HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Jackie Painter,

Director, Division of the Executive Secretariat.

[FR Doc. 2016–05684 Filed 3–11–16; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[Document Identifier: HHS–OS–0990–new–60D]

Agency Information Collection Activities; Proposed Collection; Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, announces plans to submit a new Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, OS seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on the ICR must be received on or before May 13, 2016.

ADDRESSES: Submit your comments to *Information.CollectionClearance@hhs.gov* or by calling (202) 690–6162.

FOR FURTHER INFORMATION CONTACT: Information Collection Clearance staff, *Information.CollectionClearance@hhs.gov* or (202) 690–6162.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the document identifier HHS–OS–0990–new–60D for reference.

Information Collection Request Title: Sustainability study of federally-funded programs designed to prevent or delay teen pregnancy (TPP Sustainability Study).

Abstract: The Office of Adolescent Health (OAH), U.S. Department of Health and Human Services (HHS) is requesting approval by OMB on a new collection. The TPP Sustainability Study is a key piece of OAH's broad and ongoing effort to comprehensively evaluate all of its teen pregnancy prevention funding efforts which consist of: (1) The Teen Pregnancy Prevention Program (TPP); the (2) Pregnancy Assistance Fund (PAF); and the Communitywide program funded through OAH and the Centers for Disease Control (CDC).

The proposed information request includes instruments that will collect data on: (1) Whether and how federally-funded programs have been sustained; (2) factors affecting program sustainability; (3) methods and strategies employed by grantees to sustain programs; (4) support and technical assistance that grantees received related to sustaining the programs; and (5) key lessons learned based on the outcomes of these efforts. The data will be analyzed and incorporated into study deliverables that clearly describe grantees' sustainability efforts for all audiences and highlight key challenges, successes, and lessons learned for future funding and program implementation.

The data will be used for the study team to identify key factors in program sustainability, the strategies that either worked or did not work in sustaining programs over time, and the types of support and assistance grantees required in order to sustain programs. Collecting this data is crucial to closing an existing gap in OAH knowledge about how to support the sustainability efforts of current and future grantees, including the 2015–2020 TPP grantee cohort and the 2013–2016 PAF cohort.

Likely Respondents: Program administrators at 117 grantee organizations.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Grantee Survey	39	1	0.41	16.0
In-Depth Interview Master Topic Guide	17	2	1.5	51.0
Total	56			66.0

OS specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Terry S. Clark,

Asst Collection Clearance Officer.

[FR Doc. 2016–05603 Filed 3–11–16; 8:45 am]

BILLING CODE 4168–11–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Office of Urban Indian Health Programs; 4-in-1 Grant Programs; Announcement Type: New and Competing Continuation Funding Announcement Number: HHS–2016–IHS–UIHP2–0001; Catalogue of Federal Domestic Assistance Number: 93.193

Key Dates

Application Deadline Date: May 15, 2016.

Review Period: May 23, 2016–May 27, 2016.

Earliest Anticipated Start Date: June 1, 2016.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting competitive grant applications for the FY 2016 4-in-1 Title V Programs. This program is authorized under the Snyder Act, 25 U.S.C. 13, Public Law 67–85, and Title V of the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, as amended, specifically the provisions codified at 25 U.S.C. 1652, 1653, and 1660a. This program is described in the Catalog of Federal

Domestic Assistance (CFDA) under 93.193.

Background

Prior to the 1950's, most American Indians and Alaska Natives (AI/ANs) resided on reservations, in nearby rural towns, or in Tribal jurisdictional areas such as Oklahoma. In the era of the 1950's and 1960's, the Federal Government passed legislation to terminate its legal obligations to the Indian Tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs (BIA) Relocation/Employment Assistance Programs (BIA Relocation) which enticed Indian families living on impoverished Indian Reservations to ''relocate'' to various cities across the country, *i.e.,* San Francisco, Los Angeles, Chicago, Salt Lake City, Phoenix, etc. BIA Relocation offered job training and placement, and was viewed by Indians as a way to escape poverty on the reservation. Health care was usually provided for six months through the private sector, unless the family was relocated to a city near a reservation with an IHS facility service area, such as Rapid City, Phoenix, and Albuquerque. Eligibility for IHS was not forfeited due to Federal Government relocation.

The American Indian and Policy Review Commission found that in the 1950's and 1960's, the BIA relocated over 160,000 AI/ANs to selected urban centers across the country. Today, over 61 percent of all AI/ANs identified in the 2010 census reside off-reservation.

In the late 1960's, urban Indian community leaders began advocating at the local, State and Federal levels for culturally appropriate health programs addressing the unique social, cultural and health needs of AI/ANs residing in urban settings. These community-based grassroots efforts resulted in programs targeting health and outreach services to the urban Indian community. Programs that were developed at that time were in many cases staffed by volunteers, offering outreach and referral-type services, and maintaining programs in storefront settings with limited budgets and primary care services.

In response to efforts of the urban Indian community leaders in the 1960's, Congress appropriated funds in 1966, through the IHS, for a pilot urban clinic in Rapid City. In 1973, Congress appropriated funds to study the unmet urban Indian health needs in Minneapolis. The findings of this study documented cultural, economic, and access barriers to health care for urban Indian clinics in several BIA relocation cities, *i.e.,* Seattle, San Francisco, Tulsa, and Dallas.

The awareness of poor health status of all Indian people continued to grow, and in 1976, Congress passed the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, establishing the urban Indian health program under Title V. Congress reauthorized the IHCIA in 2010 under Public Law 111–148 (2010). This law is considered health care reform legislation to improve the health and well-being of all AI/ANs, including urban Indians. Title V specific funding is authorized for the development of programs for AI/ANs residing in urban areas. Since passage of this legislation, amendments to Title V provided resources to and expanded urban Indian health programs in the areas of direct medical services, alcohol services, mental health services, human immunodeficiency virus (HIV) services, and health promotion—disease prevention services.

Purpose

This grant announcement seeks to ensure the highest possible health status for AI/ANs. Funding will be used to promote urban Indian organizations' successful implementation of the priorities of the IHS Strategic Plan 2006–2011. Additionally, funding will be utilized to meet objectives for Government Performance Results Act/Government Performance and Results Modernization Act (GPRA/GPRAMA) reporting, collaborative activities with the Veterans Health Administration, and four health programs that make health services more accessible to AI/ANs living in urban areas. The four health services programs are: (1) Health Promotion/Disease Prevention (HP/DP) services, (2) Immunizations, and Behavioral Health Services consisting of (3) Alcohol/Substance Abuse services, and (4) Mental Health Prevention and Treatment services. These programs are integral components of the IHS improvement in patient care initiative and the strategic objectives focused on improving safety, quality, affordability, and accessibility of health care.

II. Award Information

Type of Awards

Grants.

Estimated Funds Available

The total amount of funding identified for the current fiscal year (FY) 2016 is approximately $8,300,000. Individual award amounts are anticipated to be between $149,950 and $634,222. The amount of funding available for competing and continuation awards issued under this announcement are subject to the availability of appropriations and budgetary priorities of the Agency. The IHS is under no obligation to make awards that are selected for funding under this announcement.

Anticipated Number of Awards

Approximately 34 grants will be issued under this program announcement.

Project Period

The project period is for three years and will run consecutively from April 1, 2016–March 31, 2019.

III. Eligibility Information

1. Eligibility

To be eligible to apply for this New/Competing Continuation grant under this announcement, applicants must have a Title V IHCIA contract with the IHS in place as defined by 25 U.S.C. 1653(c)–(e), 1660a. Urban Indian organizations are defined by 25 U.S.C. 1603(29) as a non-profit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a).

Current UIHP 4-in-1 grantees are eligible to apply for competing continuation funding under this announcement and must demonstrate that they have complied with previous terms and conditions of the UIHP 4-in-1 grant in order to receive funding under this announcement. All prior 4-in-1 awardees from the grant segment ending in FY 2015, are required to complete and submit their FY 2016 applications based on the funding amounts received in FY 2015.

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

2. Cost Sharing or Matching

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

3. Other Requirements

If the application budget exceeds the highest dollar amount outlined under

the ''Estimated Funds Available'' section within this funding announcement, the application will be considered ineligible and will not be reviewed for further consideration. If deemed ineligible, IHS will not return the application. The applicant will be notified by email by the Division of Grants Management (DGM) of this decision.

Proof of Non-Profit Status

Organizations claiming non-profit status must submit proof. A copy of the 501(c)(3) Certificate must be received with the application submission by the Application Deadline Date listed under the Key Dates section on page one of this announcement.

An applicant submitting any of the above additional documentation after the initial application submission due date is required to ensure the information was received by the IHS by obtaining documentation confirming delivery (*i.e.* FedEx tracking, postal return receipt, etc.).

IV. Application and Submission Information

1. Obtaining Application Materials

The application package and detailed instructions for this announcement can be found at Grants.gov (*www.grants.gov*) or *http://www.ihs.gov/dgm/funding/.*

Questions regarding the electronic application process may be directed to Mr. Paul Gettys at (301) 443–2114 or (301) 443–5204.

2. Content and Form of Application Submission

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

- Table of contents.
- Abstract (one page) summarizing the key project information.
- Application forms:
  - SF–424, Application for Federal Assistance.
  - SF–424A, Budget Information—Non-Construction Programs.
  - SF–424B, Assurances—Non-Construction Programs.
- Budget Justification and Narrative (must be single-spaced and not exceed five pages).
- Project Narrative (must be single-spaced and not exceed twenty-five pages).
  - Background information on the organization.
  - Proposed scope of work, objectives, and activities that provide a description of what will be accomplished, including a one-page Timeframe Chart.
- 501(c)(3) Certificate.
- Biographical sketches for all Key Personnel.
- Contractor/Consultant resumes or qualifications and scope of work.
- Disclosure of Lobbying Activities (SF–LLL).
- Certification Regarding Lobbying (GG-Lobbying Form).
- Copy of current Negotiated Indirect Cost rate (IDC) agreement (required) in order to receive IDC.
- Organizational Chart (optional).
- Documentation of current Office of Management and Budget (OMB) A–133 or other required Financial Audit (if applicable).

Acceptable forms of documentation include:

- Email confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or
- Face sheets from audit reports. These can be found on the FAC Web site: *http://harvester.census.gov/sac/dissem/accessoptions.html?submit=Go+To+Database*.

Public Policy Requirements

All Federal wide public policies apply to IHS grants with exception of the Discrimination policy.

Requirements for Project and Budget Narratives

A. Project Narrative: The project narrative should be a separate Word document that is no longer than 25 pages and must: Be single-spaced, be type-written, have consecutively numbered pages, use black type not smaller than 12 characters per one inch, and be printed on one side only of standard size 8½ × 11 paper.

Be sure to succinctly address and answer all questions listed under the narrative and place them under the evaluation criteria (refer to Section V.1, Evaluation criteria in this announcement) and place all responses and required information in the correct section (noted below), or they shall not be considered or scored. These narratives will assist the Objective Review Committee (ORC) in becoming familiar with the applicant's activities and accomplishments prior to this grant award. If the narrative exceeds the page limit, only the first 25 pages will be reviewed. The 25-page limit for the narrative does not include the table of contents, abstract, standard forms, budget justification narrative, and/or other appendix items.

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

Part A: Program Information (3 Page Limitation)

Section 1: Needs

Describe how the urban Indian organization has expertise and administrative infrastructure to support activities of the 4-in-1 grant requirements.

Part B: Program Planning and Evaluation (18 Page Limitation)

Section 1: Program Plans

Describe fully and clearly how the urban Indian organization plans to address the four health service programs, including HP/DP, immunization, alcohol/substance abuse, and mental health.

Section 2: Program Evaluation

Describe the urban Indian organization evaluation plan including how the applicant will link program performance/services to budget expenditures.

Part C: Program Report (4 Page Limitation)

Section 1: Describe Major Accomplishments for the Last Twelve Months

Section 2: Describe Major Activities Planned for the First 12 Months

B. Budget Narrative: This narrative must include a line item budget with a narrative justification for all expenditures identifying reasonable and allowable costs necessary to accomplish the goals and objectives as outlined in the project narrative. Budget should match the scope of work described in the project narrative. The budget narrative should not exceed five pages.

3. Submission Dates and Times

Applications must be submitted electronically through Grants.gov by 11:59 p.m. Eastern Daylight Time (EDT) on the Application Deadline Date listed in the Key Dates section on page one of this announcement. Any application received after the application deadline will not be accepted for processing, nor will it be given further consideration for funding. Grants.gov will notify the applicant via email if the application is rejected.

If technical challenges arise and assistance is required with the electronic application process, contact Grants.gov Customer Support via email to *support@grants.gov* or at (800) 518–4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays). If problems persist, contact Mr. Paul Gettys (*Paul.Gettys@ihs.gov*), DGM

Grant Systems Coordinator, by telephone at (301) 443–2114 or (301) 443–5204. Please be sure to contact Mr. Gettys at least ten days prior to the application deadline. Please do not contact the DGM until you have received a Grants.gov tracking number. In the event you are not able to obtain a tracking number, call the DGM as soon as possible.

If the applicant needs to submit a paper application instead of submitting electronically through Grants.gov, a waiver must be requested. Prior approval must be requested and obtained from Mr. Robert Tarwater, Director, DGM (see Section IV.6 below for additional information). The waiver must: (1) Be documented in writing (emails are acceptable), *before* submitting a paper application, and (2) include clear justification for the need to deviate from the required electronic grants submission process. A written waiver request must be sent to *GrantsPolicy@ihs.gov* with a copy to *Robert.Tarwater@ihs.gov*. Once the waiver request has been approved, the applicant will receive a confirmation of approved email containing submission instructions and the mailing address to submit the application. A copy of the written approval *must* be submitted along with the hardcopy of the application that is mailed to DGM. Paper applications that are submitted without a copy of the signed waiver from the Senior Policy Analyst of the DGM will not be reviewed or considered for funding. The applicant will be notified via email of this decision by the Grants Management Officer of the DGM. Paper applications must be received by the DGM no later than 5:00 p.m., EDT, on the Application Deadline Date listed in the Key Dates section on page one of this announcement. Late applications will not be accepted for processing or considered for funding.

4. Intergovernmental Review

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

5. Funding Restrictions

- Pre-award costs are not allowed.
- The available funds are inclusive of direct and appropriate indirect costs.
- Only one grant/cooperative agreement will be awarded per applicant.
- IHS will not acknowledge receipt of applications.

6. Electronic Submission Requirements

All applications must be submitted electronically. Please use the *http://www.Grants.gov* Web site to submit an application electronically and select the ''Find Grant Opportunities'' link on the homepage. Download a copy of the application package, complete it offline, and then upload and submit the completed application via the *http://www.Grants.gov* Web site. Electronic copies of the application may not be submitted as attachments to email messages addressed to IHS employees or offices.

If the applicant receives a waiver to submit paper application documents, they must follow the rules and timelines that are noted below. The applicant must seek assistance at least ten days prior to the Application Deadline Date listed in the Key Dates section on page one of this announcement.

Applicants that do not adhere to the timelines for System for Award Management (SAM) and/or *http://www.Grants.gov* registration or that fail to request timely assistance with technical issues will not be considered for a waiver to submit a paper application.

Please be aware of the following:

- Please search for the application package in *http://www.Grants.gov* by entering the CFDA number of the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: *support@grants.gov* or (800) 518–4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful is there are technical issues that cannot be resolved and a waiver from the agency must be obtained.
- If it is determined that a waiver is needed, the applicant must submit a request in writing (emails are acceptable) to *GrantsPolicy@ihs.gov* with a copy to *Robert.Tarwater@ihs.gov*. Please include a clear justification for the need to deviate from the standard electronic submission process.
- If the waiver is approved, the application should be sent directly to the DGM by the Application Deadline Date listed in the Key Dates section on page one of this announcement.
- Applicants are strongly encouraged not to wait until the deadline date to begin the application process through Grants.gov as the registration process for SAM and Grants.gov could take up to fifteen working days.
- Please use the optional attachment feature in Grants.gov to attach additional documentation that may be requested by the DGM.
- All applicants must comply with any page limitation requirements described in this funding announcement.
- After electronically submitting the application, the applicant will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. The DGM will download the application from Grants.gov and provide necessary copies to the appropriate agency officials. Neither the DGM nor the Office of Urban Indian Health Programs will notify the applicant that the application has been received.
- Email applications will not be accepted under this announcement.

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

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

All Department of Health and Human Services recipients are required by the Federal Funding Accountability and Transparency Act of 2006, as amended (''Transparency Act''), to report information on sub-awards. Accordingly, all IHS grantees must notify potential first-tier sub-recipients that no entity may receive a first-tier sub-award unless the entity has provided its DUNS number to the prime grantee organization. This requirement ensures the use of a universal identifier to enhance the quality of information available to the public pursuant to the Transparency Act.

System for Award Management (SAM)

Organizations that were not registered with Central Contractor Registration and have not registered with SAM will need to obtain a DUNS number first and then access the SAM online registration through the SAM home page at *https://www.sam.gov* (U.S. organizations will also need to provide an Employer Identification Number from the Internal Revenue Service that may take an additional 2–5 weeks to become active). Completing and

submitting the registration takes approximately one hour to complete and SAM registration will take 3–5 business days to process. Registration with the SAM is free of charge. Applicants may register online at *https://www.sam.gov.*

Additional information on implementing the Transparency Act, including the specific requirements for DUNS and SAM, can be found on the IHS Grants Management, Grants Policy Web site: *http://www.ihs.gov/dgm/policytopics/.*

V. Application Review Information

The instructions for preparing the application narrative also constitute the evaluation criteria for reviewing and scoring the application. Weights assigned to each section are noted in parentheses. The 25 page narrative should include only the first year activities; information for multi-year projects should be included as an appendix. See ''Multi-year Project Requirements'' at the end of this section for more information. The narrative should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the applicant. It should be well organized, succinct, and contain all information necessary for reviewers to understand the project fully. Points will be assigned to each evaluation criteria adding up to a total of 100 points. A minimum score of 60 points is required for funding. Points are assigned as follows:

1. Criteria

The narrative should address program progress for the first 12 months.

A. Introduction and Need for Assistance (30 Points)

1. Facility Capability

Urban Indian programs provide health care services within the context of IHS Strategic Plan and four IHS priorities.

Describe the UIHP: (1) Accomplishments over the past twelve months, and (2) define activities planned for the 2016 budget period in each of the following areas:

a. IHS Priorities for American Indian/Alaska Native Health Care. Current governmental trends and environmental issues impact AI/ANs residing in urban locations and require clear and consistent support by the Title V funded UIHP. The IHS Web site is *http://www.ihs.gov.*

(1) Renew and strengthen our partnerships with Tribes and urban Indian health programs: The UIHPs have a hybrid relationship with the IHS. With the passage of Pubic Law 111–148, the Indian Health Care Improvement Act was made permanent.

• Identify what the UIHP is doing to strengthen its partnerships with Tribes and other urban Indian health programs.

a. Major accomplishments over the last twelve months.

b. Activities planned for the first 12 months, including information on how results are shared with the community.

(2) Improve the IHS: In order to support health care improvement, it must be demonstrated there is a willingness to change and improve, *i.e.,* in human resources and business practices.

• Describe activities the UIHP is taking to ensure health care improvement is being applied.

a. Major accomplishments over the last twelve months.

b. Activities planned for the first 12 months.

(3) Improve the quality of and access to care: Customer service is the key to quality care. Treating patients well is the first step to improving quality and access. This area also incorporates best practices in customer service.

• Identify activities that demonstrate the UIHP improving quality of and access to care.

a. Major accomplishments over the last twelve months.

b. Activities planned for the first 12 months.

(4) Ensure that our work is transparent, accountable, fair, and inclusive: Quality health care needs to be transparent, with all parties held accountable for that care. Accountability for services is emphasized.

• Describe activities that demonstrate how this is implemented in the UIHP program.

a. Major accomplishments over the last twelve months.

b. Activities planned for the first 12 months.

b. GPRA Reporting

All UIHPs report on IHS GPRA/GPRAMA clinical performance measures. This is required of both urban facilities using the Resource and Patient Management System (RPMS) and facilities not using RPMS. RPMS users must use the Clinical Reporting System (CRS) for reporting. Non-RPMS users must perform a 100% audit of all records and report results on an Excel template provided by the National GPRA Support Team (NGST) as per the quarterly reporting instructions distributed by the NGST. Questions related to GPRA reporting may be directed to the IHS Area Office GPRA Coordinator or the National GPRA Support Team at *caogpra@ihs.gov.*

The current GPRA Reporting Period is July 1, 2015 through June 30, 2016. GPRA reports are due for the 2nd, 3rd, and 4th quarters, which end on December 31, March 31, and June 30, respectively. Each report is cumulative, and must include data starting from July 1st of the current GPRA year.

GPRA measures to report for FY2016 include 20 clinical measures and one non-clinical measure.

FY 2016 Clinical GPRA/GPRAMA Measures

1. Diabetes DX Ever (no target, used for context only).
2. Documented A1c (no target, used for context only).
3. Diabetes: Good Glycemic Control (GPRAMA measure).
4. Diabetes: Controlled Blood Pressure.
5. Diabetes: Statin Therapy to Reduce CVD Risk in Patients with Diabetes.
6. Diabetes: Nephropathy Assessment.
7. Influenza Vaccination Rates Among Children 6 months to 17 years.
8. Influenza Vaccination Rates Among Adults 18+.
9. Pneumococcal Immunization 65+.
10. Childhood Immunizations (GPRAMA).
11. Pap Screening Rates.
12. Mammography Screening Rates.
13. Colorectal Cancer Screening Rates.
14. Tobacco Cessation.
15. Alcohol Screening (FAS Prevention).
16. Domestic Violence/Intimate Partner Violence Screening.
17. Depression Screening (GPRAMA).
18. HIV Screening.
19. Breastfeeding Rates.
20. Childhood Weight Control (long-term measures, result will be reported in FY2016).

FY 2016 NON CLINICAL GPRA/GPRAMA MEASURE

1. Suicide Surveillance (RPMS Programs only).

FY 2016 measure targets are attached. Note that since 2013, urban measure targets are the same as the targets for Tribal and Federal health programs.

1. The following GPRAMA measures should be prioritized for target achievement: Good Glycemic Control, Childhood Immunizations and Depression Screening. Briefly describe the steps/activities you will take to ensure your program meets the FY 2016 target rates for these measures.

2. Describe at least two actions you will complete to meet the FY 2016 GPRA/GPRAMA performance targets. A Performance Improvement Toolbox with information on clinical GPRA measures, screening tools, and guidelines is

available on the CRS Web site at: *http://www.ihs.gov/crs/toolbox/http://www.ihs.gov/crs/index.cfm?module=crs_performance_improvement_toolbox.*

3. GPRA Behavioral Health performance measures include Alcohol Screening (to prevent Fetal Alcohol Syndrome), Domestic (Intimate Partner) Violence Screening and Depression Screening (for adults over age 18). Describe actions you will take to improve 2015–2016 desired behavioral health performance outcomes/results.

4. Document your ability to collect and report on the required performance measures to meet GPRA requirements. Include information about your health information technology system.

c. Schedule of Charges and Maximization of Third Party Payments

1. Describe the UIHP established schedule of charges and consistency with local prevailing rates.

• If the UIHP is not currently billing for billable services, describe the process the UIHP will take to begin third party billing to maximize collections.

2. Describe how reimbursement is maximized from Medicare, Medicaid, State Children's Health Insurance Program, private insurance, etc.

3. Describe how the UIHP achieves cost effectiveness in its billing operations with a brief description of the following:

a. Establishes appropriate eligibility determination.

b. Reviews/updates and implements up-to-date billing and collection practices.

c. Updates insurance at every visit.

d. Maintains procedures to evaluate necessity of services.

e. Identifies and describes financial information systems used to track, analyze and report on the program's financial status by revenue generation, by source, aged accounts receivable, provider productivity, and encounters by payor category.

f. Indicates the date the UIHP last reviewed and updated its Billing Policies and Procedures.

B. Program Narratives and Work Plans (40 Points)

A program narrative and a program specific work plan are required for each health services program: (1) HD/DP, (2) Immunizations, (3) Alcohol/Substance Abuse, and (4) Mental Health. Title V of the IHCIA, Public Law 94–437, as amended, identifies eligibility for health services as follows.

Each grantee shall provide health care services to eligible urban Indians living within the urban service area. An ''Urban Indian'' eligible for services, as codified at 25 U.S.C. 1603(13), (27), and (28), includes any individual who:

1. Resides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under the IHCIA, as determined by the Secretary, HHS; and who

2. Meets one or more of the following criteria:

a. Irrespective of whether he or she lives on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including:

i. Those Tribes, bands, or groups terminated since 1940, and

ii. those recognized now or in the future by the State in which they reside, or

b. Is a descendant, in the first or second degree, of any such member described in a.; or

c. Is an Eskimo or Aleut or other Alaska Native; or

d. Is a California Indian; [1] or

e. Is considered by the Secretary of the Department of the Interior to be an Indian for any purpose; or

f. Is determined to be an Indian under regulations pertaining to the Urban Indian Health Program that are promulgated by the Secretary, HHS.

Each grantee is responsible for taking reasonable steps to confirm that the individual is eligible for IHS services as an urban Indian.

1. HP/DP

Contact your IHS Area Office HP/DP Coordinator to discuss and identify effective and innovative strategies to promote health and enhance prevention efforts to address chronic diseases and conditions. Identify one or more of the strategies you will conduct during the first 12 months.

a. Applicants are encouraged to use evidence-based and promising strategies which can be found at the IHS best practice database *httpp://www.ihs.gov/hpdp/,* the National Registry for Effective Programs at *http://www.nrepp.samhsa.gov/,* and the Guide to Community Preventive Services at *http://www.thecommunityguide.org/about/conclusionreport.html.*

b. Program Narrative. Provide a brief description of the collaboration activities that: (1) Were accomplished over the last 10 months, and (2) are planned and will be conducted between your UIHP and the IHS Area Office HP/DP Coordinator during the budget period April 1, 2016 through March 31, 2017.

c. An example of an HP/DP work plan is provided on the following pages. Develop and attach a copy of the UIHP HP/DP Work Plan for the first 12 months.

2. IMMUNIZATION SERVICES

a. Program Management Required Activities

i. Provide assurance that your facility is participating in the Vaccines for Children program.

ii. Provide assurance that your facility has look up capability with State/regional immunization registry (where applicable). Contact Cecile Town at *cecile.town@ihs.gov,* IHS Immunization Data Exchange Coordinator, for more information.

b. Service Delivery Required Activities—For Sites Using RPMS

i. Provide trainings to providers and data entry clerks on the RPMS Immunization package.

ii. Establish process for immunization data entry into RPMS (*e.g.,* point of service or through regular data entry).

iii. Utilize RPMS Immunization package to identify 3–27 month old children who are not up to date and generate reminder/recall letters.

c. Immunization Coverage Assessment Required Activities

i. Submit quarterly immunization reports to Area Immunization Coordinator for the 3–27 month old, Two year old and Adolescent, Influenza and Adult reports. Sites not using the RPMS Immunization package should submit a Two Year old immunization coverage report—an Excel spreadsheet with the required data elements that can be found under the ''Report Forms for non-RPMS sites'' section at: *http://www.ihs.gov/epi/index.cfm?module=epi_vaccine_reports.*

d. Program Evaluation Required Activities

i. Report coverage with the 4313314* vaccine series for children 19–35 months old.

ii. Report coverage for patients (6 months and older) who received at least one dose of seasonal flu vaccine during flu season.

iii. Report coverage for children 6 months–17 years and adults 18 years and older who received at least one dose

[1] Consistent with 25 U.S.C. 1603(3), (13), (28), and 1679, eligibility of California Indians may be demonstrated by documentation that the individual:

(1) Is a descendant of an Indian who was residing in the State of California on June 1, 1852;

(2) Holds trust interests in public domain, national forest, or Indian reservation allotments; or

(3) Is listed on the plans for distribution of assets of California Rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), or is the descendant of such an individual.

of seasonal flu vaccine during flu season.

iv. Report coverage with at least one dose of pneumococcal vaccine for adults 65 years and older.

v. Establish baseline coverage on adult vaccines, specifically: 1 dose of Tdap for adults 19 years and older; 1 dose of HPV for females 19–26 years old; 3 doses HPV for females 19–26 years; 1 dose of HPV for males 19–21 years old; 3 doses HPV for males 19–21 years; and 1 dose of Zoster for patients 60+ years.

* The 4:3:1:3:3:1:4 vaccine series is defined as: 4 doses diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, or diphtheria and tetanus toxoids and any pertussis vaccine, 3 doses of oral or inactivated polio vaccine, 1 dose of measles, mumps, and rubella vaccine, 3 or 4 doses of *Haemophilus influenzae* type b vaccine depending on brand, 3 doses of hepatitis B vaccine, 1 dose of varicella vaccine, and 4 doses of pneumococcal conjugate vaccine (PCV).

3. ALCOHOL/SUBSTANCE ABUSE

a. Program Progress Report or Results/Outcomes for the past 10 months.

i. Briefly address the extent to which the program was able to achieve its objectives over the last 10 months.

ii. Identify Specific Program Services Outcomes/Results:

1. State the number of patient encounters (or specific service) per provider staff for this program service,

2. List populations and age groups that were targeted (homeless, women, children, adolescent, elderly, men, special needs, etc.), and

3. Identify specific outcomes/results that were measured in addition to the number of patient encounters/staff.

b. Narrative Description of Program Services for the first 12 months.

i. Program Objectives

1. Clearly state the outcomes of the health service.

2. Define needs related outcomes of the program health care service.

3. Define who is going to do what, when, how much, and how you will measure it.

4. Define the population to be served and provide specific numbers regarding the number of eligible clients for whom services will be provided.

5. State the time by which the objectives will be met.

6. Describe objectives in numerical terms—specify the number of clients that will receive services.

7. Describe how achievement of the goals will produce meaningful and relevant results (*e.g.,* increase access, availability, prevention, outreach, pre-services, treatment, and/or intervention).

8. Provide a one-year work plan that will include the primary objectives, services or program, target population, process measures, outcome measures, and data source for measures (see work plan sample in Appendix 2).

a. Identify Services Provided: Primary Residential; Detox; Halfway House; Counseling; Outreach and Referral; and Other (Specify)

b. Number of beds: Residential ___, Detox___; or Half way House ___.

c. Average monthly utilization for the past year.

d. Identify Program Type: Integrated Behavioral Health; Alcohol and Substance Abuse only; Stand Alone; or part of a health center or medical establishment.

9. Address methamphetamine-related contacts.

a. Identify the documented number of patient contacts during the past twelve months, and estimate the number patient contacts during the first 12 months..

b. Describe your formal methamphetamine prevention and education program efforts to reduce the prevalence of methamphetamine abuse related problems through increased outreach, education, prevention and treatment of methamphetamine-related issues.

c. Describe collaborative programming with other agencies to coordinate medical, social, educational, and legal efforts.

ii. Program Activities

1. Clearly describe the program activities or steps that will be taken to achieve the desired outcomes/results. Describe who will provide (program, staff) what services (modality, type, intensity, duration), to whom (individual characteristics), and in what context (system, community).

2. State reasons for selection of activities.

3. Describe sequence of activities.

4. Describe program staffing in relation to number of clients to be served.

5. Identify number of Full Time Equivalents (FTEs) proposed and adequacy of this number:

a. Percentage of FTEs funded by IHS grant funding; and

b. Describe clients and client selection.

6. Address the comprehensive nature of services offered in this program service area.

7. Describe and support any unusual features of the program services, or extraordinary social and community involvement.

8. Present a reasonable scope of activities that can be accomplished within the time allotted for program and program resources.

iii. Accreditation and Practice Model

1. Name of program accreditation.

2. Type of evidence-based practice.

3. Type of practice-based model.

iv. Attach the Alcohol/Substance Abuse Work Plan.

4. BEHAVIORAL HEALTH SERVICES

a. Program Progress Report or Results/Outcomes for the past twelve months.

i. Briefly address the extent to which the program was able to achieve its objectives over the past twelve months.

ii. Identify Specific Program Services Outcomes/Results:

1. State the number of patient encounters (or specific service) per provider staff for this program service,

2. List populations and age groups that were targeted (homeless, women, children, adolescent, elderly, men, special needs, etc.), and

3. Identify specific outcomes/results that were measured in addition to the number of patient encounters/staff.

b. Narrative Description of Program Services for April 1, 2016—March 31, 2017.

i. Program Objectives

1. Clearly state the outcomes of the health service.

2. Define needs related outcomes of the program health care service.

3. Define who is going to do what, when, how much, and how you will measure it.

4. Define the population to be served and provide specific numbers regarding the number of eligible clients for whom services will be provided.

5. State the time by which the objectives will be met.

6. Describe objectives in numerical terms—specify the number of clients that will receive services.

7. Describe how achievement of the goals will produce meaningful and relevant results (*e.g.,* increase access, availability, prevention, outreach, pre-services, treatment, and/or intervention).

8. Provide a one-year work plan that will include the primary objectives, services or program, target population, process measures, outcome measures, and data source for measures (see work plan sample in Appendix 2).

a. Identify Services Provided: Community Outreach, Prevention Initiatives Trainings, Court Ordered Evaluations (Adult and Juvenile),

Schools, Treatments, Domestic Violence Programs, Specific Groups, Crisis Lines, Child Protection Assistance, and Other (Specify).

b. Identify average monthly utilization for the past year.

c. Identify Program Type: Integrated Behavioral Health, independent agency, or part of a health center or medical establishment.

9. Address Behavioral Health related contacts.

a. Identify the documented number of patient contacts during the past twelve months and estimate the number patient contacts during the first 12 months.

b. Describe your formal behavioral health prevention and education program efforts to increase access to services, outreach, education, prevention and treatment of behavioral health related issues.

c. Describe collaborative programming with other agencies to coordinate medical, social, educational, and legal efforts.

ii. Program Activities

1. Clearly describe the program activities or steps that will be taken to achieve the desired outcomes/results. Describe who will provide (program, staff) what services (modality, type, intensity, duration), to whom (individual characteristics), and in what context (system, community).

2. State reasons for selection of activities.

3. Describe sequence of activities.

4. Describe program staffing in relation to number of clients to be served.

5. Identify number of FTEs proposed and adequacy of this number:

a. Percentage of FTEs funded by IHS grant funding; and

b. Describe clients and client selection.

6. Address the comprehensive nature of services offered in this program service area.

7. Describe and support any unusual features of the program services, or extraordinary social and community involvement.

8. Present a reasonable scope of activities that can be accomplished within the time allotted for program and program resources.

iii. Accreditation and Practice Model

1. Name of program accreditation.

2. Type of evidence-based practice.

3. Type of practice-based model.

iv. Attach the Behavioral Health Work Plan

C. Project Evaluation (15 Points)

1. Describe your evaluation plan. Provide a plan to determine the degree to which objectives are met and methods are followed.

2. Describe how you will link program performance/services to budget expenditures. Include a discussion of GPRA/GPRAMA Report Measures here.

3. Include the following program specific information:

a. Describe the expected feasibility and reasonable outcomes (*e.g.,* decreased drug use in those patients receiving services) and the means by which you determined these targets or results.

b. Identify dates of reviews by the internal staff to assess efficacy:

I. Assessment of staff adequacy.

II. Assessment of current position descriptions.

III. Assessment of impact on local community.

IV. Involvement of local community.

V. Adequacy of community/governance board.

VI. Ability to leverage IHS funding to obtain additional funding.

VII. Additional IHS grants obtained.

VIII. New initiatives planned for funding year.

IX. Customer satisfaction evaluations.

4. Describe your Quality Improvement Committee (QIC).

The UIHP QIC, a planned, organization-wide, interdisciplinary team, systematically improves program performance as a result of its findings regarding clinical, administrative and cost-of-care performance issues, and actual patient care outcomes including the FY 2015 GPRA report (results of care including safety of patients).

a. Identify the QIC membership, roles, functions, and frequency of meetings. Frequency of meeting shall be at least quarterly.

b. Describe how the results of the QIC reviews provide regular feedback to the program and community/governance board to improve services.

1. Accomplishments during the past twelve months.

2. Activities planned for the first 12 months.

c. Describe how your facility is integrating the care model into your health delivery structure:

1. Identify specific measures you are tracking as part of the Improving Patient Care (IPC) work.

2. Identify community members that are part of your IPC team.

3. Describe progress meeting your program's goals for the use of the IPC model within your healthcare delivery model.

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

This section outlines the broader capacity of the organization to complete the project outlined in the continuation application and program specific work plans. This section includes the identification of personnel responsible for completing tasks and the chain of responsibility for successful completion of the project outlined in the work plans.

1. Describe the organizational structure with a current approved one page organizational chart that shows the board of directors, key personnel, and staffing. Key positions include the Chief Executive Officer or Executive Director, Chief Financial Officer, Medical Director, and Information Officer.

2. Describe the board of directors that is fully and legally responsible for operation and performance of the 501(c)(3) non-profit urban Indian organization:

a. List all current board members by name, sex, and Tribe or race/ethnicity,

b. Indicate their board office held,

c. Indicate their occupation or area of expertise,

d. Indicate if the board member uses the UIHP services,

e. Indicate if the board member lives in the health service area.

f. Indicate the number of years of continuous service.

g. Indicate number of hours of board of directors training provided, training dates and attach a copy of the board of directors training curriculum.

3. List key personnel who will work on the project.

a. Identify existing key personnel and new program staff to be hired.

b. For all new key personnel only include position descriptions and resumes in the appendix. Position descriptions should clearly describe each position and duties indicating desired qualifications, experience, and requirements related to the proposed project and how they will be supervised. Resumes must indicate that the proposed staff member is qualified to carry out the proposed project activities and who will determine if the work of a contractor is acceptable.

c. Identify who will be writing the progress reports.

d. Indicate the percentage of time to be allocated to this project and identify the resources used to fund the remainder of the individual's salary if personnel are to be only partially funded by this grant.

E. Categorical Budget and Budget Justification (5 Points)

This section should provide a clear estimate of the project program costs and justification for expenses for the first 12 months.. The budget and budget justification should be consistent with the tasks identified in the work plan.

1. Categorical Budget (Form SF 424A, Budget Information Non-Construction Programs) complete each of the budget periods requested.

a. Provide a narrative justification for all costs, explaining why each line item is necessary or relevant to the proposed project. Include sufficient details to facilitate the determination of cost allowability.

b. If indirect costs are claimed, indicate and apply the current negotiated rate to the budget. Include a copy of the current rate agreement in the appendix.

Multi-Year Project Requirements

Projects requiring a second and/or third year must include a brief project narrative and budget (one additional page per year) addressing the developmental plans for each additional year of the project.

Additional Documents Can Be Uploaded as Appendix Items in Grant.gov

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

2. Review and Selection

Each application will be prescreened by the DGM staff for eligibility and completeness as outlined in the funding announcement. Applications that meet the eligibility criteria shall be reviewed for merit by the ORC based on evaluation criteria in this funding announcement. The ORC could be composed of both Tribal and Federal reviewers appointed by the IHS Program to review and make recommendations on these applications. The technical review process ensures selection of quality projects in a national competition for limited funding. Incomplete applications and applications that are non-responsive to the eligibility criteria will not be referred to the ORC. The applicant will be notified via email of this decision by the Grants Management Officer of the DGM. Applicants will be notified by DGM, via email, to outline minor missing components (*i.e.,* budget narratives, audit documentation, key contact form) needed for an otherwise complete application. All missing documents must be sent to DGM on or before the due date listed in the email of notification of missing documents required.

To obtain a minimum score for funding by the ORC, applicants must address all program requirements and provide all required documentation.

VI. Award Administration Information

1. Award Notices

The Notice of Award (NoA) is a legally binding document signed by the Grants Management Officer and serves as the official notification of the grant award. The NoA will be initiated by the DGM in our grant system, GrantSolutions (*https://www.grantsolutions.gov*). Each entity that is approved for funding under this announcement will need to request or have a user account in GrantSolutions in order to retrieve their NoA. The NoA is the authorizing document for which funds are dispersed to the approved entities and reflects the amount of Federal funds awarded, the purpose of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period.

Disapproved Applicants

Applicants who received a score less than the recommended funding level for approval, 60 points, and were deemed to be disapproved by the ORC, will receive an Executive Summary Statement from the IHS program office within 30 days of the conclusion of the ORC outlining the strengths and weaknesses of their application submitted. The IHS program office will also provide additional contact information as needed to address questions and concerns as well as provide technical assistance if desired.

Approved But Unfunded Applicants

Approved but unfunded applicants that met the minimum scoring range and were deemed by the ORC to be ''Approved,'' but were not funded due to lack of funding, will have their applications held by DGM for a period of one year. If additional funding becomes available during the course of FY 2016, the approved, but unfunded, application may be re-considered by the awarding program office for possible funding. The applicant will also receive an Executive Summary Statement from the IHS program office within 30 days of the conclusion of the ORC.

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

2. Administrative Requirements

Grants are administered in accordance with the following regulations, policies, and OMB cost principles:

A. The criteria as outlined in this program announcement.

B. Administrative Regulations for Grants:

- Uniform Administrative Requirements for HHS Awards, located at 45 CFR part 75.

C. Grants Policy:

- HHS Grants Policy Statement, Revised 01/07.

D. Cost Principles:

- Uniform Administrative Requirements for HHS Awards, ''Cost Principles,'' located at 45 CFR part 75, subpart E.

E. Audit Requirements:

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

3. Indirect Costs

This section applies to all grant recipients that request reimbursement of indirect costs (IDC) in their grant application. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to obtain a current IDC rate agreement prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate is not on file with the DGM at the time of award, the IDC portion of the budget will be restricted. The restrictions remain in place until the current rate is provided to the DGM.

Generally, IDC rates for IHS grantees are negotiated with the Division of Cost Allocation (DCA) *https://rates.psc.gov/* and the Department of Interior (Interior Business Center) *https://www.doi.gov/ibc/services/finance/indirect-Cost-Services/indian-tribes.* For questions regarding the indirect cost policy, please call the Grants Management Specialist listed under ''Agency Contacts'' or the main DGM office at (301) 443–5204.

4. Reporting Requirements

The grantee must submit required reports consistent with the applicable deadlines. Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, withholding of

additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This requirement applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports. Per DGM policy, all reports are required to be submitted electronically by attaching them as a ''Grant Note'' in GrantSolutions. Personnel responsible for submitting reports will be required to obtain a login and password for GrantSolutions. Please see the Agency Contacts list in section VII for the systems contact information.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required semi-annually within 30 days after the budget period ends. These reports must include a brief comparison of actual accomplishments to the goals established for the period, a summary of progress to date or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 90 days of expiration of the budget/project period.

B. Financial Reports

Federal Financial Report FFR (SF–425), Cash Transaction Reports are due 30 days after the close of every calendar quarter to the Payment Management Services, HHS at: *http://www.dpm.psc.gov.* It is recommended that the applicant also send a copy of the FFR (SF–425) report to the grants management specialist. Failure to submit timely reports may cause a disruption in timely payments to the organization.

Grantees are responsible and accountable for accurate information being reported on all required reports: The Progress Reports and Federal Financial Report.

C. Federal Sub-Award Reporting System (FSRS)

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

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

IHS has implemented a Term of Award into all IHS Standard Terms and Conditions, NoAs and funding announcements regarding the FSRS reporting requirement. This IHS Term of Award is applicable to all IHS grant and cooperative agreements issued on or after October 1, 2010, with a $25,000 sub-award obligation dollar threshold met for any specific reporting period. Additionally, all new (discretionary) IHS awards (where the project period is made up of more than one budget period) and where: (1) The project period start date was October 1, 2010 or after and (2) the primary awardee will have a $25,000 sub-award obligation dollar threshold during any specific reporting period will be required to address the FSRS reporting. For the full IHS award term implementing this requirement and additional award applicability information, visit the DGM Grants Policy Web site at: *http://www.ihs.gov/dgm/policytopics/.*

D. GPRA Report

GPRA reports are required for the 2nd, 3rd, and 4th quarters, ending on December 31, March 31, and June 30 of each year. These reports are submitted to the site's IHS Area GPRA Coordinator by the date listed on the GPRA/GPRAMA Quarterly Reporting Instructions that are distributed each quarter by the NGST, usually 3–4 weeks after the end of the quarter. RPMS users must use CRS to run a quarterly GPRA report. Non-RPMS users must follow the quarterly instructions issued by the NGST to perform a 100% audit of records, and use the Excel template provided with the quarterly instructions to report GPRA data.

E. Quarterly Immunization Report

Immunization reports are required quarterly. These reports are submitted to the IHS Area Immunization Coordinator.

F. Unmet Needs Report

An unmet needs report is required quarterly. These reports will include information gathered to: (1) Identify gaps between unmet health needs of urban Indians and the resources available to meet such needs; and (2) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians.

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

Recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age and, in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. HHS provides guidance to recipients of FFA on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. Please see *http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/.*

The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see *http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html;* and *http://www.hhs.gov/civil-rights/index.html.* Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see *http://www.hhs.gov/civil-rights/for-individuals/disability/index.html.* Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at *http://www.hhs.gov/civil-rights/for-individuals/disability/index.html* or call 1–800–368–1019 or TDD 1–800–537–7697. Also note it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.*

Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for benefits and services from the Indian Health Service.

Recipients will be required to sign the HHS–690 Assurance of Compliance form which can be obtained from the following Web site: *http://www.hhs.gov/sites/default/files/forms/hhs-690.pdf,* and send it directly to the: U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW., Washington, DC 20201.

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

The IHS is required to review and consider any information about the applicant that is in the Federal Awardee Performance and Integrity Information System (FAPIIS) before making any award in excess of the simplified acquisition threshold (currently $150,000) over the period of performance. An applicant may review and comment on any information about itself that a federal awarding agency previously entered. IHS will consider any comments by the applicant, in addition to other information in FAPIIS in making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in 45 CFR 75.205.

As required by 45 CFR part 75 Appendix XII of the Uniform Guidance, non-federal entities (NFEs) are required to disclose in FAPIIS any information about criminal, civil, and administrative proceedings, and/or affirm that there is no new information to provide. This applies to NFEs that receive federal awards (currently active grants, cooperative agreements, and procurement contracts) greater than $10,000,000 for any period of time during the period of performance of an award/project.

Mandatory Disclosure Requirements

As required by 2 CFR part 200 of the Uniform Guidance, and the HHS implementing regulations at 45 CFR part 75, effective January 1, 2016, the Indian Health Service must require a non-federal entity or an applicant for a federal award to disclose, in a timely manner, in writing to the IHS or pass-through entity all violations of federal criminal law involving fraud, bribery,or gratuity violations potentially affecting the federal award.

Submission is required for all applicants and recipients, in writing, to the IHS and to the HHS Office of Inspector General all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. 45 CFR 75.113

Disclosures must be sent in writing to: U.S. Department of Health and Human Services, Indian Health Service, Division of Grants Management, ATTN: Robert Tarwater, Director, 5600 Fishers Lane, Mailstop 09E70, Rockville, Maryland 20857. (Include ''Mandatory Grant Disclosures'' in subject line) Ofc: (301) 443–5204 Fax: (301) 594–0899 Email: *Robert.Tarwater@ihs.gov*.

AND

U.S. Department of Health and Human Services, Office of Inspector General, ATTN: Mandatory Grant Disclosures, Intake Coordinator, 330 Independence Avenue SW., Cohen Building, Room 5527, Washington, DC 20201. URL: *http://oig.hhs.gov/fraud/reportfraud/index.asp*. (Include ''Mandatory Grant Disclosures'' in subject line) Fax: (202) 205–0604 (Include ''Mandatory Grant Disclosures'' in subject line) or Email: *MandatoryGranteeDisclosures@oig.hhs.gov*.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376 and 31 U.S.C. 3321).

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to: Rick Mueller, Public Health Advisor, Office of Urban Indian Health Programs, 5600 Fishers Lane, Mail Stop: 08E65B, Rockville, MD 20857, Phone: (301) 443–4680, Fax: (301) 443–4794, Email: *Rick.Mueller@ihs.gov.*

2. Questions on grants management and fiscal matters may be directed to: Pallop Chareonvootitam, Grants Management Specialist, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–5204, Fax: 301–594–0899, Email: *Pallop.Chareonvootitam@ihs.gov.*

3. Questions on systems matters may be directed to: Paul Gettys, Grant Systems Coordinator, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2114; or the DGM main line (301) 443–5204, Fax: (301) 594–0899, E-Mail: *Paul.Gettys@ihs.gov*.

VIII. Other Information

The Public Health Service strongly encourages all cooperative agreement and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

Dated: March 4, 2016.

Elizabeth Fowler,

Deputy Director for Management Operations, Indian Health Service.

Sample 2016 HP/DP Work Plan

Goal: To address physical inactivity and consumption of unhealthy food among youth who are in the 4th to 6th grade in the Watson, Kennedy, Blackwood, and Rocky Hill Elementary schools.

Objectives	Activities/time line	Person responsible	Evaluation
1. Develop school policies to address physical inactivity and consumption of unhealthy foods in the first year of the funding year.	1. Schedule a meeting with the school health board in the first quarter of the project. 2. Establish a parent advisory committee to assist with the development of the policy in 2nd quarter.	Program Coordinator School Administrator.	Progress report on status of policy and documentation of number of participants in parent advisory committee, and number of meetings held.
2. Implement a classroom nutrition curriculum to increase awareness about the importance of healthier foods in the four intervention schools by year two of the funding year.	1. Design pre/post test survey and pilot test with group of students by 2nd quarter. 2. Schedule a meeting with the School Principal to discuss dates of program implementation by 3rd quarter. 3. Implement the ''Healthy Eating'' curriculum, a 6 week program in the 2nd quarter. 4. Collect pre/post survey at beginning and end of the program to assess changes.	Program Coordinator IHS Nutritionist.	Pre/post knowledge, attitude, and behavior survey. Document the number of students who are receiving nutrition education.

Objectives	Activities/time line	Person responsible	Evaluation
3. Implement physical activity in at least four schools for grades 4th to 6th in first year of the funding.	1. Contract with SPARK PE to train classroom teachers to implement SPARK PE in the school by 3rd Quarter. 2. Train volunteers to administer FITNESSGRAM to collect baseline data and post data to assess changes.	Program Coordinator School Counselor and PE teacher.	1. Training evaluation and number of participants. 2. Pre/post FITNESSGRAM Data.

Sample 2016 HP/DP Work Plan

Goal: To reduce tobacco use among residents of community X and Y.

Objectives	Activities/time line	Person responsible	Evaluation
1. Establish a tobacco-free policy in the schools and Tribal buildings in community X and Y by year 1.	1. Schedule a meeting with the Tribal Council and school board to increase awareness of the health effects of tobacco by June 2016.	Tobacco Coordinator.	Documentation of the number of participants.
	2. Schedule and conduct tobacco awareness education in the community, schools, and worksites by July 2016 through September 2017.	Tobacco Coordinator, Health Educator.	Documentation of the number of participants.
	3. Draft a policy and present to the Tribal Council for approval by January 2017		Documentation of whether the policy was established.
2. Coordinate and establish tobacco cessation programs with the local hospitals and clinics in X and Y communities.	1. Partner with American Cancer Association and the Tribal Health Education Coordinators to establish 8-week tobacco cessation programs by July 2016.	Tobacco Coordinator, Health Educator Pharmacist.	Progress toward timeline.
	2. Meet with the hospital/clinic administrators and pharmacist to discuss and develop a behavior-based tobacco cessation program.	Tobacco Coordinator, Health Educator.	Progress report indicating timeline is being met.
	3. Train staff in tobacco cessation counseling.	Tobacco Coordinator.	# of staff trained in tobacco cessation.
	Design and disseminate brochures and flyers of tobacco cessation program that are available in the community and clinic.	Tobacco Coordinator.	# of brochures distributed.
	4. Meet with nursing and medical provider staff to increase patient referral to tobacco cessation program.	Health Educator, Tobacco Coordinator.	# of staff trained and document, changes in practice.
	6. Implement the 8-week tobacco cessation program at the community X and Y clinic.	Tobacco Coordinator.	RPMS data—baseline # of referrals, # of participants who completed program, # who quit tobacco.

Sample Urban Grant FY 2016 Work Plan

IMMUNIZATION

Primary prevention objective	Service or program	Target population	Process measure	Outcome measures
Protect children and communities from vaccine preventable diseases.	Immunization Program.	Children <3 years	On a quarterly basis: # of children 3–27 months old ..... # of children 3–27 months old who are up to date with age appropriate vaccinations. % of 3–27 month old children up to date with age appropriate vaccinations. # of children 19–35 months old # of children 19–35 months old who received the 4313314 vaccine series. % of children 19–35 months old who received the 4313314 vaccine series.	As of June 30th, 2016: # of 19–35 month olds up to date with the 4313314 vaccine series. % of 19–35 month olds up to date with the 4313314 vaccine series.

IMMUNIZATION—Continued

Primary prevention objective	Service or program	Target population	Process measure	Outcome measures
Protect adolescents and communities from vaccine preventable diseases.	Immunization Program.	Adolescents 13–17 years.	On a quarterly basis: # of adolescents 13–17 years old ..... # of adolescents 13–17 years old who are up to date with Tdap, Meningococcal, and 3 doses of HPV (males and females). % of adolescents 13–17 years old who are up to date with Tdap, Meningococcal, and 3 doses of HPV (males and females)	As of June 30th, 2016: # of adolescents 13–17 years old who are up to date with Tdap, Meningococcal and 3 doses of HPV. % of adolescents 13–17 years old who are up to date with Tdap, Meningococcal and 3 doses of HPV.
Protect adults and communities from influenza.	Immunization Program.	6 months and older.	On a quarterly basis during flu season (e.g., Sept–June) # of patients 6 months or older # of patients 6 months–17 years # of patients 18 years and older # of patients in each age group who received a seasonal flu shot during the flu season % of patients in each age group who received a seasonal flu shot during flu season	As of June 30th, 2016: # of patients in each age group who received a seasonal flu shot during the flu season. % of patients. in each age group who received a seasonal flu shot during flu season.
Protect adults and communities from influenza & Pneumovax.	Immunization Program.	Adults ≥ 65 years	On a quarterly basis: # of adults ≥ 65 years ..... # of adults ≥ 65 years who received a pneumovax shot % of adults ≥ 65+ years who received a pneumovax shot	As of June 30th, 2016: # of adults ≥ 65 years. % of adults ≥ 65+ years who received a pneumovax shot ever.

IHS URBAN GRANT FY 2016 WORK PLAN

[Alcohol/Substance Abuse Program Sample Work Plan]

Objectives	Service or program	Target population	Process measure	Outcome measures	Data source for measures
What are you trying to accomplish?	What type of program do you propose?	Who do you hope to serve in your program?	What information will you collect about the program activities?	What information will you collect to find out the results of your program?	Where will you find the information you collect?
To prevent substance abuse among urban American Indian youth.	Community-based substance abuse prevention curriculum.	American Indian youth ages 5–18 years old.	# of youth completing the curriculum, # of sessions conducted, # of staff trained.	Incidence/prevalence of substance abuse/dependence.	Medical records, RPMS behavioral health package, National Youth Survey.
To prevent substance abuse and related problems.	After-school, summer, and weekend activities (*e.g.* outdoor experiential activities, camps, classroom based problem solving activities).	American Indian youth ages 5–14 years old.	# of youth completing community-based sessions, # of parents completing community-based sessions, # of community-based sessions.	Incidence of substance abuse, incidence of negative and positive attitudes and behaviors, incidence of peer drug use.	Charts, RPMS behavioral health package, National Youth Survey.
Reduce drug use and increase treatment retention.	Matrix model for outpatient treatment.	American Indian adult methamphetamine clients.	# of clients completing program, # of relapse prevention sessions, # of family and group therapies, # of drug education sessions, # of self-help groups, # of urine tests.	Incidence of drug use, increase or decrease in treatment retention, positive or negative urine samples.	Medical records, RPMS behavioral health package, Addiction Severity Index, results of urine tests.

IHS URBAN GRANT FY 2016 WORK PLAN

[Mental Health Program Sample Work Plan]

Objectives	Service or program	Target population	Process measure	Outcome measures	Data source for measures
What are you trying to accomplish?	What type of program do you propose?	Who do you hope to serve in your program?	What information will you collect about the program activities?	What information will you collect to find out the results of your program?	Where will you find the information you collect?
To promote mental health.	American Indian Life Skills Development curriculum.	American Indian youth ages 13–17 years old.	# of youth completing the curriculum, # of sessions conducted, # of teachers trained, number of community resource leaders trained.	Feelings of hopelessness, problem solving skills.	Medical records, RPMS behavioral health package, Beck Hopelessness Scale, problem solving skills.
Improve the mental health of American Indian children and their families.	Home-based, community-based, and office-based mental health counseling.	American Indian children and their families needing services from our community-based program.	# of individual, couples, group, and family counseling sessions, # of home, community, and office-based visits.	Reduced child involvement in juvenile justice and child welfare, improved coping skills, improved school attendance and grades.	Medical records, RPMS behavioral health package coping skill measure, report cards, attendance records.
Reduce symptoms related to trauma.	Mental health counseling with cognitive behavioral therapy intervention and historical trauma intervention.	American Indian adults.	# of individual, couples, group, and family counseling sessions, # of historical trauma groups, # of adults counseled.	Incidence of Post-Traumatic Stress Disorder (PTSD) symptoms, incidence of depression, increased coping skills, increased peer and family support.	Self-report PTSD, Beck Depression Inventory, coping skills measure, peer and family support measure, medical records, RPMS behavioral health package.

RPMS Suicide Reporting Form

Instructions for Completing

This form is intended as a data collection tool only. It does not replace documentation of clinical care in the medical record and it is not a referral form. HRN, Date of Act and Provider Name are required fields. If the information requested is not known or not listed as an option, choose ''Unknown'' or ''Other'' (with specification) as appropriate. The form can be partially completed, saved and completed at a later time if needed.

LOCAL CASE NUMBER:

Indicate internal tracking number if used, not required.

DATE FORM COMPLETED:

Indicate the date the Suicide Reporting Form was completed.

PROVIDER NAME:

Record the name of Provider completing the form.

DATE OF ACT:

Record Date of Act as mm/dd/yy. If exact day is unknown, use the month, 1st day of the month (or another default day), year. If exact date of act is unknown, all providers should use the same default day of the month.

HEALTH RECORD NUMBER:

Record the patient's health record number.

DOB/AGE:

Record Date of Birth as mm/dd/yy and patient's age.

SEX:

Indicate Male or Female.

COMMUNITY WHERE ACT OCCURRED:

Record the community code or the name, county and state of the community where the act occurred.

EMPLOYMENT STATUS:

Indicate patient's employment status, choose one.

RELATIONSHIP STATUS:

Indicate patient's relationship status, choose one.

EDUCATION:

Select the highest level of education attained and if less than a High School graduate, record the highest grade completed. Choose one.

SUICIDAL BEHAVIOR:

Identify the self-destructive act, choose one. Generally, the threshold for reporting should be ideation with intent and plan, or other acts with higher severity, either attempted or completed.

LOCATION OF ACT:

Indicate location of act, choose one.

PREVIOUS ATTEMPTS:

Indicate number of previous suicide attempts, choose one.

METHOD:

Indicate method used. Multiple entries are allowed, check all that apply. Describe methods not listed.

SUBSTANCE USE INVOLVED:

If known, indicate which substances the patient was under the influence of at the time of the act. Multiple entries allowed, check all that apply. List drugs not shown.

CONTRIBUTING FACTORS:

Multiple entries allowed, check all that apply. List contributing factors not shown.

DISPOSITION:

Indicate the type of follow-up planned, if known.

NARRATIVE:

Record any other relevant clinical information not included above.
Last Updated 10/25/12

BILLING CODE 4165–16–P

RPMS Suicide Reporting Form

Local Case Number:		**Health Record Number:**	
Date Form Completed:		**DOB/Age:**	
Provider Name:		**Sex (M/F):**	
Date of Act:		**Community Where Act Occurred:**	

	Employment Status		**Relationship Status**		**Education**
	Part-time		Single		High School Graduate/GED
	Full-time		Married		Less than High School, highest grade complete
	Self-employed		Divorced/Separated		Some College/Technical
	Unemployed		Widowed		College Graduate
	Student		Cohabitating/Common-Law		Post Graduate
	Student and employed		Same Sex Partnership		Unknown
	Retired		Unknown		
	Unknown				

	Suicidal Behavior		**Location of Act**		**Previous Attempts**
	Ideation with Plan and Intent		Home or Vicinity		0
	Attempt		School		1
	Completed Suicide		Work		2
	Att'd Suicide w/ Att'd Homicide		Jail/Prison/Detention		3 or more
	Att'd Suicide w/ Compl Homicide		Treatment Facility		Unknown
	Compl Suicide w/ Att'd Homicide		Medical Facility		
	Compl Suicide w/ Compl Homicide		Unknown		
			Other *(specify):*		

Method (✔ all that apply)				
	Gunshot		***Overdose list:***	Non-prescribed opiates (e.g. Heroin)
	Hanging		Aspirin/Aspirin-like medication	Sedatives/Benzodiazepines/Barbiturates
	Motor Vehicle		Acetaminophen (e.g. Tylenol)	Alcohol
	Jumping		Tricyclic Antidepressant (TCA)	Other Prescription Medication *(specify):*
	Stabbing/Laceration		Other Antidepressant *(specify):*	Other Over-the-counter Medication *(specify):*
	Carbon Monoxide		Amphetamine/Stimulant	Other *(specify):*
	Overdosed Using (select from list)		Prescribed Opiates (eg. Narcotics)	
	Unknown			
	Other *(specify)*:			

Substances Involved (✔ all that apply)				
	None		Alcohol	Inhalants
	Alcohol & Other Drugs (select from list)		Amphetamine/Stimulant	Non-Prescribed Opiates (e.g. Heroin)

	Unknown		Cannabis (Marijuana)		Prescribed Opiates (e.g. Narcotics)
			Cocaine		Sedatives/Benzodiazepines/Barbiturates
			Hallucinogens		Other *(specify):*
Contributing Factors (✔ all that apply)					
	Suicide of Friend or Relative		History of Substance Abuse/Dependency		Divorce/Separation/Break-up
	Death of Friend or Relative		Financial Stress		Legal
	Victim of Abuse (Current)		History of Mental Illness		Unknown
	Victim of Abuse (Past)		History of Physical Illness		Other *(specify):*
	Occupational/Educational Problem				
	Disposition	**Narrative**			
	Mental Health Follow-up				
	Alcohol/Substance Abuse Follow-up				
	Inpatient MH Treatment Voluntary				
	Inpatient MH Treatment Involuntary				
	Medical Treatment (ED or In-patient)				
	Outreach to Family/School/Community				
	Unknown				
	Other (specify):				

[FR Doc. 2016–05761 Filed 3–11–16; 8:45 am]

BILLING CODE 4165–16–C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

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

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR: Innovative Therapies and Tools for Screenable Disorders in Newborns.

Date: February 26, 2016.

Time: 1:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Baishali Maskeri, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, 301–827–2864, *maskerib@mail.nih.gov*.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: March 8, 2016.

Melanie J. Gray,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05592 Filed 3–11–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

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

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Cellular Aspects of Neuropsychiatric and Developmental Disorders.

Date: March 28, 2016.

Time: 2:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Samuel C. Edwards, Ph.D., IRG CHIEF, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5210, MSC 7846, Bethesda, MD 20892, (301) 435–1246, *edwardss@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; OD15–005: Chemistry, Toxicology, and Addiction Research on Water Pipe Tobacco.

Date: March 30, 2016.

Time: 11:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892.

Contact Person: Mark P. Rubert, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5218, MSC 7852, Bethesda, MD 20892, 301–435–1775, *rubertm@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflicts and Continuous Submissions.

Date: March 31, 2016.

Time: 9:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.