Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at *https://www.hhs.gov/ocr/about-us/contact-us/index.html* or call 1–800–368–1019 or TDD 1–800–537–7697.

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 Federal Awardee Performance and Integrity Information System (FAPIIS), at *https://www.fapiis.gov,* 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. 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, non-Federal entities (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 $10,000,000 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.

Submission is required for all applicants and recipients, in writing, to the IHS and to the HHS Office of Inspector General of 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: Paul Gettys, Acting Director, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857 (Include ''Mandatory Grant Disclosures'' in subject line), Office: (301) 443–5204, Fax: (301) 594–0899, Email: *Paul.Gettys@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 Email: *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 parts 180 & 376).

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to: Minette C. Galindo, Public Health Advisor, Indian Health Service, Office of Clinical and Preventive Services, 5600 Fishers Lane, Mail Stop: 08N34A, Rockville, MD 20857, Phone: (301) 443–4644, Email: *IHSCHAP@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, Email: *Donald.Gooding@ihs.gov.*

3. Questions on systems matters may be directed to: Paul Gettys, Acting Director, Indian Health Service, Division of Grants Management, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2114; or the DGM main line (301) 443–5204, Email: *Paul.Gettys@ihs.gov.*

VIII. Other Information

The Public Health Service strongly encourages all grant, cooperative agreement and contract recipients 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.

Elizabeth A. Fowler,

Acting Director, Indian Health Service.

[FR Doc. 2021–16280 Filed 7–29–21; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Epidemiology Program for American Indian/Alaska Native Tribes and Urban Indian Communities

Announcement Type: New and Competing Continuation.

Funding Announcement Number: HHS–2021–IHS–EPI–0001.

Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.231.

Key Dates

Application Deadline Date: September 1, 2021.

Earliest Anticipated Start Date: September 30, 2021.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for a cooperative agreement for Tribal Epidemiology Centers (TECs) serving American Indian/Alaska Native (AI/AN) Tribes and Urban Indian communities. 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 (IHCIA), as amended, 25 U.S.C. 1621m. This program is described in the Assistance Listings located at *https://beta.sam.gov* (formerly known as Catalog of Federal Domestic Assistance) under 93.231.

Background

The TEC program was authorized by Congress in 1996 as a way to provide public health support to multiple Tribes and Urban Indian communities in each of the IHS Administrative Areas. The funding opportunity announcement is open to currently funded TECs.

TECs are uniquely positioned within Tribes, Tribal organizations, and Urban Indian organizations (UIO) to conduct disease surveillance, research, prevention, and control of disease, injury, or disability, and to assess the effectiveness of AI/AN public health programs. Some of the existing TECs have already developed innovative strategies to monitor the health status of Tribes and Urban Indian communities,

including development of Tribal health registries and use of sophisticated record linkage computer software to correct existing state data sets for racial misclassification.

TECs provide critical support for activities that promote Tribal Self-Governance and effective management of Tribal and Urban Indian health programs. Data generated locally and analyzed by TECs enable Tribes and Urban Indian communities to effectively plan and make decisions that best meet the needs of their communities. In addition, TECs can immediately provide feedback to local data systems, which will lead to improvements in Indian health data overall.

As more Tribes choose to operate health programs in their communities, TECs ultimately will provide additional public health services such as disease control and prevention programs. Some existing TECs provide assistance to Tribal and Urban Indian communities in such areas as sexually transmitted disease (STD) control and cancer prevention.

They also assist Tribes and Urban Indian communities to establish baseline data for successfully evaluating intervention and prevention activities.

Sexually transmitted infections (STIs) remain a major public health challenge in the United States (U.S.) with an estimated 20 million new infections occurring each year; half of them occur among adolescents and young adults ages 15–24. Many STIs, like chlamydia and gonorrhea, can be asymptomatic; however, if left untreated, STIs can lead to infertility and increase the risk of acquiring other STIs. For pregnant women, there are additional risks of ectopic pregnancy, miscarriage, stillbirth, and early infant death.

Although widespread across the U.S. among all populations, the STI epidemic disproportionately affects certain racial and ethnic groups, including AI/AN people. Such disparities in STI incidence are complex to understand but may be rooted in a number of social factors such as poverty, inadequate access to health care, lack of education, social inequality, and cultural influences. Recent surveillance data demonstrate that STI rates continue to increase in Indian Country. The latest surveillance report showed that AI/AN people have 3.8 times the incidence rate of chlamydia compared with whites and a 4.4 times higher rate of gonorrhea. For more information, please visit *https://www.ihs.gov/epi/includes/themes/responsive2017/display_objects/documents/STI/Indian_Health_Surveillance_Report_STI_2015.pdf.* AI/AN people have the second highest rates for both chlamydia and gonorrhea compared to other races/ethnicities. Gonorrhea rates have continued to increase since 2011. Regional differences in STIs in Indian Country are observed. Recurrent STIs can increase the likelihood of human immunodeficiency virus (HIV) transmission, and gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis, particularly among men who have sex with men (MSM).

AI/AN youth and AI/AN women, particularly women of reproductive age, have a disparate and increased STI burden. In addition, recent outbreaks of syphilis have been observed among AI/AN communities, resulting in a dramatic increase in congenital syphilis cases in recent years. Some of these outbreaks are also connected to the use of injection drugs and methamphetamines. Particularly concerning is the dramatic increase in syphilis cases among AI/AN women and the rise in congenital syphilis (CS) cases. The CDC national STI surveillance report demonstrated that from 2014 to 2018 CS cases, among all races, in the U.S. increased from 462 to 1,306 (183 percent). In 2018, AI/AN mothers had the highest rate of reported CS cases nationally. The rate of increase in reported CS cases among AI/AN mothers is higher than for any other race or ethnicity in the U.S. (from 13.2 cases per 100,000 live births in 2014 to 79.2 in 2018).

Untreated CS can cause miscarriage, stillbirth, prematurity, low birth weight, or death shortly after birth. The impact of CS depends on when a pregnant woman contracts syphilis and whether she has access to treatment for the infection. Up to 40 percent of babies born to pregnant women with untreated syphilis may be stillborn or die from the infection as a newborn. According to CDC data, analysis of CS cases born to AI/AN mothers in 2018 identified gaps in prenatal care and access to timely and appropriate treatment.

The STI National Strategic Plan, released on December 17, 2020, aims to reverse the recent dramatic rise in STIs in the U.S. Please visit *https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf* for the most recent documents, outlining the following goals and selected objectives:

1. Goal 1: Prevent New STIs

a. Objective 1.1—Increase awareness of STIs and sexual health.

b. Objective 1.2—Expand implementation of quality, comprehensive STI primary prevention activities.

c. Objective 1.3—Increase completion rates of routinely recommended human papillomavirus (HPV) vaccination.

d. Objective 1.4—Increase the capacity of public health, health care delivery systems, and the health workforce to prevent STIs.

2. Goal 2: Improve the Health of People by Reducing Adverse Outcomes of STIs

a. Objective 2.1—Expand high-quality affordable STI secondary prevention, including screening, care, and treatment, in communities and populations most impacted by STIs.

b. Objective 2.2—Work to effectively identify, diagnose, and provide holistic care and treatment for people with STIs by increasing the capacity of public health, health care delivery systems, and the health workforce.

3. Goal 3: Accelerate Progress in STI Research, Technology, and Innovation

a. Objective 3.4—Identify, evaluate, and scale up best practices in STI prevention and treatment, including through translational, implementation, and communication science research.

4. Goal 4: Reduce STI-Related Health Disparities and Health Inequities

a. Objective 4.1—Reduce stigma and discrimination associated with STIs.

b. Objective 4.2—Expand culturally competent and linguistically appropriate STI prevention, care, and treatment services in communities disproportionately impacted by STIs.

c. Objective 4.3—Address social determinants of health and co-occurring conditions.

5. Goal 5: Achieve Integrated, Coordinated Efforts that Address the STI Epidemic

a. Objective 5.1—Integrate programs to address the syndemic of STIs, HIV, viral hepatitis, and substance use disorders.

b. Objective 5.2—Improve quality, accessibility, timeliness, and use of data related to STIs and social determinants of health.

c. Objective 5.3—Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving national STI goals.

Furthermore, the STI National Strategic Plan identifies the following priority groups: Adolescents and young adults; MSM; and, pregnant women.

The STI National Strategic Plan also puts emphasis on other subgroups including racial and ethnic minorities (including AI/AN people) and geographic focus on regions with high STI burden. This national plan outlines goals, objectives, and indicators that

specifically focus on health disparities and particularly addresses disparities in CS among Tribal communities. Applicants should create their action plans in the context of these goals, objectives, and indicators.

The TEC program will continue to enhance the ability of the Indian health system to collect and manage data more effectively and to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography. The TEC program will also support Tribal and Urban Indian communities by providing technical training in public health practice and prevention-oriented research and by promoting public health career pathways serving AI/AN populations.

Purpose

The purpose of this IHS cooperative agreement is to strengthen public health capacity and to fund Tribes, Tribal organizations, and UIOs, and inter-Tribal consortia in identifying relevant health status indicators and priorities to support Public Health interventions that reduce morbidity and mortality in the population using sound epidemiologic principles. Work plans submitted in response to this announcement must incorporate the applicant's desired objectives and all of the required activities of the program's four goal sets, which are combined from the seven TEC core functional areas as outlined in the Indian Health Care Improvement Act (IHCIA) at 25 U.S.C. 1621m(b). The seven core functions of the TECs are:

(1) Collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal organizations, and UIOs in the service area;

(2) Evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

(3) Assist Indian Tribes, Tribal organizations, and UIOs in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

(4) Make recommendations for the targeting of services needed by the populations served;

(5) Make recommendations to improve health care delivery systems for Indians and Urban Indians;

(6) Provide requested technical assistance to Indian Tribes, Tribal organizations, and UIOs in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

(7) Provide disease surveillance and assist Indian Tribes, Tribal organizations, and Urban Indian communities to promote public health.

The seven core functions, included in the four goal sets are:

Goal Set 1: Public Health Promotion

Collect health status data, provide disease surveillance and assist Tribes, Tribal organizations, and UIOs to promote public health.

Goal Set 2: Evaluation

Evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health.

Goal Set 3: Recommendation

Assist Indian Tribes, Tribal organizations, and UIOs in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data. Make recommendations for the targeting of services needed by the populations served. Make recommendations to improve health care delivery systems for Indians and Urban Indians.

Goal Set 4: Technical Assistance

Provide technical assistance to Indian Tribes, Tribal organizations, and UIOs in the development of local health service priorities and determine incidence and prevalence rates of disease and other illness in the community.

Applicant objectives may include activities beyond the required activities but must address them. Additional activities must still fall within the seven core functions and the four Goal sets.

Required activities under the core funding are: Community Health Profiles (CHP); Data collection and Disease Surveillance; Public Health Preparedness and Response; STD Activities; technical assistance to Indian Tribes, Tribal organizations, and UIOs; evaluate and support Area-wide interventions that promote severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2) vaccine uptake; and, evaluate and support Area-wide interventions that promote SARS–CoV–2 outbreak response and recovery.

See Section I: Required, Optional, and Allowable Activities for full details.

It is the intent of IHS to fund sufficient TECs to serve Tribes and Urban Indian communities in all 12 IHS administrative areas.

Each TEC selected for funding will act under a cooperative agreement with the IHS. During funded activities, the TECs may receive Protected Health Information (PHI) for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, reporting of disease, injury, vital events, such as birth or death, and the conduct of public health surveillance, public health investigation, and public health interventions for the Tribal and Urban Indian communities that they serve. TECs acting under a cooperative agreement with IHS are public health authorities for which the disclosure of PHI by covered entities is authorized by the Privacy Rule, 45 CFR 164.512(b).

Required, Optional, and Allowable Activities

Goal Set 1: Collect health status data, provide disease surveillance, and assist Tribes, Tribal organizations, and UIOs to promote public health (Core Functions 1 and 7).

Required Activities under Goal Set 1:

(1) CHPs

a. Develop culturally appropriate community health assessments encompassing all the Tribal and/or Urban Indian communities served by the TEC.

b. CHPs should include information appropriate to allow Tribal and Urban Indian leaders to make informed decisions, prioritize health problems, and develop, implement, and evaluate their community health improvement plans.

c. Provide and enact a plan that includes a project overview, specific health indicators, and means of dissemination for both Tribe-specific and regional CHPs.

d. Participate in local, regional, and national committees that address public health priorities and, as appropriate, with other Federal agencies.

e. Establish and maintain an advisory council that can provide overall program direction and guidance. The advisory council should include some members with technical expertise in epidemiology and public health (*e.g.,* from state health departments or county health departments) and include representation from the Tribal health and Urban Indian health programs within the TECs regional area.

f. Translate available data and/or results of analyses on disease incidence/prevalence and determined risk factors into useful products, messaging, and outreach to effectively guide stakeholders' interventions addressing public health priorities.

(2) Data collection and Disease Surveillance

a. Establish and maintain data sharing agreements and Memorandums of Understanding (MOU) to support data collection and analysis. Agreements may be needed with local organizations, Tribal governments, state authorities, and Federal agencies.

b. Provide disease surveillance and assist Indian Tribes, Tribal organizations, and UIOs to promote public health.

Optional Activities with Budget Support under Goal Set 1:

(1) IHS-funded UIOs Technical Assistance

These activities are eligible for a supplemental budget of up to $100,000 per award.

The grantee will support 41 IHS-funded UIOs located in 22 states through the following activities:

a. Providing training and technical assistance on planning, conducting, and implementing community health needs assessment;

b. developing new and updating existing CHPs; and

c. providing ongoing training and tutorials on how to interpret data, such as the Census and American Community Survey data.

These activities have additional reporting requirements including quarterly progress reports that are due within 30 days after the budget period ends. 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.

(2) Group A HIV/STI Activities

These activities are eligible for a supplemental budget of up to $100,000 per awardee.

Activities under this supplement are organized under the operational strategies of the Ending the HIV Epidemic: A Plan for America initiative (EHE).

TEC sites serving areas that do not include the EHE Phase One priority Geographic area(s) and Location(s) are eligible to apply for this supplemental funding. For a list of Phase One priority Geographic Areas and Locations, please visit *https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions/phase-one*.

Coordination Operational Strategy

a. Grantees will send at least one representative to the annual HIV Coordination meeting, scheduled in September of each year to coincide with the U.S. Conference on HIV/acquired Immunodeficiency syndrome (AIDS). The budget should include travel and associated costs for participation.

b. Grantees will participate in the IHS National AI/AN STI Prevention workgroup.

Diagnosis Operational Strategy

c. The TECs will provide technical assistance and/or disease surveillance support to Tribal and Urban communities by developing analytical reports to examine the burden of HIV and other relevant comorbidities such as STIs and hepatitis C virus (HCV) in Tribal and Urban communities.

Treatment Operational Strategy

d. The TECs will provide support to Tribal and Urban communities in the development of enhanced activities and expanded capacity to better identify AI/AN people who are not in care, including those who were never linked to care following an HIV, STI, or HCV diagnosis and those who have fallen out of care.

Respond Operational Strategy

e. Respond rapidly to detect and characterize growing HIV, STI, or HCV clusters and prevent new infections. TECs will provide technical assistance and/or direct support to Tribal and Urban communities on the following activities:

i. Develop or accelerate the refinement of HIV, STI, and HCV community plans that are customized for AI/AN communities. Extensive community engagement in this process will help ensure that community-specific social norms and unique epidemic attributes are addressed.

ii. Develop collaborative partnerships among Tribal, state, and local health departments, the clinical community, and community-based organizations to expand and routinize HIV diagnosis, treatment, prevention, and response.

(3) Group B HIV/STI Activities

These activities are eligible for a supplemental budget of up to $250,000 per awardee.

Applicants may either request Group A or Group B activities based on their geographic service area. Applicants should not apply for both Group A and Group B activities.

Activities under this supplement are organized under the operational strategies of the EHE.

TEC sites serving areas that do include the EHE Phase One priority Geographic area(s) and Location(s) are eligible to apply for this supplemental funding.

For a list of Phase One priority Geographic Areas and Locations, please visit *https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions/phase-one*.

Applications for Group B HIV Activities must include the following activities.

Coordination Operational Strategy

a. Grantees will send at least one representative to the annual HIV Coordination meeting scheduled in September of each year to coincide with the U.S. Conference on AIDS. The budget should include travel and associated costs for participation.

b. Grantees will participate in the IHS National AI/AN STI Prevention workgroup.

Diagnosis Operational Strategy

c. The TECs will provide technical assistance and/or disease surveillance support to communities by developing analytical reports to examine the burden of HIV and other relevant comorbidities such as STIs and HCV in Tribal communities.

Treatment Operational Strategy

d. The TECs will provide support to communities in the development of enhanced activities and expanded capacity to better identify people who are not in care, including those who were never linked to care following an HIV, STI, or HCV diagnosis and those who have fallen out of care.

Respond Operational Strategy

e. Respond rapidly to detect and characterize growing HIV, STI, or HCV clusters and prevent new infections. TECs will provide technical assistance and/or direct support to communities on the following activities:

i. Develop or accelerate the development and/or refinement of community plans that are customized for AI/AN communities. Extensive community engagement in this process will help ensure that community-specific social norms and unique epidemic attributes are addressed.

ii. Develop collaborative partnerships among Tribal, state, and local health departments, the clinical community, and community-based organizations to expand and routinize HIV diagnosis, treatment, prevention, and response.

Further Activities under this Supplement

Applications are required to address the above activities, and must propose activities addressing at least two of the additional operational strategies below.

Diagnosis Operational Strategy

a. Diagnose all people with HIV, STIs, and HCV as early as possible after infection and connect them to immediate treatment. The TECs will provide technical assistance and/or direct support to AI/AN communities on the following activities:

i. Implementing HIV testing recommendations through the rapid replication of proven or innovative HIV screening models;

ii. Developing and implementing innovative testing and health care

engagement strategies focused on meeting the needs of groups at higher risk, including MSM, transgender individuals, high-risk heterosexuals, and persons who inject drugs.

Protection Operational Strategy

b. Protect people at risk for HIV using potent and proven prevention interventions, including Pre-Exposure Prophylaxis (PrEP), a medication that can prevent new HIV infections. The TECs will provide technical assistance and/or direct support to communities on the following activities:

i. Support efforts to increase the awareness of, access to, and utilization of PrEP among identified populations;

ii. Support efforts to incentivize providers and community-based health care organizations to integrate HIV testing, linkage, and referral to care, and linkage or referral to medical prevention (*i.e.,* PrEP) services into primary care services, particularly for their higher-risk patients;

iii. Raise awareness about the prevention benefits of ''Treatment as Prevention'' (TasP) and ''Undetectable = Untransmittable'' (U=U) among providers, people living with and at risk for HIV, and the general population;

iv. As an entry point to recovery services and overdose and infection prevention, support the development, expansion, implementation, and evaluation of harm-reduction services for people who inject drugs.

v. Evaluate the local acceptability and opportunities for establishing or increasing syringe services programs (SSPs) including: Linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.

vi. Promote early identification of individuals with recurrent STI events with focus on chlamydia, gonorrhea, and syphilis through analysis of clinical or other locally available data.

vii. Promote linkage to care including PrEP or other appropriate services to aid the prevention of HIV and other infectious disease transmission, especially for those diagnosed with STIs.

viii. Promote and support Expedited Partner Therapy (EPT) for individuals diagnosed with chlamydia and gonorrhea to control transmission.

ix. Promote enhanced STI screening among youth and MSM and engage providers in adopting best practices, such as obtaining a thorough sexual history and promoting an adolescent-friendly clinic environment.

Respond Operational Strategy

c. Respond rapidly to detect and characterize growing HIV, STI, or Viral hepatitis clusters and prevent new infections. The TECs will provide technical assistance and/or public health surveillance support to communities on the following activities:

i. Establish and support boots-on-the-ground public health workforce capacity that is culturally competent and committed to ensuring implementation of community-based HIV, STI, and/or Viral hepatitis control plans, including facilitating and troubleshooting collaborative community-wide disease control efforts;

ii. Develop or expand the capacity to detect and respond to all established or emerging HIV, STI, and/or Viral hepatitis clusters to reduce disease transmission.

Allowable Activities Under Goal Set 1:

(1) Enhance or develop disease surveillance systems. Surveillance systems can address infectious and chronic diseases, record linkage studies to improve existing surveillance systems, suicide data tracking, regional health registries, influenza surveillance, among others.

(2) Carry out at least one new disease surveillance activity per cycle, complete with evaluation and the use of measurable outcomes.

Goal Set 2: Evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health (Core Function 2).

Required Activities under Goal Set 2: None required.

Optional Activities with Budget Support under Goal Set 2:

(1) Annual Cancer Survivorship Leadership Training

This activity is eligible for a supplemental budget of up to $85,000 per awardee. One award is anticipated.

This activity supports the CDC National Center for Chronic Disease Prevention and Health Promotion activity Annual Cancer Survivorship Leadership Training. Grantee will organize and implement at least two, three-day cancer support leadership trainings for 15–25 AI/AN participants, nationally. The training will be designed to give participants a unique opportunity to work together in a safe, supportive environment to learn and practice skills to help people affected by cancer in their communities. The training will be based on the model, A Gathering of Cancer Support, using the Gathering of Native Americans (GONA) teaching methods.

Outcome:

Participants will show change in knowledge/understanding of the below elements:

Wellness from a Native American Perspective

a. Using a group discussion method such as Rez Café, identify two AI/AN core values that support wellness and healing.

b. Using a group discussion method such as Rez Café, identify two AI/AN core values to draw from to help facilitate a support group.

Cancer 101

c. Describe two ways to take personal action to reduce cancer risk

Exploring Emotional Peer Support Skills and How to Start Up Cancer Support in Your Community.

d. Determine best role for self in setting up cancer support.

e. Identify at least two steps for starting up cancer support in your community.

(2) Tribal Public Health Departments

This activity is eligible for a supplemental budget of up to $150,000 per awardee. Six awards are anticipated.

a. Conduct Ecological Assessments on Tribal public health programs and services in your Area.

b. Develop plans with specific Tribes on strengthening Tribal public health programs and services.

c. Support the establishment and/or expansion of one or more Tribal public health department(s) in your Area.

Allowable Activities Under Goal Set 2:

(1) Evaluate sufficiency of IHS electronic health record data to determine AI/AN health status, to create seamless data linkages, and to meet the health information needs for Tribes and Tribal programs. This should include an assessment of the ability for the health information systems to meet those needs, create seamless data linkages, and meet data access needs for Tribes and Tribal organizations.

Goal Set 3: Assist Indian Tribes, Tribal organizations, and UIOs in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data.

Make recommendations for the targeting of services needed by the populations served.

Make recommendations to improve health care delivery systems for Indians and Urban Indians (Core Functions 3, 4, and 5).

Required Activities Under Goal Set 3:

(1) Public Health Preparedness and Response

a. Strengthen Tribally-focused surveillance systems and data.

b. Conduct outbreak investigations and response.

c. Lead community assessments for disaster preparedness, response, and recovery.

d. Develop response plans for major public health emergencies.

e. Lead, coordinate, or participate in Federal, Tribal, state, or local emergency response exercises and activities.

f. Promote and facilitate planning and response activities among Tribes.

g. Build partnerships among government agencies, Tribes, and other organizations to advance emergency preparedness in Indian country.

(2) STD Activities

The grantees will conduct activities in this announcement to support the above STI National Strategic Plan goals and indicators pertaining to chlamydia, gonorrhea, Primary and Secondary Syphilis and congenital syphilis. While the STI National Strategic Plan includes HPV as an additional focus, applicants should not emphasize HPV in their application. However, HPV-related activities can be incorporated into project plans as a secondary focus if desired, as appropriate and if relevant or complementary to primary work.

a. Community Profiles

In year 1 of award, the grantees will develop an assessment of the overall burden of the following STIs: Chlamydia, gonorrhea, primary and secondary syphilis, and congenital syphilis within the communities they serve.

To support the profile, the grantees will analyze current, existing data or generate their own data related to STI burden with particular emphasis on priority groups listed above and any other priority groups identified during the assessment phase. When analyzing existing data, grantees will ensure analyses are novel and not duplicative of analytic approaches or products available from other sources. Data may include publically available data, surveillance data, clinical data, qualitative data, or other relevant health data source. Applicants should prioritize data that describe STI burden in Tribal communities within their jurisdiction, such as through partnerships with public health authorities at the Tribal, local or state level. Although historic data may be reviewed, analysis must incorporate data on the burden of STIs generated within the last 5 years. The applicants are encouraged to create assessments that examine STI burden at different Tribal communities and report those results accordingly; regional or IHS Area level results or national level results can be used for comparison purposes.

Special focus should be on indicators and priority areas outlined in the STI National Strategic Plan.

The assessment will serve as a living document and will be updated minimally on year 3 and year 5 of the award.

During years, 2–5 of the award the grantees should: (1) Work to obtain information from community members and Tribal leaders on defining gaps and opportunities to further improve STI prevention and care and (2) conduct relevant interventions to improve STI prevention and care services. The grantees will create a report describing the findings from their community engagement and outlining any relevant feasibility, gaps, and opportunities identified in the interventions conducted. Interventions can be expanded to more communities depending on results, feasibility, and acceptability.

b. Communication of findings

At the end of year one grantees will create a report outlining analytic findings of the community profile assessments and also create and include a strategic plan and road map on how to address STI burden within the supported AI/AN communities. Applicants are encouraged to align their strategic approach with the vision and goals of the National STI Strategic Plan and implementing the objectives and strategies most relevant to their role and communities. In addition, applicants should use available data to identify where their resources will have the most impact and to determine indicators and targets best suited to measure their progress towards selected goals. The applicant strategic plan is meant to serve as a living document and be updated based on inputs from supported communities and lessons learned as the work progresses. Please visit *https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf* for further background.

The grantees will create or adapt communication materials for appropriate audiences (community members, Tribal leaders, health care providers) and convene meetings to share findings with community members and other stakeholders such as Tribal leadership, medical providers, public health partners, etc.

The grantees will work with selected communities to create detailed strategic plans on how to improve STI prevention with specific focus on aligning to any STI National Strategic plan goals, objectives, and indicators and convene a coalition with diverse partners (community members, public health professionals, trainers, health care providers and others). Communities can self-identify or be selected in collaboration with the applicant based on available epidemiologic evidence. Each grantee will work with at least two communities.

c. Meetings

Grantees will meet with IHS Division of Epidemiology and Disease Prevention (DEDP) staff quarterly to discuss activity progress and garner technical assistance.

Grantees will regularly participate in IHS National STI program workgroup meetings. Each grantee is requested to present once a year on their activities relating to this announcement at these meetings.

Grantees are encouraged to share knowledge gained by presenting findings at Tribal meetings, regional meetings and/or publishing in peer-reviewed journals.

Grantees will attend one national STI-focused meeting such as the National Coalition of STD Directors annual meeting or the National STD conference and are strongly encouraged to submit abstracts for presentations. When such meetings are held in person, applicant's budget should include travel costs for up to three staff to attend.

d. Outcomes

The applicant will provide evidence of direct dissemination of assessment results to Tribal communities including Tribal leadership.

Dissemination could include meetings, online reports (and number of views), media releases, and newsletters.

Optional Activities with Budget Support under Goal Set 3:

(1) Targeted STD Activities

This activity is eligible for a supplemental budget of up to $150,000 per awardee. Six awards are anticipated.

To qualify for targeted STD activities, the applicant must demonstrate an increased incidence of congenital syphilis or syphilis among women of reproductive age within their jurisdiction.

The STI National Strategic Plan specifically outlines a focus on congenital syphilis (CS) in Tribal communities and includes a disparity indicator to reduce CS rate among AI/AN people/communities.

In order to achieve a reduction in CS rates among AI/AN people, a comprehensive approach to reduce syphilis rates among women of reproductive age is necessary. Grantees will conduct activities in one or more of the following domains with the goal to address the STI Disparity Indicator focusing on the reduction of CS cases among AI/AN people. Applicants can propose additional relevant work to address CS among their communities.

Activities are intended to complement and expand from required STD activities and develop a logic model specific to this activity apart from the program-wide logic model.

a. Linkage to prenatal care

Applicants will address gaps in prenatal care that contribute to late maternal syphilis screening and treatment. Applicants should prioritize hard to reach populations, including, but not limited to, persons experiencing homelessness and Persons Who Inject Drugs (PWID), and design interventions to link these populations to care. Applicants will determine whether third trimester screening is occurring within their jurisdictions and evaluate its ability to (a) avert cases before birth; and (b) detect and treat additional CS cases. Applicants may partner with health care providers to test different scalable interventions; for example, the feasibility and impact of Electronic Health Record reminders and/or screening at delivery.

b. Surveillance

Applicants will design activities to address surveillance gaps to capture and accurately report syphilis cases among AI/AN women (particularly women of reproductive age) and understand risk factors associated with transmission.

c. Outbreak response plans and trainings

Applicants will assess gaps in current practices to respond to syphilis outbreaks within their jurisdiction. Applicants will develop comprehensive syphilis outbreak response plans that incorporate and enhance health education and training for providers and disease investigators serving the community. Feasibility of response plans will be assessed with Tribes and Tribal leadership within their jurisdiction. Applicants can include other STIs in outbreak response plans. Applicants will assess training needs and identify providers/Disease Intervention Specialists in need of training and arrange or develop resources. Applicants will connect with existing resources like the STD Prevention Training Centers to create trainings for providers in their community that are tailored to local needs and that are culturally appropriate. Applicants may find more information on the STD Prevention Training Centers at *https://www.nnptc.org/*.

d. Screening in alternative locations

Applicants will create an inventory of any screening currently conducted in alternative locations within their jurisdiction and pilot novel screening programs for syphilis (but also including other STIs) that may reach heterosexual populations. Applicants will evaluate the effectiveness of such interventions at case-finding and treatment. This could include jails, inpatient or Emergency Department settings, and substance abuse treatment centers.

e. Communication of findings

The grantee will create a report outlining findings and develop a local strategic plan and road map on how to address CS and syphilis burden within the supported AI/AN communities. This plan will differentiate from the work conducted under Part A activities.

The grantees will create or adapt communication materials for appropriate audiences (community members, Tribal leaders, health care providers) and convene meetings to share findings with community members and other stakeholders such as Tribal leadership, medical providers, public health partners, etc.

Grantee will convene a coalition with diverse partners (community members, public health professionals, trainers, health care providers and others) to create concrete action steps to target CS in their jurisdiction and to inform further adaptation of the local strategic plan.

f. Meetings and Reporting

Grantees will meet with IHS DEDP staff quarterly to discuss activity progress and garner technical assistance.

Grantees will provide reports two times a year summarizing progress towards outcomes in Logic Model.

Grantees will participate in any IHS National STI program workgroup meetings focusing on CS and share their activities with other participants.

Grantees will present on their CS activities minimally once per year.

Grantees are encouraged to share knowledge gained by presenting findings at Tribal, regional, or national meetings and/or publishing in peer-reviewed journals.

g. Outcomes

Demonstrated improvement in capturing of syphilis cases among women of reproductive age and ascertainment of CS cases.

Demonstrated improvement of linkage to care and screening for syphilis with particular emphasis on hard to reach populations, including, but not limited to, persons experiencing homelessness and PWID.

The grantees will provide evidence of direct dissemination of findings to Tribal communities including Tribal leadership. Dissemination could include meetings, online reports (and number of views), media releases, and newsletters.

Allowable Activities Under Goal Set 3:

(1) Public Health Response

Grantees may conduct further activities not addressed above including:

a. Infectious Disease control.

b. Outbreak Response.

c. Assess and support Environmental Health emerging needs of local communities.

Goal Set 4: Provide technical assistance to Indian Tribes, Tribal organizations, and UIOs in the development of local health service priorities and to determine incidence and prevalence rates of disease and other illness in the community (Core Function 6).

Required Activities Under Goal Set 4:

(1) Provide culturally appropriate training and technical support based on the needs of Indian Tribes, Tribal organizations, and UIOs served. Topics may include but are not limited to program evaluation, data analysis, data quality, survey design and administration, program planning, community health assessment, and outbreak response.

a. Implement and evaluate at least one public health intervention (conducted by grantee or by supported community) to promote health or address disparities in AI/AN communities.

(2) Evaluate and support Area-wide interventions that promote SARS–CoV–2 vaccine uptake. Assess community attitudes/knowledge/beliefs around vaccine availability, vaccine coverage, and uptake among AI/AN populations and the IHS/Tribal/Urban health care workforce. Address sufficiency and/or gaps regarding vaccine messaging and public communication campaigns and develop implementation strategies to maximize vaccine coverage among AI/AN communities.

This requirement will have a separate budget of $250,000 per TEC.

a. Explain how the TEC will develop, maintain and strengthen relationships with other public health authorities (*e.g.,* Tribal, county, state) in order to facilitate Public Health assessment, response, communications and dissemination relevant to vaccine implementation to enhance uptake and overall coverage.

b. The TEC will develop a comprehensive needs assessment relevant to the ongoing SARS–CoV–2 vaccine implementation efforts within their relevant IHS Area.

i. Assessment should include implementation gaps and opportunities for improvement in local vaccination activities.

ii. Based on needs assessment findings, develop and implement intervention strategies to address gaps

and enhance opportunities related to improving local vaccine implementation, uptake, and communications.

iii. Perform ongoing evaluation of activities to determine effectiveness and impacts and to inform future efforts.

c. Perform an assessment of existing vaccination capacity, implementation, and uptake for years 1–3 of this funding cycle. Plans for years 4–5 should use this assessment to continue, adapt, and evaluate changes in local conditions and respond to ongoing vaccination needs and goals.

(3) Evaluate and support Area-wide interventions that promote coronavirus disease 2019 (COVID–19) pandemic response, mitigation, and recovery.

This requirement should have a budget of at least $1,000,000 per site.

(a) Explain how the TEC will develop, maintain, and strengthen relationships with other public health authorities (*e.g.,* Tribal, county, state) in order to facilitate collaborative pandemic outbreak response activities at the local and regional level.

(b) These COVID funds are to meet immediate needs in the response, mitigation, and recovery from the COVID–19 pandemic. Plans for activities should be explicitly tied to measurable pandemic response, mitigation, and recovery outcomes.

Optional Activities with Budget Support under Goal Set 4

(1) SASP/DVP/FHC Technical Assistance

This activity is eligible for a supplemental budget of up to $265,000 per awardee.

Twelve awards are anticipated.

Objective: To provide Technical Assistance (TA) to the Substance Abuse and Suicide Prevention (SASP), Domestic Violence Prevention (DVP), and Forensic Health Care (FHC) projects funded within their regional area. Technical Assistance (TA) should apply to Tribes, Tribal organizations, UIOs, and Federal facilities that receive grants from IHS Behavioral Health. TA should assist projects in meeting required reporting activities.

a. Cross-Site/Group TA

i. Representatives from TECs participate in monthly calls with IHS Division of Behavioral Health (DBH) program staff.

ii. The TECs will facilitate or participate in scheduled Area Project Officer (APO) monthly conference calls/webinars to include all grantees within their respective IHS Area.

iii. Organize and facilitate quarterly webinars related to the expectations and required activities of the SASP, DVP and FHC grant programs.

iv. Provide at least one opportunity per year for individual grantees to meet with local TEC annually at regional or national meeting forum (for example, regional behavioral health conferences).

v. Coordinate in-person, virtual, or teleconference peer-to-peer support opportunities for grantees.

b. Individualized Training and Technical Assistance (TTA)

i. Engage in regular communication with grantee project directors and/or project coordinators, providing individualized TTA to SASP/DVP/FHC grantees based on the needs of individual grant community to meet the expectations and required activities of the grant program.

ii. Provide monthly, individual virtual site visits.

iii. Document individual one-on-one meetings that occurred at regional or national meetings, such as regional behavioral health conferences.

iv. Develop an individualized data collection tracker to assist grantees with local data collection.

v. TECs will work with grantees to establish baseline data related to the SASP/DVP/FHC funded projects, DBH Alcohol and Substance Abuse (ASA) Government Performance and Results Act (GPRA) measures and other IHS Strategic Plan Goals.

vi. Technical assistance provided by TECs in this cooperative agreement are limited to efforts that support grantee submission of the required DBH annual progress report (APR) and grantee-specific interventions outlined in the applicant project narrative.

vii. TECs should outline available resources and technology, including software technology for project data analysis and management. TECs may use resources available to them to enhance TA support including software, maintenance, and storage capabilities. However, it is recommended that these activities include an established agreement between the TEC and the grantee.

c. Development of Resources

i. Support grantee development of publications and/or presentation for use in their program.

ii. Provide subject matter expertise, tools, and resources to enhance grantee development of culturally competent, community-based methods for local evaluation and data collection plans.

iii. Create individualized training plans for use with grantees.

iv. Support development of MOUs related to project needs (*e.g.,* provide templates for establishing data collection plans and data sharing agreements, partnerships, and/or services).

v. Develop TTA material including public health messages, and aid in public health messaging practice guides to assist grantees in developing documents identified as grant required activities.

(2) Zero Alcohol and Substance Abuse (ASA) Suicide Initiative Technical Assistance

This activity is eligible for a supplemental budget of up to $125,000 per awardee.

One award is anticipated.

Objective: To provide technical assistance that supports the data collection and data analysis requirements of local projects funded under the two IHS Alcohol and Substance Abuse Pilot Project Initiatives; the Community Opioid Intervention Pilot Project (COIPP) and the Youth Regional Treatment Center (YRTC) Aftercare Pilot Project. Technical assistance should apply to Tribes, Tribal organizations, UIOs and Federal facilities that receive grants from IHS Behavioral Health.

a. Data Collection, Analysis, and Reporting

i. Support local grantee efforts to develop data plans that will support grant objectives, project activities and evaluation efforts. Each grantee was highly recommended to develop a logic/model or theory of change as part of their project description.

1. Technical assistance provided by TECs in this cooperative agreement shall support data collection, analysis, and reporting. Data shall be coordinated and submitted with local grantee evaluation efforts and required annual progress reports.

2. Work with grantees to establish baseline data related to pilot project.

3. Work with grantees to establish a local data collection plan, including project data collection tracker related to proposed activities and evaluation efforts. Data will include a compilation of quantitative and qualitative data that addresses the project impact including outcomes such as performance measures related to evaluation outcomes and intended results.

4. TECs will assist grantees to include and prioritize the collection and reporting of DBH ASA GPRA measures and other IHS Strategic Plan Goals.

ii. Technical assistance provided by TECs in this cooperative agreement shall support grantee submission of the required DBH APR.

iii. TECs should outline available resources and technology, including software technology for project data analysis and management. TECs may use resources available to them to enhance TA support including software,

maintenance, and storage capabilities. However, it is recommended that these activities include an established agreement between the TEC and the grantee.

b. Individualized TTA

i. Engage in regular communication with grantee project directors and/or project coordinators, providing individualized TTA based on the needs of individual pilot project and Tribal community to meet the expectations and required activities of the grant program.

ii. Provide monthly, individual virtual site visits.

iii. Document individual one-on-one meetings that occurred at regional or national meetings, such as regional behavioral health conferences.

c. Development of Resources

i. Support grantee development of publications and/or presentation for use in their program.

ii. Provide subject matter expertise, tools, and resources to enhance grantee development of culturally competent, community-based methods for local evaluation and data collection plans.

iii. Support development of MOUs related to project needs (*e.g.,* provide templates for establishing data collection plans and data sharing agreements, partnerships, and/or services).

(3) Diabetes Activities

This activity is eligible for a supplemental budget of up to $100,000 per awardee.

One award is anticipated.

a. Provide data technical assistance to the Urban Indian Health Organization (UIHO) Special Diabetes Program for Indians (SDPI) grantees to support their diabetes prevention and treatment services.

b. Develop the annual Urban Diabetes Care and Outcomes Summary Report, which provides an overview of the UIHO data submitted into the IHS Diabetes Care and Outcomes Audit. These reports provide data on the diabetes care provided as well as the outcomes achieved in the UIHO patient population, including identifying areas for improvement.

Allowable Activities under Goal Set 4: None additional.

Pre-Conference Grant Requirements

The awardee is required to comply with the ''HHS Policy on Promoting Efficient Spending: Use of Appropriated Funds for Conferences and Meeting Space, Food, Promotional Items, and Printing and Publications,'' dated January 23, 2015 (Policy), as applicable to conferences funded by grants and cooperative agreements. The Policy is available at *https://www.hhs.gov/grants/contracts/contract-policies-regulations/efficient-spending/index.html?language=es.*

The awardee is required to:

Provide a separate detailed budget justification and narrative for each conference anticipated. The cost categories to be addressed are as follows: (1) Contract/Planner, (2) Meeting Space/Venue, (3) Registration website, (4) Audio Visual, (5) Speakers Fees, (6) Non-Federal Attendee Travel, (7) Registration Fees, and (8) Other (explain in detail and cost breakdown). For additional questions please contact Lisa C. Neel at (301) 443–4305 or email at *lisa.neel@ihs.gov.*

II. Award Information

Funding Instrument—Cooperative Agreement

Estimated Funds Available

The total funding identified for fiscal year (FY) 2021 is approximately $30,750,000. Individual award amounts for the first budget year are anticipated to be between $1,070,000 and $3,000,000. 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.

Funding for this award will be provided through: The IHS Office of Public Health Support, the IHS Office of Urban Indian Health Programs, the IHS Office of Clinical and Preventive Services, National Human Immunodeficiency Virus (HIV) & Viral Hepatitis C (HCV) Program in partnership with the U.S. Department of Health and Human Services (HHS) Minority HIV/AIDS Fund (MHAF), the Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion, and the National Institutes of Health's (NIH) National Institute on Minority Health and Health Disparities (NIMHD). The authorities for CDC and NIH funding will be exercised through an Intra-Departmental Delegation of Authority (IDDA) with IHS. The administration will be carried out through an Intra-agency Agreement (IAA) between CDC, NIH, and IHS. Portions of this award will be funded by the Office of the Assistant Secretary for Health, HHS, as authorized under the statutory earmark for minority AIDS prevention and treatment activities, and are to be carried out pursuant to Title III of the Public Service Act. The funding is being made available through an IDDA to award specific funding for fiscal year (FY) 2021.

Anticipated Number of Awards

Approximately 12 awards will be issued under this program announcement.

Period of Performance

The period of performance is for five years.

Cooperative Agreement

Cooperative agreements awarded by the HHS are administered under the same policies as a grant. However, the funding agency (IHS) is anticipated to have substantial programmatic involvement in the project during the entire award segment. Below is a detailed description of the level of involvement required for the IHS.

Substantial Agency Involvement Description for Cooperative Agreement

(1) Provide funded TECs with ongoing consultation and technical assistance to plan, implement, and evaluate each component as described under Recipient Activities. Consultation and technical assistance may include, but not be limited to, the following areas:

(a) Interpretation of current scientific literature related to epidemiology, statistics, surveillance, Healthy People 2030 objectives, and other public health issues;

(b) Design and implementation of each program component such as surveillance, epidemiologic analysis, outbreak investigation, development of epidemiologic studies, development of disease control programs, and coordination of activities; and

(c) Overall operational planning and program management.

(2) Coordinate all IHS epidemiologic activities on a national scope including development and management of disease surveillance systems, generation of related reports, and investigation of disease outbreaks.

(3) Conduct routine site visits to TECs and/or coordinate TEC visits to IHS to assess work plans and ensure data security; confirm compliance with applicable laws and regulations; assess program activities; and to mutually resolve problems, as needed.

(4) Participate in annual TEC meeting for information sharing, problem solving, or training.

(5) Provide training in the use of data from the Epidemiology Data Mart (EDM) and other IHS systems for the purposes of creating reports for disease surveillance, epidemiologic analysis, and epidemiologic studies. Training can be provided online or onsite, depending on staff availability.

(6) Coordinate opportunities for training of TEC staff where applicable. Examples include webinars on the EDM and data use, technical assistance, use of statistical software, and fellowship opportunities.

III. Eligibility Information

1. Eligibility

To be eligible for this FY 2021 funding opportunity applicants must:

A. Be one of the following as defined by 25 U.S.C. 1603:

1. 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.

2. 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): ''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.

3. An Intertribal Consortium or Indian organization as defined by 25 U.S.C. 1621m(d)(2) as: (A) Incorporated for the primary purpose of improving Indian health; and (B) representative of the Indian Tribes or Urban Indian communities residing in the area in which the Intertribal consortium is located.

B. Demonstrate that they have complied with previous terms and conditions of the Epidemiology Program for AI/AN Tribes and Urban Indian Communities grant in order to receive funding under this announcement; and

C. Represent or serve a population of at least 60,000 AI/AN people or 70 percent of the Tribal governments in the Area to be eligible, as demonstrated by Tribal Resolutions, blanket Tribal Resolutions, Tribal Letters of Support (LoS) or LoS from Urban Indian clinic directors and/or Chief Executive Officers (CEOs). Applicants must describe the population of AI/AN people and Tribes that will be represented. The number of AI/AN people served must be substantiated by documentation describing IHS user populations, U.S. Census Bureau data, clinical catchment data, or any method that is scientifically and epidemiologically valid. Resolutions or LoS from each Tribe, AN village and LoS from each Urban Indian community represented must be included in the application package. Resolutions or LoS must be current (*e.g.,* not pre-date inception of the applicant epidemiology center) and express explicit support for the applicant epidemiology center. Collaborations with IHS Areas, Federal agencies such as the CDC, state, academic institutions, or other organizations are encouraged (letters of support and collaboration should be included in the application). If applicants do not have 100 percent Tribal support for their work, applicants must report the proportion and estimated population of the Tribes in their Area that do not support their work explicitly through LoS or resolution.

The DEDP 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 non-profit 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 will be considered not responsive and will not be reviewed. The Division of Grants Management (DGM) will notify the applicant.

Tribal Resolution

The DGM must receive an official, signed Tribal Resolution prior to issuing a Notice of Award (NoA) to any applicant selected for funding. An Indian Tribe or Tribal organization that is proposing a project affecting another Indian Tribe must include 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.

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

IV. Application and Submission Information

1. Obtaining Application Materials

The application package and detailed instructions for this announcement are hosted on *https://www.Grants.gov.*

Please direct questions regarding the application process to Mr. Paul Gettys at (301) 443–2114 or (301) 443–5204.

2. Content and Form Application Submission

The applicant must include the project narrative as an attachment to the application package. Mandatory documents for all applicants include:

- Abstract (one page) summarizing the project.
- Application forms:

1. SF–424, Application for Federal Assistance.

2. SF–424A, Budget Information—Non-Construction Programs.

3. SF–424B, Assurances—Non-Construction Programs.

- Project Narrative (not to exceed 12 pages). See Section IV.2.A Project Narrative for instructions.

1. Background information on the organization.

2. Proposed scope of work, objectives, and activities that provide a description

of what the applicant plans to accomplish.

- Proposed logic model.
- Budget Justification and Narrative (not to exceed five pages). See Section IV.2.B Budget Narrative for instructions.
- One-page Timeframe Chart.
- Tribal Resolution(s) or Letters of Support.
- Letters of Support from organization's Board of Directors.
- 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).
- Certification Regarding Lobbying (GG-Lobbying Form).
- Copy of current Negotiated Indirect Cost rate (IDC) agreement (required in order to receive IDC).
- Organizational Chart (optional).
- Documentation of current Office of Management and Budget (OMB) Financial Audit (if applicable).

Acceptable forms of documentation include:

1. Email confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or

2. Face sheets from audit reports. Applicants can find these on the FAC website at *https://harvester.census.gov/facdissem/Main.aspx.*

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 12 pages and must: (1) Have consecutively numbered pages; (2) use black font 12 points or larger; (3) be single-spaced; (4) and be formatted to fit standard letter paper (8½ x 11 inches).

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 page limit, the application will be considered not responsive and will not be reviewed. The 12-page limit for the narrative does not include the work plan, standard forms, Tribal Resolutions or LoS, budget, budget justifications, narratives, and/or other items.

There are three parts to the 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—3 pages)

Section 1: Introduction and Need for Assistance

Must include the applicant's background information, a description of epidemiological service, epidemiologic capacity, and history of support for such activities. Applicants need to include current public health activities, what program services are currently being provided, and interactions with other public health authorities in the region (state, local, or Tribal).

Section 2: Organizational Capabilities

The applicant must describe staff capabilities or hiring plans for the key personnel with appropriate expertise in epidemiology, health sciences, and program management. The applicant must also demonstrate access to specialized expertise such as a doctoral level epidemiologist and/or a biostatistician. Applicants must include an organizational chart and provide position descriptions and biographical sketches of key personnel including consultants or contractors. The position description should clearly describe each position and its duties. Resume should indicate that proposed staff is qualified to carry out the project activities.

Section 3: User Population

The number of AI/AN people served must be substantiated by documentation describing IHS user populations, U.S. Census Bureau data, clinical catchment data, or any method that is scientifically and epidemiologically valid.

Part 2: Program Planning and Evaluation (Limit—5 pages)

Section 1: Program Plans

Applicant must include a work plan that describes program goals, objectives, activities, timeline, and responsible person for carrying out the objectives/activities. The applicant must include at least a minimum of four of the seven core functions of the IHCIA and other activities listed under the Required, Optional, and Allowable Activities.

Section 2: Program Evaluation

Applicant must define the criteria to be used to evaluate activities listed in the work plan under the Grantee Cooperative Agreement Award Activities. Criteria must include the collection, management, and reporting of established TEC IHS GPRA measures. They must explain the methodology that will be used to determine if the needs identified for the objectives are being met and if the outcomes identified are being achieved and describe how evaluation findings will be disseminated to the IHS, co-funders, and the population served. The evaluation plan must include a logic model (not counted in the page limit) with at least one measurable outcome per required activity. Applicants are strongly encouraged to base their logic model on the Draft Logic Model supplied with this notice.

Part 3: Program Report (Limit—4 pages)

Section 1: Describe Major Accomplishments Over the Last 24 Months

Please identify and describe significant program achievements associated with the delivery of quality health services. Provide a comparison of the actual accomplishments to the goals established for the project period or, if applicable, provide justification for the lack of progress.

Section 2: Describe Major Activities Over the Last 24 Months

Please identify and summarize recent, major project activities related to the work proposed in the last 24 months.

Section 3: Describe Epidemiology Activities Over the Last 5 Years

Please identify and summarize substantial epidemiology center activities conducted over the last five years, especially those you propose to continue.

B. Budget Narrative (Limit—5 pages)

Provide a budget narrative that explains the amounts requested for each line item of the budget from the SF–424A (Budget Information for Non-Construction Programs). The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Be very careful about showing how each item in the ''Other'' category is justified. For subsequent budget years (see Multi-Year Project Requirements in Section V.1. Application Review Information, Evaluation Criteria), the narrative

should highlight the changes from year 1 or clearly indicate that there are no substantive budget changes during the period of performance. 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 email 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 (*Paul.Gettys@ihs.gov*), Acting Director, DGM, by telephone at (301) 443–2114 or (301) 443–5204. Please be sure to contact Mr. Gettys at least ten 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.

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 will be awarded per applicant.

6. Electronic Submission Requirements

All applications must be submitted via *Grants.gov*. Please use the *https://www.Grants.gov* website 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 the applicant cannot submit an application through *Grants.gov*, a waiver must be requested. Prior approval must be requested and obtained from Mr. Paul Gettys, Acting Director, DGM. A written waiver request must be sent to *GrantsPolicy@ihs.gov* with a copy to *Paul.Gettys@ihs.gov.* The waiver request must: (1) Be documented in writing (emails are acceptable) before submitting an application by some other method, and (2) include clear justification for the need to deviate from the required application submission process.

Once the waiver request has been approved, the applicant will receive a confirmation of approval email containing submission instructions. A copy of the written approval must be included with the application that is submitted to the DGM. Applications that are submitted without a copy of the signed waiver from the Acting Director of the DGM will not be reviewed. The Grants Management Officer of the DGM will notify the applicant via email 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, the applicant will receive an automatic acknowledgment from *Grants.gov* that contains a *Grants.gov* tracking number. The IHS will not notify the applicant that the application has been received.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS)

Applicants and grantee organizations are required to obtain a DUNS number and maintain an active registration in the SAM database. The DUNS number is a unique 9-digit identification number provided by D&B that uniquely identifies each entity. The DUNS number is site specific; therefore, each distinct performance site may be assigned a DUNS number. Obtaining a DUNS number is easy, and there is no charge. To obtain a DUNS number, please access the request service through *https://fedgov.dnb.com/webform,* or call (866) 705–5711.

The Federal Funding Accountability and Transparency Act of 2006, as amended (''Transparency Act''), requires all HHS recipients to report information on sub-awards. Accordingly, all IHS grantees must notify potential first-tier sub-recipients that no entity may receive a first-tier sub-award unless the entity has provided its DUNS number to the prime grantee 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.

System for Award Management (SAM)

Organizations that are not registered with SAM must have a DUNS number first, then access the SAM online registration through the SAM home page at *https://www.sam.gov/SAM/* (U.S. organizations will also need to provide an Employer Identification Number from the Internal Revenue Service that may take an additional 2–5 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://www.sam.gov/SAM/.*

Additional information on implementing the Transparency Act, including the specific requirements for DUNS and SAM, are available on the DGM Grants Management, Policy Topics web page: *https://www.ihs.gov/dgm/policytopics/.*

V. Application Review Information

Possible points assigned to each section are noted in parentheses. The 12-page project narrative should include only the first year of activities; information for multi-year projects should be included as an appendix. See ''Multi-year Project Requirements'' at the end of this section for more information. The narrative section

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 understand the project fully. 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

The instructions for preparing the application narrative also constitute the evaluation criteria for reviewing and scoring the application. Points are assigned as follows:

A. Introduction and Need for Assistance (10 points)

a. Describe the applicant's current public health activities including programs or services currently provided, interactions with other public health authorities in the regions (state, local, or Tribal) and how long it has been operating. Specifically describe current epidemiologic capacity and history of support for such activities.

b. Provide a physical location of the TEC and area to be served by the proposed program, including a map (include the map in the attachments) and specifically describe the office space and how it is going to be paid for.

c. Describe the applicant's user population. The applicant must demonstrate AI/AN people will be served and must be substantiated by using documentation describing IHS user populations, U.S. Census Bureau data, clinical catchment data, or any method that is scientifically and epidemiologically valid data.

B. Project Objectives, Work Plan, and Approach (35 points)

a. State in measurable and realistic terms the objectives and appropriate activities to achieve each objective for the projects as listed in the Required, Optional, and Allowable Activities. The work plan needs to include the grantees desired objectives and must demonstrate a minimum of four of the seven TEC core functional areas as outlined in the IHCIA.

b. Identify the expected results, benefits, and outcomes or products to be derived from each objective of the project.

c. Include a work plan for each objective that indicates when the objectives and major activities will be accomplished and who will conduct the activities.

C. Program Evaluation (10 points)

a. Define the criteria to be used to evaluate activities listed in the work plan under the Required, Optional, and Allowable Activities.

b. Explain the methodology that will be used to determine if the needs identified for the objectives are being met and if the outcomes identified are being achieved. Be explicit about how the logic model relates to the objectives and activities. Include the logic model in the appendix.

c. Explain how the organization will participate in cross-organization evaluation activities, as needed.

d. Describe how evaluation findings will be disseminated to stakeholders.

D. Organizational Capabilities, Key Personnel, and Qualifications (10 points)

a. Explain both the management and administrative structure of the organization, including documentation of current certified financial management systems from the Bureau of Indian Affairs, IHS, or a Certified Public Accountant and an updated organizational chart (include in appendix).

b. Describe the ability of the organization to manage a program of the proposed scope.

c. Provide position descriptions and biographical sketches of Key Personnel, including those of consultants or contractors in the Other Attachments form in *Grants.gov*. Position descriptions should very clearly describe each position and its duties, indicating desired qualification and experience requirements related to the project. Resumes should indicate that the proposed staff is qualified to carry out the project activities. Applicants with expertise in epidemiology will receive priority.

d. Applicant must at least have two epidemiologists as part of the proposal.

E. Epidemiology Center Capacity (30 points)

a. Applicant must demonstrate current capacity and successes over time (five years) in providing epidemiology center services to Tribes and Tribal populations in their area.

F. Categorical Budget and Budget Justification (5 points)

a. The five points for Categorical Budget only applies to Year 1. Provide a line item budget and budget narrative for Year 1.

b. Provide a justification by line item in the budget including sufficient cost and other details to facilitate the determination of cost allowance and relevance of these costs to the proposed project. The funds requested should be appropriate and necessary for the scope of the project. Be aware of and incorporate budget limits and requirements listed in the Required, Optional, and Allowable Activities in Section I.

i. IHS recommends that applicants review *https://www.ihs.gov/dper/evaluation/evaluation-policy/* and plan their budget proposals in compliance with the general Evaluation Policy of IHS.

c. If use of consultants or contractors are proposed or anticipated, provide a detailed budget and scope of work that clearly defines the deliverables or outcomes anticipated.

d. If the applicant will be hosting a conference, the applicant must include a separate detailed budget justification and narrative for the conference. The cost categories to be addressed are as follows: (1) Contract/Planner, (2) Meeting Space/Venue, (3) Registration website, (4) Audio Visual, (5) Speakers Fees, (6) Non-Federal Attendee Travel, (7) Registration Fees, and (8) Other (explain in detail and cost breakdown).

e. Applicant is required to submit a line item budget and budget narrative by category for years 2–5 as an appendix to show the five-year plan of the proposal.

Multi-Year Project Requirements

Applications must include a brief project narrative and budget (one additional page per year) addressing the developmental plans for each additional year of the project. This attachment will not count as part of the project narrative or the budget narrative.

Additional documents can be uploaded as Appendix Items in *Grants.gov*.

- Work plan, 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).
- Logic model.
- 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 evaluation criteria. Incomplete applications and applications that are not responsive to the administrative thresholds (budget limit, project period limit) will not be referred to the ORC and will not be funded. The applicant will be notified 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 Office of Public Health Support 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 grant, the terms and conditions of the award, the effective date of the award, and the budget/project period. 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

Cooperative agreements 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-2020-title45-vol1/pdf/CFR-2020-title45-vol1-part75.pdf.*
- Please review all HHS regulatory provisions for Termination at 45 CFR 75.372, at *https://www.ecfr.gov/cgi-bin/retrieveECFR?gp&SID=2970eec67399fab1413ede53d7895d99&mc=true&n=pt45.1.75&r=PART&ty=HTML&se45.1.75_1372#se45.1.75_1372.*

C. Grants Policy:

- HHS Grants Policy Statement, Revised 01/07, at *http://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.

E. Audit Requirements:

- Uniform Administrative Requirements for HHS Awards, ''Audit Requirements,'' at 45 CFR part 75, subpart F.

F. As of August 13, 2020, 2 CFR 200 has been updated to include a prohibition on certain telecommunications and video surveillance services or equipment. This prohibition is described in 2 CFR 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 recipients that request reimbursement of indirect costs (IDC) in their application budget. In accordance with HHS Grants Policy Statement, Part II–27, 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 [*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 (MTDC) 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 non-Federal entity chooses to negotiate for a rate, which the non-Federal entity 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 grantees are negotiated with the Division of Cost Allocation (DCA) 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 the main DGM office at (301) 443–5204.

3. Reporting Requirements

The grantee 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 grant, 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 see the Agency Contacts list in Section VII for the systems contact information.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required semi-annually. The progress reports are due within 30 days after the reporting period ends (specific dates will be listed in the NoA Terms and Conditions). 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 90 days of expiration of the period of performance.

B. Financial Reports

Federal Cash Transaction Reports are due 30 days after the close of every calendar quarter to the Payment Management Services at *https://pms.psc.gov.* Failure to submit timely reports may result in adverse award actions blocking access to funds.

Federal Financial Reports are due 30 days after the end of each budget period, and a final report is due 90 days after the end of the Period of Performance.

Grantees are responsible and accountable for reporting accurate information on all required reports: The Progress Reports, the Federal Cash Transaction Report, and the Federal Financial Report.

C. Data Collection and Reporting

Based on the required activities in Section II, describe how grantee plans to collect data for the proposed project and activities. Identify any type(s) of evaluation(s) that will be used and how you will collaborate with partners to complete any evaluation efforts or data collection. Progress reports will include compilation of quantitative data (*e.g.,* number served; screenings completed) and qualitative or narrative (text) data. Reporting elements should be specific to activities/programs, processes, and outcomes such as performance measures and other data relevant to evaluation outcomes, including intended results (*i.e.,* impact and outcomes). Grantees will be required to collect and submit responses to specific data calls upon request, as well as semi-annual and annual progress reports.

D. Post Conference Grant Reporting

The following requirements were enacted in Section 3003 of the Consolidated Continuing Appropriations Act, 2013, Public Law 113–6, 127 Stat. 198, 435 (2013), and; *Office of Management and Budget Memorandum M–17–08, Amending OMB Memorandum M–12–12:* All HHS/IHS awards containing grants funds allocated for conferences will be required to complete a mandatory post award report for all conferences. Specifically: The total amount of funds provided in this award/cooperative agreement that were spent for ''Conference X,'' must be reported in final detailed actual costs within 15 calendar days of the completion of the conference. Cost categories to address should be: *(1) Contract/Planner, (2) Meeting Space/Venue, (3) Registration website, (4) Audio Visual, (5) Speakers Fees, (6) Non-Federal Attendee Travel, (7) Registration Fees, and (8) Other.*

E. 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 1 70.

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 recipients of Federal grants to report information about first-tier sub-awards and executive compensation under Federal assistance awards.

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 website at *https://www.ihs.gov/dgm/policytopics/.*

F. Compliance With Executive Order 13166 Implementation of Services Accessibility Provisions for All Grant Application Packages and Funding Opportunity Announcements

Recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex. This includes ensuring programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. Please see *https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html* and *http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html.*

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. HHS provides guidance to recipients of FFA on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. Please 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 further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at *https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.*

- Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see *http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.*

- HHS funded health and education programs must be administered in an environment free of sexual harassment. Please see *https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html; https://www2.ed.gov/about/offices/list/ocr/docs/shguide.html;* and *https://www.eeoc.gov/eeoc/publications/fs-sex.cfm.*

- Recipients of FFA must also administer their programs in compliance with applicable Federal religious nondiscrimination laws and applicable Federal conscience protection and associated anti-discrimination laws. Collectively, these laws prohibit exclusion, adverse treatment, coercion, or other discrimination against persons or entities on the basis of their consciences, religious beliefs, or moral convictions. Please see *https://www.hhs.gov/conscience/conscience-protections/index.html* and *https://www.hhs.gov/conscience/religious-freedom/index.html.*

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at *https://www.hhs.gov/ocr/about-us/contact-us/index.html* or call 1–800–368–1019 or TDD 1–800–537–7697.

G. 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 Federal Awardee Performance and Integrity Information System (FAPIIS) at *https://www.fapiis.gov* 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. 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, non-Federal entities (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 $10,000,000 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 a non-Federal entity 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.

Submission is required for all applicants and recipients, in writing, 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: Paul Gettys, Acting Director, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, (Include ''Mandatory Grant Disclosures'' in subject line), Office: (301) 443–5204, Fax: (301) 594–0899, Email: *Paul.Gettys@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, Email: *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 parts 180 & 376).

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to: Lisa C. Neel, MPH, Public Health Advisor, Indian Health Service, Office of Public Health Support, Division of Epidemiology & Disease Prevention, Indian Health Service, 5600 Fishers Lane, Mailstop 09E10D, Rockville, MD 20857, Phone: (301) 443–4305, Email: *lisa.neel@ihs.gov*.

2. Questions on grants management and fiscal matters may be directed to: John Hoffman, Senior Grants Management Specialist, Indian Health Service, Division of Grants Management, 5600 Fishers Lane, Mailstop 09E70, Rockville, MD 20857, Phone: (301) 443–2116, Email: *John.Hoffman@ihs.gov*.

3. Questions on systems matters may be directed to: Paul Gettys, Acting Director, Indian Health Service, Division of Grants Management, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2114; or the DGM main line (301) 443–5204, E-Mail: *Paul.Gettys@ihs.gov*.

VIII. Other Information

The Public Health Service strongly encourages all grant, cooperative agreement and contract recipients 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.

Elizabeth A. Fowler,

Acting Director, Indian Health Service.

[FR Doc. 2021–16281 Filed 7–29–21; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Center for Complementary & Integrative Health; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Center for Complementary and Integrative Health Special Emphasis Panel; Institutional Research Training Grants (IT).

Date: August 24, 2021.

Time: 10:00 a.m. to 12:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Center for Complementary and Integrative, Democracy II, 6707 Democracy Blvd., Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Shiyong Huang, Ph.D., Scientific Review Officer, Office of Scientific Review, Division of Extramural Activities, NCCIH/NIH, 6707 Democracy Boulevard, Suite 401, Bethesda, MD 20817, *shiyong.huang@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.213, Research and Training in Complementary and Alternative Medicine, National Institutes of Health, HHS)

Dated: July 26, 2021.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2021–16261 Filed 7–29–21; 8:45 am]

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