I. AWARD DESCRIPTION

Two-year Program Awards for Indian Health System (IHS) Service Units working in partnership with Direct Service Tribes.

A. Key Dates

- Application Deadline Date: Monday, June 12, 11:59 U.S. Eastern Time
- Earliest Anticipated Project Start Date: August 1, 2023
- Technical Assistance Webinars: Date to be announced
- Budget period length: 12 months

B. Purpose

The Program Award aims to 1) improve recognition, diagnosis, assessment, and management of care for persons living with dementia (PLWD), and 2) improve care and access to dementia caregiver services and supports for Tribes receiving primary health care services from IHS Direct Services.

IHS Service Units have the opportunity to apply for either (but not both) of two types of Program Awards:

1. **Comprehensive Model of Care Program Award** – Up to $200,000 per year for each of two years to support the development and implementation of culturally-appropriate comprehensive and sustainable dementia care and services that are responsive to the needs of PLWD and the caregivers of PLWD.
2. **New Care and Services Program Award** – Up to $50,000 per year for up to two years to support the development and implementation or expansion of specific services for PLWD or the caregivers of PLWD, including necessary training, education, or collaboration with multi-disciplinary teams or programs.

C. Background

Alzheimer's disease and other dementias (ADRD) affect lives in every Tribal and Urban Indian community. Alzheimer's 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 substantial risk factor for Alzheimer's, though early onset occurs in younger populations and persons with Down Syndrome or Trisomy 21. Additional conditions

and factors, including diabetes, cardiovascular disease, chronic kidney disease, chronic liver disease, depression, hearing loss, and traumatic brain injury, increase the risk of dementia and can lead to a more progression of dementia symptoms.

Dementia of all types is under-recognized, underdiagnosed, and undertreated in all populations in the U.S. Evidence suggests that this is very much true for the American Indian and Alaska Native (AI/AN) populations. Many individuals with ADRD go unrecognized in the community, never seeking care, and live with impaired cognition that puts them at risk for financial exploitation, poor health outcomes, and accidental injury. Diagnosis of dementia should most often be made in the primary care office or clinic, with specialty referral needed when the presentation is not typical or apparent. However, primary care providers may lack the confidence, training, systems, or support to make the diagnosis or plan effective care. In addition, they may lack access to an interdisciplinary team or specialists through consultation or referral to support diagnosis and care management decisions. Effective dementia management spans many disciplines, involving medical care, personal care, social services, legal, financial services, and housing. Ongoing coordination between clinical and community-based services is also essential. This complex coordination of care is too often left to those living with dementia and their informal caregivers. Informal caregivers are critical in care provision and assistance for PLWD, particularly as the disease advances. Caregivers are very often, but not always, family members. Formal assessment and consideration for dementia caregiver needs and health issues should be included as part of care for the PLWD but is often overlooked.

Following FY 2021 first-time funding and subsequent Tribal Consultation and Urban Confer, the IHS Alzheimer's Program was established. The Alzheimer's Grant Program, started in FY 2022, provides grants to Tribes, Tribal Organizations, and Urban Indian Organizations. The purpose of Grants is to support the development of models of comprehensive and sustainable dementia care and services in Tribal and Urban Indian Organizations that are responsive to the needs of PLWD and their caregivers in their communities. The current Program Awards are designed to support federal Service Units serving Direct Service Tribes in developing new dementia care and services.

D. Program Award Opportunity and Requirements

Option 1: The **Comprehensive Model of Care** program award will provide up to $200,000 per year for each of two years to support the development of comprehensive and sustainable dementia care and services that are responsive to the needs of PLWD and their caregivers.

Evidence-based or evidence-informed models of care or interventions should be considered, when feasible and applicable to the local community systems of care.[1,2,3] This funding option intends to support the specific allocation of staff to coordinate the development and implementation of a multi-year, comprehensive approach to dementia care and services. It is expected the Service Unit will establish a plan for sustainable sources of revenue for the services provided by the end of the project period. Service Units receiving this award shall plan and implement a comprehensive approach to care and services for PLWD and their caregivers that address **the following five areas:**

(1) Awareness and Recognition.

Enhancing community awareness and early recognition of signs and symptoms of dementia are essential elements of a comprehensive system of care and drive increases in referrals to clinical care for evaluation and diagnosis.[4] The United States Preventive Services Task Force (USPSTF) has concluded that "current evidence is insufficient to assess the benefits and harms of screening for cognitive impairment in older adults" 65 years or older, community-dwelling, **and** without recognized or reported signs or symptoms of cognitive impairment.[5] Still, there is a broad and strengthening consensus supporting screening (e.g., Mini-Cog[6]) and case findings to promote early recognition and diagnosis of dementia or mild cognitive impairment.

(2) Accurate and Timely Diagnosis.

Individuals and their families should have confidence that concerns about potential cognitive impairment will be acknowledged, result in full evaluation if warranted, and lead to accurate and timely dementia or differential diagnosis. Most diagnoses of mild cognitive impairment[7] or dementia will be made in primary care settings. Still, clinical programs should have or establish clear referral and consultation mechanisms (either in person or via telehealth) to support

[1] Lees Haggerty, Epstein-Lubow, G., Spragens, L. H., Stoeckle, R. J., Evertson, L. C., Jennings, L. A., & Reuben, D. B. (2020). Recommendations to Improve Payment Policies for Comprehensive Dementia Care. Journal of the American Geriatrics Society (JAGS), 68(11), 2478–2485. https://doi-org.ezproxyhhs.nihlibrary.nih.gov/10.1111/jgs.16807
[2] Hostetter, M., & Klein, S. (2017). In focus: Spreading innovative approaches to dementia care. Commonwealth Fund. https://www.commonwealthfund.org/publications/2017/dec/focus-spreading-innovative-approaches-dementia-care
[3] Best Practices Caregiving: Evidence-based programs. Benjamin Rose Institute. n.d. https://bpc.caregiver.org/#home\
[4] Fazio, D., Pace, D., NHA, Maslow, K., Zimmerman, S., Kallmyer, B. Alzheimer's Association dementia care practice recommendations. (2018). *The Gerontologist*, Volume 58, Issue suppl_1, Pages S1-S9. https://doi.org/10.1093/geront/gnx182
[5] USPSTF. Cognitive impairment in older adults: Screening. 2020. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cognitive-impairment-in-older-adults-screening
[6] Mini-Cog: Quick screening for early dementia detection. 2022. https://mini-cog.com/
[7] Albert, M.S., DeKosky, S.T., Dickson, D., Dubois, B., Feldman, H.H., Fox, N.C., Gamst, A., Holtzman, D.M., Jagust, W.J., Petersen, R.C., Snyder, P.J., Carrillo, M.C., Thies, B. and Phelps, C.H. (2011), The diagnosis of mild cognitive impairment due to Alzheimer's disease: Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimer's & Dementia, 7: 270-279. https://doi.org/10.1016/j.jalz.2011.03.008

diagnosis when needed. This shall include special attention to adults with common neuroatypical (e.g., brain injury, intellectual disability, severe mental illness) and neurodivergent (e.g., autism spectrum disorders, cerebral palsy, and sensory impairments) conditions. These populations have a higher risk for dementia and have more complex screening and case finding needs.[8]

(3) Person-Centered Interdisciplinary Assessment.

PLWD have complex and evolving care needs. A person-centered interdisciplinary assessment helps identify goals of care and gaps in services, and sets the stage for appropriate and culturally-relevant care and services.[9] In best practice, this assessment includes an attempt to understand the cultural, spiritual, and personal values that will guide goals and preferences for care. Primary assessment domains should consist of cognitive assessment, functional abilities, behavioral and psychological symptoms of dementia (BPSD), medical status, living environment, advanced care planning, and safety, including signs of abuse or neglect.[10] It also includes an assessment of the family and other caregiving resources and the needs, health concerns, and capabilities of those partners in care and caregivers.

(4) Care Plan, Management, and Referral.

Care for the person living with dementia should be guided by an interdisciplinary assessment and requires planning and coordination of health care, social services, and community-based services and supports to meet the needs of the PLWD and their caregiver. CPT® code 99483 provides reimbursement for a clinical visit for evaluation that results in a comprehensive care plan[11]. PLWD and their caregivers should be actively engaged in plan of care development and supported in navigating through the various systems of care. In addition to ongoing medical management, information, education, and ongoing support for BPSD and Activities of Daily Living (ADLs), specifically, attention to care transitions are essential.[12]

(5) **Support for Caregivers.**

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[8] Janicki, M.P., Hendrix, J.A., McCallion, P. Examining older adults with neuroatypical conditions for MCI/dementia: Barriers and recommendations of the Neuroatypical Conditions Expert Consultative Panel. (2022). *Alzheimer's Dement*, 14:e12335. https://doi.org/10.1002/dad2.12335

[9] Fazio, D., Pace, D., NHA, Maslow, K., Zimmerman, S., Kallmyer, B. Alzheimer's Association dementia care practice recommendations. (2018). *The Gerontologist*, Volume 58, Issue suppl_1, Pages S1-S9. https://doi.org/10.1093/geront/gnx182

[10] Molony, S.L., Kolanowski, A., Van Haitsma, K., Rooney, K.E., Person-Centered assessment and care planning. (2018). *The Gerontologist*. Volume 58, Issue suppl_1, Pages S32–S47. https://doi.org/10.1093/geront/gnx173

[11] Health systems and medical professionals: Care planning. Alzheimer's Association. https://www.alz.org/professionals/health-systems-medical-professionals/care-planning

[12] Fazio, D., Pace, D., NHA, Maslow,K., Zimmerman, S., Kallmyer, B. Alzheimer's Association dementia care practice recommendations. (2018). *The Gerontologist*, Volume 58, Issue suppl_1, Pages S1-S9. https://doi.org/10.1093/geront/gnx182

Caring for persons living with dementia includes caring 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 to reduce caregiver burden, depression, and related health outcomes. Available evidence-based interventions that provide caregiver education, training, care, and support, including several that have been specifically adapted or are in use with Tribal communities,[13] should comprise elements of a comprehensive set of caregiver services and supports.

Option 2: The **New Care and Services** program award will provide up to $50,000 per year for up to two years to support the implementation of specific services within one of the five areas above for PLWD or their caregivers. This funding option is intended to support start-up training and workforce development of existing staff to support the delivery of new services, or create significant and measurable improvement in existing services and service delivery. It is expected the Service Unit will establish a plan for sustainable sources of revenue for the services provided by the end of the project period. The services developed under this award should target at least one of the five areas identified in the Comprehensive Model of Care Award: 1) Awareness and Recognition, 2) Accurate and Timely Diagnosis, 3) Person-Centered Interdisciplinary Assessment, 4) Care Plan, Management and Referral, or 5) Support for Caregivers.

Examples include:

- **Development of Caregiver Services and Support** to include evidence-based interventions for caregivers of persons living with dementia.[14]
- A program of **Care Coordination and Care Management** for PLWD, based on an assessment and a plan of care developed with the PLWD and their caregiver and family.
- An initiative to improve **Early Detection and Diagnosis** within the clinic that broadens the use of evidence-based screening tools to detect cognitive impairment, implements new clinical workflows, and creates the pathway toward timely and accurate diagnosis.
- Testing of innovative care models, such as the use of a Geriatric or Family Nurse Practitioner or physician's assistant to serve as a specialty Alzheimer's lead leveraging these roles in providing consultations in-clinic, remotely, and for other locations to improve access to care

[13] Best Practices Caregiving: Evidence-based programs. Benjamin Rose Institute. n.d. https://bpc.caregiver.org/#home
[14] Ibid.

and enhancing **Early Detection and Diagnosis** efforts.

- Implementation of an **Interdisciplinary Assessment** of individuals newly diagnosed with dementia or with change in status and of their caregivers that enables the development of a **Plan of Care** that mobilizes and guides care and services.
- A cross-departmental, multi-disciplinary effort to increase staff knowledge, awareness, and understanding of dementia to enhance **Awareness and Recognition** and referral for diagnostic evaluation of suspected cognitive impairment.
- Community or public health-focused evidence-based or evidence-informed initiative to enhance collaboration and referrals between clinical and community supports to address dementia **Caregiver Services and Support, Community Care Coordination, Early Detection,** or **Awareness and Recognition**.

Applicants are encouraged to identify new services or measurable improvements in services and care that best meet the needs of the Tribes they serve.

E. Additional Expectations

Awardees for both the **Comprehensive Model of Care** and the **New Care and Services** Program Award are expected to:

1. Participate in up to quarterly virtual learning collaborative meetings with other program awardees and quarterly one-to-one meetings with Program Award officials.
2. In collaboration with the Alzheimer's Grant Program, share any emerging, promising, or best practices, including tools, resources, reports, and presentations that will be accessible to Federal, Tribal, and Urban Indian health systems.
3. Develop and implement a brief sustainability plan <u>at the start of year two</u> that identifies reimbursement and funding streams to support the new and/or improved service delivery and facilitate sustainability. Opportunities are dependent on the specific interventions planned, but potential sources might include:
    - Medicare reimbursement through the Physician Fee Schedule.
    - Medicaid and other state programs.
    - Purchased and Referred Care resources.
    - IHS and Third Party Revenue.

    The IHS Alzheimer's Program team will provide technical assistance to awardees in developing the sustainability plan.

II. AWARD INFORMATION

A. Funds Available

- An estimated $600,000 per year in total funding is available with a duration of up to two years, pending the availability of funding and IHS priorities.
- Individual award amounts: **New Care and Services** program awardees may apply for a maximum of $50,000 per year, and **Comprehensive Model of Care Grantees** may apply for a maximum of $200,000 per year.
- A brief six-month progress report and annual continuation application are required annually for the continuation of funding each year. Continuation applications shall include a year-end progress report, next year's work plan, and next year's budget narrative. A closeout progress report will be due within 90 days of the project period end date. Report templates are provided.
- Continued annual funding will be contingent on compliance with reporting requirements and submission and approval of an annual continuation application.

III. ELIGIBILITY INFORMATION

A. All: Applicants must be IHS Services Units currently providing ambulatory care services in partnership with Direct Service Tribes.

B. New Care and Services program award: All IHS Service Units providing primary care services to Tribes are eligible for this funding.

C. Comprehensive Model of Care program award:

1. IHS Service Units whose Tribes are not currently receiving an IHS grant under the Addressing Alzheimer's in Indian Country Grants program are eligible. Awardees under this funding option must work in close coordination with the Tribe(s) or Tribal Organization(s) to which they provide direct services. They shall demonstrate that the approach developed under the program award will be integrated with Tribal programs serving the elderly.
2. In the instance of IHS Service Units serving more than one Tribe or Tribal Organization, if one or more, but not all, Tribes or Tribal Organizations served by the IHS Service Unit are receiving an IHS grant under the Addressing Alzheimer's in Indian Country Alzheimer's Grant program, the IHS Service Unit will be eligible for **Comprehensive Model of Care** program award only if the majority of their IHS Service Unit User Population comes from Tribe(s) or Tribal Organization(s) not awarded the grant.

3. Must coordinate with elder services in the Tribe, Tribal Organization, or communities served.

IV. APPLICATION AND SUBMISSION INFORMATION

A. Mandatory documents for all applicants include:

1. Letter(s) of support from appropriate Tribal agencies, offices, or enterprises with which the IHS Service Unit plans to partner to address their Alzheimer's work.
2. A letter of endorsement for the application from the Area Director or Area Chief Medical Officer that includes a signature from the facility's Chief Executive Officer.
3. Abstract summarizing the project (1-page limit).
4. Completed Program Award application (template provided) that includes:
   - Selection of the type of program award: **Comprehensive Model of Care** or **New Care and Services**.
   - **New Care and Services** program award applications must indicate in the title the specific care or services that will be implemented or improved.

   Project Narrative (10-page limit; double-spaced except for tables which can be single-spaced) that includes:

   a. Section 1: Organizational Overview

   - Provide a brief description of the Service Unit and the Tribe(s) or Tribal Organization(s) served, including the 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.

   b. Section 2: Needs

   - Include any quantitative data on the existing dementia patient population and a narrative description of any dementia or caregiving-related activities undertaken to support the need for the proposed project. Identify the gaps in care and services and/or quality of care the project is intended to fill. If data is not currently available describe in detail how the applicant will obtain or develop this data in the first year of the program.

   c. Section 3: Program Plan

   - Describe in 2-3 sentences how the application specifically addresses the identified problem.
   - List project goal(s) and SMART (Specific, Measurable, Achievable, Relevant, and Time-

based) objectives achievable within the project period.

- Describe the proposed plan and approach, including plans to demonstrate new or expanded services and enhanced patient outcomes. Identify specific potential sources of revenue that may, eventually, support service delivery. Applicants should consider existing evidence-based or evidence-informed strategies that meet their needs or describe the rationale and evaluation approach for new strategies.
- Identify all key personnel and any contractors or consultants instrumental to the project's success, and both current and expected roles and responsibilities, including details about the Senior Sponsor. The Senior Sponsor is the administrative or clinical leader in the Service Unit with the responsibility and authority to support the project, provide strategic guidance, and ensure that barriers to success are addressed. **Comprehensive Model of Care** applicants shall specifically note which staff will be allocated to coordinate development and implementation.
- Provide a work plan that includes key activities, projected timeframes, and assigned staff (2-page limit).

d. Section 4: Evaluation Plan

- Include an evaluation plan in table form that includes key activities, outputs, outcomes, and data sources relevant to the project scope to be used for assessment of progress towards achieving the goals and objectives (1-page limit) (see example metrics in the appendix).
- The evaluation plan for <u>both applicant types</u> must include metrics about the number of persons newly diagnosed, and persons living with a pre-existing dementia diagnosis. The evaluation plan should also include metrics for essential outcomes of care for those living with dementia and their family or caregiver(s) and processes of care that contribute to better outcomes related to the specific proposed work.
- The evaluation plan for **Comprehensive Model of Care** applicants and **New Care and Services applicants** *proposing a project focused on* ***Accurate and Timely Diagnosis*** must also include metrics for screening and case-finding efforts among their patient population.
- If the applicant needs to obtain or develop data as an element of this funding, the data needed and a description of how that data will be developed or acquired in the first year should be identified.

- In one paragraph, describe any significant factors that influenced the evaluation planning and implementation, including opportunities or constraints that affected or will affect decisions about plan implementation.

e. Section 5: Dissemination (2-page limit)

- Identify any new tools or products (e.g., EHR templates, position descriptions, policies, and procedures) anticipated as a result of the project that can be shared with other IHS, Tribal, and Urban Indian Health providers.

5. Baseline Data (1-page limit) that includes the following table:

At what age does your community consider an individual to be an older adult?	
Total number of user population*	
Total number of individuals from the user population that have been diagnosed with dementia*	
Number of individuals 55 years and older in the user population	
Number of individuals 65 years and older in the user population	
Number of individuals 75 and older in the user population	
Number of veterans in the user population	
Number of veterans 65 and older in the user population	
Percentage of individuals age 65 years and older who are veterans.	

**See template for definition of user population and Alzheimer's and dementia diagnostic codes.*

6. Budget and Budget Narrative (5-page limit). Applicants must submit an itemized budget and budget narrative. The narrative will provide budget justification and explain the specific line item amounts requested and how they will be spent. Describe how each budget line item will support achieving your proposed objectives. For multi-year projects, describe how the budget might change over the second budget year. Do NOT use the budget narrative to expand the project narrative. Template provided.
   - Applicant must budget sufficient funds in each budget year to support at least two people to attend one IHS meeting annually.
7. Contractor or consultant resumes or qualifications and their related scope of work, as

applicable.

B. Optional documents may be submitted, including:

- Organizational chart.
- Map of area identifying project location(s).
- Letters of support from key project collaborators.
- Additional documents to support the narrative (e.g., data tables, news articles, etc.).

C. Submission Dates and Times

1. Applications must be submitted to Dr. Jolie Crowder (email: Jolie.Crowder@ihs.gov), with the Division of Clinical and Community Services (DCCS), by 11:59 p.m. Eastern Time Monday June 12, 2023.
2. Applications must be submitted using the IHS Secure Data Transfer Service.
3. Any application received after the application deadline will not be accepted for review.

V. APPLICATION REVIEW INFORMATION

A. Internal Review Process

1. **Initial Review.** All applications will undergo initial review for eligibility and completeness. Complete applications will be reviewed for responsiveness. Only complete and responsive applications will advance to Panel Review.
2. **Panel Review.** An objective review committee will score and rank applications based on points assigned to each section. Points are assigned to each evaluation criterion, adding up to 100 possible points.

B. Evaluation Criteria

The project narrative and budget narrative should include only the first year of activities unless otherwise noted above. The project narrative should be written in a manner that is clear to outside reviewers unfamiliar with the 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 narrative page limits.

1. Section 1: Organizational Overview (5 points)

The extent to which the applicant:

- Provides a brief, clear 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).

2. **Section 2: Needs (5 points)**

   The extent to which the applicant:

- Describes the number of individuals living with dementia in the service population, the prevalence of risk factors for dementia (including age as reflected in the population's demographics), and any limitations of the available data.
- Identifies the most urgent and pressing gaps in the availability or quality of care and services for persons living with dementia and their families.
- Describes in detail how the applicant will obtain or develop data in the first year if this information is unavailable, including identification of related items in the work plan.

3. **Section 3: Program Plan (50 points)**

   The extent to which the applicant:

- For **Comprehensive Model of Care Program Awards** provides an overall vision for a comprehensive approach to care and services for PLWD and their caregivers that addresses all five areas. For **New Care and Services Program Awards** clearly articulates an overall vision and clear rationale for addressing the specific services within one of the selected five areas.
- Describes essential elements of this vision that the awardee anticipates implementing over the one-year budget period, including planning activities and assessment of need, if not already available.
- Identifies training and workforce development needs of existing staff necessary to support the delivery of new services or create significant and measurable improvement in existing services.
- Identifies relevant and achievable project goal(s) and SMART objectives.
- Describes a logical and reasonable planned approach to develop new or expanded services.
- Indicates potential sources of revenue that may contribute to program sustainability.
- Identifies evidence-based or evidence-informed strategies[15,16,17] to be incorporated into the project, or provides a strong rationale and an evaluation approach for new strategies.

[15] Lees Haggerty, Epstein-Lubow, G., Spragens, L. H., Stoeckle, R. J., Evertson, L. C., Jennings, L. A., & Reuben, D. B. (2020). Recommendations to Improve Payment Policies for Comprehensive Dementia Care. Journal of the American Geriatrics Society (JAGS), 68(11), 2478–2485. https://doi-org.ezproxyhhs.nihlibrary.nih.gov/10.1111/jgs.16807
[16] Hostetter, M., & Klein, S. (2017). In focus: Spreading innovative approaches to dementia care. Commonwealth Fund. https://www.commonwealthfund.org/publications/2017/dec/focus-spreading-innovative-approaches-dementia-care
[17] Best Practices Caregiving: Evidence-based programs. Benjamin Rose Institute. n.d. https://bpc.caregiver.org/#home\

- Demonstrates organizational capacity as demonstrated through key personnel and contractor roles and responsibilities. This should include identification of the Project Owner (the individual who will lead the work envisioned in the program award) and the Senior Sponsor. The Senior Sponsor is the administrative or clinical leader in the Service Unit with the responsibility and authority to support the project, provide strategic guidance, and ensure that barriers to success are addressed.
- Provides sufficient information to ensure that the Service Unit has the staffing needed to accomplish the project objectives or that there is a specific plan and timeline to hire, contract, or reallocate staff. For **Comprehensive Models of Care** program awards, the budget must include staff with dedicated and protected time to coordinate and lead the project.
- Provides a work plan that includes activities, timeframe, and assigned staff that is responsive to the identified needs of persons living with dementia and their families.
- Includes in the work plan, at a minimum, both the provision of clinical services and for the **Comprehensive Model of Care** program award, the engagement of elder services and activities to address all five program areas.

4. **Section 4: Evaluation Plan (20 points)**
   The extent to which the applicant:

- Includes an evaluation plan that addresses key activities, outputs, outcomes, and data sources relevant to the proposed project scope.
- Provides at least one evaluation measure for each SMART objective.
- Includes required diagnosis measures and metrics for important care outcomes for PLWD and their caregiver(s) and essential processes of care linked to improved outcomes.
- Describes clearly the methods and data sources for evaluating project activities that will be used to report on project outcomes.
- Identifies significant factors influencing the evaluation plan and implementation, including opportunities or constraints.

5. **Section 5: Dissemination (10 points)**
   The extent to which the applicant:

- Describes in the work plan or approach related activities for developing and disseminating tools, resources, reports, and presentations to support the development of programs by other IHS Service Units, Tribes, Tribal organizations, or Urban Indian health programs.

6. Budget and Budget Justification (10 points)

The extent to which the applicant:

- Provides a clear and succinct description of specific roles, activities, and associated salary and fringe benefit expense allocation for each person involved.
- Provides a clear and strong justification for budget activities.
- Includes budget and budget justification consistent with activities identified in the work plan.

C. Selection

Applications that meet the eligibility criteria shall be reviewed and ranked for merit by an Objective Review Committee (ORC) based on the evaluation criteria. IHS will determine, at its discretion, based on funds available, the final mix of program award types. The following factors may affect the rank order and decision: 1) geographic balance, 2) user population served, 3) diversity in the program award types, and 4) diversity in areas identified for **New Care and Services** awards.

D. Notification of Disposition

All applicants will receive notification within 30 days of the conclusion of the ORC.

VI. PROGRAM AWARD ADMINISTRATION INFORMATION

The IHS Alzheimer's Program team will work in partnership with recipients to ensure the success of the program award by providing technical assistance to the recipient. IHS will collaborate with the recipient to develop work plans, evaluation plans, and other measures of program outcomes, as needed. IHS will facilitate peer-to-peer sharing opportunities, provide technical assistance calls and webinars, and initiate calls/email communications to support technical assistance needs. Monitoring activities include routine and ongoing communication between IHS and award recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting).

A. Reporting Requirements

Mid-year program progress reports are required 30 days after the six-month reporting period ends. Progress reports will include a brief comparison of actual accomplishments to the goals established for the period, a summary of progress to date, and other pertinent information as required. The progress reports should include an expenditures report. An annual continuation application to include a progress report, annual work plan, and budget narrative will be required 45 days before the end of the budget year for the continuation of funding each year, annually. A final progress report will be due within 90 days of the end of the last performance period. Report

templates will be provided. Continuation of funding in the second year of the performance period will be contingent on compliance with reporting requirements.

B. Data Collection and Reporting

The program awardee will participate in periodic (not more frequently than quarterly) web-based calls with the program office or designee and other awardees to share their progress, interim evaluation findings, experience, tools, and resources that might be useful for other awardees and grantees. The awardee will be expected to work with the program office to develop a driver diagram (an action-oriented logic model) by the end of year two that accurately captures their approach to care and services and identifies key performance metrics based on their evaluation plan. IHS Office of Privacy has reviewed and approved the request for program award data and reporting. In the event potentially de-identified data or information is shared, IHS will protect reported information as required by applicable law and regulations.

C. Program Contact

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National Elder Care Program Consultant
Email: jolie.crowder@ihs.gov