Program Name:

Indian Health Service
Special Diabetes Program for Indians
Community-Directed Grant Program
FY 2016 Competitive Application Project Narrative Template

Instructions for Using this Template

1. **Save** this PDF on your computer for your records.
2. **Ensure** Adobe Acrobat Reader[1] (version 10 or 11) is used to complete this template.
3. **Complete** ALL pertinent items in the template electronically (do **not** handwrite) by selecting a response from a list or typing the requested information. Ensure that this Project Narrative and other application documents provide a clear and complete, but brief, description of your program. Anticipate that reviewers know nothing about your program and little about IHS and Indian health systems.
4. **Review** the completed template to ensure that all required items are filled in. Required items have fields that are outlined in red.
5. **Attach** your completed Project Narrative Template to the grants.gov application package using the "Project Narrative Attachment Form." Upload your completed PDF template; do not merge with other documents or submit a scanned copy of a printed document. **Note**: If you are a sub-grantee, submit your completed template per your primary grantee's specifications.

Additional Information

1. **Form fields**. Free text fields are not limited to the space you see on the form. Additional text that you enter can be seen by clicking on the plus sign in the lower right-hand corner of the field.
2. **Grantees with sub-grantees** must submit a separate Project Narrative Template for the primary and each sub-grantee.
3. **Commonly used abbreviations.** Below is a list of commonly used abbreviations that may be found and/or can be used throughout this template. Any other abbreviation you use should be spelled and explained the first time it is used.

    a. ADC = Area Diabetes Consultant
    b. FOA = Funding Opportunity Announcement
    c. GPRA = Government Performance and Results Act
    d. HHS = Health and Human Services
    e. IHS = Indian Health Service
    f. I/T/U = IHS/Tribal/Urban
    g. NOA/NGA = Notice of (Grant) Award
    h. MOA/MOU = Memorandum of Agreement/Understanding
    i. PDF = Portable Document Format (access using Adobe Acrobat Reader or Pro)
    j. SDPI = Special Diabetes Program for Indians
    k. RKM = Required Key Measure
    l. RPMS = Resource and Patient Management System
    m. URL = Uniform Resource Locator (full link to a specific webpage)

[1] Adobe Acrobat Reader download URL: http://get.adobe.com/reader/otherversions/

Program Name:

Part A. Program Identifiers

A1.1 Date (mm/dd/yyyy):

A1.2 IHS Area:

A1.3 Program Name (Include Tribal or Clinic name):

A1.4 IHS/Tribal/Urban:

A1.5 Briefly describe your geographic location, including how this affects your SDPI activities/services. Also include proximity to specialty medical services and describe local food resources.

A1.6 Did you receive an SDPI Community-Directed grant in FY 2015? If yes, answer items a - c. If no, proceed to item A1.7.

a. Provide your Grant Number, which can be found on item 4 of your FY 2015 NOA/NGA:

b. Select your FY 2015 budget cycle:

c. Approximately how many total people in your community received services or participated in activities funded by your SDPI Community-Directed grant program in the past year? Include people that participated in all types of activities/services (e.g., community events, education classes, fitness activities, clinical services).

A1.7 If you are a sub-grantee, check this box: ☐

A1.8 Information about person completing this template.

a. Name:

b. Title:

c. Email:

d. Phone:

A1.9 Will your FY 2016 SDPI program be primarily clinic-based, community-based, or both?

a. Briefly describe your SDPI program's relationship or role with your local Indian health clinic.

Program Name:

A1.10 **Optional**: If you have any other information to help us identify your SDPI program or how it is related to any other programs, provide it here.

Part B. Needs Assessment

Section 1: Diabetes Needs Assessment

B1.1 Describe key diabetes-related health issues identified by your community and local leadership.

B1.2 **Diabetes Prevalence Estimation**

a. What is the number of AI/AN people in your community that receive health care from your local Indian health clinic? This is also known as "user population".

Note: You might be able to get this information from your local Indian health clinic administration office, Tribal Epidemiology Center, or Area Statistical Officer.

b. What is the number of AI/AN people in your community with diagnosed diabetes that receive health care from your local Indian health clinic?

Note: You might be able to get this information from your local Indian health clinic's IHS Diabetes Audit, RPMS (or other electronic health record) search, GPRA reports, or your ADC.

c. Estimated diabetes prevalence:
(This number will be automatically calculated)

Program Name:

Section 2: Review of Diabetes Audit Reports

B2.1 Were you able to obtain copies of your local clinic's 2014 and 2015 Annual IHS Diabetes Care and Outcomes Audit Reports?

If yes, proceed to item B2.2.

a. If no, provide a reason as to why you were not able to obtain copies of these Reports. (**Note**: For current SDPI grantees, this should only apply if you received a *Waiver from Submitting 2014 Diabetes Care and Outcomes Audit Report for FY 2015*.)

B2.2 Provide three to five items/elements that need to be improved based on the Audit Reports for 2014 and 2015. If you were not able to obtain these Reports, provide three to five issues based on the needs assessment that need improvement.

	a. Audit Item/Element	b. Audit 2014 Result	c. Audit 2015 Result
1.			
2.			
3.			
4.			
5.			

B2.3 Describe how your program will address these three to five items/elements that need to be improved and/or describe how your program will work with your local Indian health clinic to address these issues.

Program Name:

Section 3: Challenges

B3.1 Indicate which of the following common challenges your program experiences or may face related to prevention and/or treatment of diabetes.

a. Select Common Challenges.

- ☐ 1. Staff recruitment/retention
- ☐ 2. Patient/participant recruitment and/or retention
- ☐ 3. Lack of staff training opportunities
- ☐ 4. Lack of resources
- ☐ 5. Transportation
- ☐ 6. Location (e.g., remote, urban)
- ☐ 7. Perception of diabetes in the community
- ☐ 8. Other

b. Briefly describe each item selected above.

Program Name:

Part C: Program Support and Resources

Section 1: Leadership Support

C1.1 Identify at least one organization administrator or Tribal leader (other than your Program Coordinator) who has agreed to support your SDPI Community-Directed program efforts for FY 2016 and briefly describe how they will be actively involved in your program.

Section 2: Key Personnel

C2.1 List all key personnel that will be involved in your program's activities/services. This may be your "Diabetes Team." If there are more than 15 people, provide the information for additional individuals in Part F, Section 3 of this Project Narrative Template. You must also separately provide a brief resume or biographical sketch for **all** key personnel listed.

	A. First name	B. Last name	C. Title and credentials	D. Paid with SDPI funds (at least in part)?	E. How long involved with your program?
1.			**Diabetes Program Coordinator** **Credentials:**		
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Program Name:

	A. First name	B. Last name	C. Title and credentials	D. Paid with SDPI funds (at least in part)?	E. How long involved with your program?
13.					
14.					
15.					

Section 3: Partnerships and Collaborations

C3.1 List current active partnerships related to your SDPI program. If there are more than 15, provide a list of the additional partnerships Part F, Section 3 of this Project Narrative Template.

	A. Partner name	B. Start date (mm/yy)	D. Activities/services provided or primary focus of partnership (brief description)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Program Name:

C3.2 Describe any new partnerships and collaborations that your SDPI program is planning to implement. Include information about how these partners and collaborators will contribute to the activities/services you plan to provide. **If there are no new planned partnerships, proceed to item D1.1**.

Part D. SDPI Diabetes Best Practice

Per the Funding Opportunity Announcement Cooperative Agreement, you must select one SDPI Diabetes Best Practice (also referred to as "Best Practice") which addresses one of the needs that was identified in your needs assessment (See Part B). During the FY 2016 budget period, grantees will implement their selected Best Practice activities/services, as well as track and report data on their Target Group for their Required Key Measure (RKM).

There is a list of all the Best Practices on the Best Practices webpages.[2] For each Best Practice, there is a brief statement on the importance, RKM information, and guidance for selecting a Target Group, and tools and resources. A SDPI Diabetes Best Practices for FY 2016 List and Summary Table of the Best Practices is also provided on pages 20 - 22.

D1.1 **SDPI Diabetes Best Practice selected**:

D1.2 **Required Key Measure (RKM)**: Review the summary table provided on pages 20 – 22. Enter the RKM from this table for your selected Best Practice.

[2] http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=programsSDPIcommunityDirectedApp

Program Name:

D1.3 **Proposed Activities/Services:** What activity(ies)/service(s) do you propose to implement that would improve this RKM? List each activity/service planned and provide a brief description.

Program Name:

Target Group

Grantees will be required to report RKM data for one Target Group for their selected Best Practice. A Target Group is the largest number of patients/participants that you can realistically include in the activities/services you provided in item D1.3 for the budget period. The following should be considered in selecting your Target Group:

1. The size and characteristics (e.g., ages, health status, settings, locations) of the community or patient population that you are going to draw your Target Group from
2. Intensity of the activities/services you plan to do
3. SDPI funding and other resources available to provide activities/services

To determine your Target Group, complete the following steps:

Step one: Review the Target Group Guidance for your selected Best Practice in the summary table (see pages 20 – 22).

Step two: From those in step one, determine which group of patients/participants you plan to serve and for whom you will report RKM data. Consider characteristics such as:

- Ages (e.g., youth, elders, women of reproductive age, ages 40 – 75 years)
- Health status (e.g., at risk for diabetes, prediabetes, new onset diabetes, diabetes complications)
- Settings (e.g., school, senior home, clinic)
- Geographic locations (e.g., areas of the reservation, villages, communities)

Step three: Determine approximately how many patients/participants in your community/clinic are in the group you defined in step two.

Step four: Assess the intensity of your Best Practice activities/services. The intensity will affect the number of patients/participants you can serve (i.e., higher intensity activities/services = smaller Target Group; lower intensity activities/services = larger Target Group).

- **High intensity**: Require most staff time and resources per patient/participant.
  Examples: Diabetes Prevention Program intervention, intensive clinical case management.
- **Medium intensity**: Require moderate staff time and resources per patient/participant.
  Examples: Diabetes education classes, periodic diabetes clinical care.
- **Low intensity**: Require less staff time and resources per patient/participant.
  Examples: Depression screening, foot exams.

Step five: Considering the total number of potential patients/participants in step three, the intensity of the planned activities/services as assessed in step four, and SDPI and other resources available, determine the number of patients/participants that you are able to realistically serve. This is your Target Group.

D1.4 Based on the steps provided above, what is the number of patients/participants in your Target Group?

D1.5 Describe your Target Group (see Steps one and two).

Program Name:

Part E. Activities/Services not related to selected Best Practice (Optional)

Provide information for up to 5 major activities/services, supported by SDPI funds, to address needs that were identified in your needs assessment (See Part B). Activities/services reported here should be based on the following criteria:

- Utilize the most grant funding and program time.
- Address significant needs/challenges.

Activity/Service #1

E1.1 What activity/service will you be providing with your SDPI funds (in addition to your selected Best Practice) to reduce risk factors for diabetes and related conditions?

E1.2 **Target Group for this activity/service**: See the Best Practice section (steps two – five) on how to select a Target Group.

a. What is the number of patients/participants in your Target Group for this activity/service?

b. Describe your Target Group for this activity/service.

E1.3 What improvements do you anticipate will result from implementing this activity/service?

E1.4 How will you evaluate whether these improvements occurred?

Program Name:

Activity/Service #2

E2.1 What activity/service will you be providing with your SDPI funds (in addition to your selected Best Practice) to reduce risk factors for diabetes and related conditions?

E2.2 **Target Group for this activity/service**: See the Best Practice section (steps two – five) on how to select a Target Group.

a. What is the number of patients/participants in your Target Group for this activity/service?

b. Describe your Target Group for this activity/service.

E2.3 What improvements do you anticipate will result from implementing this activity/service?

E2.4 How will you evaluate whether these improvements occurred?

Program Name:

Activity/Service #3

E3.1 What activity/service will you be providing with your SDPI funds (in addition to your selected Best Practice) to reduce risk factors for diabetes and related conditions?

E3.2 **Target Group for this activity/service**: See the Best Practice section (steps two – five) on how to select a Target Group.

a. What is the number of patients/participants in your Target Group for this activity/service?

b. Describe your Target Group for this activity/service.

E3.3 What improvements do you anticipate will result from implementing this activity/service?

E3.4 How will you evaluate whether these improvements occurred?

Program Name:

Activity/Service #4

E4.1 What activity/service will you be providing with your SDPI funds (in addition to your selected Best Practice) to reduce risk factors for diabetes and related conditions?

E4.2 **Target Group for this activity/service**: See the Best Practice section (steps two – five) on how to select a Target Group.

a. What is the number of patients/participants in your Target Group for this activity/service?

b. Describe your Target Group for this activity/service.

E4.3 What improvements do you anticipate will result from implementing this activity/service?

E4.4 How will you evaluate whether these improvements occurred?

Program Name:

Activity/Service #5

E5.1 What activity/service will you be providing with your SDPI funds (in addition to your selected Best Practice) to reduce risk factors for diabetes and related conditions?

E5.2 **Target Group for this activity/service**: See the Best Practice section (steps two – five) on how to select a Target Group.

a. What is the number of patients/participants in your Target Group for this activity/service?

b. Describe your Target Group for this activity/service.

E5.3 What improvements do you anticipate will result from implementing this activity/service?

E5.4 How will you evaluate whether these improvements occurred?

Program Name:

Part F. Additional Program Information

Section 1: Program or Community Activities

This information provides a background on what is currently available in your community. If you did not receive SDPI funds in FY 2015, only provide responses in column C.

Indicate in column B if your SDPI program supports or funds the programs/activities/services listed in column A. Indicate in column C if your Tribe, community, health care facility, or partners supports or funds the items listed in column A.

A. Program/Activity/Services	B. SDPI Program Involvement	C. Other Involvement
1. Diabetes team(s) (people working together to provide coordinated care to individuals with or at risk for diabetes)		
2. Diabetes registry (list of people with diabetes)		
3. Diabetes clinic(s)		
4. Registered dietitian(s)		
5. Diabetes educator(s)		
6. Physical activity or exercise specialist(s)		
7. Organized diabetes education (individual or group classes)		
8. Access to culturally appropriate diabetes education materials		
9. Talking circles or support groups		
10. Nutrition services for children and youth		
11. Nutrition services for adults		
12. Weight management programs for children and youth		
13. Weight management programs for adults		
14. Community fitness programs, such as walking or running groups or events		
15. Community exercise classes, such as aerobics or strength building		
16. School-based nutrition services for children and youth		
17. Community-based food supplementation program (e.g., community gardens, Tribal food programs)		
18. Traditional foods program		
19. School-based physical activity programs for children and youth		
20. Diabetes prevention for children and youth		
21. Community-based physical activity programs for children and youth		
22. Playground construction or improvement		
23. Physical activity programs for school-age youth		
24. Safe environments that encourage physical activity		
25. Partnership or collaboration with social services		
26. Partnership or collaboration with behavioral health services		
27. Partnership or collaboration with behavioral health services for youth		
28. Partnership with local school systems		
29. Clinic and/or community-based services specifically for men's health		

Program Name:

A. Program/Activity/Services	B. SDPI Program Involvement	C. Other Involvement
30. Clinic and/or community-based services specifically for women's health		
31. Clinic-based services specifically for youth		
32. Use of social media (e.g., facebook, twitter)		
33. Use of mobile technology (e.g., texting, apps, mobile websites)		

Section 2: Involvement in Select National Campaigns and Initiatives

SDPI programs may support or participate in other HHS/IHS initiatives. Involvement in these campaigns and initiatives are not mandatory for this grant.

Involvement in IHS Improving Patient Care (IPC)[3]

F2.1 Did your I/T/U clinic officially participate as an IPC collaborative site? If no, proceed to item F2.2.

a. If your I/T/U clinic officially participated, was your SDPI team involved in IPC? If no, proceed to item F2.2.

b. If your SDPI Team was involved in IPC, describe how:

F2.2 Does your I/T/U clinic plan to participate in IPC 2.0?

Involvement in *Let's Move!* in Indian Country (LMIC) initiative

F2.3 Has your SDPI program attended any sessions offered as part of the IHS LMIC Webinar Series[4]?

F2.4 Has your SDPI program been involved in or sponsored any activities related to *Let's Move!*[5] and/or the LMIC initiative?

F2.5 If so, briefly list activities.

[3] IPC URL: http://www.ihs.gov/ipc/index.cfm
[4] LMIC Webinar Series URL: http://lmic.ihs.gov/webinarsevents/
[5] *Let's Move!* URL: http://www.letsmove.gov/

Program Name:

Involvement in Million Hearts Initiative[6]

F2.6 Has your SDPI program been involved in or sponsored any activities related to the Million Hearts Initiative?

F2.7 If so, briefly list activities.

Other National Initiatives or Campaigns

F2.8 List any other nationwide initiatives or campaigns that your SDPI program is involved with.

Section 3: Other Information (optional)

F3.1 If there is any other information you would like to share about your SDPI program, including additional program staff or partnerships, add it here.

You have now completed the Project Narrative Template. Save this PDF document to your computer before closing.

Attach your completed template to your Grants.gov application package using the "Project Narrative Attachment Form."

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[6] Million Hearts URL: http://millionhearts.hhs.gov/index.html

Program Name:

SDPI Diabetes Best Practices for FY 2016

List and Summary Table

Topic	Importance	Required Key Measure	Target Group Guidance
Aspirin or Other Antiplatelet Therapy in Cardiovascular Disease	Antiplatelet therapy reduces the risk of cardiovascular disease (CVD) events in patients who have known CVD.	Number and percent of individuals in your Target Group **who are prescribed aspirin or other antiplatelet therapy.**	Select from adults with **BOTH** diabetes and CVD. Exclude pregnant individuals.
Blood Pressure Control	Blood pressure control reduces the risk for diabetes complications, including cardiovascular disease and chronic kidney disease.	Number and percent of individuals in your Target Group **who have mean blood pressure <140/<90 mmHg.**	Select from adults with diabetes. Exclude pregnant individuals.
Chronic Kidney Disease Screening and Monitoring	People with diabetes are at higher risk for chronic kidney disease (CKD). Regular screening and monitoring allow for interventions which may help slow CKD progression.	Number and percent of individuals in your Target Group **who have both a Urine Albumin-to-Creatinine Ratio (UACR) and estimated Glomerular Filtration Rate (eGFR) completed.**	Select from adults with diabetes who are not on dialysis. Exclude pregnant individuals.
Dental Exam	People with diabetes frequently have problems with their teeth and gums, especially when they have poor glycemic control. Dental exams and treatment of dental problems improve oral health outcomes.	Number and percent of individuals in your Target Group **who receive a dental exam.*** *Performed by a dental professional.	Select from adults and/or youth with diabetes.
Depression Screening	Depression can make it difficult for individuals with diabetes to carry out their daily activities, including diabetes self-management. Depression screening, with follow up of positive results, can improve depression outcomes.	Number and percent of individuals in your Target Group **who are screened for depression.**	Select from adults and/or adolescents with diabetes who do not have a current diagnosis of depression.
Diabetes-related Education	Diabetes education helps reduce the risk for developing diabetes and its complications.	Number and percent of individuals in your Target Group **who receive education on any diabetes topic*, either in a group or individual setting.** *Includes nutrition education, physical activity education, and any other diabetes education.	Select from adults and/or youth with diabetes and/or at risk for developing diabetes.

Program Name:

Topic	Importance	Required Key Measure	Target Group Guidance
Eye Exam – Retinopathy Screening	People with diabetes are at risk for developing retinopathy. Screening for retinopathy allows for early detection and management to reduce the risk of vision loss.	Number and percent of individuals in your Target Group **who receive an eye exam.*** *An eye exam includes a dilated eye exam by an optometrist or ophthalmologist or by using digital retinal imaging.	Select from adults and/or youth with diabetes.
Foot Exam	Diabetes can cause nerve and vascular changes that reduce sensation and blood flow in the feet and legs. Regular foot exams allow for early detection and intervention to reduce the risk of foot ulcers and amputations.	Number and percent of individuals in your Target Group **who receive a comprehensive foot exam.*** *A foot exam includes assessment of sensation and vascular status.	Select from adults and/or youth with diabetes.
Glycemic Control	Good glycemic control, as measured by A1C, reduces the risk of diabetes complications.	Number and percent of individuals in your Target Group **with most recent A1C <8.0%.**	Select from adults and/or youth with diabetes. Exclude pregnant individuals.
Immunizations: Hepatitis B	People with diabetes are at increased risk of contracting several vaccine-preventable infections, including hepatitis B. Vaccination helps reduce the risk of developing hepatitis B disease in patients who are exposed.	Number and percent of individuals in your Target Group **who have ever completed the hepatitis B vaccine series (all 3 doses).**	Select from adults with diabetes.
Immunizations: Influenza	People with diabetes are at increased risk of developing serious complications from influenza. Influenza vaccination reduces this risk.	Number and percent of individuals in your Target Group **who receive the influenza vaccine.**	Select from adults and/or youth with diabetes.
Immunizations: Pneumococcal	People with diabetes are at increased risk of developing serious complications from pneumonia. Pneumococcal vaccination reduces this risk.	Number and percent of individuals in your Target Group **who have ever received a pneumococcal vaccine.**	Select from adults with diabetes.
Immunizations: Tetanus/Diphtheria	Tetanus/diphtheria immunization helps protect people from tetanus and diphtheria.	Number and percent of individuals in your Target Group **who have received a Tetanus/diphtheria (Td or Tdap) vaccine in the past 10 years.**	Select from adults with diabetes.

Program Name:

Topic	Importance	Required Key Measure	Target Group Guidance
Lipid Management in Cardiovascular Disease	Cardiovascular disease (CVD) is a major cause of morbidity and mortality for individuals with diabetes. Appropriate use of statin therapy results in significant CVD risk reduction for adults with diabetes.	Number and percent of individuals in your Target Group **who are prescribed a statin.**	Select from adults ages 40-75 years with diabetes and individuals of any age who have **BOTH** diabetes and CVD. People who are pregnant or have a statin allergy, intolerance, or contraindication should NOT be included in the Target Group.
Nutrition Education	Nutrition education helps reduce the risk for developing diabetes and its complications.	Number and percent of individuals in your Target Group **who receive nutrition education.*** * Performed by a Registered Dietitian or other health or wellness program staff.	Select from adults and/or youth with diabetes and/or at risk for developing diabetes.
Physical Activity Education	Physical activity education helps reduce the risk for developing diabetes and its complications.	Number and percent of individuals in your Target Group **who receive physical activity education.**	Select from adults and/or youth with diabetes and/or at risk for developing diabetes.
Tobacco Use Screening	Commercial tobacco use increases the risk of cardiovascular disease, microvascular complications, and premature death. Cessation of tobacco use reduces the risk of stroke and heart attack. Screening for tobacco use in people with diabetes helps programs connect patients/participants with tobacco cessation interventions.	Number and percent of individuals in your Target Group **who are screened for tobacco use.**	Select from adults and/or youth with diabetes or at risk for developing diabetes.
Tuberculosis Screening	Adults with diabetes and latent tuberculosis (TB) infection are at higher risk for progressing to active TB disease if they are not screened and treated.	Number and percent of individuals in your Target Group **who have ever had a TB test result documented.**	Select from adults with diabetes.