#  Background Information

**Purpose.**

This special initiative serves as a Community Health Representative (CHR) pilot project to test the applicability of the Mini-Cog© cognitive assessment in community settings, including a referral process. Secondary aims are to raise awareness of dementia and Alzheimer’s among I/T/U staff and tribal members, establish peer-to-peer learning networks, and examine data collection and documentation approaches. The Indian Health Service (IHS) Division of Clinical and Community Services (DCCS) Alzheimer’s program will fund up to 10 programs ($10,000 per program) to participate in this six-month demonstration project.

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**IHS Division Clinical and Community Services/CHR program.**

Using a community-based approach, the CHR program aims to improve the Social Drivers of Health (SDoH) and promote health equity for American Indian and Alaskan Native (AI/AN) people. CHRs are frontline public/community health workers (CHWs) who improve access to healthcare and help build health capacity in the AI/AN communities they serve.

CHR Program Objectives include:

* Increase the frequency and quality of communication among social service and health systems, patients, and communities through cultural mediation, outreach, interpretation/translation, and electronic health information management.
* Improve patient and community health and human service care management through care coordination, case management, and system navigation.
* Improve the work-life experience of healthcare providers by serving as the link/intermediary/liaison to understanding the role of Native traditions, value systems, and cultural beliefs in meeting the health and wellness needs of the communities.
* Provide direct services, coaching and social support, health promotion and disease prevention education, and screenings to improve the prevention and management of health conditions.
* Improve the social drivers of health through individual and community-level assessments, advocacy, and capacity building.
* Monitor program processes and outcomes at the CHR, client, community, and health and social system levels through assessment and quality improvement activities.

**Alzheimer’s and Dementia and CHR Collaborations.**

In 2024, the IHS implemented the first pilot year of the Community Health Representative (CHR) Early Dementia Detection Initiative. This six-month program, developed in partnership with the IHS National CHR consultant, aimed to evaluate the feasibility of CHRs performing cognitive screenings using the Mini-Cog®. The six participating Tribal locations from six IHS areas collectively conducted 193 screenings, resulting in 34 positive screenings (17.6 percent). As part of the pilot, IHS collaborated with the University of Oklahoma (OU) Health Sciences’ Geriatrics Workforce Enhancement Program (GWEP) program to provide core dementia training and developed detailed electronic coding and workflow job aids. As a direct result of pilot participation, one tribal participant applied for and was awarded a competitive IHS Dementia Models of Care 3-year grant to expand their work.

**Alzheimer’s Disease and the AI/AN Population.**

Alzheimer's disease (AD) is the leading cause of dementia and the most rapidly increasing cause of death in the United States. Although AI/ANs are culturally diverse and dispersed across the United States, they share a high prevalence of well‐known AD risk factors, including limited physical activity, low socioeconomic status, hypertension, type 2 diabetes, obesity, smoking, and high cholesterol. Life expectancy among AI/ANs over the last 50 years has improved by as much as 30 years, resulting in a tripling of the population share of people aged 65 and older. From 2012 to 2050, the number of AI/ANs in this age range is expected to triple again to 1,624,000, while the number of those aged 85 and older will increase sevenfold to 300,000. People aged 65 and older comprise 15% of the overall AI/AN population, compared to 4.8% in the 1970s.[[1]](#footnote-2)

* A 2024 NIH study found that 54% of older American Indians have cognitive impairment, including 10% with dementia.[[2]](#footnote-3)
* A study based on Medicare data estimated the prevalence of Alzheimer’s disease or related dementias at 10.5 percent among American Indian and Alaska Native populations.[[3]](#footnote-4)
* Recent IHS research finds that 14% of American Indian and Alaska Native IHS patients had early-onset dementia (between the ages of 45 and 64). This is higher than the global average of 9%.
* One of every six American Indian and Alaska Native adults aged 45 and older reports experiencing subjective cognitive decline, which can be a precursor to dementia.[[4]](#footnote-5)

In January 2021, IHS received dedicated first-time appropriations to address the dementia challenges facing tribal communities. As a result, from 2022 through 2024, grant awards were made to tribal and urban Indian health recipients to engage in designing and implementing locally developed, innovative models of culturally competent screening, diagnosis, and management of dementia.

In December 2021, HHS Secretary Becerra announced an annual update to the Department’s [National Plan to Address Alzheimer’s Disease](https://aspe.hhs.gov/reports/national-plan-2021-update), which for the first time includes a goal focused on work being done to promote healthy aging and reduce risks that may contribute to the onset of Alzheimer’s disease and related dementias.

**Why Should CHR’s Be Involved?**

CHR professionals can play a key role for people with dementia and their caregivers. In addition to ongoing CHR services, they can promote timely detection and diagnosis, help educate about dementia, and connect people living with dementia and their caregivers with community resources. Several initiatives aimed at the community health worker (CHW) workforce, including CHR professionals in the U.S. and U.K., are underway, and resources have been developed to support this work.[[5]](#footnote-6),[[6]](#footnote-7),[[7]](#footnote-8)

There may be a significant number of AI/AN patients who present to the CHR programs who may not have had a medical visit in the past year. As many as six in 10 older American Indian, Alaska Native, Hispanic, and other historically underserved groups with probable dementia remain either undiagnosed or are unaware of their diagnosis.[[8]](#footnote-9)

**What is the Mini-Cog©?**

The Mini-Cog© is an evidence-based quick screening tool for early dementia. As a screening tool that can be done in just 3 minutes, the Mini-Cog may help identify the need for detailed assessment and is intended for use by trained care professionals.[[9]](#footnote-10) A Cochrane review in 2021[[10]](#footnote-11) showed that the Mini-Cog had a sensitivity of 76% (meaning up to 24% in false negatives) and a specificity of 73% (meaning up to 27% in false positives), but that same review noted the sparsity of research, with only four studies included in the review. Another study published in 2018[[11]](#footnote-12) showed that the Mini-Cog had a sensitivity of 85.71%, specificity of 79.41%, positive predictive value of 0.8108, and negative predictive value of 0.6550, while 2015 meta-analyses reported a sensitivity of 91% and specificity of 86% based on nine studies in the cohort.[[12]](#footnote-13)

The Mini-Cog consists of two components, a 3-item recall test for memory and a simply scored clock drawing test. It is only a screening test and is not designed to be diagnostic. Providers, including CHRs, using the Mini-Cog must be able to make appropriate referrals for patients based on the results of the Mini-Cog. Learn more about the Mini-Cog standardized instrument at [www.mini-cog.com](http://www.mini-cog.com).

#  Description of the Pilot Project

Participating programs that fulfill all project activities will receive a payment of $10,000.

This pilot project will take place over a six-month period from January 1, 2025, to June 30, 2025. What we hope to evaluate across our respective CHR pilot sites are can CHRs: conduct a brief cognitive assessment on AI/AN elders, record data on Mini-Cog screenings, provide basic patient education on dementia screening and brain health, and develop or promote appropriate referrals to primary care providers for diagnostic follow-up appointments or to other community resources. We also hope to learn about the facilitators and barriers that may exist in adopting the Mini-Cog screening in CHR settings, such as provider time, staff perceptions, patient acceptance, patient access to diagnostic and community supports, or other reported barriers.

Once we select participating programs, programs will receive limited funding (pending funds availability) for this project. All selected programs are required to participate in the mandatory (on-site) dementia and Mini-cog screening tool training (January 14-15, 2025) and launch meeting (January 16, 2025) in Phoenix, Arizona.

Programs will be required to provide an aggregate count (via data report template) each month to the project team on:

(1) the number of Mini-Cog screenings completed,

(2) number of patient refusals to screen,

(3) the number of referrals made to primary care or other community resources,

(4) barriers faced, and

(5) recommendations.

These reports will be shared on monthly conference calls, which participating programs will be required to attend. These calls will also give programs the opportunity to seek guidance from subject matter experts. At the conclusion of the project – June 30, 2025—programs will be required to submit a final report in a format prescribed by the project team.

#  Application Process

Applicants should follow the process below to apply for this FY 2025 CHR Dementia Special Initiative funding:

1. Read this entire Request for Proposals before applying.
2. Complete all parts of this document (application must be typed, not handwritten).
3. Submit the application – **in Word format** – by 5:00 Eastern Time on Monday, November 18, 2024, via e-mail to Jamie Olsen at IHSElderHealth@ihs.gov.
4. Applicants will be notified by December 2, 2024, if their program is selected.

# Key Dates and Mandatory Activities

|  |  |
| --- | --- |
| **Date** | **Activity** |
| December 17, 2024, from 1:00 p.m. to 2:00 p.m. Eastern Time | Mandatory welcome/orientation webinar. |
| January 1 to June 30, 2025 (6 months) | Project period. |
| January 14-16, 2025  | In-person Mini-Cog© dementia and training and launch meeting in Phoenix, Arizona. |
| * February 20, 2025, 2:45 PM to 4:00 PM ET,
* March 20, 2025, 2:45 PM to 4:00 PM ET
* April 17, 2025, 2:45 PM to 4:00 PM ET
* May 22, 2025, 2:45 PM to 4:00 PM ET
* June 19, 2025, 2:45 PM to 4:00 PM ET
* July 17, 2025, 2:45 PM to 4:00 PM ET
 | Monthly peer-to-peer collaborative webinar and report out. |
| February 28, 2025 | IHS Division of Clinical and Community Services will transfer $5,000, pending funds availability, upon completion of the in-person training. The funded program is responsible for following up with their Area/tribal finance contacts to ensure the transfer of funds to their local program. |
| * February 28 (January report)
* March 31 (February report)
* April 30 (March report)
* May 30 (April report)
* June 30 (May report)
* July 15 (Final report plus June data)
 | Monthly project report due. *Non-completion of all monthly reports and non-submittal of a final written report will cause non-transference of pilot funds.*  |
| May 12-16, 2025 | (Optional) Clinical and Community Services Summit, Seattle, Washington |
| July 17, 2025 | Pilot project closeout. Complete any outstanding project reports, submit a final written report, and participate in a final project debrief call. |
| August 15, 2025 | IHS Division of Clinical and Community Services will transfer $5,000, pending funds availability, upon submission of all six monthly reports and the final written report. The funded program is responsible for following up with their Area/tribal finance contacts to ensure the transfer of funds to their local program. |

#  Project Application

**What is the name of your CHR program?**

|  |  |
| --- | --- |
| **Program Name** | Click here to enter text. |
| **Location (City, State)** | Click here to enter text. |
| **IHS Area (if known)** | Click here to enter text. |
| **Type of Program (IHS, Tribal, or Urban)** | Click here to enter text. |

**Who is the primary contact for this initiative?** This individual will be the one that the project team communicates with regarding this initiative and the one who will be responsible for submitting the final evaluation report upon completion of this project if it is funded.

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| --- | --- |
| **Contact Name, Credentials (John Smith, CHR Director)** | Click here to enter text. |
| **E-mail Address** | Click here to enter text. |
| **Telephone Number** | Click here to enter text. |

*If your program completes all requirements by July 17, 2025,* funds will be transferred from the IHS Headquarters Division of Clinical and Community Services to your respective program. Please provide the following information to expedite this transfer.

|  |  |
| --- | --- |
| **Common Accounting Number (if IHS-Direct)** | Click here to enter text. |
| **Annual Funding Agreement Number (if Tribal/Urban)** | Click here to enter text. |
| **Area/Tribe Finance Point of Contact – Name** | Click here to enter text. |
| **Area/Tribe Finance Point of Contact – E-mail** | Click here to enter text. |
| **Area/Tribe Finance Point of Contact – Telephone Number** | Click here to enter text. |

**Describe why you and your program want to participate in this pilot project.**

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| Click here to enter text. |

**Describe what current primary care screenings you conduct in your CHR program**, if any. Examples include hypertension, diabetes (point of care), depression, etc. Also, describe what collaborative projects you’ve had with your medical department over the past two years.

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| --- |
| Click here to enter text. |

#  CHR and Leadership Attestation

**To be considered for this project, you must attest to the following statements by checking the boxes (click on the box to mark) and completing the signatures page.**

* I agree to participate in a pre-and post-project evaluation to include an all-practice survey of knowledge, competence, and dementia training and resource needs.
* I agree to participate in monthly conference calls in support of this project, where I will provide updated data from my program to the IHS National CHR Program and project team.
* I agree to participate in the 3-day training on Dementia training and Mini-Cog training and pilot project launch on January 14-16, 2025, in Phoenix, AZ.
* I agree to not use the Mini-Cog© screening tool until I am adequately trained.
* I agree to use the Mini-Cog regularly in my CHR program and make referrals, when appropriate, to primary care providers.
* I agree to provide monthly reports and a written final report in the prescribed format to the IHS National CHR Program by July 17, 2025
* I agree to participate in a national webinar to describe my project in Quarter Three/CY 2025.
* I give permission to the IHS and the IHS National CHR Program to share best practices learned from my program’s implementation of this project, including data results.

**The following signatures are required for participation in the project and must be submitted with this application. Each signature confirms their understanding and support for participation in the Community Health Representative (CHR) Early Dementia Detection Initiative:**

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Signature of CHR Program Manager Date Signed

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Signature of Direct Supervisor Date Signed

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Signature of Clinical Director Date Signed

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Signature of CEO or Administrator Date Signed

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9. Mni-Cog Quick Screening for Early Dementia Detection. Why? <https://mini-cog.com/why-mini-cog/> [↑](#footnote-ref-10)
10. Seitz DP, Chan CCH, Newton HT, Gill SS, Hermann N, Smailagic N, Nikolauou V, Fage BA. How accurate is the mini-cog test when used to assess dementia in general practice? Cochrane, July 14, 2021. <https://www.cochrane.org/CD011415/DEMENTIA_how-accurate-mini-cog-test-when-used-assess-dementia-general-practice> [↑](#footnote-ref-11)
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