manages the close-out process of negotiated and simplified acquisition actions and other related actions.

Section RJ.30 Delegation of Authority

All delegations of authority and re-delegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further redelegation, if allowed, provided they are consistent with this reorganization.

This reorganization is effective upon date of signature.

(Authority: 44 U.S.C. 3101)

Carole Johnson,

Administrator.

[FR Doc. 2024–05871 Filed 3–19–24; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Native Public Health Resilience

Announcement Type: New.

Funding Announcement Number: HHS–2024–IHS–NPHR–0001.

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

Key Dates

Application Deadline Date: May 14, 2024.

Earliest Anticipated Start Date: July 1, 2024.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for grants for Native Public Health Resilience. This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the American Rescue Plan Act, Public Law 117–2, 135 Stat. 42 (2021). The Assistance Listings section of *SAM.gov* (*https://sam.gov/content/home*) describes this program under 93.231.

Background

The IHS, an agency within the Department of Health and Human Services (HHS), is the principal Federal health care provider and health advocate for American Indian and Alaska Native (AI/AN) people, and its goal is to raise their health status to the highest possible level. One core strategic goal of the IHS is to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. The Division of Epidemiology and Disease Prevention (DEDP) provides and supports applied public health and epidemiologic services to further the overall IHS mission. Through the provision of direct services and key partnerships, our collective work strives to improve overall awareness, understanding, and mitigation of priority health conditions negatively impacting AI/AN populations. The American Rescue Plan Act appropriated funding to IHS for purposes that include enhancing public health capacity.

Purpose

The purpose of this program is to enhance Tribes', Tribal organizations', and Urban Indian Organizations' capacity to implement core Public Health functions, services, and activities, and to further develop and improve their Public Health management capabilities.

As part of the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, this program seeks to build on and strengthen community resilience by supporting wider access to the 10 Essential Public Health Services (EPHS) [1] in Indian Country, a framework designed to offer all people a fair and just opportunity to achieve optimal health and well-being. For more information on the EPHS, please visit *https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.* The framework of the EPHS has served as a guide to the public health field since 1994 and describes the public health activities that all communities should undertake, including, (1) monitor health status to identify and solve community health problems, and (2) Diagnose and investigate health problems and health hazards in the community. The EPHS framework was revised in 2020 with an emphasis on equity and reflects current and future priorities for public health practice. The EPHS have been included in the HHS Healthy People initiatives since 2010, when the initiative first included a focus area of Public Health Infrastructure with the goal to ''ensure that Federal, Tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively.''

The IHS is offering competitive awards to assist applicants in enhancing EPHS implementation within established public health programs serving AI/AN communities.

The 10 EPHS include:

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve health.
5. Create, champion, and implement policies, plans, and laws that impact health.
6. Use legal and regulatory actions designed to improve and protect the public's health.
7. Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy. This Service description has been adapted to better align with the anticipated scope of intended recipient jurisdictions.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public health.

Required and Allowable Activities

The following activities are required under this funding announcement. For more guidance on the proposal requirements, please see Project Narrative, below.

Required Activities

Select and implement one or more new EPHS or implement significant expansion of existing EPHS to support Tribal communities throughout the planned project period. Recipients are required to offer new or expanded EPHS activities through the award's period of performance. Applicants must address at least two core elements of their selected EPHS in their proposal, as described below.

EPHS 1: Assess and monitor population health status, factors that influence health, and community needs and assets.

Core elements:

a. Maintaining an ongoing understanding of health in the jurisdiction by collecting, monitoring, and analyzing data on health and factors that influence health to identify threats,

[1] For the full details of each EPHS, please review the resources posted at: *https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.*

patterns, and emerging issues, with a particular emphasis on disproportionately affected populations.

b. Using data and information to determine the root causes of health disparities and inequities.

c. Working with the community to understand health status, needs, assets, key influences, and narrative.

d. Collaborating and facilitating data sharing with partners, including multisector partners.

e. Using innovative technologies, data collection methods, and data sets.

f. Utilizing various methods and technology to interpret and communicate data to diverse audiences.

g. Analyzing and using disaggregated data (*e.g.,* by race) to track issues and inform equitable action.

h. Engaging community members as experts and key partners.

EPHS 2: Investigate, diagnose, and address health problems and hazards affecting the population.

Core elements:

a. Anticipating, preventing, and mitigating emerging health threats through epidemiologic identification.

b. Monitoring real-time health status and identifying patterns to develop strategies to address chronic diseases and injuries.

c. Using real-time data to identify and respond to acute outbreaks, emergencies, and other health hazards.

d. Using public health laboratory capabilities and modern technology to conduct rapid screening and high-volume testing.

e. Analyzing and utilizing inputs from multiple sectors and sources to consider social, economic, and environmental root causes of health status.

f. Identifying, analyzing, and distributing information from new, big, and real-time data sources.

EPHS 3: Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.

Core elements:

a. Developing and disseminating accessible health information and resources, including through collaboration with multi-sector partners.

b. Communicating with accuracy and necessary speed.

c. Using appropriate communications channels (*e.g.,* social media, peer-to-peer networks, mass media, and other channels) to effectively reach the intended populations.

d. Developing and deploying culturally and linguistically appropriate and relevant communications and educational resources, which includes working with stakeholders and influencers in the community to create effective and culturally resonant materials.

e. Employing the principles of risk communication, health literacy, and health education to inform the public, when appropriate.

f. Actively engaging in two-way communication to build trust with populations served and ensure accuracy and effectiveness of prevention and health promotion strategies.

g. Ensuring public health communications and education efforts are asset-based when appropriate and do not reinforce narratives that are damaging to disproportionately affected populations.

EPHS 4: Strengthen, support, and mobilize communities and partnerships to improve health.

Core elements:

a. Convening and facilitating multisector partnerships and coalitions that include sectors that influence health (*e.g.,* planning, transportation, housing, education, etc.).

b. Fostering and building genuine, strengths-based relationships with a diverse group of partners that reflect the community and the population.

c. Authentically engaging with community members and organizations to develop public health solutions.

d. Learning from, and supporting, existing community partnerships and contributing public health expertise.

EPHS 5: Create, champion, and implement policies, plans, and laws that impact health.

Core elements:

a. Developing and championing policies, plans, and laws that guide the practice of public health.

b. Examining and improving existing policies, plans, and laws to correct historical injustices.

c. Ensuring that policies, plans, and laws provide a fair and just opportunity for all to achieve optimal health.

d. Providing input into policies, plans, and laws to ensure that health impact is considered.

e. Continuously monitoring and developing policies, plans, and laws that improve public health and preparedness and strengthen community resilience.

f. Collaborating with all partners, including multi-sector partners, to develop and support policies, plans, and laws.

g. Working across partners and with the community to systematically and continuously develop and implement health improvement strategies and plans, and evaluate and improve those plans.

EPHS 6: Use legal and regulatory actions designed to improve and protect the public's health.

Core elements:

a. Ensuring that applicable laws are equitably applied to protect the public's health.

b. Conducting enforcement activities that may include, but are not limited to sanitary codes, especially in the food industry; full protection of drinking water supplies; and timely follow-up on hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings.

c. Licensing and monitoring the quality of healthcare services (*e.g.,* laboratory, nursing homes, and home healthcare).

d. Reviewing new drug, biologic, and medical device applications.

e. Licensing and credentialing the healthcare workforce.

f. Including health considerations in laws from other sectors (*e.g.,* zoning).

EPHS 7: Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.

Core elements:

a. Connecting the population to needed health and social services that support the whole person, including preventive services.

b. Ensuring access to high-quality and cost-effective healthcare and social services, including behavioral and mental health services, that are culturally and linguistically appropriate.

c. Engaging health delivery systems to assess and address gaps and barriers in accessing needed health services, including behavioral and mental health.

d. Addressing and removing barriers to care.

e. Building relationships with payers and healthcare providers, including the sharing of data across partners to foster health and well-being.

f. Contributing to the development of a competent healthcare workforce.

EPHS 8: Build and support a diverse and skilled public health workforce

Core elements:

a. Providing education and training that encompasses a spectrum of public health competencies, including technical, strategic, and leadership skills.

b. Ensuring that the public health workforce is the appropriate size to meet the public's needs.

c. Building a culturally competent public health workforce and leadership that reflects the community and practices cultural humility.

d. Incorporating public health principles in non-public health curricula.

e. Cultivating and building active partnerships with academia and other

professional training programs and schools to assure community-relevant learning experiences for all learners.

f. Promoting a culture of lifelong learning in public health.

g. Building a pipeline of future public health practitioners.

h. Fostering leadership skills at all levels.

EPHS 9: Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.

Core elements:

a. Building and fostering a culture of quality in public health organizations and activities.

b. Linking public health research with public health practice.

c. Using research, evidence, practice-based insights, and other forms of information to inform decision-making.

d. Contributing to the evidence base of effective public health practice.

e. Evaluating services, policies, plans, and laws continuously to ensure they are contributing to health and not creating undue harm.

f. Establishing and using engagement and decision-making structures to work with the community in all stages of research.

g. Valuing and using qualitative, quantitative, and lived experience as data and information to inform decision-making.

EPHS 10: Build and maintain a strong organizational infrastructure for public health.

Core elements:

a. Developing an understanding of the broader organizational infrastructures and roles that support the entire public health system in a jurisdiction (*e.g.,* government agencies, elected officials, and non-governmental organizations).

b. Ensuring that appropriate, needed resources are allocated equitably for the public's health.

c. Exhibiting effective and ethical leadership, decision-making, and governance.

d. Managing financial and human resources effectively.

e. Employing communications and strategic planning capacities and skills.

f. Having robust information technology services that are current and meet privacy and security standards.

g. Being accountable, transparent, and inclusive with all partners and the community in all aspects of practice.

Allowable Activities

Allowable costs and activities must align with the 10 EPHS. Additional activities that complement but are not explicitly captured within the defined core elements are allowable but should be clearly associated with the selected EPHS.

II. Award Information

Funding Instrument—Grant

Estimated Funds Available

The total funding identified for fiscal year (FY) 2024 is approximately $6,000,000. Individual award amounts for the first budget year are anticipated to be between $300,000 and $400,000. The funding available for competing and subsequent continuation awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. The IHS is under no obligation to make awards that are selected for funding under this announcement.

Anticipated Number of Awards

The IHS anticipates issuing approximately 15 awards under this program announcement.

Period of Performance

The period of performance is for 3 years.

III. Eligibility Information

1. Eligibility

To be eligible for this funding opportunity applicant must be one of the following, as defined by 25 U.S.C. 1603:

- A federally recognized Indian Tribe as defined by 25 U.S.C. 1603(14). The term ''Indian Tribe'' means any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation, as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 *et seq.*], which is recognized as eligible for the special programs and services provided by the United States (U.S.) to Indians because of their status as Indians.
- A Tribal organization as defined by 25 U.S.C. 1603(26). The term ''Tribal organization'' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304(l)): ''Tribal organization'' means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: provided that, in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant. Applicant shall submit letters of support and/or Tribal Resolutions from the Tribes to be served.
- An Urban Indian organization, as defined by 25 U.S.C. 1603(29). The term ''Urban Indian organization'' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a). Applicants must provide proof of nonprofit status with the application, *e.g.,* 501(c)(3). Each awardee shall provide services under this award only to eligible Urban Indians living within the urban center in which the Urban Indian Organization (UIO) is situated.

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

2. Additional Information on Eligibility

The IHS does not fund concurrent projects. Specifically, an applicant may not be awarded under both this opportunity and the Native Public Health Resilience Planning opportunity (number HHS–2024–IHS–NPHRP–0001). Applications on behalf of individuals (including sole proprietorships) and foreign organizations are not eligible and will be disqualified from competitive review and funding under this funding opportunity.

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

3. Cost Sharing or Matching

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

4. Other Requirements

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

be reviewed. The DGM will notify the applicant.

Additional Required Documentation

Tribal Resolution

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

Applicants organized with a governing structure other than a Tribal council must submit an equivalent document commensurate with their governing organization. Please include documentation explaining and substantiating your organization's governing structure.

Proof of Nonprofit Status

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

IV. Application and Submission Information

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

1. Obtaining Application Materials

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

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

2. Content and Form Application Submission

Mandatory documents for all applications are listed below. An application is incomplete if any of the listed mandatory documents are missing. Incomplete applications will not be reviewed.

- *Application forms:*

1. SF–424, Application for Federal Assistance.

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

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

4. Project Abstract Summary form.

- Project Narrative (not to exceed 15 pages). See Section IV.2.A, Project Narrative for instructions.
- Budget Narrative (not to exceed 5 pages). See Section IV.2.B, Budget Narrative for instructions.
- One-page Work Plan Chart.
- Logic Model (Included as an attachment, not in the narrative page limit).
- Biographical sketches for all Key Personnel.
- Contractor/Consultant resumes or qualifications and scope of work.
- Certification Regarding Lobbying (GG-Lobbying Form).

The documents listed here may be required. Please read this list carefully.

- Tribal Resolution(s) as described in Section III, Eligibility.
- Letters of Support from organization's Board of Directors, if applicable.
- 501(c)(3) Certificate, if applicable.
- Disclosure of Lobbying Activities (SF–LLL), if applicant conducts reportable lobbying.
- Copy of current Negotiated Indirect Cost (IDC) rate agreement (required in order to receive IDC).
- 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://facdissem.census.gov/.*

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

- 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).
- Organizational chart.
- Map of area identifying project location(s).
- Additional documents to support narrative (for example, data tables and key news articles).

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 15 pages and must: (1) have consecutively numbered pages; (2) use black font 12 points or larger (applicants may use 10 point font for tables); (3) be single-spaced; and (4) be formatted to fit standard letter paper (8½ x 11 inches). Do not combine this document with any others.

Be sure to succinctly answer all questions listed under the evaluation criteria (refer to Section V.1, Evaluation Criteria), and place all responses and required information in the correct section noted below or they will not be considered or scored. If the narrative exceeds the overall page limit, the reviewers will be directed to ignore any content beyond the page limit. The 15-page limit for the project narrative does not include the work plan, standard forms, Tribal Resolutions, budget, budget narratives, and/or other items. Page limits for each section within the project narrative are guidelines, not hard limits.

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

Part 1: Program Information (Limit—3 Pages)

Section 1: Introduction and Need for Assistance

Briefly describe the population that will be served, including the estimated population size, and geographic reach.

Briefly describe the public health problem your proposed project will address, including community and/or organizational strengths, and any existing capacities it would build upon to foster success. This section should include a description of the needs and strengths of the population. Clearly identify any existing public health system and unmet community needs.

Part 2: Program Planning and Evaluation (Limit—10 Pages)

Section 1: Program Planning

Identify one or more new EPHS or implement significant expansion of existing EPHS to support Tribal communities throughout the planned project period. Applications must address at least two core elements of their selected EPHS in their proposal, as described above. If additional activities are proposed, explicitly link each to at least one of the 10 EPHS. Applicants must include a clear description of how the selected EPHS will address the problem described in Part 1, Section 1: Needs and select existing evidence-based strategies that meet those needs. Part 1, Section 1: Needs, or describe novel strategies that will be evaluated over the course of the project period. Applicants are encouraged to consider using or adapting strategies identified in Healthy People 2030 at *https://health.gov/healthypeople,* the Foundational Public Health Services Framework at *https://phnci.org/transformation/fphs,* Public Health Accreditation Standards and Measures at *https://phaboard.org/,* and the HHS Equity Action Plan at *https://www.hhs.gov/sites/default/files/hhs-equity-action-plan.pdf.*

The Program Plan should include details of the applicant's plan to address the project objectives. The work plan should include details of the applicant's plan to address each required activity.

Section 2: Program Evaluation

The evaluation plan should identify how the applicant plans to measure program progress, outcomes, success, and opportunities for refinement. List measurable and attainable goals with explicit timelines that detail expectation of findings. Applicants must clearly identify the outcomes they expect to achieve by the end of the period of performance, as identified in the logic model. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (*e.g.,* increase, decrease).

Part 3: Program Report (Limit—2 Pages)

Describe your organization's significant program activities and accomplishments over the past 5 years, if any, in performing activities related to the proposed project.

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

3. Submission Dates and Times

Applications must be submitted through *Grants.gov* by 11:59 p.m. Eastern Time on the Application Deadline Date. Any application received after the application deadline will not be accepted for review. *Grants.gov* will notify the applicant via 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, Deputy Director, DGM, by email at *DGM@ihs.gov.* Please be sure to contact Mr. Gettys at least 10 days prior to the application deadline. Please do not contact the DGM until you have received a *Grants.gov* tracking number. In the event you are not able to obtain a tracking number, contact the DGM as soon as possible by email at *DGM@ihs.gov.*

The IHS will not acknowledge receipt of applications.

4. Intergovernmental Review

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

5. Funding Restrictions

- Pre-award costs are allowable up to 90 days before the start date of the award provided the costs are otherwise allowable if awarded. Pre-award costs are incurred at the risk of the applicant.
- The available funds are inclusive of direct and indirect costs.
- Only one grant may be awarded per applicant.
- The purchase of food (*i.e.,* as supplies, for meetings or events, etc.) is an allowable cost with this grant funding and should be included in the budget/budget justification where there is a clear relationship between the chosen intervention and food (such as community gardens, traditional food, promotion activities, etc.).

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. The IHS will not accept any applications submitted through any means outside of *Grants.gov* without an approved waiver.

If you cannot submit an application through *Grants.gov,* you must request a waiver prior to the application due date. You must submit your waiver request by email to *DGM@ihs.gov.* Your waiver request must include clear justification for the need to deviate from the required application submission process.

If the DGM approves your waiver request, you will receive a confirmation of approval email containing submission instructions. You must include a copy of the written approval with the application submitted to the DGM. Applications that do not include a copy of the waiver approval from 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 number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- If you experience technical challenges while submitting your application, please contact *Grants.gov*

Customer Support (see contact information at *https://www.Grants.gov*).

- Upon contacting *Grants.gov,* obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.
- Applicants are strongly encouraged not to wait until the deadline date to begin the application process through *Grants.gov* as the registration process for SAM and *Grants.gov* could take up to 20 working days.
- Please follow the instructions on *Grants.gov* to include additional documentation that may be requested by this funding announcement.
- Applicants must comply with any page limits described in this funding announcement.
- After submitting the application, you will receive an automatic acknowledgment from *Grants.gov* that contains a *Grants.gov* tracking number.

The IHS will not notify you that the application has been received.

System for Award Management

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

Unique Entity Identifier

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

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

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

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

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

V. Application Review Information

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

1. Evaluation Criteria

A. Introduction and Need for Assistance (10 Points)

Proposal should succinctly describe the population that will be served, including the estimated population size, and geographic reach.

Proposals will be scored on how adequately they describe the public health problem they propose to address, including community and/or organizational strengths and any existing capacities it would build upon to foster success.

B. Program Planning (30 Points)

Adequately describe the proposed project for implementing activities within the targeted community. The Program Plan should include details of the applicant's plan to address the project objectives. The narrative should provide sufficient details of the applicant's plan to address each required activity. Applicants must link their chosen EPHS with the problem described in Part 1, Section 1: Needs and plan to implement existing evidence-based strategies that meet those needs or describe novel strategies that will be evaluated over the course of the project period.

C. Program Evaluation (30 Points)

The evaluation plan will be scored on the feasibility of appropriately measuring program implementation. Reviewers will focus on whether goals are measurable, attainable, and related to the outcomes proposers expect to achieve by the end of the period of performance, as identified in their logic model.

D. Program Report, Organizational Capabilities, Key Personnel, and Qualifications (10 Points)

Provide a detailed biographical sketch of each member of key personnel assigned to carry out the objectives of the program plan. The sketches should detail the qualifications and expertise of identified staff.

E. Categorical Budget and Budget Narrative (20 Points)

Provide a detailed budget of each expenditure directly related to the identified program activities. Ensure that allowable activities are identified separately from required activities.

2. Review and Selection

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

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

3. Notifications of Disposition

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

A. Award Notices for Funded Applications

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

B. Approved but Unfunded Applications

Approved applications not funded due to lack of available funds will be held for 1 year. If funding becomes available during the course of the year, the application may be reconsidered.

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

VI. Award Administration Information

1. Administrative Requirements

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

A. The criteria as outlined in this program announcement.

B. Administrative Regulations for Grants:

- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards currently in effect or implemented during the period of award, other Department regulations and policies in effect at the time of award, and applicable statutory provisions. At the time of publication, this includes 45 CFR part 75, at *https://www.govinfo.gov/content/pkg/CFR-2022-title45-vol1/pdf/CFR-2022-title45-vol1-part75.pdf.*
- If you receive an award, HHS may terminate it if any of the conditions in 2 CFR 200.340(a)(1)–(4) are met. Please review all HHS regulatory provisions for Termination at 2 CFR 200.340, at the time of this publication located at *https://www.govinfo.gov/content/pkg/CFR-2023-title2-vol1/pdf/CFR-2023-title2-vol1-sec200-340.pdf.* No other termination conditions apply.

C. Grants Policy:

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

D. Cost Principles:

- Uniform Administrative Requirements for HHS Awards, ''Cost Principles,'' at 45 CFR part 75 subpart E, at the time of this publication located at *https://www.govinfo.gov/content/pkg/CFR-2022-title45-vol1/pdf/CFR-2022-title45-vol1-part75-subpartE.pdf.*

E. Audit Requirements:

- Uniform Administrative Requirements for HHS Awards, ''Audit Requirements,'' at 45 CFR part 75 subpart F, at the time of this publication located at *https://www.govinfo.gov/content/pkg/CFR-2022-title45-vol1/pdf/CFR-2022-title45-vol1-part75-subpartF.pdf.*

F. As of August 13, 2020, 2 CFR part 200 was updated to include a prohibition on certain telecommunications and video surveillance services or equipment. This prohibition is described in 2 CFR 200.216, at the time of this publication located at *https://www.govinfo.gov/content/pkg/CFR-2023-title2-vol1/pdf/CFR-2023-title2-vol1-sec200-216.pdf.* 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 IDC in their application budget. In accordance with HHS Grants Policy Statement, Part II–27, the IHS requires applicants to obtain a current IDC rate agreement and submit it to the DGM prior to the DGM issuing an award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate agreement is not on file with the DGM at the time of award, the IDC portion of the budget will be restricted. The restrictions remain in place until the current rate agreement is provided to the DGM.

Per 2 CFR 200.414(f) Indirect (F&A) costs, found at *https://www.govinfo.gov/content/pkg/CFR-2023-title2-vol1/pdf/CFR-2023-title2-vol1-sec200-414.pdf.* Electing to charge a de minimis rate of 10 percent can be used by applicants that have 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 award.

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 recipients are negotiated with the Division of Cost Allocation at *https://rates.psc.gov/* or the Department of the Interior (Interior Business Center) at *https://ibc.doi.gov/ICS/tribal.* For questions regarding the indirect cost policy, please write to *DGM@ihs.gov.*

3. Reporting Requirements

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

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required 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 120 days of expiration of the period of performance.

B. Financial Reports

Federal Financial Reports are due 90 days after the end of each budget period, and a final report is due 120 days after the end of the period of performance.

Recipients are responsible and accountable for reporting accurate information on all required reports: the Progress Reports and the Federal Financial Report.

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

C. Data Collection and Reporting

Reporting for recipients will be required semi-annually (two progress reports per year).

Recipients will track the implementation of strategies and activities and determine the progress made in achieving outcomes based on their selected evaluation plan elements.

D. Federal Sub-Award Reporting System (FSRS)

This award may be subject to the Transparency Act sub-award and executive compensation reporting requirements of 2 CFR part 170.

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

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

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

E. Non-Discrimination Legal Requirements for Recipients of Federal Financial Assistance

• If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in *SAM.gov.* You must also submit an Assurance of Compliance (HHS–690). To learn more, see *https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html.* Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by Federal law to individuals eligible for benefits and services from the IHS.

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

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

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

Mandatory Disclosure Requirements

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

All applicants and recipients must disclose in writing, in a timely manner, to the IHS and to the HHS Office of Inspector General all information related to violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. 45 CFR 75.113.

Disclosures must be sent in writing to:

U.S. Department of Health and Human Services, Indian Health Service, Division of Grants Management, ATTN: Marsha Brookins, Director, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857 (Include ''Mandatory Grant Disclosures'' in subject line), Office: (301) 443–5204, Fax: (301) 594–0899, Email: *DGM@ihs.gov*.

AND

U.S. Department of Health and Human Services, Office of Inspector General, ATTN: Mandatory Grant Disclosures, Intake Coordinator, 330 Independence Avenue SW, Cohen Building, Room 5527, Washington, DC 20201, URL: *https://oig.hhs.gov/fraud/report-fraud/* (Include ''Mandatory Grant Disclosures'' in subject line), Fax: (202) 205–0604 (Include ''Mandatory Grant Disclosures'' in subject line) or 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 part 180 and 2 CFR part 376).

VII. Agency Contacts

1. Questions on the program matters may be directed to: Lisa Neel, Public Health Advisor, Office of Public Health Support, 5600 Fishers Lane, Rockville, MD 20852, Phone: (301) 443–4305, Email: *lisa.neel@ihs.gov*.

2. Questions on grants management and fiscal matters may be directed to: Indian Health Service, Division of Grants Management, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Email: *DGM@ihs.gov*.

3. For technical assistance with *Grants.gov,* please contact the *Grants.gov* help desk at (800) 518–4726, or by email at *support@grants.gov.*

4. For technical assistance with GrantSolutions, please contact the GrantSolutions help desk at (866) 577–0771, or by email at *help@grantsolutions.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.

Roselyn Tso,

Director, Indian Health Service.

Sample Logic Model for the 10 Essential Public Health Services Implementation Proposals

Background

The 10 Essential Public Health Services (EPHS) describe the public health activities that all communities should undertake. For the past 25 years, the EPHS have served as a well-recognized framework for carrying out the mission of public health. The EPHS framework was originally released in 1994 and more recently updated in 2020. The revised version is intended to bring the framework in line with current and future public health practice.

For an implementation tool kit, please see the Public Health National Center for Innovations. 10 Essential Public Health Services Toolkit. September 9, 2020. *ph.phnci.net/10ephs.*

Resources/inputs	Activity example	Output example	Outcomes example
1. Assess and monitor population health status, factors that influence health, and community needs and assets			
Identified via proposal	a. Begin and/or maintain an ongoing understanding of health in the population by collecting, monitoring, and analyzing data on health and factors that influence health to identify threats, patterns, and emerging issues.	Number of internal and external reports on the selection and use or adaptation of health data sources.	Increased program capacity to describe the health of the population served. Increased program capacity to communicate the root causes of health disparities in the service population.
Identified via proposal	b. Work with the community to understand health status, needs, assets, and key influences. Include social determinants of health measures when assessing health risks and outcomes.	Number of in-person and virtual outreach events to form connections with community members on health status, needs, assets, and key influences.	Increased program capacity to describe the health knowledge, attitudes, and beliefs of the population served.
Identified via proposal	c. Engage community members as experts and key partners.	Number of completed community-based participatory research (CBPR)-informed events to engage community members and community organizations in program planning and implementation.	Increased local participation in program planning and implementation.
2. Investigate, diagnose, and address health problems and hazards affecting the population			
Identified via proposal	a. Increase access to public health laboratory capabilities to conduct rapid screening and high-volume testing.	Number of completed activities to implement the ''Competency Guidelines for Public Health Laboratory Professionals'' in a Tribal laboratory. Number of formal agreements with existing public health laboratories.	Increased rapid screening and high-volume testing in the service population.
Identified via proposal	b. Monitor real-time health status and identify patterns to develop strategies to address chronic disease and injuries.	Number of internal and external reports on the selection and use or adaptation of data benchmarks.	Increased program capacity to document and describe the health of the service population.
Identified via proposal	c. Use real-time data to identify and respond to acute outbreaks, emergencies, and other health hazards.	Number of completed action plans to stand up a rapid response to outbreaks, emergencies, and other health hazards.	Increased number of active data-sharing agreements to support real-time data access, analysis, and action.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it			
Identified via proposal	a. Develop and deploy culturally and linguistically appropriate and relevant communications and educational resources, working with community influencers to create effective and culturally resonant materials.	Number of health communication campaigns using and reporting the reach of multiple channels, including mass media.	Increase in Health communication campaigns that apply integrated strategies to deliver messages that aim to affect people's health behaviors.
Identified via proposal	b. Actively engage in two-way communication to build trust with populations served and ensure accuracy and effectiveness of prevention and health promotion strategies.	Number of completed community-based participatory research (CBPR)-informed events to engage community members and community organizations in program planning and implementation.	Increased local participation in prevention and health promotion planning and implementation.
Identified via proposal	c. Ensure public health communication and education efforts are asset-based when appropriate and do not reinforce narratives that are damaging to disproportionately affected populations.	Number of public health communication and education campaigns that are asset-based and do not reinforce narratives that are damaging to the service population.	Increased public health communication and education programs with positive and affirming messages.
4. Strengthen, support, and mobilize communities and partnerships to improve health			
Identified via proposal	a. Convene and facilitate multi-sector partnerships and coalitions that include sectors that influence health (planning, transportation, housing, education, etc.).	Number of formal collaborations across local services to host and teach seasonal cultural and traditional practices that support health and wellness.	Increased consumption of healthy traditional foods and/or increased physical activity in communities.
Identified via proposal	b. Foster and build genuine, strengths-based relationships with a diverse group of partners that reflect the community and the population.	Use community-based participatory research (CBPR) methods to engage community members and community organizations in program planning and implementation.	Increased local participation in program planning and implementation.

Resources/inputs	Activity example	Output example	Outcomes example
Identified via proposal	c. Authentically engage with community members and organizations to develop public health solutions.	Number of completed community-based participatory research (CBPR)-informed events to engage community members and community organizations in program planning and implementation.	Increased local participation in program planning and implementation.
5. Create, champion, and implement policies, plans, and laws that impact health			
Identified via proposal	a. Provide input into policies, plans, and laws to ensure that health impact is considered and addressed.	Number of laws, policies, and related resources that ultimately accommodate health implications and/or promote health.	Increased consideration for health protection when writing policies, plans, and laws in your tribal government.
Identified via proposal	b. Assess health impacts of policies, plans, and laws.	Number of completed reviews of law and policy resources related to tribal public health for applicability to the policies, plans, and laws in your tribal government.	Increased advocacy for health protection when writing policies, plans, and laws in your tribal government.
Identified via proposal	c. Monitor and develop policies, plans, and laws that improve public health and preparedness and strengthen community resilience.	Number of completed reviews of law and policy resources related to tribal public health for applicability to the policies, plans, and laws in your tribal government. Number of new or amended policies, plans, and laws. Number of adapted Health Improvement Plans in the service community.	Increase in community resilience measures such as educational access, households without reliable transportation, hospital capacity, or presence of civic and social organizations.
6. Utilize legal and regulatory actions designed to improve and protect the public's health			
Identified via proposal	a. Conduct enforcement activities that may include, but are not limited to sanitary codes, especially in the food industry; full protection of drinking water supplies; and timely follow-up on hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings.	Number of completed reviews of Tribal Laws Related to Occupational Safety and Health.	Reduction in preventable injuries and exposure-related diseases identified in occupational and community settings.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy			
Identified via proposal	a. Connect the population to needed health and social services that support the whole person, including preventive services.	Number of activities implementing the evidence-based practices in The Healthy Brain Initiative Road Map for Indian Country.	Increased discussion about dementia and caregiving within tribal communities. Increased use of a public health approach to dementia and associated caregiving.
Identified via proposal	b. Engage health delivery systems to assess and address gaps and barriers in accessing needed health services, including behavioral and mental health.	Number of persons needing alcohol and/or illicit drug treatment who received specialty treatment for a substance use problem in the past year.	Reduce gaps and barriers in accessing needed health services, including behavioral and mental health.
8. Build and support a diverse and skilled public health workforce			
Identified via proposal	a. Build a culturally competent public health workforce and leadership that reflects the community and practices cultural humility.	Number of programs using core competencies for public health in continuing education planning.	Increase in public health professionals using Core Competencies for Public Health in their work.
Identified via proposal	b. Incorporate public health principles in non-public health curricula.	Number of formal collaborations across local services to host and teach seasonal cultural and traditional practices that support health and wellness.	Increased consumption of healthy traditional foods and/or increased physical activity in communities.
Identified via proposal	c. Cultivate and build active partnerships with academia and other professional training programs and schools to assure community-relevant learning experiences for all learners.	Number of culturally-informed training, educational materials, and process evaluation tools available to service population.	Increased dissemination or development of culturally-informed training, educational materials, and process evaluation tools that build workforce capacity.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement			
Identified via proposal	a. Contribute to the evidence base of effective public health practice.	Number of reports, journal articles, oral histories, and presentations on public health practice evaluations and program outcomes.	Increased inclusion of Tribal contexts in the public health evidence base to support future continuous quality improvement.
Identified via proposal	b. Establish and use engagement and decision-making structures to work with the community in all stages of Public Health research.	Number of events using best practices in planning, designing, and delivering virtual events with the service population.	Increase in the use of innovative public health functions.
Identified via proposal	c. Value and use qualitative, quantitative, and lived experience as data and information to inform decision-making.	Number of qualitative data analyses, inclusive of a wide range of perspectives from the service population.	Increase in decision-making that includes a range of perspectives and lived experiences in the service population.
10. Build and maintain a strong organizational infrastructure for public health			
Identified via proposal	a. Develop an understanding of the broader organizational infrastructures and roles that support the entire public health system in your jurisdiction.	Number of assessments of organizational infrastructure and roles in the jurisdiction.	Increased capacity to implement public health programs and services to address prioritized public health problems in AI/AN communities.

Resources/inputs	Activity example	Output example	Outcomes example
Identified via proposal	b. Develop and/or maintain robust information technology services in your jurisdiction's public health program. They should be current and meet privacy and security standards.	Number of program plans using informatics in public health (Healthy people 2030: Public Health Infrastructure.)	Increased capacity to implement public health programs and services to address public health priorities in AI/AN communities.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Native Public Health Resilience Planning

Announcement Type: New.
Funding Announcement Number: HHS–2024–IHS–NPHRP–0001.
Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.231.

Key Dates

Application Deadline Date: May 14, 2024.
Earliest Anticipated Start Date: July 1, 2024.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for grants for Native Public Health Resilience Planning. This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the American Rescue Plan Act, Public Law 117–2, 135 Stat. 42 (2021). The Assistance Listings section of *SAM.gov* (*https://sam.gov/content/home*) describes this program under 93.231.

Background

The IHS, an agency within the Department of Health and Human Services (HHS), is the principal Federal health care provider and health advocate for American Indian and Alaska Native (AI/AN) people, and its goal is to raise their health status to the highest possible level. One core strategic goal of the IHS is to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. The Division of Epidemiology and Disease Prevention (DEDP) provides and supports applied public health and epidemiologic services to further the overall IHS mission. Through the provision of direct services and key partnerships, our collective work strives to improve overall awareness, understanding, and mitigation of priority health conditions negatively impacting AI/AN populations. The American Rescue Plan Act appropriated funding to IHS for purposes that include enhancing public health capacity.

Purpose

The purpose of this program is to assist applicants to establish goals and performance measures, assess their current management capacity, and determine if developing a Public Health program is practicable. Specifically, programs should assess the availability and feasibility of the 10 Essential Public Health Services (EPHS), described further below.

As part of the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, this program seeks to build on and strengthen community resilience by supporting wider access to the 10 EPHS in Indian Country, a framework designed to offer all people a fair and just opportunity to achieve optimal health and well-being. For more information on the EPHS, please visit *https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.* The framework of the EPHS has served as a guide to the public health field since 1994, and describes the public health activities that all communities should undertake, including, (1) monitor health status to identify and solve community health problems, and (2) Diagnose and investigate health problems and health hazards in the community.

The EPHS framework was revised in 2020 with an emphasis on equity and reflects current and future public health practice goals. The EPHS have been included in the HHS Healthy People initiatives since 2010, when the initiative first included a focus area of Public Health Infrastructure with the goal to ''ensure that Federal, Tribal, state, and local health agencies have the infrastructure to provide essential public health services effectively.''

The 10 EPHS include:

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve health.
5. Create, champion, and implement policies, plans, and laws that impact health.
6. Use legal and regulatory actions designed to improve and protect the public's health.
7. Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy. This Service description has been adapted to better align with the anticipated scope of intended recipient jurisdictions.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public health.

Required and Allowable Activities

The following activities are required for awardees under this funding announcement. For more guidance on the proposal requirements, please see Project Narrative, below.

Required Activities

1. Assess community-specific public health needs.
2. Conduct an assessment to identify current EPHS activities and/or priorities.
3. Identify gaps in EPHS functions currently available within supported communities.
4. Quantify costs for establishing priority EPHS functions.
5. Assess feasibility of establishing priority EPHS functions.

Allowable Activities

Allowable costs and activities must align with the 10 EPHS.

II. Award Information

Funding Instrument—Grant

Estimated Funds Available

The total funding identified for fiscal year (FY) 2024 is approximately $3,600,000. Individual award amounts