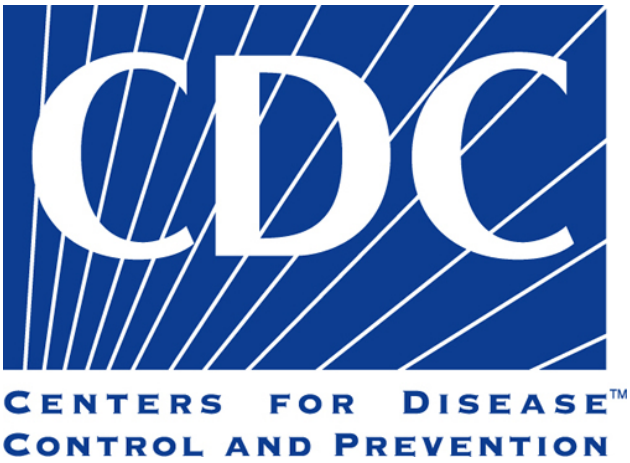


**Centers for Disease Control and Prevention**

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

# BOLD Public Health Programs to Address Alzheimer's Disease and Related Dementias

CDC-RFA-DP-23-0010

03/27/2023

# Table of Contents



## Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-DP-23-0010. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

### A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

### B. Notice of Funding Opportunity (NOFO) Title:

BOLD Public Health Programs to Address Alzheimer's Disease and Related Dementias

### C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

New Type 1

### D. Agency Notice of Funding Opportunity Number:

CDC-RFA-DP-23-0010

### E. Assistance Listings Number:

93.334

## F. Dates:

**1. Due Date for Letter of Intent (LOI):**
02/19/2023
Recommended but not Required

**2. Due Date for Applications:**
03/27/2023
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

**3. Due Date for Informational Conference Call**

Time: *12:30* U.S Eastern Time (US and Canada)
Topic: DP23-0010 Informational Conference Call

1. Zoom Meeting ID 161 494 8218, Passcode: BOLD2023! or at this invite link: https://cdc.zoomgov.com/j/1614948218?pwd=WWpCRlZQMEtUcXMyZHJwdVRwU3lQQT09

After 1/25/2023, the Informational Conference Call recording and transcript will be added to the DP23-0010 Information Webpage BOLD Public Health Programs |CDC-RFA-DP23-0010 | CDC.

## F. Executive Summary:

**Summary Paragraph**
This NOFO supports actions from the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act PL115-406. It will fund public health departments to build infrastructure in the field of Alzheimer's disease and related dementias (ADRD). This 5-year NOFO will fund recipients in two different components. Component 1 will be funded for 2 Capacity-Building years and 3 Implementation years. Component 2 will be funded for 5 Implementation years. Recipients will use a public health approach to ADRD using CDC's Healthy Brain Initiative *State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map*, the *Road Map for Indian Country* (RM Series), as well as future updates of both, as guides to expand and improve the response to ADRD in their jurisdictions. Recipients will increase awareness and understanding among the general public (including populations of high burden), providers, and other professionals of ADRD topics corresponding to primary, secondary, and tertiary prevention (see Glossary). Recipients will address the social determinants of health (SDOH) to achieve health equity goals including but not limited to the improvement of community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations.

**a. Eligible Applicants:**
Open Competition

**b. NOFO Type:**
CA (Cooperative Agreement)

**c. Approximate Number of Awards**
35
The program will fund Component 1 and Component 2 awards in approximately equal amounts. Final numbers of programs funded in each Component will be decided after Phase II and Phase III review.

**d. Total Period of Performance Funding:**
$70,000,000

**e. Average One Year Award Amount:**
$450,000
*Component 1 = years 1-2 = $250,000 Years 3-5 = $450,000;*
*Component 2 = $450,000*

**f. Total Period of Performance Length:**
5 year(s)

**g. Estimated Award Date:**
September 30, 2023

**h. Cost Sharing and / or Matching Requirements:**
Yes
"MATCHING REQUIREMENT.—Each health department that is awarded a cooperative agreement under this award shall provide, from non-Federal sources, an amount equal to 30 percent of the amount provided under such agreement (which may be provided in cash or in-kind) to carry out the activities supported by the cooperative agreement."

WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive all or part of the matching requirement described here for any fiscal year for a health department of a State, political subdivision of a State, or Indian tribe or tribal organization (including those located in a rural area or frontier area), if the Secretary determines that applying such matching requirement would result in serious hardship or an inability to carry out the purposes of the cooperative agreement awarded to such health department of a State, political subdivision of a State, or Indian tribe and tribal organization."

Match Waivers may be considered. If your agency determines that applying such matching requirement would result in serious hardship or an inability to carry out the purposes of the cooperative agreement, you may submit a match waiver request. To submit a match waiver request, **submit a letter**, no more than 2 pages in length, 12 pt font on your agency's letterhead with Office of Budget and Program Leadership signatures, with your application.

Match waiver requests will be determined on a case-by-case basis for the period of performance of this award. A match waiver may be approved, as described here, for the period of performance of this award unless circumstances change for any awardee that would then enable the awardee to meet the match requirement.
Your letter requesting a match waiver should include the following elements:

- Your agency and your proposed project budget

- A brief statement of the hardship circumstances. (e.g., pandemic response, budget shortfall, emergency situation or other extenuating circumstances)
- Documentation indicating that not receiving a match waiver may cause a serious hardship or an inability to carry out the purposes of the cooperative agreement
- Signed by your state agency budget office authorized representative and the Principal Investigator
- Name this file "XX Matching Waiver Request" as a PDF and upload with your application to www.grants.gov.

## Part II. Full Text

## A. Funding Opportunity Description

### 1. Background

**a. Overview**

Alzheimer's disease is the most common form of dementia and the 5th leading cause of death for people aged ≥ 65 years in the United States. By 2060, approximately 14 million people are expected to have Alzheimer's disease, a nearly three-fold increase, with minority populations disproportionately affected.

This NOFO will fund public health departments to build infrastructure and increase capacity in the field of Alzheimer's disease and related dementias (ADRD). Recipients will expand and improve the response to ADRD in their jurisdictions. To do so, they will use a public health approach to ADRD with an emphasis on addressing the social determinants of health to achieve health equity goals and using CDC's Healthy Brain Initiative *State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map*, the *Road Map for Indian Country* (RM Series), as well as future updates of both, as guides. The need for a well-coordinated public health approach is essential given advancements in knowledge about risk factors (see below in this section) related to cognitive decline, and the growing awareness of the role of SDOH. A public health approach can build coordinated systems that binds together jurisdiction efforts for ADRD and caregiving for persons with dementia. These coordinated systems, such as community-clinical linkages, are crucial for improving equitable outcomes for ADRD. The Secretary of the Department of Health and Human Services added a new goal to accelerate action to promote healthy aging and reduce risk factors for ADRD in the 2021 National Alzheimer's Disease Plan. This goal focuses on reducing prevalence of 10 key risk factors, including: depression, diabetes, hearing loss, mid-life hypertension, physical inactivity, poor diet quality and obesity, poor sleep quality and sleep disorders, tobacco use, traumatic brain injury, and alcohol use.

This NOFO is authorized by the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act; PL115-406 that amends the Public Health Service Act (Section 398A; 42 U.S.C. 280c-3-4.). This act authorizes funding for "health departments of states, political subdivisions of states, and Indian [American Indian/Alaska Native] tribes and tribal organizations" to develop a strong and uniform dementia infrastructure. This NOFO supports recipients to use a public health approach to ADRD promoting SDOH to achieve healthy equity and encouraging data driven decision-making and action along with strategies that correspond to

primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis, linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for persons with dementia) prevention (see glossary). This 5-year NOFO will fund recipients in two different components. Component 1: "Capacity Building and Implementation" will be funded for 2 years as Capacity-Building and 3 years as Implementation. Component 2: "Implementation" will be funded for 5 Implementation years.

**b. Statutory Authorities**

Section 398A of the Public Health Service Act, 42 U.S.C. 280c-4.

**c. Healthy People 2030**

Dementias (DIA):
DIA-1: Increase the proportion of older adults with dementia, or their caregivers, who know they have it
DIA-2: Reduce the proportion of preventable hospitalizations in older adults with dementia
DIA-3: Increase the proportion of older adults with subjective cognitive decline who have discussed their symptoms with a provider

Older Adults (OA):
OA-1: Increase the proportion of older adults with physical or cognitive health problems who get physical activity
OA-2: Reduce the proportion of older adults who use inappropriate medications

Health Care Access and Quality (AHS):
AHS-8: Increase the proportion of adults who get recommended evidence-based preventive health care

**d. Other National Public Health Priorities and Strategies**

National Alzheimer's Project Act (NAPA; PL 111-375) defined "Alzheimer's" as Alzheimer's disease and related dementias (ADRD) and directs the Department of Health and Human Services (HHS) to develop an Annual Alzheimer's Plan.

Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act; PL115-406 authorizes funding for "health departments of states, political subdivisions of states, and Indian [American Indian/Alaska Native] tribes and tribal organizations" to develop a strong and uniform dementia infrastructure.

Recognize, Assist, Include, Support and Engage (RAISE) Family Caregivers Act ( PL No: 115-119) directs HHS to develop a national caregiving strategy.

**e. Relevant Work**

BOLD Public Health Programs to Address Alzheimer's Disease and Related Dementias (CDC-RFA-DP20-2004)

BOLD Public Health Centers of Excellence to Address Alzheimer's Disease and Related Dementias (CDC-RFA-DP20-2005)

National Healthy Brain Initiative (CDC-RFA-DP20-2003)

## 2. CDC Project Description

**a. Approach**

**Bold** indicates period of performance outcome.

| FUNDED STRATEGIES AND ACTIVITIES | SHORT-TERM OUTCOMES (1-2 Years) | INTERMEDIATE OUTCOMES (3-5 Years) | IMPACTS/LONG-TERM OUTCOMES |
|---|---|---|---|
| **Strategy 1:**Create, maintain or enhance a jurisdiction ADRD coalition. (Component 1 and Component 2)<br><br>**Strategy 2:** Educate coalition members/partners on ADRD topics. (Component 1 and Component 2)<br><br>**Strategy 3:** Create or update a jurisdiction ADRD Strategic Plan using the Road Map Series as guides. (Component 1 only)<br><br>**Strategy 4:** Lead the coalition to develop and track an Implementation Plan to aid implementation of the jurisdiction | Increased number and variety of coalition members/partners collaborating on jurisdiction dementia projects or initiatives.<br><br>Improved quality and comprehensiveness of jurisdiction ADRD goals across public health domains, ADRD topics, and prevention levels.<br><br>Increased availability of information, tools, resources, and training on ADRD topics.<br><br>Increased availability and use of data to inform, | Increased number of coalition members/partners implementing actions of jurisdiction ADRD Strategic Plan.<br><br>**Improved implementation of jurisdiction ADRD goals that are comprehensive across public health domains, ADRD topics, and prevention levels.**<br><br>**Increased awareness and understanding of ADRD topics among the general public, providers, and other professionals.** | Accelerated action to reduce risk factors for ADRD (NAPA Goal 6)**.**<br><br>Increased emphasis of integrating the caregiver into processes and systems from which they have been traditionally excluded. (RAISE Family Caregiver Act Goal).<br><br>Increased proportion of older adults with dementia, or their caregivers, who are aware of the diagnosis.* (HP2030 – DIA-1)<br><br>Increased proportion of |

| | | | |
|---|---|---|---|
| ADRD Strategic Plan. (Component 1 Phase II, and Component 2)<br><br>**Strategy 5 & 6:** Educate the general public, providers, and other professionals about ADRD topics. (Component 1 Phase II, and Component 2)<br><br>**Strategy 7:** Increase the availability and use of data to improve knowledge, assess, plan and implement priorities. (Component 1 Phase II, and Component 2)<br><br>**Strategy 8:** Improve sustainability of ADRD efforts. (Component 1 and Component 2)<br><br>**Strategy 9:** Develop community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations. (Component 1 Phase II, and Component 2) | monitor or improve ADRD goal implementation and other supporting activities<br><br>Increased implementation of goals and activities that lead to sustainable jurisdiction ADRD program activities.<br><br>**Increased number of community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations.** | Increased use among the general public, providers, and other professionals of information, tools, resources and training on ADRD topics.<br><br>Increased number of jurisdiction ADRD projects and initiatives that are created and influenced by available data.<br><br>Increased sustainability of program activities.<br><br>Increased coordination across among health care systems and existing services, public health agencies, and community-based organizations**.** | older adults with subjective cognitive decline who have discussed their symptoms with a provider.* (HP2030 – DIA-3)<br><br>Reduced proportion of preventable hospitalizations in older adults with dementia.* (HP2030-DIA2)<br><br>Sustained ADRD program activities.<br><br>Development of a robust national data system that accurately reflects ADRD. (BOLD Legislation) |

**i. Purpose**

This NOFO will fund state, local, and tribal public health departments to build infrastructure and increase capacity in the field of Alzheimer's disease and related dementias (ADRD). Recipients will expand the response to ADRD in their jurisdictions. To do so, they will use a public health approach with an emphasis on SDOH to promote health equity and using CDC's Healthy Brain Initiative State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map, the Road Map for Indian Country (RM Series), as well as future updates of both, as guides.

**ii. Outcomes**

For all recipients, it is expected, at a minimum, that progress towards the **bolded** outcomes presented in the logic model above will be achieved during the period of performance. These are listed below.

- **Improved implementation of jurisdiction ADRD goals that are comprehensive across public health domains, ADRD topics, and prevention levels.**
- **Increased awareness and understanding of ADRD topics among the general public, providers, and other professionals.**
- **Increased number of community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations.**

**iii. Strategies and Activities**

This 5-year NOFO will fund recipients in two different components.

**Component 1:** "Capacity Building and Implementation" will be funded for 2 Capacity-Building years (Phase I) and 3 Implementation years (Phase II). This component is intended for applicants without a current jurisdiction dementia strategic plan or full active coalition. Applicants previously funded under CDC-RFA-DP20-2004 are not eligible for Component 1 awards.

**Component 2:** "Implementation" will be funded for 5 Implementation years. This component is intended for applicants that already have an active dementia coalition and dementia strategic plan in place.

**Component 1 — Capacity Building and Implementation**

**Component 1**
**Phase I -- Capacity Building (Years 1-2)**

**Strategy 1: Create or expand** an existing jurisdiction Alzheimer's Disease and Related Disease **Coalition.**

The **required output** for this activity is a jurisdiction coalition that addresses the criteria below.

1. The recipient is required to create, maintain, or expand a jurisdiction coalition (state, local or tribal). For the purposes of this program, a jurisdiction coalition is defined as a formal arrangement for cooperation and collaboration among a diverse cross-section of groups or sectors across the entire jurisdiction. Each group retains its identity and agrees to work together toward a common goal(s).

2. The jurisdiction coalition proposed by the applicant, at a minimum, should include representatives of the identified organizations. If the applicant's current coalition does not have representatives from the organizations listed below, they should work to include these organizations on their coalitions. Tribes and Tribal organizations should include members from their equivalent organizations.

- Jurisdiction public health department representatives (the applicant)
- Jurisdiction aging services department representative

- Jurisdiction public health department representatives from identified risk reduction areas (e.g., heart disease, diabetes)
- National non-profit organization whose primary mission is Alzheimer's disease (state or local chapter, as appropriate)
- Persons with a lived experience (e.g., persons living with dementia (PLWD) or caregiver for person with ADRD)

3. Letters of support **are required** from the organizations serving on the jurisdiction coalition for the application from the aging services and a national non-profit organization whose primary mission is Alzheimer's disease (state or local chapter, as appropriate). This letter must include a specific description of their unique role in support of the proposed work. Please see the "Collaborations" section for additional detail. 4. Applicants should name this file "XX Letters of Support" (where XX is the applicant name) and upload all letters of support in one PDF file to www.grants.gov.

4. Recipients are **strongly encouraged** to have representatives from the following groups or organizations on their coalitions. The list below is not an exhaustive list. Recipients are encouraged to expand their coalition membership according to the needs, priorities, and goals of the jurisdiction.

- State administrators managing applicable programs (e.g., Medicaid, senior public health officials, public health chronic disease directors)
- Subject-matter experts with expertise in dementia risk reduction, brain health and cognitive impairment, including ADRD care and service providers and caregiving for persons with dementia
- Subject-matter experts with expertise in public health tools, strategies, and resources, including advanced knowledge of the public health systems at the national, state, tribal and local levels
- Primary care practice representatives
- Healthcare organization representatives (who provide services for PLWD and their caregivers)
- Health systems representatives
- Local community-based organization representative where their work aligns with aging, ADRD, brain health.
- Local public health departments
- Representatives of programs addressing SDOH (e.g., transportation, social connectedness). Further topics can be found at: CDC SDOH or NCCDPHP SDOH.
- Representatives of communities of high ADRD risk or incidence
- Colleges and universities engaged in aging, dementia, and brain health work
- Long term care providers
- Policymakers
- Caregivers
- Organizations representing those populations at high risk including those with intellectual disabilities or others

5. The coalition proposed by the applicant should have the following **capacities and/or characteristics:**

- Ability to leverage partnerships across settings and sectors to address key contributors to ADRD within their community.
- Incorporate input from a diverse set of partners and community coalition members.
- If an existing coalition, a detailed description of their history of success in working together with partners on issues relating to ADRD.
- Include coalition members who will champion specific implementation plan steps as outlined in the coalition implementation plan.

6. Recipients are encouraged to engage their coalition to **conduct the following types of activities**. The list below is not an exhaustive list. Recipients are encouraged to expand their activities to reflect their coalition goals and priorities.

- Use results of an existing needs assessment (if conducted in the past 3 years) or conduct a new needs assessment to establish jurisdiction ADRD priorities for either the ADRD strategic plan or implementation plan.
- Convey the current state of the ADRD science and program to their larger community using health communication strategies.
- Update or create a jurisdiction ADRD strategic plan that proposes recommendations for objectives or initiatives that are consistent with Road Map actions and that address jurisdiction priorities.
- Build linkages to bridge science and implementation across their jurisdiction.
- Participate in the development or revision of a balanced set of recommendations including primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis, linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for persons with dementia) prevention to be used to develop or revise the jurisdiction wide ADRD strategic plan and implementation plan.

7. CDC will review and approve the ADRD coalition membership (during continuation application time) before approving a move into Phase II (Implementation).

**Strategy 2:** Educate coalition members and partners to orient them to brain health and ADRD issues and the broad spectrum of actions needed to fully address ADRD across the jurisdiction.

**Strategy 3:** Create or update a jurisdiction **ADRD Strategic Plan** using actions from the CDC's Healthy Brain Initiative RM Series, as well as future updates, as guides.
The **required output** for this activity is a jurisdiction *ADRD Strategic Plan* that addresses the key elements below:

1. **Uses available data** (e.g., BRFSS, health system data, registries, community listening sessions, needs assessments, and other available data sources) to assess, identify and set the goals and activities of the Strategic Plan to inform implementation in Strategy 4. This includes prioritizing populations and communities experiencing the greatest disparities in the prevalence of ADRD or ADRD-associated risk factors.
2. The ADRD strategic plan must ensure that a balanced approach to ADRD is proposed. A balanced approach includes the following:

- Include goals that represent each of the prevention levels. The prevention levels are primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) prevention.
- Include at least 4 Road Map actions. This includes a minimum of one (1) action from each of the Road Map domains (i.e., Educate and Empower (E), Develop Policies and Mobilize Partnerships (P), Assure a Competent Workforce (W), and Monitor and Evaluate (M)).
- Prioritizes populations and communities experiencing the greatest disparities in the prevalence of ADRD or ADRD-associated risk factors and also have plans to address SDOH (e.g., transportation, social connectedness). Further topics can be found at: CDC SDOH or NCCDPHP SDOH

3. CDC will review and approve the ADRD strategic plan (during continuation application time) before approving a move into Phase II (Implementation).

**Component I**
**Phase II -- Implementation (years 3-5)**

**Strategy 4:** Lead the coalition to develop and track an **Implementation Plan** to achieve the priorities, activities, and goals specified in the jurisdiction's ADRD Strategic Plan:
The **required output** for this activity is an *Implementation Plan* (e.g., a detailed description of the specific strategies, objectives, actions, and champions that are needed to **implement** the jurisdiction ADRD Strategic Plan goals) for the coalition that addresses the below criteria:

1. Is a living, dynamic document that allows for adjustments that are informed by experience, science, data, and contextual influences.
2. Has objectives that are specific, measurable, attainable, relevant, time bound, inclusive, and equitable (SMARTIE).
3. **Uses available data** (e.g., BRFSS, health system data, registries, community listening sessions, needs assessments, and other available data sources) to create the Implementation plan and monitor its progress. Uses specific best practices to address ADRD topics.
4. Contains actions that address sustainability (e.g., continuation of effort beyond the conclusion of the period of performance).
5. Prioritizes populations and communities experiencing the greatest disparities in the prevalence of ADRD or ADRD-associated risk factors, including addressing SDOH and health equity.
6. Identifies champions and the role they will play in implementation of each action.

**Strategy 5: Educate members of the general public** (including populations of high burden) about ADRD topics, including but not limited to primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable

hospitalizations and poor health outcomes; caregiving for persons with dementia) prevention.

**Strategy 6: Educate providers and other professionals** about ADRD topics, including but not limited to primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; and caregiving for persons with dementia) prevention.

**Strategy 7: Increase the availability and use of data** (e.g., BRFSS, health system data, registries, community listening sessions, needs assessments, and other available data sources) to improve knowledge and inform data driven decision-making about ADRD goals and activities. Such data may include, as appropriate, information on cognitive decline, caregiving, and health disparities experienced by disproportionately-affected populations and individuals with cognitive decline and their caregivers. State recipients should support the collection of data from the BRFSS caregiving and subjective cognitive decline modules.
Recipients will also be expected to use available data to:

1. Increase program visibility.
2. Attract partners.
3. Assist ready communication.
4. Understand community achievements and public health burden.
5. Facilitate evolution of initiatives and overall sustainability of activities over time.

**Strategy 8: Improve sustainability** of jurisdiction ADRD efforts. This includes adopting activities that address all the following items :

1. Enhance the ability to effectively implement evidence-based practices over time.
2. Increase scalability.
3. Considers the changing landscape of resource and partner availability.
4. Improve systems, environments, and policies to support dementia (e.g., organizational policies, academic curricula, professional associations, accreditation, certification entities).
5. Incorporate the best available science about brain health, cognitive impairment, and caregiving for persons with dementia into their policies and training.

**Strategy 9:** Increase the number of **community-clinical linkages** among health care systems and existing services, public health agencies, and community-based organizations to improve both coordination and dementia outcomes, which will also address a key social determinant of health. This will include, but is not limited to, increasing the number of people knowing how and where to seek care and support, establishing formal agreements between entities, and connecting health care systems and providers to community services and programs to increase referrals between those entities. Community-clinical linkages should be bi-directional, meaning organizations both provide and receive the information needed to support increased coordination among public health, health care, and community-based sectors. Community-based organizations includes existing community services and programs related to ADRD or its modifiable risk factors.

## Component 2 — Implementation

**Strategy 1:** ***Maintain or expand*** an existing jurisdiction Alzheimer's Disease and Related Disease **Coalition.**
The **required output** for this activity is a jurisdiction coalition that addresses the criteria below

1. The recipient is required to maintain, or expand a jurisdiction coalition (state, local or tribal). For the purposes of this program, a jurisdiction coalition is defined as a formal arrangement for cooperation and collaboration among a diverse cross-section of groups or sectors across the entire jurisdiction. Each group retains its identity and agrees to work together toward a common goal(s).

2. The jurisdiction coalition proposed by the applicant, at a minimum, should include representatives of the identified organizations. If the applicant's current coalition does not have representatives from the organizations listed below, they should work to include these organizations on their coalitions. Tribes and Tribal organizations should include members from their equivalent organizations.

- Jurisdiction public health department representatives (the applicant)
- Jurisdiction aging services department representative
- Jurisdiction public health department representatives from identified risk reduction areas (e.g., heart disease, diabetes)
- National non-profit organization whose primary mission is Alzheimer's disease (state or local chapter, as appropriate)
- Persons with a lived experience (e.g., persons living with dementia (PLWD) or caregiver for person with ADRD)

3. Letters of support **are required** from the organizations on their jurisdiction coalition for the application from the aging services and a national non-profit organization whose primary mission is Alzheimer's disease (state and local chapter as appropriate) and must include a specific description of their role in support of the proposed work. Please see the "Collaborations" section for additional detail. Applicants should name this file "XX Letters of Support" (where XX is the applicant name) and upload all letters of support in one PDF file to www.grants.gov.

4. Recipients are **strongly encouraged** to have representatives from the following groups or organizations on their coalitions. The list below is not an exhaustive list. Recipients are encouraged to expand their coalition membership according to the needs, priorities, and goals of the jurisdiction.

- State administrators managing applicable programs (e.g., Medicaid, senior public health officials, public health chronic disease directors)
- Subject matter experts with expertise in dementia risk reduction, brain health and cognitive impairment, including ADRD care and service providers and caregiving for persons with dementia
- Subject matter experts with expertise in public health tools, strategies, and resources, including advanced knowledge of the public health systems at the national, state, tribal and local levels

- Primary care practice representatives
- Healthcare organization representatives (who provide services for PLWD and their caregivers)
- Health systems representatives
- Local community-based organization representative where their work aligns with aging, ADRD, brain health.
- Local public health departments
- Representatives of programs addressing SDOH (e.g., transportation, social connectedness). Further topics can be found at: CDC SDOH or NCCDPHP SDOH.
- Representatives of communities of high ADRD risk or incidence
- Colleges and universities engaged in aging, dementia, and brain health work
- Long term care providers
- Policymakers
- Caregivers
- Organizations representing those populations at high risk including those with intellectual disabilities or others

5. The coalition proposed by the applicant should have the following **capacities and/or characteristics:**

- Ability to leverage partnerships across settings and sectors to address key contributors to ADRD within their community.
- Incorporate input from a diverse set of partners and community coalition members.
- If an existing coalition, as by demonstrated a detailed description of the history of success in working together with partners on issues relating to ADRD.
- Include coalition members who will champion specific implementation plan steps as outlined in the coalition implementation plan.

6. Recipients are encouraged to engage their coalitions to **conduct the following types of activities**. The list below is not an exhaustive list. Recipients are encouraged to expand their activities to reflect their coalition goals and priorities.

- Use results of an existing needs assessment (if conducted in the past 3 years) or conduct a new needs assessment to establish jurisdiction ADRD priorities for either the ADRD strategic plan or implementation plans.
- Convey the current state of the ADRD science and program to their larger community using health communication strategies.
- Build linkages to bridge science and implementation across their jurisdiction.
- Develop a coalition implementation plan, based on their jurisdiction ADRD plan, that includes the use of specific best practices to address Alzheimer's disease and related dementia that includes primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) prevention to be used to develop or revise the jurisdiction wide ADRD plan.

**Strategy 2:** Educate coalition members and partners to orient them to brain health and ADRD issues and the broad spectrum of actions needed to fully address ADRD across the jurisdiction.

**Strategy 3: Not required for Component 2**

**Strategy 4:** Lead the coalition to develop and track an **Implementation Plan** to achieve the priorities, activities, and goals specified in the jurisdiction's ADRD Strategic Plan The **required output** for this activity is an *Implementation Plan* (a comprehensive description of the specific strategies, objectives, actions, and champions that are needed to **implement** the jurisdiction ADRD Strategic Plan goals) for the coalition that addresses the below criteria:

1. Is a living, dynamic document that allows for adjustments that are informed by experience, science, data, and contextual influences.
2. Has objectives that are specific, measurable, attainable, relevant, time bound, inclusive, and equitable (SMARTIE).
3. Uses specific best practices to address ADRD topics
4. Contains actions that address sustainability (e.g., continuation of effort beyond the conclusion of the period of performance).
5. Prioritizes populations and communities experiencing the greatest disparities in the prevalence of ADRD or ADRD-associated risk factors, including addressing SDOH and health equity.
6. Identifies champions and the role they will play in implementation of each action.

**Strategy 5: Educate members of the general public** (including populations of high burden) about ADRD topics, including but not limited to primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis, linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for persons with dementia) prevention.

**Strategy 6: Educate providers and other professionals** about ADRD topics, including but not limited to primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis, linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for persons with dementia) prevention.

**Strategy 7: Increase the availability and use of data** (e.g., BRFSS, health system data, registries, community listening sessions, needs assessments, and other available data sources) to improve knowledge and inform data driven decision-making about ADRD goals and activities. Such data may include, as appropriate, information on cognitive decline, caregiving, and health disparities experienced by disproportionately-affected populations and individuals with cognitive decline and their caregivers. State recipients should support the collection of data from the BRFSS caregiving and subjective cognitive decline modules.
Recipients will also be expected to use available data to:

1. Increase program visibility.

2. Attract partners.
3. Assist ready communication.
4. Understand community achievements and public health burden.
5. Facilitate evolution of initiatives and overall sustainability of activities over time.

**Strategy 8: Improve sustainability** of jurisdiction ADRD efforts. This includes adopting activities that address all of the following items below:

1. Enhance the ability to effectively implement evidence-based practices over time.
2. Increase scalability.
3. Considers the changing landscape of resource and partner availability.
4. Improve systems, environments, and policies to support dementia (e.g., organizational policies, academic curricula, professional associations, accreditation, certification entities).
5. Incorporate the best available science about brain health, cognitive impairment, and caregiving for persons with dementia into their policies and training.

**Strategy 9:** Increase the number of **community-clinical linkages** among health care systems and services, public health agencies, and community-based organizations to improve both coordination and dementia outcomes, which will also address a key social determinant of health. This will include, but is not limited to, increasing the number of people knowing how and where to seek care and support, establishing formal agreements between entities, and connecting health care systems and providers to community treatment care and services and programs to increase referrals between those entities. Community-clinical linkages should be bi-directional, meaning organizations both provide and receive the information needed to support increased coordination among public health, health care, and community-based sectors. Community-based organizations includes community services and programs related to ADRD or its modifiable risk factors.

**1. Collaborations**

**a. With other CDC programs and CDC-funded organizations:**

All recipients are expected to identify and leverage opportunities with other CDC-funded public health programs with common interests and objectives related to brain health and cognitive impairment including dementia risk reduction (primary prevention) by addressing modifiable risk factors for ADRD (e.g., high blood pressure, heart disease, diabetes, smoking, lack of physical activity etc.), early detection and diagnosis; linkages to treatment, care, and services (secondary prevention), and prevention and treatment of comorbidities and avoidable hospitalizations; caregiving for persons with dementia (tertiary prevention). These collaborations would include, but are not limited to, CDC programs funded by the National Center for Chronic Disease Prevention and Health Promotion related to brain health risk factors (e.g., CDC Heart Disease and Stroke Prevention, CDC National Diabetes Prevention Program, CDC's National Tobacco Control Program, CDC's Nutrition, Physical Activity and Obesity programs; Division of Population Health's Good Health and Wellness in Indian Country Excessive Alcohol Use Prevention, and others). To avoid duplication of effort, recipients of this NOFO will use their coalitions as well as these partnerships to build linkages to bridge science and implementation

across their jurisdiction.

All recipients will be required to collaborate with other successful applicants funded through this NOFO, as well as organizations funded under CDC-RFA-DP20-2005 "BOLD Public Health Centers to Address Alzheimer's Disease and Related Dementias", and CDC-RFA-DP20-2003 "The National Healthy Brain Initiative" as well as relevant contracts and other projects. CDC will facilitate collaboration with these recipients. Applicants must indicate in their application that they will collaborate with these organizations. Applicants should name this file "XX Letters of Support" (where XX is the applicant name) and upload all letters of support in one PDF file to www.grants.gov.

**b. With organizations not funded by CDC:**
All recipients are strongly encouraged to identify and leverage opportunities to enhance their work with organizations across their jurisdiction in all levels of prevention activities. Recipients will build infrastructure to encourage linking together existing efforts by partners to avoid duplication of effort, enhance reach, consider SDOH, and bridge between science and implementation across their jurisdiction. Component 1-- Phase II and Component 2 recipients are expected to collaborate with and assist other organizations not funded by CDC in implementing the RM Series actions identified.

Collaborations, **at a minimum**, should include representatives of the identified organizations. Tribes and Tribal applicant organizations should include members from their equivalent organizations.

a. Jurisdiction public health department representatives (the applicant)
b. Jurisdiction aging services department representative
c. Jurisdiction public health department representatives from identified risk reduction areas (e.g., heart disease, diabetes)
d. National non-profit organization whose primary mission is Alzheimer's disease (state or local chapter as appropriate)
e. Persons with a lived experience (e.g., PLWD or caregiver for person with ADRD)

All recipients are **strongly encouraged** to collaborate with groups and individuals, including but not limited to, the following:

a. State administrators managing applicable programs (e.g., Medicaid, senior public health officials, public health chronic disease directors)
b. Subject matter experts with expertise in dementia risk reduction, brain health and cognitive impairment, including ADRD care and service providers and caregiving for persons with dementia
c. Subject matter experts with expertise in public health tools, strategies, and resources, including advanced knowledge of the public health systems at the national, state, tribal and local levels
d. Primary care practice representatives
e. Healthcare organization representatives (who provide services for PLWD and their caregivers)
f. Health systems representatives

g. Local community-based organization representative where their work aligns with aging, ADRD, brain health.
h. Local public health departments
i. Representatives of programs addressing SDOH (e.g., transportation, social connectedness). Further topics can be found at: CDC SDOH or NCCDPHP SDOH.
j. Representatives of communities of high ADRD risk or incidence
k. Colleges and universities engaged in aging, dementia, and brain health work
l. Long term care providers
m. Policymakers
n. Caregivers
o. Organizations representing those populations at high risk including those with intellectual disabilities or others

Letters of Support: Letters of support **are required** from the organizations from the aging services and a national non-profit Alzheimer's organization (state or local chapter as appropriate) and must include a specific description of their unique role in support of the proposed work. Tribal organizations/tribes should include members from their equivalent organizations. Applicants are encouraged to also provide letters of support for other coalition members, if applicable. Letters of support should clearly describe the partnership with the applicant and how the organization will support the program. Applicants should name this file "XX Letters of Support" (where XX is the applicant name) and upload all letters of support in one PDF file to www.grants.gov.

**2. Target Populations**

The target populations for health impact should be all persons within the jurisdiction at risk for or who have ADRD, as well as their caregivers. All recipients are expected to plan for impact in all levels of prevention, as well as emphasize impact for those with an identified high burden of ADRD. Examples include, but are not limited to, Hispanic adults, African-American adults, American Indian/Alaska Native adults, women, older adults, and people with intellectual or developmental disabilities. Applicants should use available data to identify high risk populations in their jurisdiction.

**a. Health Disparities**

ADRD is a leading cause of high burden of morbidity and mortality in the United States. African American race and Hispanic ethnicity are associated with higher prevalence of dementias. There are significant disparities in ADRD prevalence among population subgroups defined by race and ethnicity. American Indian and Alaska Native populations, like other populations, are living longer. Because Alzheimer's disease and other dementias are more common with advanced age in any population group, gains in longevity, will increasingly affect Indian Country with a higher health burden. People with disabilities and others who have significant limitations in functioning (e.g., mobility, hearing, vision) or lack of access to services experience higher amounts of ADRD. People who live in rural areas and those with limited transportation options are often overlooked. There is a need to ensure materials and interventions are culturally relevant and accessible. A definition of a more diverse group of those at risk for dementia, their caregivers, and persons with ADRD is still an unmet need. Given the expected growth in the burden of

disease, particularly among minority populations, culturally aware care for adults at high risk for ADRD is of paramount importance. The activities of this NOFO can help inform policy development and mobilize partnerships. This takes into account ADRD risk, disease burden, economic and SDOH, and other disparities in minority or underserved populations as well as incorporating such information when developing jurisdiction public health initiatives. For more detailed information please see our partners at International Association for Indigenous Aging (IA2), University of Illinois at Chicago Health Matters Program for People with Intellectual and Developmental Disabilities (UIC) and UsAgainstAlzheimer's Center for Brain Health Equity (UsA2). This NOFO also supports efforts to develop a culturally aware workforce of all types of providers that would help to improve risk reduction messaging and awareness, as well as the recognition of early signs and symptoms of ADRD.

**iv. Funding Strategy**

This 5-year NOFO will fund recipients in two different components.
Applicants may apply for only one component.

**Component 1:** "Capacity Building and Implementation" will be funded for 2 Capacity-Building years (Phase I) and 3 Implementation years (Phase II). This component is intended for applicants without a current jurisdiction dementia strategic plan or full active coalition.

Component 1 Year 3 Continuation Application APR will require recipients to submit the two items below for CDC to review and approve before moving from Phase I to Phase II:
• Documentation of the ADRD coalition including description of the structure and activities.
• An updated/created jurisdiction wide ADRD Strategic Plan. If these documents are not submitted, the recipient will not be approved for implementation.

**Component 2:** "Implementation" will be funded for 5 Implementation years. This component is intended for applicants that already have an active dementia coalition and dementia strategic plan in place.

**Matching Funds**

- PL115-406, which amends Section 398 of the Public Health Service Act, 42 U.S.C. 280c-3, specifically requires a 30% match from recipients. The required 30% match must be reflected clearly in the proposed budget. Please see above section "Cost Sharing or Matching".
- Match Waivers may be considered. If your agency determines that applying such matching requirement would result in serious hardship or an inability to carry out the purposes of the cooperative agreement, you may submit a match waiver request. See "Budget Narrative" section for more information on how to submit a Match Waiver request.
- Match waiver requests will be determined on a case-by-case basis for the period of performance of this award. A match waiver may be approved, as described here, for the period of performance of this award unless circumstances change for any awardee that would then enable the awardee to meet the match requirement.

**b. Evaluation and Performance Measurement**

**i. CDC Evaluation and Performance Strategy**

**Evaluation Questions and Performance Measures**
Throughout the 5-year period of performance, CDC will work with recipients to answer the following **evaluation questions** based on the required (bolded) program logic model outcomes:

1. What progress has been made adding designated RM Series actions to ADRD jurisdiction strategic plans?
2. What progress has been made in the implementation of RM Series Actions?
3. To what degree have **members of the public** increased their awareness and understanding of **ADRD topics?** (Including but not limited to brain health, cognitive aging, dementia risk reduction, early detection and diagnosis, linkages to treatment, care, and services, prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for persons with dementia)
4. How have changes in awareness and understanding of ADRD topics varied across key segments of the general public?
5. To what degree have **providers** increased their awareness and understanding of ADRD topics?
6. To what degree have **other professionals** increased their awareness and understanding of ADRD topics?
7. To what degree has there been increased coordination across health care systems and existing services, public health agencies, and community-based organizations by means of community-clinical linkages?

**Performance measures** developed for this program are derived from selected outcomes described in the logic model. The following measures must be reported on annually as part of the Annual Performance Report. Measures are preceded by their associated logic model outcome (in bold).

**Outcome: Improved implementation of jurisdiction ADRD goals that are comprehensive across public health domains, ADRD topics, and prevention levels. Required measures are:**

- Number of and distribution of RM Series actions addressed.
- Prevention level of each program activity identified with a specific RM Series action.

**Outcome: Increased awareness and understanding of ADRD topics among the general public, providers, and other professionals. Required measures are:**

- Number and categories of the general public (including populations of high burden) who received or accessed messages, materials, or training providing information on ADRD topics.
- Number and categories of providers who received or accessed messages, tools, resources, or training, providing information on ADRD topics.
- Number and categories of other professionals (other than health care workers) who received or accessed messages, tools, resources, or training, providing information on ADRD topics.

**Outcome: Increased number of community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations. Required measures are:**

- Number and types of jurisdiction primary health care providers that have been educated about how to connect to existing community-based services and programs regarding ADRD or related modifiable risk factors.
- Number of jurisdiction community-based service providers and program staff regarding ADRD or related modifiable risk factors that have been educated about how to connect to primary health care providers or health care systems.
- Number and categories of new mechanisms/connections that facilitate linkages between health care systems and existing services, public health agencies, and community-based organizations regarding ADRD or related modifiable risk factors.

CDC may work with recipients to refine and add project measures and indicators as needed.

CDC will use information gathered from recipient monitoring and evaluation activities to answer the evaluation questions.

Required data collection will be limited to data that can be used by CDC for the purposes outlined below (see *Uses of Evaluation and Performance Data* below). CDC will manage and analyze the required performance measure data submitted by recipients and synthesize evaluation findings across recipients.

This NOFO does not involve the generation or collection of public health data. A Data Management Plan is not required for this NOFO.

**Uses of Evaluation and Performance Data**

CDC will use evaluation and performance data to demonstrate the impact of the NOFO. This includes gauging progress on the achievement of NOFO outcomes and assessing the effectiveness of NOFO activities. For example, performance measure data will be used to assess progress on the nationwide implementation of RM Series activities and the distribution of activities across the four domains of public health. Performance measurement and evaluation can help to build a stronger evidence base for NOFO strategies and activities as effective approaches for addressing ADRD. Performance measurement and evaluation data can also clarify the applicability of the evidence base to different populations, settings, and contexts to determine if strategies and activities are scalable and effective at reaching target populations.

Performance measures and evaluation findings will also facilitate continuous program quality improvement and provide information needed to improve future NOFOs. For example, in consultation with recipients, CDC will use performance measurement and evaluation data to identify areas for program improvement and to develop tailored technical assistance as needed.

CDC will review evaluation plans in order to facilitate CDC understanding of these plans, create broad consistency across evaluation plans, and to provide suggestions with respect to strategy

and execution. The CDC review will review evaluation plan completeness, coherence, and fit with the CDC evaluation and performance measurement strategy. CDC will discuss the review with recipients and, in collaboration with recipients, identify any required revisions. Evaluation plans may be updated on an annual basis and updated plans must also be submitted for CDC review and approval. Component 1 applicants will update their evaluation plans when moving from Phase I to Phase II.

CDC will work with recipients within the first 6 months of the award to further refine each performance measure based on their proposed activities. CDC will also collaborate with recipients on minor revisions to performance measures throughout the period of performance to account for emerging evaluation priorities.

More detailed guidance will be provided upon award including instructions for recommended evaluation plan sections and examples. CDC will review and approve the detailed evaluation plans as well and any annual updates made to evaluation plans.

**ii. Applicant Evaluation and Performance Measurement Plan**

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additional-requirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

**c. Organizational Capacity of Recipients to Implement the Approach**
All applicants should have adequate organizational capacity, including:

- Ability to plan, implement, monitor performance and evaluate programs.
- Ability to improve population health, via past implementation experience, especially in high-risk populations, by implementing strategies that inform the development or revision of health-related policies or systems.
- Provide a staffing plan, including an organizational chart, CVs, and position descriptions that will be sufficient to meet the goals of the proposed project and which clearly defines staff roles and reporting structure. Key personnel for this program must include program director (minimum of 25%), program coordinator (minimum of 100%), and evaluator (minimum of 15%). Applicants must show the capacity to plan, implement, monitor performance, and evaluate programs.
    - CV's: Provide CVs/Resumes for key staff and name this file "XX CVs/Resumes"
    - Position Descriptions: Name this file "XX Position Descriptions"
    - Organizational Charts: Provide Organizational Charts and name this file "XX Organizational Charts" and upload these documents as PDFs on www.grants.gov.
- Show past evidence of effectively gathering, analyzing, interpreting, and using evidence-based or evidence-informed strategies by providing examples of past work in these areas.
- Clearly describes the need to improve community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations.

In addition, Component 2 applicants should show evidence of the following:

- Show evidence of an existing jurisdiction coalition comprised of representatives from the list provided in the Strategies and Activities Section of this NOFO. This includes providing a current coalition membership list with names and organizational affiliation and naming the file "XX Coalition Membership Roster" and upload as a PDF on www.grants.gov.
- A current jurisdiction ADRD Strategic Plan with the elements provided in the Strategies and Activities Section of this NOFO. This includes submitting the current jurisdiction ADRD strategic plan with the application and naming the file "XX ADRD Strategic Plan" and upload as a PDF on www.grants.gov.

* "XX" above denotes applicant organization name (e.g., state/local/tribal name)

**d. Work Plan**
**DP23-0010 - Work Plan Sample**
Applicants should complete a work plan, to include the information described below. Component 1 applicants should provide a detailed workplan for year 1, and a high-level workplan for year 2 (Phase I-planning), as well as years 3 through 5 (Phase II-implementation).

Component 2 applicants should provide a detailed workplan for year 1, and a high-level workplan for years 2 through 5.
All applicants: Please provide additional details for these activities in the Project Narrative section of your application, where indicated.

**Strategy 1 Table:** Create, maintain or enhance a jurisdiction wide ADRD coalition

| | |
|---|---|
| **Annual Objective (Letter)** | Annual Objective A |
| **Annual Objective Description** | (description) |
| **Priority Populations** | (description) |

**Activities Table**

| # | Activity Details (for each Objective) |
|---|---|
| 1 | **Description:**<br>**Start Date:**<br>**End Date:**<br>**Milestone:**<br>**Lead Personnel Assigned:** |
| 2 | |
| 3 | |

(This table can be duplicated for additional annual objectives for this strategy. While this format is not required, please include all of the elements above as part of the workplan.)

**For each of the strategies 1(above) and 2 - 9 listed below, complete the strategy and activities tables as shown above.**

- **Strategy 2:** Educate coalition members and partners to orient them to brain health and ADRD issues and the broad spectrum of actions needed to fully address ADRD across the jurisdiction.
- **Strategy 3:** Create or update a jurisdiction **ADRD Strategic Plan** using actions from the CDC's Healthy Brain Initiative RM Series, as well as future updates, as guides. (Component 1 only)
- **Strategy 4:** Lead the coalition to develop and track an **Implementation Plan** to achieve the priorities, activities, and goals specified in the jurisdiction's ADRD Strategic Plan.
- **Strategy 5: Educate members of the general public** (including populations of high burden) about ADRD topics, including but not limited to primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) prevention.

- **Strategy 6: Educate providers and other professionals** about ADRD topics, including but not limited to primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) prevention.
- **Strategy 7:** Increase the availability and use of data (e.g., BRFSS, health system data, registries, community listening sessions, needs assessments, and other available data sources) to improve knowledge and decision making about ADRD goals and activities.
- **Strategy 8: Improve sustainability** of jurisdiction ADRD efforts.
- **Strategy 9:** Increase the number of **community-clinical linkages** among health care systems and services, public health agencies, and community-based organizations.

**e. CDC Monitoring and Accountability Approach**

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

CDC will collaborate with the recipient to develop work plans, evaluation plans, and other measures of program outcomes as necessary. This includes advising recipient on a revised work plan and evaluation plan for proposed activities.

**f. CDC Program Support to Recipients**

The CDC will provide substantial involvement beyond site visits, regular performance, and financial monitoring during the recipient's period of performance. Substantial involvement means that recipients can expect federal programmatic partnership during the cooperative agreement.

The CDC will work in partnership with recipients to ensure the success of the cooperative agreement by providing technical assistance to the recipient through the availability of subject matter experts in ADRD, subjective cognitive decline, caregiving, and using the Behavioral Risk Factor Surveillance System (BRFSS) and other data to inform activities.

CDC will also facilitate peer to peer sharing opportunities, provide technical assistance calls and webinars, and initiate calls/email communications for these activities as well as other technical assistance needs, as needed.

This also includes facilitating collaboration with other successful applicants funded through this NOFO, as well as organizations funded under CDC-RFA-DP20-2005 “BOLD Public Health Centers to Address Alzheimer’s Disease and Related Dementias”, and CDC-RFA-DP20-2003 “The National Healthy Brain Initiative” as well as relevant contracts and other projects.

## B. Award Information

**1. Funding Instrument Type:**
CA (Cooperative Agreement)
CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

**2. Award Mechanism:**
U58

**3. Fiscal Year:**
2023

Estimated Total Funding:
$70,000,000

**4. Approximate Total Fiscal Year Funding:**
$13,000,000
This amount is subject to the availability of funds.

**5. Approximate Period of Performance Funding:**
$70,000,000

**6. Total Period of Performance Length:**
5 year(s)

**7. Expected Number of Awards:**
35
The program will fund Component 1 and Component 2 awards in approximately equal amounts. Final numbers of programs funded in each Component will be decided after Phase II and Phase III review.

**8. Approximate Average Award:**

$450,000
Per Budget Period

*Component 1 = years 1-2 = $250,000 Years 3-5 = $450,000;*
*Component 2 = $450,000*

**9. Award Ceiling:**
$0
Per Budget Period

No Ceiling

**10. Award Floor:**
$0
Per Budget Period

No Floor

**11. Estimated Award Date:**
September 30, 2023
Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

**12. Budget Period Length:**
12 month(s)

**13. Direct Assistance**
Direct Assistance (DA) is not available through this NOFO.

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR Part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

## C. Eligibility Information

### 1. Eligible Applicants

Eligibility Category:
00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

07 (Native American tribal governments (Federally recognized))

11 (Native American tribal organizations (other than Federally recognized tribal governments))

Additional Eligibility Category:

Government Organizations:

State (includes the District of Columbia)

Local governments or their bona fide agents

Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

## 2. Additional Information on Eligibility

"This NOFO is authorized by the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act; PL115-406 that amends the Public Health Service Act (Section 398A; 42 U.S.C. 280c-3-4.). This act authorizes funding for "health departments of states, political subdivisions of states, and Indian [American Indian/Alaska Native] tribes and tribal organizations" to develop a strong and uniform dementia infrastructure."

**All applicants:**

1. The applicant must be a state/local or tribal Public Health Department/Department of Health and must administer and oversee this cooperative agreement.

**Component 1**: Applicants previously funded under CDC-RFA-DP20-2004 are ineligible for Component 1 awards.

**Component 2**: no other criteria

Applicants may apply for only one component. All applicants must clearly indicate which component (Component 1: Capacity Building/Implementation, or Component 2: Implementation) they are applying for in their application title. Multiple applicants from the same entity, with the same Unique Entity ID (UEI) will not be accepted.

Applications over $350,000 for Component 1 or $600,000 for Component 2 will be deemed non-responsive and will not be reviewed.

If any of these requirements are not met, the application will be deemed non-responsive and will not be reviewed.

## 3. Justification for Less than Maximum Competition

## 4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:
Yes
"MATCHING REQUIREMENT.—Each health department that is awarded a cooperative agreement under this award shall provide, from non-Federal sources, an amount equal to 30 percent of the amount provided under such agreement (which may be provided in cash or in-kind) to carry out the activities supported by the cooperative agreement."

WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive all or part of the matching requirement described here for any fiscal year for a health department of a State, political subdivision of a State, or Indian tribe or tribal organization (including those located in a rural area or frontier area), if the Secretary determines that applying such matching requirement would result in serious hardship or an inability to carry out the purposes of the cooperative agreement awarded to such health department of a State, political subdivision of a State, or Indian tribe and tribal organization."

Match Waivers may be considered. If your agency determines that applying such matching requirement would result in serious hardship or an inability to carry out the purposes of the cooperative agreement, you may submit a match waiver request. To submit a match waiver request, **submit a letter**, no more than 2 pages in length, 12 pt font on your agency's letterhead with Office of Budget and Program Leadership signatures, with your application.

Match waiver requests will be determined on a case-by-case basis for the period of performance of this award. A match waiver may be approved, as described here, for the period of performance of this award unless circumstances change for any awardee that would then enable the awardee to meet the match requirement.
Your letter requesting a match waiver should include the following elements:

- Your agency and your proposed project budget
- A brief statement of the hardship circumstances. (e.g., pandemic response, budget shortfall, emergency situation or other extenuating circumstances)

- Documentation indicating that not receiving a match waiver may cause a serious hardship or an inability to carry out the purposes of the cooperative agreement
- Signed by your state agency budget office authorized representative and the Principal Investigator
- Name this file "XX Matching Waiver Request" as a PDF and upload with your application to www.grants.gov.

### 5. Maintenance of Effort

Maintenance of effort is not required for this program.

## D. Required Registrations

### 1. Required Registrations

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

**PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c).** The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the GSA website, SAM.gov, and Grants.gov- Finding the UEI.

**a. Unique Entity Identifier (UEI):**

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI numbers before accepting any funds.

**b. System for Award Management (SAM):**

The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number and a Unique Entity Identifier (UEI). All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at SAM.gov and the SAM.gov Knowledge Base.

**c. Grants.gov:** The first step in submitting an application online is registering your organization atwww.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option atwww.grants.gov.

All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more

than five days to complete. Applicants should start the registration process as early as possible.

| Step | System | Requirements | Duration | Follow Up |
|---|---|---|---|---|
| 1 | System for Award Management (SAM) | 1. Go to SAM.gov and designate an E-Biz POC (You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration. | 3-5 Business Days but up to 2 weeks and must be renewed once a year | For SAM Customer Service Contact https://fsd.gov/ fsd-gov/ home.do Calls: 866-606-8220 |
| 2 | Grants.gov | 1. Set up an individual account in Grants.gov using organization's new UEI number to become an Authorized Organization Representative (AOR)<br>2. Once the account is set up the E-BIZ POC will be notified via email<br>3. Log into grants.gov using the password the E-BIZ POC received and create new password<br>4. This authorizes the AOR to submit applications on behalf of the organization | It takes one day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding. | Register early! Applicants can register within minutes. |

## 2. Request Application Package

Applicants may access the application package at www.grants.gov.

## 3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov.

## 4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by OGS.

**a. Letter of Intent Deadline (must be emailed)**

Number Of Days from Publication 30

02/19/2023

**b. Application Deadline**

Due Date for Applications 03/27/2023

03/27/2023
11:59 pm U.S. Eastern Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which Grants.gov operations resume.

**Due Date for Informational Conference Call**

Time: *12:30* U.S Eastern Time (US and Canada)
Topic: DP23-0010 Informational Conference Call

1. Zoom Meeting ID 161 494 8218, Passcode: BOLD2023! or at this invite link: https://cdc.zoomgov.com/j/1614948218?pwd=WWpCRlZQMEtUcXMyZHJwdVRwU3lQQT09

After 1/25/2023, the Informational Conference Call recording and transcript will be added to the DP23-0010 Information Webpage BOLD Public Health Programs |CDC-RFA-DP23-0010 | CDC.

## 5. Pre-Award Assessments

**Risk Assessment Questionnaire Requirement**

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and UEI.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

**Duplication of Efforts**

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

## 6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

## 7. Letter of Intent

Is a LOI:
Recommended but not Required
*The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications.*

Please provide a Letter of Intent that includes:

1. Applicant organization name
2. Jurisdiction (state/local/tribal name) of the applicant
3. Which Component you are applying for (Component 1 or Component 2)
4. Any priority populations proposed to be served if known

*LOI must be sent via email to:*
**Subject:** Letter of Intent for CDC-RFA-DP23-0010, Component "x"
BOLD Program Coordinators
BOLDProgramsNOFO@cdc.gov

## 8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the “Table of Contents” for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

## 9. Project Abstract Summary

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

## 10. Project Narrative

Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for

Project Narrative subsections that are specific to each component.

Text should be single spaced, 12 point font, 1-inch margins, and number all pages. Page limits include work plan; content beyond specified limits may not be reviewed.

Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity Announcement. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

The page limit for the Project Narritive is 25 pages. This includes the work plan. Content beyond the specified page number will not be reviewed.

### a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

## b. Approach

### i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the CDC Background section.

### ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the period of performance. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). (See the logic model in the Approach section of the CDC Project Description.)

### iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the period of performance. (See CDC Project Description: Strategies and Activities section.)

**1. Collaborations**

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

**2. Target Populations and Health Disparities**

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

## c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys,

questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see https://www.cdc.gov/od/science/integrity/reducePublicBurden/.

- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

### d. Organizational Capacity of Applicants to Implement the Approach

Applicants must address the organizational capacity requirements as described in the CDC Project Description.

### 11. Work Plan

(Included in the Project Narrative's page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

### 12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative,

applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment

- Supplies
- Travel
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and upload it as a PDF file

at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients

under such a plan. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

- Applicant must budget funds sufficient for at least two people to attend one CDC meeting annually (for each budget year), in Atlanta, Georgia.
- Key personnel for this program must include program director (minimum of 25%), program coordinator (minimum of 100%), and evaluator (minimum of 15%).
- PL115-406, which amends Section 398 of the Public Health Service Act, 42 U.S.C. 280c-3, specifically requires a 30% match from recipients. The required 30% match must be reflected clearly in the proposed budget. Please see above section “Cost Sharing or Matching”.
- Match Waivers may be considered. If your agency determines that applying such matching requirement would result in serious hardship or an inability to carry out the purposes of the cooperative agreement, you may submit a match waiver request. To submit a match waiver request, **submit a letter**, no more than 2 pages in length, 12 pt font on your agency’s letterhead with Office of Budget and Program Leadership signatures, with your application.

  Match waiver requests will be determined on a case-by-case basis for the period of performance of this award. A match waiver may be approved, as described here, for the period of performance of this award unless circumstances change for any awardee that would then enable the awardee to meet the match requirement.

  Your letter requesting a match waiver should include the following elements:

  - Your agency and your proposed project budget
  - A brief statement of the hardship circumstances. (e.g., pandemic response, budget shortfall, emergency situation or other extenuating circumstances)
  - Documentation indicating that not receiving a match waiver may cause a serious hardship or an inability to carry out the purposes of the cooperative agreement
  - Signed by your state agency budget office authorized representative and the Principal Investigator
  - Name this file "XX Matching Waiver Request" as a PDF and upload with your application to www.grants.gov.

## 13. Pilot Program for Enhancement of Employee Whistleblowers Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations

(CFR) section 3.908 to the award and requires that recipients inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

### 13a. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds.

Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded.

Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

**13b. Copyright Interests Provisions**

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

**13c. Data Management Plan**

As identified in the Evaluation and Performance Measurement section, applications involving

data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information: https://www.cdc.gov/grants/additional-requirements/ar-25.html.

## 14. Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
  - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
  - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition andadditional guidance on lobbying for CDC recipients.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

## 15. Other Submission Requirements

**a. Electronic Submission:** Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity atwww.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

**b. Tracking Number:** Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt whenwww.grants.gov receives the

application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

**c. Validation Process:** Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated bywww.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the NOFO. Non- validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide.
https://www.grants.gov/help/html/help/index.htm?callingApp=custom#t=GetStarted%2FGetStarted.htm

**d. Technical Difficulties:** If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service atwww.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note thatwww.grants.gov is managed by HHS.

**e. Paper Submission:** If technical difficulties are encountered at www.grants.gov, applicants should call thewww.grants.gov Contact Center at 1-800-518-4726 or e-mail them

at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application.

Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application via email.

## E. Review and Selection Process

## 1. Review and Selection Process: Applications will be reviewed in three phases

### a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

### b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

i. Approach

ii. Evaluation and Performance Measurement

iii. Applicant's Organizational Capacity to Implement the Approach

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

**i. Approach** **Maximum Points:** 40

***COMPONENT 1***

This 5-year NOFO will fund recipients in two different components. Component 1: "Capacity Building and Implementation" will be funded for 2 Capacity-Building years (Phase I) and 3 Implementation years (Phase II). This component is intended for applicants without a current jurisdiction dementia strategic plan or full coalition.

- The extent to which the applicant describes their plans to include a jurisdiction coalition that includes the following representatives: **(6 points)**
    - Jurisdiction public health department representatives (the applicant) (1 point)
    - Jurisdiction aging services department representative (1 point)
    - Jurisdiction public health department representatives from identified risk reduction areas (e.g., heart disease, diabetes) (1point)
    - National non-profit organization whose primary mission is Alzheimer's disease (state or local chapter as appropriate) (1 point)
    - Person with lived experience (1 point)
    - Other members from the "strongly encouraged" list described in the Strategies and Activities section (1 point)
- The extent to which letters of support are included from the aging services department and a national non-profit Alzheimer's organization state or local chapter, as appropriate. **(5 points)**
- The extent that the applicant describes overall program-specific strategies and activities and outcomes for years 1 and 2. These should be consistent with the CDC Project

Description, logic model, outcomes, and are achievable and appropriate for the project. **(5 points)**

- The extent to which the applicant proposes creating or updating a jurisdiction ADRD Strategic Plan that: **(10 points)**
    - Uses available data for setting goals and priorities for action. (3 points)
    - Includes goals that represent each of the prevention levels of primary prevention (e.g., dementia risk reduction), secondary prevention (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary prevention (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) at least once. (3 points)
    - Includes at least 4 Road Map actions. This includes a minimum of one (1) action from each of the Road Map domains (i.e., Educate and Empower (E), Develop Policies and Mobilize Partnerships (P), Assure a Competent Workforce (W), and Monitor and Evaluate (M)). (4 points)
- The extent to which the applicant prioritizes populations and communities experiencing the greatest disparities in the prevalence of ADRD or ADRD-associated risk factors by addressing the underlying SDOH. **(4 points)**
- The extent to which the proposal includes a high-level work plan for years 3-5 (Phase II) which outlines how they will implement the ADRD Strategic plan that is consistent with Phase II "strategies and activities". **(5 points)**
- The extent to which the applicant plans to increase the availability and use of data, including BRFSS, to improve knowledge. **(4 points)**
- The extent to which the applicant discusses coordination with other CDC programs as well as recipients of CDC-RFA-DP20-2005 and CDC-RFA-DP20-2003 as well as relevant contracts and other projects. **(1 point)**

**ii. Evaluation and Performance Measurement** **Maximum Points:** 25

***COMPONENT 1***

The extent to which the applicant clearly describes:

- Evaluation questions that align with the overarching questions specified by CDC (above, *CDC Evaluation and Performance Measurement Strategy*). **(6 points)**
- Data sources and methods that can be used to report on the outcome performance measures specified by CDC (above, *CDC Evaluation and Performance Measurement Strategy*). **(6 points)**
- How evaluation findings will be used for program improvement. **(6 points)**
- How key stakeholders will participate in evaluation and performance measurement processes. **(4 points)**
- How evaluation findings will be communicated to CDC and other partners. **(3 points)**

**iii. Applicant's Organizational Capacity to Implement the Approach** **Maximum Points:** 35

***COMPONENT 1***

- The extent to which the applicant demonstrates their ability to plan, implement, monitor performance and evaluate programs. **(10 points)**
- The extent to which the applicant demonstrates the ability to improve population health, via past implementation experience, especially in high-risk populations, by implementing strategies that inform the development or revision of health-related policies or systems. **(6 points)**
- Provides a proposed staffing plan, including an organizational chart, CVs, and position descriptions that will be sufficient to meet the goals of the proposed project and which clearly defines staff roles and reporting structure. Key personnel for this program must include program director (minimum of 25%), program coordinator (minimum of 100%), and evaluator (minimum of 15%). **(9 points)**
- The extent to which the applicant shows past evidence of effectively gathering, analyzing, interpreting, and using evidence-based or evidence-informed strategies. **(5 points)**
- The extent to which the applicant demonstrates the need to improve community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations. **(5 points)**

**Budget** **Maximum Points:** 0

***COMPONENT 1***

- The extent to which the applicant provides a strong justification for budget activities and whether they align closely with activities described in the work plan.
- Applicant must budget funds sufficient for at least two people to attend one CDC meeting annually (for each budget year), in Atlanta, Georgia.
- Applicants must clearly reflect the required 30% match in the proposed budget or a matching waiver request in their application.

The Budget is not scored.

---

_

---

_

**i. Approach** **Maximum Points:** 27

**COMPONENT 2**

Component 2: “Implementation” will be funded for 5 Implementation years. This component is intended for applicants that already have an existing dementia coalition and dementia strategic plan in place.

- The extent that the applicant describes overall program-specific strategies and activities and outcomes. These should be consistent with the CDC Project Description, logic model, outcomes, and are achievable and appropriate for the project. **(12 points)**

- The extent to which the applicant prioritizes populations and communities experiencing the greatest disparities in the prevalence of ADRD or ADRD-associated risk factors by addressing the underlying SDOH. **(5 points)**
- The extent to which the proposal includes a high-level work plan for years 2-5. This should outline how they will continue to implement the ADRD Strategic plan. This work plan should be consistent with the CDC Project Description, logic model, outcomes and is achievable and appropriate for the project. **(5 points)**
- The extent to which the applicant plans to increase the availability and use of data, including BRFSS, to improve knowledge. **(4 points)**
- The extent to which the applicant discusses coordination with other CDC programs as well as recipients of CDC-RFA-DP20-2005 and CDC-RFA-DP20-2003 as well as relevant contracts and other projects. **(1 point)**

**ii. Evaluation and Performance Measurement** **Maximum Points:** 25
**COMPONENT 2**

The extent to which the applicant clearly describes:

- Evaluation questions that align with the overarching questions specified by CDC (above, CDC Evaluation and Performance Measurement Strategy). **(6 points)**
- Data sources and methods that can be used to report on the outcome performance measures specified by CDC (above, CDC Evaluation and Performance Measurement Strategy). **(6 points)**
- How evaluation findings will be used for program improvement. **(6 points)**
- How key stakeholders will participate in evaluation and performance measurement processes. **(4 points)**
- How evaluation findings will be communicated to CDC and other partners. **(3 points)**

**iii. Applicant's Organizational Capacity to Implement the Approach** **Maximum Points:** 48
**COMPONENT 2**

- The extent to which the applicant shows evidence of an existing jurisdiction coalition that includes the following representatives: **(6 points)**
    - Jurisdiction public health department representatives (the applicant) (1 point)
    - Jurisdiction aging services department representative (1 point)
    - Jurisdiction public health department representatives from identified risk reduction areas (e.g., heart disease, diabetes) (1 point)
    - National non-profit organization whose primary mission is Alzheimer’s disease (state or local chapter as appropriate) (1 point)
    - Person with lived experience (1 point)
    - Other members from the “strongly encouraged” list described in the Strategies and Activities section, above (1 point)

- The extent to which letters of support are included from the aging services department and a national non-profit Alzheimer's organization state or local chapter, as appropriate. **(4 points)**
- The extent to which the applicant includes in their application a current jurisdiction ADRD Strategic Plan that: (10 points)
- Uses available data for setting goals and priorities for action. (2 points)
- Includes goals that represent each of the prevention levels of primary prevention (e.g., dementia risk reduction), secondary prevention (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary prevention (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) at least once. (4 points)
- Includes at least 4 Road Map actions. This includes a minimum of one (1) action from each of the Road Map domains (i.e., Educate and Empower (E), Develop Policies and Mobilize Partnerships (P), Assure a Competent Workforce (W), and Monitor and Evaluate (M)). (4 points)
- The extent to which the applicant demonstrates their ability to plan, implement, monitor performance and evaluate programs. **(6 points)**
- The extent to which the applicant demonstrates the ability to improve population health, via past implementation experience, especially in high-risk populations, by implementing strategies that inform the development or revision of health-related policies or systems. **(5 points)**
- Provides a staffing plan, including an organizational chart, CVs, and position descriptions that will be sufficient to meet the goals of the proposed project and which clearly defines staff roles and reporting structure. Key personnel for this program must include program director (minimum of 25%), program coordinator (minimum of 100%), and evaluator (minimum of 15%). **(9 points)**
- The extent to which the applicant shows past evidence of effectively gathering, analyzing, interpreting, and using evidence-based or evidence-informed strategies. **(3 points)**
- The extent to which the applicant demonstrates the need to improve community-clinical linkages among health care systems and existing services, public health agencies, and community-based organizations. **(5 points)**

**Budget** **Maximum Points:** 0

**COMPONENT 2**

- The extent to which the applicant provides a strong justification for budget activities and whether they align closely with activities described in the work plan.
- Applicant must budget funds sufficient for at least two people to attend one CDC meeting annually (for each budget year), in Atlanta, Georgia.
- Applicants must clearly reflect the required 30% match in the proposed budget or a matching waiver request in their application.

The Budget is not scored.

**c. Phase III Review**
Component 1 and Component 2 applications will be reviewed and ranked in separate panels.

CDC will determine, based on funds available, the final mix of Component 1 and Component 2 awards.

The following factors may affect the rank order and decision. CDC will provide justification for any decision to fund out of rank order:

- Geographic Balance – Applicants may be funded out of order to ensure geographic balance
    - This includes, but is not limited to, an approximate equal representation of recipients throughout the 10 HHS regions.
- Ensuring diversity in the type of recipient organizations to assure a variety of jurisdictions (state/local/tribal)
    - Type is defined as the type of eligible organization as described in the "Additional Information on Eligibility" section. This includes "health departments of states, political subdivisions of states, and Indian [American Indian/Alaska Native] tribes and tribal organizations."

**Review of risk posed by applicants.**
Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

### 2. Announcement and Anticipated Award Dates

Funded applicants will be notified in writing, and awards will be made by September 29, 2023.

## F. Award Administration Information

### 1. Award Notices

***Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC.*** The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to annual SAM Registration and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt.

### 2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at https://www.cdc.gov/grants/additional-requirements/index.html.

The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title XI and Section 1557 prohibit discrimination on the basis of sexual orientation, and gender identity. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider- obligations/index.html and https://www.hhs.gov/civil-rights/for- individuals/nondiscrimination/index.html.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, 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, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

## 3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the project period. Also, reporting is a requirement for recipients who want to apply for yearly continuation of funding. Reporting helps CDC and recipients because it:

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance and to determine

applicability of evidence-based approaches to different populations, settings, and contexts; and

- Enables CDC to assess the overall effectiveness and influence of the NOFO.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the "Agency Contacts" section of the NOFO copying the CDC Project Officer.

| Report | When? | Required? |
|---|---|---|
| Recipient Evaluation and Performance Measurement Plan, including Data Management Plan (DMP) | 6 months into award | Yes |
| Annual Performance Report (APR) | No later than 120 days before end of budget period. Serves as yearly continuation application. | Yes |
| Federal Financial Reporting Forms | 90 days after the end of the budget period. | Yes |
| Final Performance and Financial Report | 90 days after end of project period. | No |

**a. Recipient Evaluation and Performance Measurement Plan (required)**

With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets

• The frequency that performance data are to be collected.

• How performance data will be reported.

• How quality of performance data will be assured.

• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).

• Dissemination channels and audiences.

• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).

• The frequency that evaluations will be conducted.

• How evaluation reports will be published on a publicly available website.

• How evaluation findings will be used to ensure continuous quality and program improvement.

• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).

• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

**b. Annual Performance Report (APR) (required)**

The recipient must submit the APR via www.Grantsolutions.gov no later than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.

- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

The recipient must submit the Annual Performance Report via https://www.grantsolutions.gov 120 days prior to the end of the budget period.

**Component 1, Phase I** – Component 1: "Capacity Building and Implementation" will be funded for 2 Capacity-Building years (Phase I) and 3 Implementation years (Phase II).
Year 3 Continuation Application APR will require recipients to submit the two items below for CDC to review and approve before moving from Phase I to Phase II:

- Documentation of the ADRD coalition including description of the structure, membership and activities.
- An updated/created jurisdiction wide ADRD Strategic Plan.

If these documents are not submitted, the recipient will not be approved for Component 1 Phase II (Implementation).

**c. Performance Measure Reporting (optional)**
CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

**d. Federal Financial Reporting (FFR) (required)**
The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period through the Payment Management System (PMS). The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

**e. Final Performance and Financial Report (required)**
The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report

should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the period of performance, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

No additional requirements.

## 4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

## 5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign

Operations and Related Programs Appropriations Act (SFOAA) ("United States foreign assistance funds"). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:

a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

## 6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

## G. Agency Contacts

CDC encourages inquiries concerning this NOFO.

### Program Office Contact

**For programmatic technical assistance,** contact:

First Name:
Bold Program
Last Name:
Coordinators
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
4770 Buford Hwy, C107-6
Atlanta, GA 30341

Telephone:

Email:
BOLDProgramsNOFO@cdc.gov

### Grants Management Office Information

For **financial, awards management, or budget assistance,** contact:

First Name:
LaKasa

Last Name:
Wyatt
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:
2920 Brandywine Rd
Atlanta, GA 30341

Telephone:
770-488-2728

Email:
Lgw5@cdc.gov
For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348

## H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:
Resumes / CVs

Position descriptions

Letters of Support

Organization Charts

Bona Fide Agent status documentation, if applicable

**ALL APPLICANTS (Both Component 1 and Component 2)**
* "XX" below denotes applicant organization name (e.g., state/local/tribal name)

- CV's: Provide CVs/Resumes for key staff and name this file "XX CVs_Resumes"
- Position Descriptions: Name this file "XX Position Descriptions"
- Organizational Charts: Provide Organizational Charts and name this file "XX Organizational Charts"
- Letters of Support: Letters of support **are required** from the organizations from the aging services and a national non-profit Alzheimer's organization (state or local chapter as appropriate) and must include a specific description of their unique role in support of the proposed work. Tribal organizations/tribes should include members from their equivalent organizations. Applicants are encouraged to also provide letters of support for other coalition members, if applicable. Letters of support should clearly describe the partnership with the applicant and how the organization will support the program. Applicants should name this file "XX Letters of Support"
- Matching Waiver Request: If applicable. Name this file "XX Matching Waiver Request"

**Component 2**
Coalition Membership Roster (Component 2). Name this file "XX Coalition Membership Roster"
ADRD Strategic Plan (Component 2). Name this file " XX ADRD Strategic Plan"

The page limit for the Project Narrative is 25 pages. Text should be single spaced, 12-point font, 1-inch margins, and number all pages.

## I. Glossary

**Activities:** The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements**(ARs):** Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see https://www.cdc.gov/grants/additional-requirements/index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

**Approved but Unfunded:** Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

**Assistance Listings:** A government-wide collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

**Assistance Listings Number:** A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency.

**Award:** Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

**Budget Period or Budget Year:** The duration of each individual funding period within the period of performance. Traditionally, budget periods are 12 months or 1 year.

**Carryover:** Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

**Continuous Quality Improvement:** A system that seeks to improve the provision of services with an emphasis on future results.

**Contracts:** An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

**Cooperative Agreement:** A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

**Cost Sharing or Matching:** Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

**Direct Assistance:** A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. https://www.cdc.gov/grants/additional-requirements/index.html.

**Evaluation (program evaluation):** The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

**Evaluation Plan:** A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

**Federal Funding Accountability and Transparency Act of 2006 (FFATA):** Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

**Fiscal Year:** The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

**Grant:** A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

**Grants.gov:** A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

**Grants Management Officer (GMO):** The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

**Grants Management Specialist (GMS):** A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

**Health Disparities:** Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

**Health Equity:** Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
**Health Inequities:** Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

**Healthy People 2030:** National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

**Inclusion:** Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

**Indirect Costs:** Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

**Letter of Intent (LOI):** A preliminary, non-binding indication of an organization's intent to submit an application.

**Lobbying:** Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

**Logic Model:** A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

**Maintenance of Effort:** A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount. Memorandum of Understanding (MOU) or Memorandum of Agreement**(MOA):** Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

**Nonprofit Organization:** Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

**Notice of Award (NoA):** The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

**Objective Review:** A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

**Outcome:** The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

**Performance Measurement:** The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

**Period of performance –formerly known as the project period - :** The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

**Period of Performance Outcome:** An outcome that will occur by the end of the NOFO's funding period

**Plain Writing Act of 2010:** The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs. **Program Strategies:** Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

**Program Official:** Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

**Public Health Accreditation Board (PHAB)**: A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.

**Social Determinants of Health:** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Statute:** An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

**Statutory Authority:** Authority provided by legal statute that establishes a federal financial assistance program or award.

**System for Award Management (SAM):** The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic

Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

**Technical Assistance:** Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

**UEI:** The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit www.sam.gov.

**Work Plan:** The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

## NOFO -Specific Glossary and Acronyms

**ADRD Topics** for this NOFO include and are not limited to brain health, cognitive aging, dementia risk reduction, early detection and diagnosis, linkages to treatment, care, and services, prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for persons with dementia.

**Alzheimer's Disease** is an irreversible, progressive brain disorder and the most common cause of dementia. Early symptoms include difficulty with memory and thinking. As the disease progresses, symptoms include impaired communication and judgment, confusion, behavior changes, and challenges with basic bodily functions. Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks.

**Alzheimer's disease and related dementias (ADRD)** include Alzheimer's disease as well as frontotemporal degeneration (FTD), Lewy body dementia (LBD), vascular contributions to cognitive impairment and dementia (VCID), and mixed etiology dementias (MED).

**Alzheimer's disease and related dementias (ADRD) Jurisdiction Strategic Plans** are created through a jurisdiction-wide, comprehensive and collaborative effort that includes a wide variety dementia stakeholders. An ADRD strategic plan helps to coordinate and support the work of private, non-profit, public entities, and other stakeholders throughout the jurisdiction. The ADRD strategic plan is intended to help the jurisdiction leverage limited resources and set priorities for action, with a focus on supportive, population based, policies, systems, and environments that will support widespread impact and address the needs identified by the jurisdiction effort. The recommendations and strategies of the plan are meant to be accomplished through the joint efforts of private organizations, non-profit entities, state, tribal and local government agencies, as well as interested stakeholders and individuals.

**Balanced Approach** is a principle applied to the ADRD Strategic Plan. It requires including goals and actions that address all 4 domains of the Road Map at least once as well as each of the prevention levels at least once.

**Behavioral Risk Factor Surveillance System (BRFSS)** is the nation's premier system of health-related telephone surveys that collects state-level data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. The BRFSS includes two optional modules related to the activities in this NOFO- Cognitive Decline and Caregiving.

**Brain Health** is a concept that involves making the most of the brain's capacity and helping to reduce some risks that occur with aging. Brain health refers to the ability to draw on the strengths of the brain to remember, learn, play, concentrate, and maintain a clear, active mind.

**Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act** (P.L. 115-406) is a law that creates an Alzheimer's public health infrastructure across the country to implement effective Alzheimer's interventions focused on public health issues such as increasing early detection and diagnosis, reducing risk, and preventing avoidable hospitalizations. The BOLD Infrastructure for Alzheimer's Act will accomplish this by establishing Alzheimer's and Related Dementias Public Health Centers of Excellence, providing funding to state, local, and tribal public health departments, and increasing data analysis and timely reporting.

**Caregiving for persons with dementia** is unpaid help provided by spouses, partners, adult children, other relatives, and friends to persons living with dementia. Caregivers for persons with dementia often assist with activities of daily living such as personal care, household management, medication and healthcare management, and coordination of financial matters.

**Coalition** For the purposes of this program, a jurisdiction coalition is defined as a formal arrangement for cooperation and collaboration among a diverse cross-section of groups or sectors across the entire jurisdiction. Each group retains its identity and agrees to work together toward a common goal(s).

**Cognition** is the mental function involved in attention, thinking, understanding, learning, remembering, solving problems, and making decisions. Cognition is a fundamental aspect of an individual's ability to engage in activities, accomplish goals, and successfully negotiate the world. It can be viewed along a continuum—from optimal functioning to mild cognitive impairment to Alzheimer's and severe dementia.

**Cognitive Impairment** is trouble remembering, learning new things, concentrating, or making decisions that affect everyday life.

**Community-Clinical Linkages** (CCL) are connections between community and clinical sectors that aim to improve health within a community. CCLs are an effective, evidence-based approach to preventing and managing chronic diseases such as ADRD.

**Dementia** is an umbrella term for a particular group of symptoms, including difficulties with memory,

language, problem-solving, and other thinking skills that are severe enough to interfere with daily life. Alzheimer's disease is the most common cause of dementia. Other causes include vascular dementia, dementia with Lewy bodies, and frontotemporal dementia. Often, dementia can be caused by multiple types and is referred to as mixed dementia.

**Healthy Brain Initiative (HBI)** envisions a nation in which public health embraces brain health and caregiving as vital components of health that are included in public health efforts. To advance public health activities in brain health, cognitive impairment, and caregiving, *State and Local Public Health Partnerships to Address Dementia: The 2018—2023 Road Map* was released in 2018 and the *Road Map for Indian Country* was released in 2019.

**Implementation Plan** a detailed description of the specific strategies, objectives, actions, and champions that are needed to **implement** the jurisdiction ADRD Strategic Plan goals.

**Intellectual and Developmental Disabilities (IDD)** are disorders that are usually present at birth and that negatively affect the trajectory of the individual's physical, intellectual, and/or emotional development. Many of these conditions affect multiple body parts or systems. Intellectual disability starts any time before a child turns 18 and is characterized by problems with both: (1) Intellectual functioning or intelligence, which include the ability to learn, reason, problem solve, and other skills; and (2) Adaptive behavior, which includes everyday social and life skills. The term "developmental disabilities" is a broader category of often lifelong disability that can be intellectual, physical, or both.

**Jurisdiction** is the entire political/geographical boundary of the state, political subdivision of a state, or Indian [American Indian/Alaska Native] tribes and tribal organization for which the applicant represents.

**National Alzheimer's Project Act (NAPA)** creates an important opportunity to build upon and leverage Department of Health and Human Services (HHS) programs and other federal efforts to help change the trajectory of Alzheimer's disease and related dementias (ADRD). The law calls for a National Plan for ADRD with input from a public-private Advisory Council on Alzheimer's Research, Care and Services. The Advisory Council makes recommendations to HHS for priority actions to expand, coordinate, and condense programs in order to improve the health outcomes of people with ADRD and reduce the financial burden of these conditions on those with the diseases, their families, and society.

**Prevention Levels** are opportunities for public health intervention that include primary (e.g., dementia risk reduction), secondary (e.g., early detection and diagnosis; linkages to treatment, care, and services), and tertiary (e.g., prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes; caregiving for persons with dementia) prevention.

**Primary Prevention** is intervening before health effects or conditions occur. For the purpose of this NOFO, this means dementia risk reduction activities such as altering risky behaviors like poor eating habits or tobacco use or preventing and managing certain chronic conditions such as high blood pressure.

**Provider** includes any individual who **promotes, protects, and improves the health of individuals and communities. This includes health care providers, first responders, paid caregivers, and others who provide care or services to people living with dementia and/or their caregivers.**

**Public Health Approach,** for this NOFO, focuses on improving the health of entire populations across the lifespan, including dementia risk reduction, early detection and diagnosis, prevention and management of comorbidities leading to preventable hospitalizations, community-clinical linkages, referral to services, and caregiving for persons with dementia. It also includes building coordinated systems that bind together jurisdiction efforts for ADRD and caregiving for persons with dementia.

**Risk Reduction** (see Primary Prevention) is a comprehensive approach to your brain and cognitive wellness through healthy behaviors and preventing and managing certain chronic conditions that may elevate your risk for dementia.

**Road Map Series** (RM Series) refers to the Healthy Brain Initiative's (HBI) series of Road Map documents and supporting materials. These can be found at www.cdc.gov/aging, and include *the State and Local Public Health Partnerships to Address Dementia, The 2018-2023 Road Map* and the *Road Map for Indian Country* and all related supporting materials such as RM implementation and dissemination guides, topic specific Issue Maps, 1 pagers and supporting messaging. The Road Map Series prepares all communities to act quickly and strategically by stimulating changes in policies, systems, and environments and can be incorporated efficiently into existing public health initiatives.

**RM domains** refers to 4 of 10 essential services of public health used as a framework for the State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map, as well as future updates. These domains include Educate and Empower (E), Develop Policies and Mobilize Partnerships (P), Assure a Competent Workforce (W), and Monitor and Evaluate (E)).

**Secondary Prevention** is detecting diseases in the earliest stages before the onset of more severe symptoms. For the purpose of this NOFO, this means early detection and diagnosis of cognitive impairment and ADRD and linkages to treatment, care, and services.

**Strategic Plan** is a jurisdiction level document that lays out a range of goals, objectives, and strategies, including new initiatives to address ADRD.

**Subjective Cognitive Decline (SCD)** is the self-reported experience of worsening or more frequent confusion or memory loss in the past year. It is a form of cognitive impairment and is an early indicator of possible future Alzheimer's disease and related dementias.

**Sustainability** is the capacity for program activities and resources to continue after the conclusion of the period of performance.

**Tertiary Prevention** includes managing disease post diagnosis to minimize negative health and

quality of life effects. For the purpose of this NOFO, this means prevention and management of comorbidities leading to preventable hospitalizations and poor health outcomes, and caregiving for people with dementia.