The overall vision for a comprehensive approach to care and services for persons living with dementia and their caregivers, including:
    - Awareness and recognition.
    - Timely and accurate diagnosis.
    - Multidisciplinary assessment.
    - Management and referral.
    - Caregiver Support.
2. The elements of this vision that the awardee anticipates implementing, including planning activities and assessment of need, if not already available.
3. Describe the approach to accomplishing the work plan, including planning activities and assessment of need, if not already available. This work plan should be responsive to the most urgent and pressing gaps in availability and quality of care and services for persons living with dementia and their families. This work plan must include, at minimum, both the provision of clinical services, either directly or through coordination with IHS Direct Services, and the engagement of elder services.

4. The accompanying work plan and approach should include developing tools, resources, reports, and presentations to support the development of programs by other Tribes, Tribal organizations, or Urban Indian health programs.
5. If the applicant is the recipient of other HHS grants that will provide funding to address dementia over the same time period (e.g. Dementia Capability in Indian Country Grant program of the Administration for Community Living), indicate how the work plan and approach supported through this funding will complement and not supplant or overlap that already-funded work.

C. Program Evaluation (30 points)

1. Clearly identify a goal or goals and plans for program evaluation to ensure that the objectives of the program are met at the conclusion of the period of performance.
2. Include SMART (Specific, Measurable, Achievable, Relevant and Time-based) objectives to establish a specific set of evaluation criteria to ensure the goals are attainable within the period of performance.
3. Evaluation should include metrics that provide insight into the implementation of those elements of a comprehensive approach to care and services for persons living with dementia and their families that the applicant has proposed to implement. The evaluation plan should include metrics about the number of persons newly diagnosed, persons living with a pre-existing dementia diagnosis, screening measures, and case finding efforts among their patient population. The evaluation should also include metrics for important outcomes of care for persons living with dementia and their family or caregiver(s), such as

avoidance of crisis-driven care (e.g. emergent transfers and undesired out-of-home placement) and processes of care that contribute to better outcomes (e.g. reduction of medications that impair cognition). If the applicant intends to obtain or develop new data collection methods or metrics as an element of this award, the applicant should describe how that data will be developed or acquired in the first year. Please refer to the draft logic model example in the appendix as a guide.

D. Organizational Capabilities, Key Personnel, and Qualifications (20 points)
    1. Include an organizational capacity statement that demonstrates the ability to execute program strategies within the period of performance.
    2. Project management and staffing plan. Detail that the organization has the current staffing and expertise to address each of the program activities. If capacity does not exist, please describe the applicant's actions to fill this gap within a specified timeline.
    3. Identify any partnerships or collaborations that will be needed to implement the work plan and include letters of support or intent to coordinate or collaborate with those partners.
    4. Demonstrate that the applicant has previous successful experience providing technical or programmatic support to Tribal communities.
E. Categorical Budget and Budget Justification (10 points)

    Provide a detailed budget and accompanying narrative to explain the activities being considered and how they are related to proposed program objectives.

Additional documents can be uploaded as Other Attachments in Grants.gov. These can include:

- Logic model and/or timeline for proposed objectives.

- Position descriptions for key staff.
- Resumes of key staff that reflect current duties.
- Consultant or contractor proposed scope of work and letter of commitment (if applicable).
- Current Indirect Cost Rate Agreement.
- Organizational chart.
- Map of area identifying project location(s).
- Additional documents to support narrative (i.e., data tables, key news articles, etc.).

2. Review and Selection

Each application will be prescreened for eligibility and completeness as outlined in the funding announcement. Applications that meet the eligibility criteria shall be reviewed for merit by the Objective Review Committee (ORC) based on the evaluation criteria. Incomplete applications and applications that are not responsive to the administrative thresholds (budget limit, period of performance limit) will not be referred to the ORC and will not be funded. The DGM will notify the applicant of this determination.

Applicants must address all program requirements and provide all required documentation.

3. Notifications of Disposition

All applicants will receive an Executive Summary Statement from the IHS DCCS within 30 days of the conclusion of the ORC outlining the strengths and weaknesses of their application. The summary statement will be sent to the Authorizing Official identified on the face page (SF-424) of the application.

A. Award Notices for Funded Applications

The NoA is the authorizing document for which funds are dispersed to the

approved entities and reflects the amount of Federal funds awarded, the purpose of the award, the terms and conditions of the award, the effective date of the award, the budget period, and period of performance. Each entity approved for funding must have a user account in GrantSolutions in order to retrieve the NoA. Please see the Agency Contacts list in Section VII for the systems contact information.

B. Approved but Unfunded Applications

Approved applications not funded due to lack of available funds will be held for one year. If funding becomes available during the course of the year, the application may be reconsidered.

NOTE: Any correspondence, other than the official NoA executed by an IHS grants management official announcing to the project director that an award has been made to their organization, is not an authorization to implement their program on behalf of the IHS.

VI. Award Administration Information

1. Administrative Requirements

Awards issued under this announcement are subject to, and are administered in accordance with, the following regulations and policies:

A. The criteria as outlined in this program announcement.

B. Administrative Regulations for Grants:

- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards currently in effect or implemented during the period of award, other Department regulations and policies in effect at the time of award, and applicable statutory provisions. At the time of publication, this includes 45 CFR part 75, at https://www.govinfo.gov/content/pkg/CFR-2021-title45-

vol1/pdf/CFR-2021-title45-vol1-part75.pdf.

- Please review all HHS regulatory provisions for Termination at 45 CFR 75.372, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2021-title45-vol1/pdf/CFR-2021-title45-vol1-sec75-372.pdf.

C. Grants Policy:

- HHS Grants Policy Statement, Revised January 2007, at https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

D. Cost Principles:

- Uniform Administrative Requirements for HHS Awards, "Cost Principles," at 45 CFR part 75 subpart E, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2021-title45-vol1/pdf/CFR-2021-title45-vol1-part75-subpartE.pdf.

E. Audit Requirements:

- Uniform Administrative Requirements for HHS Awards, "Audit Requirements," at 45 CFR part 75 subpart F, at the time of this publication located at https://www.govinfo.gov/content/pkg/CFR-2021-title45-vol1/pdf/CFR-2021-title45-vol1-part75-subpartF.pdf.

F. As of August 13, 2020, 2 CFR part 200 was updated to include a prohibition on certain telecommunications and video surveillance services or equipment. This prohibition is described in 2 CFR part 200.216. This will also be described in the terms and conditions of every IHS grant and cooperative agreement awarded on or after August 13, 2020.

2. Indirect Costs

This section applies to all awardees that request reimbursement of IDC in their

application budget. In accordance with HHS Grants Policy Statement, Part II-27, the IHS requires applicants to obtain a current IDC rate agreement and submit it to the DGM prior to the DGM issuing an award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate agreement is not on file with the DGM at the time of award, the IDC portion of the budget will be restricted. The restrictions remain in place until the current rate agreement is provided to the DGM.

Per 45 CFR 75.414(f) Indirect (F&A) costs,

> any non-Federal entity (NFE) [i.e., applicant] that has never received a negotiated indirect cost rate, ... may elect to charge a de minimis rate of 10 percent of modified total direct costs which may be used indefinitely. As described in Section 75.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as the NFE chooses to negotiate for a rate, which the NFE may apply to do at any time.

Electing to charge a de minimis rate of 10 percent only applies to applicants that have never received an approved negotiated indirect cost rate from HHS or another cognizant Federal agency. Applicants awaiting approval of their indirect cost proposal may request the 10 percent de minimis rate. When the applicant chooses this method, costs included in the indirect cost pool must not be charged as direct costs to the grant.

Available funds are inclusive of direct and appropriate indirect costs. Approved indirect funds are awarded as part of the award amount, and no additional funds will be provided.

Generally, IDC rates for IHS awardees are negotiated with the Division of Cost Allocation at https://rates.psc.gov/ or the Department of the Interior (Interior Business Center) at https://ibc.doi.gov/ICS/tribal. For questions regarding the

indirect cost policy, please call the GMS listed under "Agency Contacts" or write to DGM@ihs.gov.

3. Reporting Requirements

The awardee must submit required reports consistent with the applicable deadlines. Failure to submit required reports within the time allowed may result in suspension or termination of an active award, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in the imposition of special award provisions and/or the non-funding or non-award of other eligible projects or activities. This requirement applies whether the delinquency is attributable to the failure of the awardee organization or the individual responsible for preparation of the reports. Per DGM policy, all reports must be submitted electronically by attaching them as a "Grant Note" in GrantSolutions. Personnel responsible for submitting reports will be required to obtain a login and password for GrantSolutions. Please use the form under the Recipient User section of https://www.grantsolutions.gov/home/getting-started-request-a-user-account/. Download the Recipient User Account Request Form, fill it out completely, and submit it as described on the web page and in the form.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required quarterly. The progress reports are due within 90 days after the reporting period ends (specific dates will be listed in the NoA Terms and Conditions). A progress report template will be provided. These reports must include a brief comparison of actual accomplishments to the goals established for the period, a summary of progress to date, or, if

applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 120 days of expiration of the period of performance.

B. Financial Reports

Federal Financial Reports are due 90 days after the end of each budget period, and a final report is due 120 days after the end of the period of performance. Awardees are responsible and accountable for reporting accurate information on all required reports: the Progress Reports and the Federal Financial Report.

Failure to submit timely reports may result in adverse award actions blocking access to funds.

C. Data Collection and Reporting

The grantee will participate in periodic (not more frequently than monthly) web-based calls with the program office or designee and the other recipients to share their progress, experience, and tools and resource that might be useful for other recipients. The grantee will be expected to work with the program office to develop a driver diagram (an action-oriented logic model) that describes the comprehensive approach to care and services for persons living with dementia and their caregivers and identifies key performance metrics based on their evaluation plan.

The grantee will be expected to share, on a quarterly basis, the tools, resources, reports, and presentations produced that may support the development of programs by other Tribes, Tribal organizations, or Urban Indian health programs.

D. Federal Sub-award Reporting System (FSRS)

This award may be subject to the Transparency Act sub-award and executive

compensation reporting requirements of 2 CFR part 170.

The Transparency Act requires the OMB to establish a single searchable database, accessible to the public, with information on financial assistance awards made by Federal agencies. The Transparency Act also includes a requirement for awardees of Federal grants to report information about first-tier sub-awards and executive compensation under Federal assistance awards.

The IHS has implemented a Term of Award into all IHS Standard Terms and Conditions, NoAs, and funding announcements regarding the FSRS reporting requirement. This IHS Term of Award is applicable to all IHS grant and cooperative agreements issued on or after October 1, 2010, with a $25,000 sub-award obligation threshold met for any specific reporting period.

For the full IHS award term implementing this requirement and additional award applicability information, visit the DGM Grants Management web site at https://www.ihs.gov/dgm/policytopics/.

E. Non-Discrimination Legal Requirements for Awardees of Federal Financial Assistance (FFA)

The awardee must administer the project in compliance with Federal civil rights laws, where applicable, that prohibit discrimination on the basis of race, color, national origin, disability, age, and comply with applicable conscience protections. The awardee must comply with applicable laws that prohibit discrimination on the basis of sex, which includes discrimination on the basis of gender identity, sexual orientation, and pregnancy. Compliance with these laws requires taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights

provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficiency individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including reasonable modifications and making services accessible to them, see https://www.hhs.gov/civil-rights/for-individuals/disability/index.html.
- HHS funded health and education programs must be administered in an environment free of sexual harassment. See https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
- For guidance on administering your program in compliance with applicable Federal religious nondiscrimination laws and applicable Federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.
- Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by Federal law to individuals eligible for benefits and services from the IHS.

F. Federal Awardee Performance and Integrity Information System (FAPIIS)

The IHS is required to review and consider any information about the applicant that is in the FAPIIS at https://www.fapiis.gov/fapiis/#/home before making any award in excess of the simplified acquisition threshold (currently $250,000) over the period of performance. An applicant may review and comment on any information about itself that a Federal awarding agency previously entered. The IHS will consider any comments by the applicant, in addition to other information in FAPIIS, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicants, as described in 45 CFR 75.205.

As required by 45 CFR part 75 Appendix XII of the Uniform Guidance, NFEs are required to disclose in FAPIIS any information about criminal, civil, and administrative proceedings, and/or affirm that there is no new information to provide. This applies to NFEs that receive Federal awards (currently active grants, cooperative agreements, and procurement contracts) greater than $10 million for any period of time during the period of performance of an award/project.

Mandatory Disclosure Requirements

As required by 2 CFR part 200 of the Uniform Guidance, and the HHS implementing regulations at 45 CFR part 75, the IHS must require an NFE or an applicant for a Federal award to disclose, in a timely manner, in writing to the IHS or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. All applicants and awardees must disclose in writing, in a timely manner, to the IHS and to the HHS Office of Inspector General all information related to

violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. 45 CFR 75.113. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services

Indian Health Service

Division of Grants Management

ATTN: Marsha Brookins, Director

5600 Fishers Lane, Mail Stop: 09E70

Rockville, MD 20857

(Include “Mandatory Grant Disclosures” in subject line)

Office: (301) 443-4750

Fax: (301) 594-0899

E-mail: DGM@ihs.gov

AND

U.S. Department of Health and Human Services

Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator

330 Independence Avenue, SW, Cohen Building

Room 5527

Washington, DC 20201

URL: https://oig.hhs.gov/fraud/report-fraud/

(Include “Mandatory Grant Disclosures” in subject line)

Fax: (202) 205-0604 (Include “Mandatory Grant Disclosures” in subject line) or

E-mail: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies

described in 45 CFR 75.371 Remedies for noncompliance, including suspension or debarment (see 2 CFR part 180 and 2 CFR part 376).

VII. Agency Contacts

1. Questions on the program matters may be directed to:

   Dr. Jolie Crowder, National Elder Services Consultant

   Office of Clinical and Preventive Services

   Division of Clinical and Community Services

   Indian Health Service

   5600 Fishers Lane, Mailstop: 08N34-A

   Rockville, MD 20857

   Phone: (301) 526-6592

   Fax: (301) 594-6213

   E-mail: jolie.crowder@ihs.gov

2. Questions on grants management and fiscal matters may be directed to:

   Donald Gooding, Grants Management Specialist

   Indian Health Service, Division of Grants Management

   5600 Fishers Lane, Mail Stop: 09E70

   Rockville, MD 20857

   Phone: (301) 443-2298

   E-mail: Donald.Gooding@ihs.gov

3. For technical assistance with Grants.gov, please contact the Grants.gov help desk at 800-518-4726, or by e-mail at support@grants.gov.

VIII. Other Information

The Public Health Service strongly encourages all grant, cooperative agreement, and contract awardees to provide a smoke-free workplace and promote the

non-use of all tobacco products. In addition, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

_____

Roselyn Tso,
Director,
Indian Health Service.

[FR Doc. 2023-06455 Filed: 3/28/2023 8:45 am; Publication Date: 3/29/2023]