



Request for Proposals

Privacy, Security and Consent Management for Electronic Health Information Exchange

Part A and Part B

**Part A: Review of e-Health Legal Issues, Analysis and
Identification of Leading Practice**

**Part B: e-Health Privacy, Security and Consent Management
Technical Assistance and Education**

October 6, 2014

Minnesota Department of Health

Privacy, Security and Consent Management for Electronic Health Information Exchange

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I. Introduction

Purpose

The Minnesota Department of Health (MDH) invites interested and qualified organizations and/or individuals to submit competitive and innovative proposals for services related to ***Privacy, Security and Consent Management for Electronic Health Information Exchange***. This funding is intended to support health care professionals, hospitals and health settings in using e-health to improve health, increase patient satisfaction, reduce health care costs, and improve access to the information necessary for individuals and communities to make the best possible health decisions. This funding will further support readiness to advance the Minnesota Accountable Health Model and Accountable Communities for Health.

This request for proposal has two distinct parts:

- Part A: Review of e-Health Legal Issues, Analysis and Identification of Leading Practice
- Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education

Overall goals for this Request for Proposals:

- Ensure health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services have the access to the knowledge and tools required to use, disclose and share health information in a safe and secure manner.
- Ensure that health care professionals, hospitals and health settings have access to education and technical assistance on privacy, security and consent management practices that are based on both the Health Insurance Portability and Accountability Act (HIPAA) and Minnesota Statutes.
- Identify opportunities for improvement in current patient consent processes for the release of protected health information required for health information exchange – and provide access to education and technical assistance for health care professionals, hospitals and health settings on implementing leading practices for enabling safe and secure electronic health information exchange across multiple and diverse health care settings for the purpose of care coordination activities. This includes, but is not limited to: consistent and uniform policies and procedures.

Available Funding and Estimated Awards

This funding is intended to support health care professionals, hospitals and health-related settings in using e-health to improve health, increase patient satisfaction, reduce health care costs, and improve access to the information necessary for individuals and communities to make the best possible health decisions. It is anticipated there will be one grant recipient for Part A and one grant recipient for Part B. An Applicant may qualify for one or both parts, and may submit a response for either Part A or Part B or for both Part and Part B. If an Applicant applies for both Part A and Part B is selected there would be one Grant Recipient.

PART A: Review of e-Health Legal Issues, Analysis and Identification of Leading Practice

Up to \$200,000 for 18 month grant period

PART B: E-Health Privacy, Security and Consent Management Technical Assistance and Education

Up to \$300,000 for 18 month grant period

Grant Timeline

#	Event	Day/Date/Time
1	RFP posted at: Minnesota SIM RFPs (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs)	Monday, October 6, 2014
2	Optional RFP Informational Call <ul style="list-style-type: none"> • Call-in number: 1-888-742-5095 • Passcode: 4477200226 	Monday, October 20, 2014 10:00 am –12:00 pm Central Time
3	Required Non-binding Letters of Intent to Respond due to MDH	Monday, November 3, 2014 by 4:00 pm Central Time
4	Written questions due to MDH in order to receive a combined Q&A response	Monday, November 17, 2014 by 4:00 pm Central Time
5	Responses to written questions sent to anyone who submitted a Letter of Intent to Respond and posted on Minnesota SIM RFPs (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs)	Tuesday, November 25, 2014
6	Proposals due to MDH	Friday, December 5, 2014 4:00 pm Central Time
7	Estimated Grant notification	Monday, January 5, 2015
8	Estimated Grant period	March 1, 2015 – August 30, 2016

Background

Statement of the e-Health Privacy, Security and Consent Issue

The goal of health information exchange (HIE) is to facilitate access to and retrieval of clinical data to provide safer, timely, efficient, effective, equitable, patient-centered care. Enacted to protect electronic patient health data, complex and sometimes-divergent state and federal laws create additional complexities to health information exchange. These laws influence a health care provider's ability to securely share information seamlessly across the care continuum as authorized by law. Known as "fragmentation," the inability to get patient health information at the point of care where health care providers need it has a negative impact on the delivery of patient care. Limited access to information can affect patient outcomes by decreasing the kinds of patient information available for clinical decision making - creating silos of data between disparate health information systems for providers who are responsible for implementing federal accountable care activities and shared risk agreements.

Fueled by financial incentives in the [Health Information Technology for Economic and Clinical Health Act](http://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra_with_index.pdf) (http://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra_with_index.pdf) and the [Patient Protection and Affordable Care Act](http://www.hhs.gov/healthcare/rights/law/patient-protection.pdf) (<http://www.hhs.gov/healthcare/rights/law/patient-protection.pdf>) these activities are part of a larger nationwide effort to modernize the health and health care infrastructure, promising better patient outcomes because of improved access to health information through exchange. This evolution to interoperability of electronic health records is causing growing pains, as a multitude of diverse health settings prepare to share health information. In this environment, care coordination is finding power and influence- yet without privacy, security and consent policies that are harmonized or at least understood, the goals of accountable care and the transformation of the healthcare system may have trouble finding success.

Minnesota Approach to e-Health and Health Information Exchange

Adoption of Electronic Health Records is increasing

The movement toward the adoption and effective use of electronic health records (EHRs), as well as the secure, standards-based exchange of health information, is foundational to the success of new health care delivery models for patient care and population health. States like Minnesota have led the nation in EHR adoption. Now that EHRs are in place in some settings, the sharing of information between health care providers through health information exchange is increasingly becoming the focus. A critical piece of this transformation is that patients must be able to have confidence in the integrity of the information being shared, and trust that providers using the information have procedures in place to keep their information safe and secure.

Necessary Trust Relationship

To achieve this level of confidence and trust, all providers of health and health care services, regardless of size or specialty, must implement standards for securing electronic health information to ensure that appropriate safeguards are in place to protect that data from unauthorized access. These administrative, technical and physical safeguards, together with sound policies, procedures and practices for how health care providers can effectively use technology to deliver patient care- are critical elements of a framework in which patient trust and confidence can grow, and meaningful health information exchange can occur.

Minnesota e-Health Initiative

Minnesota has been a leader in e-health by leveraging a public-private collaborative through the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) (http://www.health.state.mn.us/e-health/abouthome.html). Established in 2004, the Initiative pursues e-health policies and guidance to achieve the Minnesota Model for Adopting Interoperable EHRs and the [Minnesota 2015 Interoperable EHR Mandate](https://www.revisor.mn.gov/statutes/?id=62j.495) (https://www.revisor.mn.gov/statutes/?id=62j.495). The mandate, established in 2007 states that “By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records systems”. Minnesota’s e-health efforts have contributed to high rates of EHR adoption and growing rates of effective use and health information exchange (see [Minnesota e-Health Assessment Reports, Factsheets and Briefs](http://www.health.state.mn.us/e-health/assessment.html#brief) (http://www.health.state.mn.us/e-health/assessment.html#brief).

Minnesota Accountable Health Model

The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the [Center for Medicare & Medicaid Innovation](http://innovations.cms.gov) (http://innovations.cms.gov) and administered in partnership by the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH). The purpose of the Minnesota Accountable Health Model is to provide Minnesotans with better value in health care through integrated, accountable care using innovative payment and care delivery models that are responsive to local health needs. The funds will be used to help providers and communities work together to create healthier futures for Minnesotans, and drive health reform in the state.

The vision of the Minnesota Accountable Health Model is:

- Every patient receives coordinated, patient-centered primary care.
- Providers are held accountable for the care provided to Medicaid enrollees and other populations, based on quality, patient experience and cost performance measures.
- Financial incentives are fully aligned across payers and the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving quality of care.

- Provider organizations effectively and sustainably partner with community organizations, engage consumers, and take responsibility for a population’s health through accountable communities for health that integrate medical care, mental/chemical health, community health, public health, social services, schools and long term supports and services.

The Minnesota Model will test whether increasing the percentage of Medicaid enrollees and other populations (i.e. commercial, Medicare) in accountable care payment arrangements will improve the health of communities and lower health care costs. To accomplish this, the state will expand the [Integrated Health Partnerships \(IHP\) demonstration](#)

(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441), formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services.

The expanded focus will be on the development of integrated community service delivery models and use coordinated care methods to integrate health care, behavioral health, long-term and post-acute care, local public health, and social services centered on patient needs.

To achieve the vision of shared cost and coordinated care, the Minnesota Accountable Health Model includes key investments in five Drivers that are necessary for accountable health models to be successful. ([Minnesota Accountable Health Model Driver Diagram](#)

http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_182962.pdf)

- Driver-1** Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement--HIT/HIE
- Driver-2** Providers have analytic tools to manage cost/risk and improve quality--Data Analytics
- Driver-3** Expanded numbers of patients are served by team-based integrated/coordinated care--Practice Transformation
- Driver-4** Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health—ACH
- Driver-5** ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations--ACO Alignment

The activities contained in this RFP are linked to Driver-1. Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement--HIT/HIE

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. Tools have been developed to assess a broad range of organization readiness to expand the “triple aim”.

The [Minnesota Accountable Health Model: Continuum of Accountability Matrix](#)

(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) is designed to illustrate the basic capabilities, relationships, and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It will help the state identify criteria and priorities for investment, and lay out developmental milestones that demonstrate organizations or partnerships are making progress towards the vision.

In addition, the [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](#) (<http://www.health.state.mn.us/e-health/mahmassessmenttool.docx>) is an interactive tool that allows organizations to answer questions to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve the goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress.

For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit [State Innovation Model Grant](#) (<http://www.mn.gov/sim>).

II. Grant Overview

Applicants are asked to provide services related to *Part A: Review of e-Health Legal Issues, Analysis and Identification of Leading Practice* and/or *Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education* that will support health information exchange activities for the Minnesota provider community required for care coordination in an accountable care organization - in the presence of strong policy and legal framework. This funding is intended to support health care professionals, hospitals and health-related settings in using e-health to improve health, increase patient satisfaction, reduce health care costs, and improve access to the information necessary for individuals and communities to make the best possible health decisions.

Applicants should be familiar with the content in all sections of the RFP before responding.

It is anticipated there will be one grant recipient for Part A and one grant recipient for Part B. An Applicant may qualify for one or both parts, and may submit a response for either Part A or Part B or for both Part and Part B. If an Applicant who applies for both Part A and Part B is selected there would be one Grant Recipient.

PART A:

Review of e-Health Legal Issues, Analysis and Identification of Leading Practices

Up to \$200,000 (18 month grant period)

PART B:

E--Health Privacy, Security and Consent Management Technical Assistance and Education

Up to \$300,000 (18 month grant period)

Eligible Applicants must meet the following criteria:

- **Part A Proposals: Review of Legal Issues, Analysis and Identification of Leading Practice** must include the identification of legal and other staff that will be completing the review of legal issues and analysis for this grant project.
- **Part B Proposals: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must include:
 - Identification of health information exchange and care coordination subject matter experts that will be assigned to this grant project.
 - Customer evaluation results from at least two past educational and/or technical assistance projects for which Applicant provided similar services.

Applicants should be familiar with the federal and state privacy and security laws, rules and guidance, including but not limited to:

- Health Insurance Portability and Accountability Act (HIPAA), 45 CFR section 164.501
- HIPAA Privacy and Security Rule added in 2000¹
- HIPAA Omnibus Final Rule added in 2013 ²
- Minnesota Health Records Act, Minnesota Statutes, section 144.291-144.298
- Minnesota Government Data Practices Act (MGDPA), Minnesota Statute Chapter 13.46-13.47
Family Welfare and Benefit Data and Foster Care Data
- Minnesota Health Care Homes, Minnesota Statutes, section 256B.0751 et seq.
- Health Information Technology for Economic Clinical Health Act (HITECH) 42 USC 201 sect §§300jj *et seq.*; §§17901 *et seq.*
- Family Educational Rights and Privacy Act (FERPA) 20 U.S.C. § 1232g; 34 CFR Part 99
- Federal Alcohol and Substance Abuse Treatment Records statutes, 42 USC section 290 dd-2 and 42 CFR section 2.1 to 2.67
- Title 38 Section 7332 Protections
- Women Infants and Children (WIC) 7 CFR part 246.26 and the Minnesota WIC program
- Other regulations, laws or policies that restrict or control the sharing of data (e.g. payer, claims and administrative data)

Part A Scope of Services:

Review of e-Health Legal Issues, Analysis and Identification of Leading Practice

Grant Recipient(s) will work with State to:

1. Complete a legal review and analysis of the differences, barriers and tensions between state and federal laws, regulations, rules and policies for health information exchange required for care coordination activities across diverse health and health care settings, including communities that are part of e-Health grant projects and Accountable Communities for Health under the Minnesota Accountable Health Model;
2. Identify leading practices related to e-health privacy, security and consent management issues that are identified through the **Part A** Grant. Identify opportunities for standardization of necessary business processes related to health information exchange so that providers, health care organizations and community settings can integrate health care, behavioral health, long-term

¹ 45 C.F.R. 160 and 164 modifications made for the HIPAA final rule effective March 26, 2013

² 65 Fed. Reg. 82,474 (Dec. 28, 2000).

and post-acute care, local public health, and social services as outlined in the Minnesota Accountable Health Model;

3. Provide information in Part A that will be used in Part B to educate providers, hospitals, clinics and community groups and social services organizations on the legal barriers and tensions that exist between federal and state laws and may influence the integration of behavioral health, long-term and post-acute care, local public health, and social services into the traditional medical models of care.

Part B Scope of Services:

E-Health Privacy, Security and Consent Management Technical Assistance and Education

Grant Recipient(s) will work with State and where appropriate stakeholder groups as identified in e-Health Roadmap work and other Minnesota Accountable Health Model activities to:

- Use information gained in Part A and develop educational tools, tips, guides and materials related to privacy/security of electronic health records and exchange of health information (Part B) to meet the needs of health care providers in Minnesota;
- Part B education will be focused on addressing the needs of communities or partnerships that are part of e-health grant projects and Accountable Communities for Health (ACH), or that are working to achieve broader SIM goals related to coordination of care across settings for complex patients or populations. The purpose of this education is to ensure safe, secure data practices are followed and effective patient consent for exchange of information. Education will include statewide and regional trainings on privacy/security issues covering both HIPAA and relevant Minnesota state laws and regulations to optimize the movement of electronic health information.
- Part B education activities will begin with the dissemination of health care provider information materials developed through 2013-2014 e-Health Initiative Privacy and Security Workgroup, including but not limited to; Minnesota Notice of Privacy Practices, Summary of Proactive Monitoring Processes, Security Risk Assessment Tip Sheet, 2014 Standard Consent Form, Psychotherapy Notes Guidance Document and Patient Breach Notification Procedures Tip Sheet.
- Provide technical assistance to providers, community/services organizations to integrate health care, behavioral health, long-term and post-acute care, local public health, and social services, and communities or partnerships that are selected to become Accountable Communities for Health to ensure effective patient consent for exchange of information, and lead statewide and regional trainings on privacy/security issues covering both HIPAA and relevant Minnesota state laws and regulations to optimize the movement of electronic health information (Part B).

PART A

Review of e-Health Legal Issues, Analysis and Identification of Leading Practices

- Up to \$200,000 award over 18 month grant period
- Applicant must submit hourly rate for all billable legal and non-legal services directly related to the Part A. This information should be submitted using the budget form.

Applicant must submit a range of hours necessary to complete the deliverables outlined in the Part A.

In an effort to support the Minnesota health and health care community, the Applicant for Part A, under the direction of MDH-DHS, will provide legal subject matter expertise on e-Health issues related to health information exchange for care coordination activities across multiple and diverse health care settings. This work will directly affect providers and health care providers in the Minnesota Accountable Health Model and throughout Minnesota. Activities in the Part A Grant include but are not limited to:

- Review of e-Health Legal Issues and Analysis for each Health Information Exchange Use Case outlined in this RFP and four additional uses cases as determined by the Minnesota Accountable Health Model.
- Develop and submit to MDH-DHS written Modular Guidance Documents for each of the identified e-Health Legal issues identified through the *Part A* Grant. These Modular Guidance Documents will be reviewed and approved through a public/private collaborative validation process as outlined in the *Part A* Grant.
- Provide continuous, ongoing and transparent Subject Matter Expertise to MDH-DHS on e-Health legal issues that are discovered during the course of this RFP Grant. This includes ongoing close collaboration with other RFP Grant Recipients through planned meetings, telephone calls, training and educational offerings scheduled as a result of this RFP.

The *Part A* grant length is 18 months. The goal of this RFP is to procure the services for legal subject matter expertise that will assist providers and Minnesota Accountable Health Model grantees in sorting out and identifying the differences, barriers and tensions that exist between federal and Minnesota state law related to privacy, security and consent of electronic health information. The deliverables from the Part A Grant should focus on enabling the authorized secure exchange of health information across multiple and diverse health care settings through HIE for care coordination and accountable care activities in the Minnesota Accountable Health Model.

NOTE: The materials, and any policies, procedures, processes and deliverables that are developed through this project will need to be applicable to multiple health care settings, and take into consideration Minnesota State and Federal privacy, security, and data practice laws for the management of electronic health information. These activities will directly support the work of the larger Minnesota Accountable Health Model

Timeline for Part A Grant Required Deliverables

	Required Deliverable	0-6 months	6-12 months	12-18 months
A	<u>Review and Analysis of e-Health Legal Issues: Health Information Exchange Use Cases and development of Written Modular Guidance Documents</u>			
B	<u>Review and Analysis of e-Health Legal Issues: Development of Modular Guidance Documents</u>			
C	<u>Identification of Leading Practices: This includes Part A Grant work that is supported by non-legal staff and is necessary in order for this work to be complete.</u>			
D	<u>Modular Guidance Document Validation Process for each Modular Guidance Document</u>			
E	<u>Subject Matter Expertise: That is continuous, ongoing and collaborative with MDH, DHS and other Grant Recipients</u>			

The timeline is structured so that early legal review and analysis for HIE Use Cases is completed in the first 6 months of the grant period. Early completion of the Review and Analysis of e-Health Legal Issues is important so that the Part B Grant can quickly move this information into education and technical assistance materials for use in the larger Minnesota Accountable Health Model projects and communities.

Required Deliverables:

A. Review and Analysis of e-Health Legal Issues: Health Information Exchange Use Cases

This section of the *Part A* Grant fits the definition of legal business and should be completed by an attorney with demonstrated knowledge and expertise in national and state e-Health topics, Health Information Technology, and Health Information Exchange.

For each *Health Information Exchange Use Case* (HIEUC) in this section, the *Part A* Grant Recipient will need to complete a review and analysis of the applicable state and federal laws, regulations, rules and policies that govern data privacy, security and consent management in secure electronic health information exchange required for care coordination activities. The intent of this review and analysis is to

identify the differences and tensions between Minnesota state law and federal regulations that may create e-Health legal barriers for the exchange of health information necessary for care coordination activities in the following *Health Information Exchange Use Cases* (HIEUC):

1. A patient with chronic medical conditions requiring care by multiple health care providers and is being referred to a new specialty care provider.
2. A patient that has a medical condition and is accessing care for a behavioral health and chemical dependency issue requiring inpatient and/or outpatient services.
3. A patient that resides in rural Minnesota requires emergency medical services, but who otherwise is regularly accessing care at a healthcare system across state lines.
4. An individual and/or patient that is part of a health care home and that is receiving county social services from a community organization or social services agency (bi-directional exchange) (e.g., welfare data in Chapter 13.46).
5. A patient that transitions between multiple unique health care settings and receives care coordination services from a Minnesota certified Health Care Home.
6. A patient that was discharged from acute care setting to home health care or local public health services, and now requires a new hospital admission.
7. A patient that participates in an Integrated Health Partnership as part of a Medicaid Accountable Care Organization and receives services from a community mental health center.

NOTE: In addition the grant recipient will work with MDH to identify at least four other health information exchange use cases as identified by State based on the work of SIM/MAHM.

B. Review and Analysis of e-Health Legal Issues: Development of Modular Guidance Documents

Develop a Modular Guidance Document (MGD) for each key or major identified legal barrier, difference, tension or issue found for the use cases above. This MGD should include a consistent framework for describing the topic: 1) clear identification of legal barrier, difference, tension or issue 2) the federal and state legal references 3) related key findings from the review and analysis of e-Health legal issues 4) a description of possible recommendations for remediation, mitigation strategy or development of leading practices to manage legal barrier, difference, tension or issue until legal remedies are determined at a later date. See example in Appendix A.

Considerations for each use case should include, but not be limited to the following issues:

1. Identification of the type of protected health information that must be exchanged to satisfy each use case.
2. Description of all applicable federal and state privacy, security and consent laws, regulations, rules and policies for each identified use case.
3. Analysis and description of the current understanding of the applicable provider, health care organization or health setting for the identified issue related to privacy, security and consent management for each use case. The minimum statutory requirements for all HIEUC that include HIPAA, Minnesota Health Records Act and Minnesota Statute Chapter 13. All other relevant statutory requirements need to be considered when they are applicable to the specific type of information that is being exchanged (e.g., substance abuse data, State Operations Information Systems Data, WIC data, etc.).
4. Identification of knowledge deficit, misinformation and/or perceived legal barriers to sharing electronic health information exchange.
5. Identification of similarities and differences between federal and state law, regulations, rules and policies; and identify the barriers that reduce the electronic exchange of health information needed for care coordination activities in accountable care organizations.
6. Review of policy levers (e.g., 2015 EHR Mandate, e-Prescribing Mandate, etc.) that are in place in Minnesota and their effects on electronic exchange, clinical workflow, and sharing across multiple and diverse care settings.
7. Identification of legal barriers that increase fragmentation and negatively affect the access to health information in an accountable care/accountable health organization or across care settings.
8. Identification of the available electronic processes that currently exist and any work-around or paper processes that may be used to accomplish each care coordination activity.
9. Identification of unique needs for privacy, security and consent based on health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services needs and legal requirements (i.e., 42 CFR Part 2, Title 38, etc.).
10. Identification of resources and materials to educate providers and patients. These should be focused on the issues discovered through the **Part A** Grant for privacy, security and consent for electronic health information. These resources will be shared with the Part B Grant Recipient responsible for education and technical assistance.
11. Identification of legal resources that can bridge the legal gaps identified through the **Part A: Review of e-Health Legal Issues, Analysis, and Identification of Leading Practice** until other

solutions come to pass in the way of modification or harmonization of the laws on the topics of privacy, security and consent.

12. Identification of when and where data sharing agreements between sharing partners for care coordination need to exist and develop a standardized version of these documents.
13. Identification of materials and tools on related topics; minor consent, behavioral health specific, caregiver consent, emergency consent situations to improve understanding for consumers and health care workforce. Support the development of materials with **Part B** Grant Recipient when no materials or resources can be found.

C. Identification of Leading Practices

Identification of Leading Practices must be completed for each use case (HIEUC). These Leading Practices should be developed in support of the findings of the legal analysis and review. They can be included in the same MGD. This work does not fit under the definition of legal business and may be completed by a non-attorney with demonstrated knowledge and expertise in national and state e-Health topics, Health Information Technology, and Health Information Exchange:

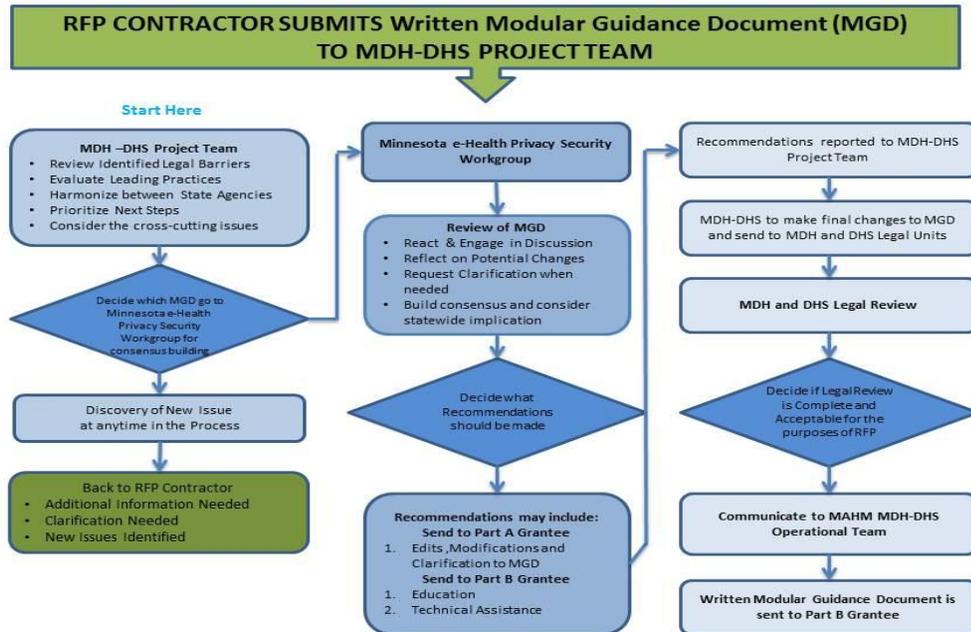
1. Identification of available policies and procedures, and document any gaps and/or opportunities that would improve the flow of information between health care providers and settings.
2. Identification of gaps or barriers in practice, process and knowledge for health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services; propose solutions to address each unique opportunity.
3. Identification of strategies to improve workflow as it relates to protecting electronic health information and privacy. Focus strategies on people, process and technology to improve information exchange and care coordination efforts.
4. Identification of opportunities for education and technical assistance on health information exchange and e-Health topics.
5. Identification of opportunities and gaps, including but not limited to; use of paper processes for consent management, work-arounds that have been implemented in the absence of efficient processes, policies/procedures that are difficult to operationalize or that are based on difficult state/federal policies for protecting electronic health, and other found issues.
6. Identification of leading practices to mitigate, remediate or improve the flow of data across health care settings.

D. Modular Guidance Document Validation Process

All deliverables developed by the Grant Recipient will be subject to the following validation process:

1. **Review by MDH-DHS Project Team** (state agency review).
2. **Review by Minnesota e-Health Privacy and Security Workgroup** that is commissioned by the MDH- Commissioner of Health and e-Health Advisory Committee. The Minnesota e-Health Privacy and Security Workgroup uses a public/private collaborative model based on long-standing community relationships with stakeholders and legal experts from the community. Workgroup members include privacy attorneys, privacy officers from hospitals and clinics (both rural and urban), state government and interagency attorneys, health care providers, health information exchange vendors and health care associations. The review may include material changes to the Modular Guidance Document, such as edits, comments and request for additional information to substantiate or clarify content within the MGD. The document may be returned to Grant Recipient if more information or clarification is needed.
3. **Review by MDH legal team.** The Modular Guidance Document will be reviewed by the legal units of MDH and DHS. Any questions about content or additional questions will be directed back to the Grant Recipient directly. If material changes are required to the Modular Guidance Document then the document will need to move back through the Minnesota e-Health Privacy and Security Workgroup for notification of changes. No approval is needed from the Minnesota e-Health Privacy and Security Workgroup in this step; this is primarily to notify the workgroup of materials changes to MGD content.
4. **Review by Inter-agency SIM Operations Team** for final approval before moving to Part B Grant Recipient for use in development of education and technical assistance.

Modular Guidance Document Validation Process Flow



E. Subject Matter Expertise (SME)

Subject Matter Expertise is continuous, ongoing and collaborative with MDH, DHS and other RFP Grant Recipients:

- Part A** Grant Recipient will need to be available to answer questions posed by the Part B Grant Recipient throughout the life of this Grant.
- Part A** Grant Recipient will need to be available to the MDH-DHS Project Team and MDH-DHS Legal Units when clarification is required or more information is needed for Modular Guidance Documents. This includes ongoing review and collaboration with other state efforts related to these topics.
- Part A** Grant Recipient will support the Part B Grant Recipient by providing subject matter expertise on e-Health legal issues and will openly share any identified leading practices for privacy, security, and consent management that can be used to inform the work of the *Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education* Grant.
- Part A** Grant Recipient will review, collaborate and work with e-Health Roadmaps on identified use cases for HIE found at [Minnesota Accountable Health Model](http://www.mn.gov/sim) (<http://www.mn.gov/sim>) - so that e-Health legal issues for privacy, security and consent management are consistently addressed in each scenario and the appropriate mechanisms for safe and secure sharing of electronic health information is considered.

This work is developmental and will require the Applicant to seek ongoing input from MDH and DHS, identified stakeholders, and the Minnesota e-Health Privacy Security Workgroup throughout the grant period through planned meetings.

This scope of work and all deliverables in the Part A will be subject to the following requirements:

1. Deliver work products on-time and share all materials that are developed at the time that they are requested.
2. Work within a legal framework using both federal and state law for privacy, security and consent considerations.
3. Synthesize and utilize the legal review and analysis completed in the [Upper Midwest Health Information Exchange final report](http://www.health.state.mn.us/divs/hpsc/ohit/umhie.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/umhie.html>) with any additional review and analysis of the state and federal laws, regulations, rules and policies for health information.
4. Review available information from sources like the Minnesota Accountable Health Model evaluation, public comments or focus group activities that may further assist in the identification of needs for privacy, security and consent management related to HIE.
5. When necessary, conduct key informant interviews and/or focus groups with community stakeholders, including consumers to formulate a comprehensive and global understanding of the community needs for privacy, security and consent. Provide a neutral third party facilitator when needed for activities related to these services.

Part A Grant Recipient (attorney as part of legal business) will be responsible for assisting Part B Grant Recipient with the incorporation of strong legal framework into all education materials, with special attention to Minnesota specific legal requirements, and incorporate the legal framework and recommendations from the **Part A** Grant Recipient as well as any relevant learnings from other SIM e-health activities (including community collaborative HIE Grants and HIE roadmap Grants).

The **Part A** Grant Recipient (attorney as part of legal business) will create when applicable standardized forms, business documents, and agreements to enable HIE for the Minnesota Accountable Health Model- Accountable Health Communities (e.g., Data Use Agreement for health information exchange, etc.)

PART B

E-Health Privacy, Security and Consent Management Technical Assistance and Education

The purpose of the Part B Grant is to identify and/or develop and disseminate tools, tips, guides and materials that can be used to provide education and technical assistance to Minnesota accountable communities for health, Minnesota health care providers and organizations on the topics of privacy, security and consent of electronic health information exchange. Activities in the Part B Grant include but are not limited to:

- A. Establish a plan for education and technical assistance for health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services
- B. Conduct an environmental scan of available materials and resources
- C. Develop materials and resources to be used for education and technical assistance for health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services
- D. Provide education and technical assistance based on approved plan
- E. Plan for and implement widespread dissemination of materials and resources used for education and technical assistance
- F. Evaluate effectiveness of education and technical assistance

All activities will be coordinated by the Part B Grant Recipient. All materials used will need to meet the educational and technical assistance needs for multiple and diverse health care settings, must be developed in consultation with MDH, and are subject to approval.

Note: Recommendations from the Part A Grant will inform the ***e-Health Privacy, Security and Consent Management Technical Assistance and Education*** work completed in the Part B Grant. The Part B Grant length is 18 months. The information acquired in the Part A Grant will inform the development of education materials and resources that support the privacy, security and consent management activities required for health information exchange in the Minnesota Accountable Health Model project.

Note: The materials and any policies, procedures, processes and deliverables that are developed through this project will need to be applicable to multiple health care settings, and take into consideration Minnesota State and Federal privacy, security, and data practice laws for the

management of electronic health information. These activities will directly support the work of the larger Minnesota Accountable Health Model.

Timeline for Part B Grant Required Deliverables

	Required Deliverable	0-3 months	3-6 months	6-12 months	13-18 months
A	Establish a Plan for Education and Technical Assistance				
B	Environmental Scan of available materials and resources				
C	Develop materials and resources to be used for education and technical assistance				
D	Provide Education and Technical Assistance				
E	Plan for and then implement widespread dissemination of materials and resources used for education and technical assistance				
F	Evaluate effectiveness of education and technical assistance				

Note: General Privacy Security Training using education materials developed by 2013-2014 e-Health Initiative Privacy and Security Workgroup will begin early in the Grant. Education and technical assistance informed by the Part A Grant will begin no later than 6 months into the Grant period. All materials and resources will be hosted on the MDH website and will include the MDH logo.

Required Deliverables:

A. Establish a Plan for Education and Technical Assistance

Establish an education and technical assistance plan that includes, but is not limited to, the following:

1. A plan for early and widespread dissemination of educational materials
2. A detailed timeline of activities
3. A detailed list of each proposed training activities and materials to meet the deliverables described in the Part B Grant for education and technical assistance, including; the delivery mode for each activity, identification of target audience, evaluation of effectiveness and related dissemination tools and methods.
4. Attention to the accessibility needs of all potential users of these materials and resources.

B. Environmental Scan of available materials and resources

Complete an environmental scan to identify available education and technical assistance materials and resources that can be used or easily adapted to address identified gaps for privacy, security and consent management of electronic health information and health information exchange.

The environmental scan will need to analyze, classify and make recommendations in the following areas linked to identified knowledge gaps:

- Materials that are useful in the current form
- Materials that are useful but need to be modified
- Needed materials that do not exist and must be developed

Information sources for the environmental scan will include, but not be limited to:

1. Review deliverables from *Part A: Review of e-Health Legal Issues, Analysis, and Identification of Leading Practice* Grant.
2. Review and analyze applicable information sources that may inform this work, including:
 - A. [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) (<http://www.health.state.mn.us/e-health/abouthome.html>)
 - B. [Minnesota e-Health Assessment Reports, Factsheets and Briefs](http://www.health.state.mn.us/e-health/assessment.html) (<http://www.health.state.mn.us/e-health/assessment.html>)
 - C. [Minnesota Health Records Access Study legislative report](http://www.health.state.mn.us/e-health/hras/hras2012.html) (<http://www.health.state.mn.us/e-health/hras/hras2012.html>)
 - D. Work of the State Health Policy Consortium to Advance Interstate Exchange of Patient Health Records. The [Upper Midwest Health Information Exchange final report](http://www.health.state.mn.us/divs/hpsc/ohit/umhie.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/umhie.html>)
 - E. ONC Beacon Program findings, including those from the Southeast Minnesota Beacon Program available at:
 - a. <http://semnbeacon.wordpress.com>
 - b. <http://www.healthit.gov/sites/default/files/onc-beacon-lg5-enabling-community-level-hie.pdf>
 - c. <http://www.healthit.gov/sites/default/files/onc-beacon-lg4-clinical-transformation-via-hit.pdf>
 - F. [Regional Extension Center for Health IT- REACH](http://www.khareach.org/) (<http://www.khareach.org/>)
 - G. [Substance Abuse Mental Health Services Administration](http://www.samhsa.gov/healthIT/) (<http://www.samhsa.gov/healthIT/>)

H. Public Health Law Institute, Accountable Care Organization Legal Framework

<http://www.cdc.gov/phlp/publications/topic/transformation.html>

3. Identify resources and materials based on the identified needs of providers and patients related to the domains of privacy, security and consent for electronic health information.
4. Identify key resources and materials that are not available and make recommendations to MDH for what materials should be developed through the Part B Grant.
5. Identify resources that will fit the identified gaps and needs found in the Part A Grant ***Part A: Review of e-Health Legal Issues, Analysis, and Identification of Leading Practice.***
6. Provide a catalogue or report of materials, resources and tools identified in a format agreed upon by MDH.
7. Consult and coordinate with the Grant Recipient for the Roadmap RFP including but not limited to any education gaps that are identified.

C. Develop materials and resources to be used for education and technical assistance

In consultation with MDH, develop education and technical assistance materials that meet the needs of providers and patients for privacy, security and consent management of electronic health information and health information exchange. These materials will include, but not be limited to: tools, tips, templates, tables, guides and webinar training materials using the following methods.

1. Incorporate strong legal framework into all education materials (or tools- consistency), with special attention to Minnesota specific legal requirements, and incorporate the legal framework and recommendations from the ***Part A*** Grant Recipient as well as any relevant learnings from other SIM e-health activities (including community collaborative HIE Grants and HIE roadmap Grants).
2. Develop deliverables that are specific to health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services and approved by MDH.
3. Consult on the development of needed policies, procedures and processes- harmonizing with national standards where available.
4. All materials and resources that are developed through this Grant should be scalable and easy to generalize to both large and small health care organizations.
5. Develop materials for use with consumers and patients that promote health literacy on topics related to privacy, security and patient consent.

6. Develop tools on the value of standards based health information exchange, and trust agreements like those supported by DirectTrust.org for the Direct Protocol, Connect and other identified national transport standards to improve data sharing.
7. Develop example data sharing agreements between sharing partners for care coordination
8. Develop materials on related topics; minor consent, behavioral health specific, caregiver consent, emergency consent situations to improve understanding for consumers and health care workforce.
9. Leverage use of materials that are created and supported by the MDH-Privacy Security Workgroup when available.
10. Seek ongoing support and consensus from the Minnesota e-Health Privacy Security Workgroup as a stakeholder community for input and expertise throughout the process.

D. Provide Education and Technical Assistance

Provide education and technical assistance using materials and resources that focus on privacy, security and consent for health information exchange. The target audiences for these activities are health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services and others specified by MDH.

- **For health professionals:** education on privacy and legal aspects that support adoption, use and exchange of electronic health information, including both large and small health care providers.
- **For patients and consumers:** education on how electronic health information is used disclosed and shared to improve health outcomes and patient safety.
- **For health care delivery system staff:** education on creating a culture of compliance and awareness for the privacy, security and consent management topics.

The Plan will include offering education and technical assistance on the following topics:

1. Implementation of education and technical assistance programs that will use tools, tips, templates, tables, guides and webinar training materials. This should include electronic methods, and consider new applications such as mobile technology.
2. Other related topics; minor consent, behavioral health specific, caregiver consent, emergency consent situations to improve understanding for consumers and health care workforce.
3. Data sharing agreements between sharing partners for care coordination.
4. Educate providers and organizations on the value of standards based health information exchange, and trust agreements like those supported by DirectTrust.org for the Direct Protocol.

5. Using the tools, tips, guides, policies, procedures that are developed through this work to improve the exchange of health information that is necessary for care coordination activities.
6. Using the Health Information Technology and Health Information Exchange Tool-Kits and Roadmaps for the four priority settings.
7. Provide at least four training opportunities for stakeholders, including:
 - A series of webinar or similar open access trainings requiring minimal or no or travel for participants. The Applicant should provide up to 24 training sessions over the 18 month period.
 - Provide (8-10) Training sessions on privacy and related topics
 - Provide (8-10) Training sessions on security and related topics
 - Provide (8-10) Training sessions on patient consent and/or related topics
 - At least one training opportunity that will be recorded and available on or linked to the MDH website for each of the topic areas.

E. Plan for and then implement widespread dissemination of materials and resources used for education and technical assistance

Identify and document a robust and sustainable communication plan to ensure that information acquired or developed through this Grant reaches The target audiences for these activities are health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services, regulators, consumers, privacy officers and health information management on leading practices for privacy, security and consent management of electronic health information. This plan must be approved by MDH before work begins.

Plan for dissemination of information will include, but not be limited to, the following activities:

1. Evaluate MDH-OHIT Webpages, which are used as a key e-health resource tool for health care providers and organizations. Identify opportunities for improvement. Provide written recommendations for improvement to MDH and submit examples of other web-based information that can serve as template for future improvements to webpage format and content.
2. Identify opportunities for widespread use and dissemination across multiple and diverse health care settings that will support the cross-functional work and related projects of the Minnesota Accountable Health Model.
3. Share lessons learned through a report to the Minnesota Department of Health,-Office of Health Information Technology and additional stakeholders including the Minnesota e-Health Initiative, SIM Community Advisory Task Force and SIM Multi-Payer Alignment Task Force.

4. Use templates, format and content for all materials that are web-enabled or web-ready for use on the Minnesota Department of Health website.
5. Other activities as identified.

F. Evaluate effectiveness of education and technical assistance

Develop a plan for evaluation of the effectiveness of education and technical assistance tools, tips, guides, policies, procedures that are developed through this work to improve the exchange of health information that is necessary for care coordination activities. Implement this plan.

1. The evaluation plan must include an assessment of the target audiences for these activities; health care professionals, hospitals, behavioral health, long-term and post-acute care, local public health, and social services, regulators and consumers.
2. The evaluation plan must be approved by MDH prior to implementation of education and technical assistance deliverables. The evaluation report must include a detailed description of evaluation methodologies, assessment tools, plan and implementation for gathering data and proposed report format that includes findings and recommendations.

Other Responsibilities

In addition, the Part A and Part B Grant(s) will:

1. Provide a description of project management timeline tools used for scheduling and managing the Granted work, as well as the basis for invoicing.
2. Inform and update MDH-OHIT through regular and planned meetings (at least weekly) on progress of work as it relates to this project, and emerging key findings or themes.
3. Provide monthly written progress reports to the MDH-OHIT.
4. Inform MDH and update appropriate workgroups on new and emerging trends in the market and/or identified gaps as a result of this program review and observations.
5. Participate in the Minnesota Accountable Health Model grant evaluation throughout and at the closure of the Grant.
6. Participate in Minnesota Department of Health provided or identified trainings, meetings and technical assistance.
7. Collaborate with other Grant Recipient(s) should more than one Grant be awarded, and MDH identified partners on intersecting issues, including privacy, security and consent considerations for education and technical assistance materials and new/related issues discovered during the course of this Grant.

III. Proposal Instructions and Requirements

Applicants are expected to provide MDH with as much information as necessary in their proposal for MDH to objectively evaluate the proposal and Applicant qualifications. At a minimum, proposals must be fully responsive to the specific requirements stated in this RFP. Applicants must identify any requirements of this RFP that they cannot satisfy. All responses to the RFP must comply with the requirements of this section.

Proposal Requirements

- Proposals must be written in 12-point font with one-inch margins.
- Proposals must meet the page limits as noted below.
- All pages must be numbered consecutively.
- Applicants must submit ten (10) copies of the proposal and an electronic version of the proposal on a USB drive. Faxed or emailed Proposals will not be accepted.
- Proposals must meet application deadline requirements; late Proposals will not be reviewed.
- Proposals must be complete and signed where noted. Incomplete Proposals will not be considered for review.

Failure to submit all information listed under this section, may at the discretion of MDH, result in the rejection of the proposal. If all Applicants fail to meet one or more of the mandatory requirements, MDH reserves the right to continue evaluating the proposals. Applicants must complete and submit the following attachments as detailed below.

Applicants must submit proposals in this order using forms provided in Word and Excel where appropriate:

1. Application face sheet (Form A)
2. Provide a table of contents for the remainder of the proposal (no page limit)
3. Project Description (no page limit).

Describe how the Applicant complies with the following:

- Proposals for **Part A: Review of Legal Issues, Analysis and Identification of Leading Practice** must include the identification of legal and other staff that will be completing the review of legal issues and analysis for this Grant
- Proposals for **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must include the identification of health

information exchange and care coordination subject matter experts that will be assigned to this Grant.

- Proposals for **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must include customer evaluation results of at least two past educational and/or technical assistance projects that Applicant has provided similar services to. Deliverables and services offered for **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must be print-ready and available in a format that can be posted on the MDH website, and in compliance with ADA and state accessibility requirements: (<http://mn.gov/oet/programs/policies/accessibility/#>). The deliverables must cite all source material, and have all rights to publish or re-publish any materials obtained by others. Deliverables or services that do not fully comply with the identified standards will be rejected and will receive no further consideration.

4. Project Goals (limit 3 pages)

Provide a statement of the goals, objectives, and tasks to show or demonstrate the Applicant's view and understanding of the nature of the Grant and required subject matter expertise for each part of this RFP Applicant describes how their current knowledge and awareness of state and national activities for e-Health and Health Information Exchange influence their proposed approach to the scope of work and project schedule.

5. Project Deliverables and Work Plan (limit 10 pages not including appendices)

- Applicants must describe their proposed approach for meeting each of the requirements in Part A and Part B. This must include a description of the proposed approach to achieving deliverables along with a detailed work plan that identifies the major tasks to be accomplished and identification of scheduling and managing tool, as well as the basis for invoicing.
- Applicant submits as part of their plan, a detailed approach to project governance, including use of advisory or steering teams, plan for stakeholder engagement. This includes a description of plan for project management including but not limited to the scope and risk management plans for Grant.
- Part B Applicant must describe how they will approach and plan for accessibility needs of the multiple and diverse end users of the products, services and deliverables. Any materials developed must be print-ready and available in a format that can be posted on the MDH website, and in compliance with ADA and state accessibility requirements:

<http://mn.gov/oet/programs/policies/accessibility/#>). The materials must cite all source material, and have all rights to publish or re-publish any materials obtained by others.

The applicant response must contain adequate information to evaluate the responsiveness to the accessibility standards.

6. Project Team (limit 5 pages, not including the Project team Organizational Chart, Resumes and Appendices).

MDH is interested in the qualifications of the proposed team members who will be working on the Grant project, including any proposed sub-Grant Recipients. Applicants must submit a Project Team Organizational Chart indicating reporting relationships of proposed project staff with roles that relate to the Applicants' approach and methodologies described in Proposed Approach to the Scope of Work.

The Applicant must identify the specific individuals to be assigned to the roles identified in the Project Team Organization Chart, with additional details provided relative to their specific area of expertise, qualifications, training, work experience, skill set related this Grant, resume and number of years of experience for each Grant Recipient who will conduct the project. Provide examples of similar work done.

7. Budget (no page limit)

Applicant will provide costs by line item and by deliverables and justification for all associated activities in either/both Part A and Part B as outlined below using Forms C and D.

8. Required Forms and Attachments (no page limit)

- Application Cover Form (Form A)
- Project work plan (Form B)
- Budget Form (Form C)
- Budget Narrative (Form D)
- Due diligence form (Form E) and most recent audit report
- Resumes of key staff
- Client references

9. Letters of Support (no page limit)

Budget

All duties must be performed in accordance with the Federal Department of Health and Human Services Grants Policy Statement which is available at <http://www.gsa.gov/portal/category/100000>

Eligible Expenses:

Grant funds may be used to cover costs of personnel, consultants, subcontracts, supplies, grant related travel, stipends and some other costs.

Ineligible Expenses:

Funds may not be used to pay for purchase of computers, equipment, building alterations or renovations, construction, fund raising activities, or political education or lobbying.

Indirect Costs:

Indirect costs are not allowed in this proposal.

In-Kind:

An established minimum level of in-kind contribution is not a grant requirement. However, a description of in-kind that will be provided is required and will be considered in scoring the budget section.

Proposals are to include the amounts and sources of financial or in-kind resources that will be used. In-kind should be expressed in dollars, and can include but is not limited to: staff time (the value of salaries and fringe) spent by collaborating organizations on the project (for example, staff time spent in planning, governance, or IT support); communications and mileage costs related to planning or governance meetings; or other project costs for which grant funding is not being requested.

Budget Forms

Use the Minnesota Accountable Health Model Contractor Budget Template (Form C) for Years 1 and 2 budget templates. Form C includes an example. Use Budget Justification Narrative (Form D) to provide justification for any funds requested.

Form C: Minnesota Accountable Health Model Contractor Budget Template

Section One:

The budget form includes two sections and must be completed for each year. Section One should list eligible expenses by line item. Section Two should provide a summary of expenses by deliverable.

Provide information on how each line item in the budget was calculated.

A. Salaries and Wages:

For all positions proposed to be funded from this grant provide the position title, the hourly rate, and the number of worked hours allocated to this project.

- In the budget narrative, provide a brief position description for each of the positions listed.

B. Fringe:

List the rate of fringe benefits calculated for the total salaries and wages for positions in 1A.

C. Consultant Costs.

Provide the name of contractors or organizations, the services to be provided, hourly rate, and projected costs.

- In the budget narrative, include brief background information about contractors, including how their previous experience relates to the project.
- If a contractor has not been selected, include a description of the availability of contractors for the services and/or products required and the method for choosing contractor in the budget narrative.

D. Equipment:

Equipment, including medical equipment, is not allowed in this grant.

E. Supplies:

Expected costs for general operating expenses, such as office supplies, postage, photocopying, printing and software. For software the type of software must be specified in the budget including the cost per person, the number of people using the software and total costs. Software costs must be specific to the ACH project work and described in the budget justification narrative.

F. Travel:

Include the cost for any proposed in-state travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (may not exceed current rate established by the [Minnesota Management and Budget Commissioner's Plan](http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf) (<http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf>))

- Include expected travel costs for hotels and meals.
- Out of state travel is not an eligible expense.

G. Other:

If it is necessary to include expenditures in the "Other" category, include a detailed description of the proposed expenditures as they relate to the project. Add additional "Other" lines to the budget form as needed.

- **Support Expenses:** Telephone equipment and services, internet connection costs, teleconferences, videoconferences, meeting space rental, and equipment rental.

Section Two: Budget Deliverables:

The total amount paid for the all deliverables in section two, is based upon the total dollars requested in section one. See Form C budget.

Budget deliverables should cross reference your work plan and include key work plan deliverables for:

Part A Proposal

- Review and Analysis of e-Health Legal Issues: Health Information Exchange Use Cases and development of Written Modular Guidance Documents
- Review and Analysis of e-Health Legal Issues: Development of Modular Guidance Documents
- Identification of Leading Practices: This includes Part A Grant work that is supported by non-legal staff and is necessary in order for this work to be complete.
- Modular Guidance Document Validation Process for each Modular Guidance Document
- Subject Matter Expertise: That is continuous, ongoing and collaborative with MDH, DHS and other RFP Grant Recipients

Part B Proposal

- Establish a Plan for Education and Technical Assistance
- Environmental Scan of available materials and resources
- Develop materials and resources to be used for education and technical assistance
- Provide Education and Technical Assistance
- Plan for and then implement widespread dissemination of materials and resources used for education and technical assistance
- Evaluate effectiveness of education and technical assistance

Due Diligence Review Form

This form must be completed by the applicant organization's administrative staff, for example, finance manager, accountant or executive director. It is a standard form MDH uses to determine the accounting system and financial capability of all grant applicants that will be receiving at least \$50,000.

Proposal Filing Instructions

Intent to Respond

Potential Applicants must submit a written non-binding Intent to Respond via e-mail to MDH by Monday, November 3, 2014, 4:00 pm Central Time. The Intent to Respond (see template in Form F) should indicate the parts of the RFP for which an Applicant intends to submit a response (e.g., Part A, Part B, or Part A and Part B).

Letters of Intent to Respond must be submitted by the deadline above via e-mail to:

Lisa Moon
Minnesota Department of Health
Office of Health Information Technology
lisa.moon@state.mn.us

Contact for Questions

Questions about these grants and proposal process should be directed in writing by Monday, November 17, 2014, 4:00 pm Central Time via e-mail to:

Lisa Moon
Minnesota Department of Health
Office of Health Information Technology
lisa.moon@state.mn.us

All Applicants with a written Intent to Respond on file will receive a copy of all written questions and answers that MDH has addressed for questions submitted by the deadline above.

All proposals must be received not later than 4:00 p.m. Central Time, Friday, December 5, 2014, as indicated by a notation made by the MDH Receptionist, 2nd Floor (Suite 220), 85 East 7th Place, St. Paul, MN. All costs incurred in responding to this RFP will be borne by the Applicant. Fax and email responses will not be accepted or considered.

LATE PROPOSALS WILL NOT BE ACCEPTED

Proposal Evaluation

All proposals received by the deadline will be evaluated by representatives of the Minnesota Department of Health- Office of Health Technology and external partners. The State reserves the right, based on the scores of the proposals, to create a short-list of applicants who have received the highest scores to interview, or conduct demonstrations/presentations. A 100-point scale will be used to create the final evaluation recommendation.

All Proposals must meet the following requirements

The following will be considered on a pass/fail basis:

1. Proposals must be received on or before the due date and time specified in this RFP.
2. Proposals for **Part A: Review of Legal Issues, Analysis and Identification of Leading Practice** must include the identification of legal and other staff that will be completing the review of legal issues and analysis for this Grant.
3. Proposals for **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must include the identification of health information exchange and/or care coordination subject matter expert(s) that will be assigned to this Grant.
4. Proposals for **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must include customer evaluation results of at least two past education and/or technical assistance projects that Applicant has provided similar services for.
5. Deliverables and services offered for **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education** must be print-ready and available in a format that can be posted on the MDH website, and in compliance with ADA and state accessibility requirements: (<http://mn.gov/oet/programs/policies/accessibility/#>). The materials must cite all source material, and have all rights to publish or re-publish any materials obtained by others. Deliverables or services that do not fully comply with the identified standards will be rejected and will receive no further consideration.

Proposal Evaluation Criteria

Proposals that pass the prequalification evaluation will undergo an evaluation process conducted by an evaluation committee composed MDH staff and stakeholders selected by MDH. These may be supported by external consultants or other designees (e.g. an extended evaluation team of subject matter experts). All responses received by the deadline will be evaluated. In some instances, an interview may be part of the evaluation process. A 100-point scale will be used to create the final evaluation recommendation. The factors and weighting on which proposals will be judged are:

#	Proposal Evaluation Criteria	Percentage of points awarded or Pass/Fail
1.	Proposals for Part A: Review of Legal Issues, Analysis and Identification of Leading Practice must include the identification of legal and other staff that will be completing the review of legal issues and analysis for this Grant	Minimum Requirement
2.	Proposals for Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education must include the identification of health information exchange and/or care coordination subject matter expert(s) that will be assigned to this Grant.	Minimum Requirement
3.	Proposals for Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education must include customer evaluation results of at least two past education and/or technical assistance projects that Applicant has provided similar services to.	Minimum Requirement
4.	Deliverables and services offered for Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education must be print-ready and available in a format that can be posted on the MDH website, and in compliance with ADA and state accessibility requirements: (http://mn.gov/oet/programs/policies/accessibility/#). The materials must cite all source material, and have all rights to publish or re-publish any materials obtained by others. Deliverables or services that do not fully comply with the identified standards will be rejected and will receive no further consideration	Minimum Requirement
5.	Expressed understanding of project objectives <ul style="list-style-type: none"> • A statement of the objectives, goals, and tasks to show or demonstrate the Applicant's view and understanding of the nature of the Grant and required subject matter expertise. • Demonstrate Applicant's current knowledge and awareness of national activities for e-Health activities and health information exchange. • Demonstrate that Applicant is qualified to effectively negotiate and balance the needs of health 	30 points

#	Proposal Evaluation Criteria	Percentage of points awarded or Pass/Fail
	care providers, health care payers, HIE service providers, and consumers to fulfil the requirements of the scope of work contained in each Grant.	
6.	<p>Deliverables and work plan</p> <ul style="list-style-type: none"> • Description of the proposed approach to achieving deliverables along with a detailed work plan that identifies the major tasks to be accomplished and identification of scheduling and managing tool, as well as the basis for invoicing. • A project schedule that is appropriate based on the needs of both Part A and Part B Grants to have Major Deliverables completed within the first six months of the Grant term. • Description of Applicant’s experience and approach and describes tasks in direct response to the Scope of Work in this RFP. • Detailed approach to project governance, including use of advisory or steering teams, plan for stakeholder engagement. • Detailed approach to project management including but not limited to the scope and risk management plans for Grant. 	30 points
7.	<p>Qualifications/experience of personnel working on the project</p> <ul style="list-style-type: none"> • Description of Applicant’s project team that is capable of successfully carrying out the full scope of work • Part A Grant ONLY: Examples of other legal work that Applicant has done • Part B Grant ONLY: Examples of other education and technical assistance work that Applicant has been done • An outline of the Applicant's background and experience that includes examples of similar work done by the Applicant. This will include a list of personnel and detail training, work experience; skill set related this Grant, resume and number of years of experience for each Grant Recipient who will conduct the project. 	30 points
8.	<p>Budget detail</p> <ul style="list-style-type: none"> • Line item budget costs and costs by deliverables for all associated activities in both Part A and/or Part B Grants using Form C and Form D. 	10 points

Grant Requirements

All organizations that are awarded funding will be expected to:

1. Submit a final work plan and budget, if requested, to MDH.
2. Execute original and two copies of grant agreement and return to MDH for final signature.
3. Refrain from working on grant activities until a fully-executed grant agreement is received from MDH. *Note: Grant Recipients cannot be reimbursed for work completed before the grant agreement is fully executed.*
4. The grant(s) will begin on the date stated in the grant agreement or upon full execution of the grant, whichever is later. The terms of these grants are anticipated to start March 1, 2015, and go until August 30, 2016, for Parts A and B of this RFP.
5. Upon receipt of fully executed grant agreement, begin work. Complete required deliverables and activities as outlined in grant agreement. Grant recipients are expected to contact MDH if they encounter difficulties. If grant deliverables are not completed satisfactorily, MDH has the authority to withhold and/or recover funds.
6. Ensure that all materials produced with grant funds state, “Developed with funds from the Minnesota Department of Health..... grant.” All materials and resources will be hosted on the MDH website and will include the MDH logo.
7. Submit invoices, financial reports, and expenditure reconciliation reports according to the schedule in the grant agreement. All financial transactions will be on a reimbursement basis only.
8. Provide grant summary information to MDH upon request for incorporation in legislative and other MDH reports.
9. Act in a fiscally-responsible manner, including following standard accounting procedures; spending grant funds responsibly; charging the grant only for the activities stated in the grant agreement; properly accounting for how grant funds are spent; maintaining financial records to support expenditures billed to the grant; and meeting audit requirements. Participate in site visits or conference calls to report on progress, barriers or lessons learned.
10. Submit final narrative and expenditure reports for the grant period within 30 days of the grant agreement ending.
11. Additional details that may be requested to comply with federal reporting requirements.

Final 10 percent of the total grant award will be withheld until grant duties are completed.

Please note that all submitted grant proposal materials become public information once grant agreements have been executed.

IV. Required Forms

Below is a listing of forms required for submission of the grant proposal. Forms are included in the RFP for reference only. Do not use the forms in the RFP; instead use the version of the forms posted on the SIM website in completing the grant application. In some cases only the first part of the form is included in this RFP because of its length.

Form A: Application Face Sheet with Instructions

Form B: Project Work Plan

Form C: Budget Form, Minnesota Accountable Health Model Contractor Budget Template

Form D: Budget Justification Narrative

Form E: Due Diligence Review Form

Form F: Letter of Intent to Respond Template

Form A: Application Face Sheet

Legal name and address of the applicant agency with which grant agreement would be executed	
Minnesota Tax I.D. Number	Federal Tax I.D. Number
Requested funding for the total grant period	\$
Director of applicant agency	
Name, Title and Address	Email Address:
	Telephone Number: ()
	FAX Number: ()
Fiscal management officer of applicant agency	
Name, Title and Address	Email Address:
	Telephone Number: ()
	FAX Number: ()
Contact person for applicant agency (if different from number 4 above)	
Name, Title and Address	Email Address:
	Telephone Number: ()
	FAX Number: ()
Contact person for further information on grant application	
Name, Title Address	Email Address:
	Telephone Number: ()
	FAX Number: ()
Certification	
I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant agency.	
_____ Signature of Authorized Agent for Grant Agreement	_____ Title
	_____ Date

Form A: Application Face Sheet Instructions

Please type or print all items on the Application Face Sheet.

- **Applicant agency**

Legal name of the agency authorized to enter into a grant contract with the Minnesota Department of Health.

- **Applicant agency's Minnesota and Federal Tax I.D. number**

- **Requested funding for the total grant period**

Amount the applicant agency is requesting in grant funding for the grant period. The grant period will be from March 1, 2015 – July 1, 2016. The Grant Recipient must submit a budget for each year, starting with March 1, 2015 – December 31, 2015 and January 1, 2016 – July 1, 2016. The budget for each year will be based on deliverables being met the previous year.

- **Director of the applicant agency**

Person responsible for direction at the applicant agency.

- **Fiscal Management Officer of applicant agency**

The chief fiscal officer for the applicant agency who would have primary responsibility for the grant agreement, grant funds expenditures, and reporting.

- **Contact Person for Applicant Agency**

The person who may be contacted concerning questions about implementation of this proposed program. Complete only if different from the individual listed in 5 above.

- **Contact person for Further Information**

Person who may be contacted for detailed information concerning the application or the proposed program.

- **Signature of Authorized Agent of Applicant Agency**

Provide an original signature of the director of the applicant agency, their title, and the date of signature.

Form B: Work Plan

Applicant:

Instructions: Enter objectives, activities, tracking methods, and milestones/timelines for grant years 1 and 2 on separate lines. Use the key objectives and deliverables in the work plan to crosswalk to Section 2 Deliverables of Budget Form C.

<i>OBJECTIVES</i>	<i>ACTIVITIES</i>	<i>TRACKING METHODS</i>	<i>MILESTONES/ TIMELINES</i>

Form C: Minnesota Accountable Health Model Contractor Budget Template

Applicant:

Total Contract Period: March 1, 2015 - August 30, 2016

Budget Form Instructions for Applicants:

1. Complete a separate budget for each grant year - Year 1 (2015) and Year 2 (2016) (see tabs).
2. Include costs for the grant recipient (fiscal agent) and partners in Salaries & Wages, Fringe, Supplies, Travel, and Other categories.
3. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group facilitation, or consultation) in C. Consultant Costs.
4. Enter information in cells highlighted in blue as applicable for your project.

The amount paid for deliverables in section two is based on costs in section one.

Section One

A. SALARIES & WAGES: For each position, provide the following information: position title, hourly rate, and number of hours allocated to the project.

In Form D Budget Justification Narrative, provide a brief position description for each position listed.

Title	Hourly Rate	Hours	Total
			\$
			\$
			\$
Total Salaries and Wages:		0	\$

B. FRINGE: Provide information on the rate of fringe benefits calculated for the total salaries and wages for positions in 1A.

Enter the fringe benefit rate as a % of the total salaries and wages in decimal format.

Total Fringe:	\$

C. CONSULTANT COSTS: Provide the following information for consultants/contractors: name of contractor or organization, hourly rate, number of hours, services to be provided.

In Form D provide a brief background about the contractor including how previous experience relates to the project. If the contractor has not been selected, include a description of the availability of contractors for the services or product, a description of the availability of contractors for the services or product, and the method that will be used for choosing a contractor.

Hourly rate and number of hours	Hourly Rate	Hours	Total
			\$
Name:			
Organization:			
Services:			
Total Consultant Costs:			\$

D. EQUIPMENT: Equipment costs are not allowed.

Item	Unit	Cost/Unit	Total Cost
Total Equipment Costs:			\$

E. SUPPLIES: List each item requested, the number needed, and cost per unit. Include expected costs for general operating expenses such as office supplies, postage, photocopying, and printing.

Item	Unit	Cost/Unit	Total Cost
			\$
			\$
Total Supply Costs:			\$

F. TRAVEL: Provide estimated travel costs below for in-state travel. Include travel costs for hotels, meals, and attending meetings. Include the estimated number of miles planned for project activities and the rate of reimbursement per mile. Out of state travel is not an eligible expense. Travel costs are not to exceed rates established in the Commissioner's Plan at <http://www.mmd.admin.state.mn.us/commissionersplan.htm>

Item	Total Cost
Total Travel Costs:	\$

G. OTHER: If applicable, list items not included in previous budget categories below.

Include a detailed description of the proposed expenditures in Form D Budget Justification Narrative.

Item	Total
Total Other Costs:	\$

GRAND PROJECT TOTAL	\$
----------------------------	-----------

Section Two

DELIVERABLES: The amount paid for deliverables in section two is based upon the total dollars requested in section one. Budget deliverables are to cross reference Form B Work Plan and include key deliverables.			
Deliverable:	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$
Deliverable:	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$
Deliverable:	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$
Deliverable:	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$
GRAND PROJECT TOTAL			\$

In-kind support

In-kind: Include amounts and sources of in-kind including financial resources that will be used and for which grant funds are not being requested.	
In-kind Item	Amount
TOTAL	\$

Form D: Budget Justification Narrative

The Budget Narrative provides additional information to justify costs in Form C Budget.

Instructions: Provide a narrative justification where requested. The narrative justification must include a description of the funds requested and how their use will support the proposal.

A. Salaries and Wages

This should include all personnel whose work is tied to the proposal.

Narrative Justification (*enter a brief description of the roles, responsibilities, and unique qualifications of each position*):

B. Fringe

Narrative Justification (*provide information on the rate of fringe benefits calculated for salaries and wages*):

C. Consultant Costs

Narrative Justification (*provide a brief background about the contractor including how previous experience relates to the project. If the contractor has not been selected, include a description of the availability of contractors for the services and the method that will be used for choosing a contractor*):

E. Supplies

Describe costs related to each type of supply, either in Budget Form C or below.

Narrative Justification (*enter a description of the supplies requested and how their purchase will support the purpose and goals of this proposal*):

F. Travel

Travel may include costs associated with travel for meetings, community engagement, and other items included in the work plan.

Narrative Justification (*describe the purpose and need of travel and how costs were determined for each line item in the budget*):

G. Other

Narrative Justification (*explain the need for each item and how their use will support the purpose and goals of this proposal. Break down costs into cost/unit: i.e. cost/meeting and explain the use of each item requested*):

In-kind

Narrative Justification (*describe in-kind contributions that will be provided by any partners. Include sources and types of in-kind such as staff time, communications, mileage, and other project costs for which grant funding is not being requested*):

Form E: Due Diligence Form and Instructions

The applicant organization's administrative staff (finance manager, accountant, or executive director) must complete the Due Diligence form.

Purpose

The Minnesota Department of Health (MDH) must conduct due diligence reviews for non-governmental organizations applying for grants, according to MDH Policy 240.

Definition

Due diligence refers to the process through which MDH researches an organization's financial and organizational health and capacity (MDH Policy 240). The due diligence process is not an audit or a guarantee of an organization's financial health or capacity. It is a review of information provided by a non-governmental organization and other sources to make an informed funding decision.

Restrictions

An organization with a medium or high risk due diligence score may still be able to receive MDH funding. If MDH staff decide to grant funds to organizations with medium or high risk scores, they must follow the conditions or restrictions in MDH Policy 241: Grants, Organizations with Limited Fiscal Capacity.

Instructions

If the applicant is completing the form: Answer the following questions about your organization. When finished, return the form with the Additional Documentation Requirements to the grant manager as instructed.

If the grant manager is completing the form: Use the applicant's responses and the Additional Documentation Requirements to answer the questions. When finished, use the Due Diligence Review Scoring Guide to determine the applicant's risk level.

Due Diligence Review Form

Instructions: Please use Form E (word format) provided on the [Minnesota SIM RFPs](#) page)

Organization Information

1. How long has your organization been doing business?
2. Does your organization have a current 501(c) 3 status from the IRS? Yes or No.
3. How many employees does your organization have (both part time and full time)?
4. Has your organization done business under any other name(s) within the last five years? Yes or No.
If yes, list name(s) used.
5. Is your organization affiliated with or managed by any other organizations, such as a regional or national office? Yes or No. If yes, provide details.
6. Does your organization receive management or financial assistance from any other organizations? Yes or No. If yes, provide details.
7. What was your organization's total revenue in the most recent 12-month accounting period?
8. How many different funding sources does the total revenue come from?
9. Have you been a grantee of the Minnesota Department of Health within the last five years? Yes or No.
If yes, from which division(s)?
10. Does your organization have written policies and procedures for accounting processes? Yes or No.
If yes, please attach a copy of the table of contents.
11. Does your organization have written policies and procedures for purchasing processes? Yes or No.
If yes, please attach a copy of the table of contents.
12. Does your organization have written policies and procedures for payroll processes? Yes or No.
If yes, please attach a copy of the table of contents.
13. Which of the following best describes your organization's accounting system? Manual, Automated, Both
14. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately? Yes, No, or Not sure
15. If your organization has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items? Yes, No, Not applicable, or Not sure
16. Are time studies conducted for employees who receive funding from multiple sources? Yes, No, Not applicable, or Not sure
17. Does the accounting system have a way to identify over-spending of grant funds? Yes, No, Not sure
18. If grant funds are mixed with other funds, can the grant expenses be easily identified?. Yes, No, Not sure
19. Are the officials of the organization bonded? Yes, No, or Not sure
20. Did an independent certified public accountant (CPA) ever examine the organization's financial statements? Yes, No, or Not sure
21. Has any debt been incurred in the last six months? Yes or No. If yes, what was the reason for the new debt? What is the funding source for paying back the new debt? Yes or No.
22. What is the current amount of unrestricted funds compared to total revenues?
23. Are there any current or pending lawsuits against the organization? Yes or No.
24. If yes, could there be an impact on the organization's financial position? Yes, No or Not applicable
25. Has the organization lost any funding due to accountability issues, misuse, or fraud? Yes or No. If yes, please describe the situation, including when it occurred and whether issues have been corrected.

Additional Documentation Requirements

- Non-governmental organization **with annual income under \$25,000**: Submit your most recent board-reviewed financial statement.
- Non-governmental organization **with annual income between \$25,000 and \$750,000**: Submit your most recent IRS Form 990.
- Non-governmental organization **with annual income over \$750,000**: Submit your most recent certified financial audit.

Form F: Letter of Intent to Respond

Place on Letterhead:

Deadline November 3, 2014, 4:00 pm Central Time

(date)

This is written notification of the intent to submit an application to the Minnesota Department of Health for funding under the Minnesota Accountable Health Model Privacy, Security and Consent Management for Electronic Health Information Exchange grant program (Indicate for Part A, Part B or for both). We understand that the application deadline for our proposal is December 5, 2014, at 4:00 pm Central Time. Information organization is provided below.

Applicant organization name:

Contact person:

Contact person email:

Signature:

Title:

Please submit the letter as an email attachment to lisa.moon@state.mn.us

Or provide the letter via mail or courier to:

Minnesota Department of Health
Office of Health Information Technology
Attention: Lisa Moon

Courier Address:

85 East 7th Place, Suite 220
Saint Paul, Minnesota 55101

Mailing Address (must arrive by the deadline to be accepted):

P.O. Box 64882
Saint Paul, Minnesota 55164-0882

V. Appendices:

Appendix A: Sample Modular Guidance Document

Appendix B: Minnesota Accountable Health Model Glossary

Appendix C: MDH Sample Grant Agreement

Appendix A: Sample Modular Guidance Document

HIPAA, Minnesota's Health Records Act, and Psychotherapy Notes

Overview for providers

Mental health professionals in Minnesota need to be aware of —and comply with—both the compliance obligations imposed by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, as well as those imposed by the Minnesota Health Records Act. While the two laws are generally in alignment, there is a difference between HIPAA and the Health Records Act when it comes to psychotherapy notes.

Psychotherapy Notes Defined. Notes recorded by a health care provider who is a mental health professional that: 1) Document or analyze the contents of conversations during a counseling session; and 2) Are separated from the rest of the patient's medical records. (45 C.F.R. § 164.501).

HIPAA Standard: *Right of Access.* Under HIPAA's Privacy Rule, a mental health professional is not required to disclose psychotherapy notes to a patient. In fact, psychotherapy notes are specifically excluded from a patient's general right to access or inspect their own medical records. If a mental health professional ever wishes to disclose the psychotherapy notes, however, they are permitted to do so, but must first receive the patient's authorization (45 C.F.R. § 164.524(a)).*

There are only three instances in which a mental health professional *does not* need patient authorization to use or disclose psychotherapy notes under HIPAA:

- Use by the provider for treatment;
- Use or disclosure for certain training purposes; or
- Use or disclosure to defense in a legal action. (45 C.F.R. § 164.508(a)(2)).

Minnesota Standard: *Patient Access.* Minnesota's Health Records Act gives patients broader rights when it comes to accessing mental health records because it does not distinguish psychotherapy notes from other medical records. Minnesota law requires that a provider give a patient "complete and current" information concerning *any* diagnosis, treatment or prognosis that relates to the patient upon request. (Minn. Stat. § 144.292, subd. 2). A client also has the right to *access and consent* to release records related to psychological services under administrative rules governing psychologists (Minn. R. 7200.4710).

Minnesota has created an exception, however, that gives providers the discretion to withhold health records (including psychotherapy notes) if the provider believes that "the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self-harm, or to harm another." (Minn. Stat. § 144.292, subd. 7).

Minnesota also has a "Duty to Warn" statute that places a provider under a duty to disclose protected information to "predict, warn of, or take reasonable precautions to provide protections from, violent behaviors." This duty arises when a patient has communicated a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim. If this occurs, a provider *must* make reasonable efforts to communicate the threat to the potential victim or to law enforcement. (Minn. Stat. § 148.975, subd. 2).

Preemption Analysis. If HIPAA and a state law differ as to patient access to medical records, HIPAA says that the law that gives the patients *more* access is the law that the covered entities within the state should follow (45 C.F.R. § 160.203(b)). Because Minnesota provides the right for a patient to access all of their medical records (without any restrictions as to psychotherapy notes), Minnesota mental health professionals should be aware that their patients will be able to access any psychotherapy notes that relate to that patient.

Appendix B: Minnesota Accountable Health Model Glossary

Accountable Care

The terms “accountable care” or “Accountable Care Organization,” or “ACO” are being used to reflect the concept of a group of diverse health care providers that have collective responsibility for patient care and that coordinate services. This term is meant to include the broad range of health and health care providers that are not formally part of an existing ACO as defined by the Centers for Medicare and Medicaid Services (CMS) or other payers, but that are also moving towards greater accountability for the quality and cost of care they provide to their patients.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

Accountable Care Organizations (ACOs)

An Accountable Care Organization is a group of health care providers with collective responsibility for patient care that helps providers coordinate services—delivering high-quality care while holding down costs.

Source: Robert Wood Johnson Foundation Accountable Care Organizations, (www.rwjf.org/en/topics/search-topics/A/accountable-care-organizations-acos.html) accessed 09.10.13

Behavioral Health

The term “behavioral health” is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders. Behavioral health includes the identification, treatment of, and recovery from mental health and substance use disorders. It also increasingly refers to lifestyle changes and actions which improve physical and emotional health, as well as the reduction or elimination of behaviors which create health risks.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

Care Coordination

Care coordination is a function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. The goal of coordination is to ensure that patients’ needs and preferences are achieved and that care is efficient and of high quality. Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.

Source: U.S. Department of Health and Human Services, www.nevhs.hhs.gov/091013p9.pdf

Care Coordinator

A care coordinator is a person who has primary responsibility to organize and coordinate care and services for clients/patients served in a variety of settings, e.g. health care homes, behavioral health clinics, acute care settings and so on.

Care Manager

A care manager is a person who has primary responsibility to organize and coordinate care based on a set of evidence-based, integrated clinical care activities that are tailored to the individual patient, and that ensure each patient has his or her own coordinated plan of care and services.

Care Plan

A care plan **is** the structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Community-based Prevention/Community-based Interventions/Community-based Programs

are terms used interchangeably to refer to programs or policies within a community that seek to improve the health of a population by addressing non-medical factors, or social determinants of health. Such programs often include the application of non-clinical preventive methods in non-traditional health care settings by non-clinical providers.

Source: [Financing Prevention: How states are balancing delivery system & public health roles](http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf) (http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf) accessed 07.23.2014)

Community Care Team is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations to provide citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services.

Source: MN Department of Health Request for Proposals, Health Care Homes: Community Care Team Grants April 15, 2011 <https://www.staterforum.org/system/files/hchcareteamsrfp.pdf> accessed 07/24/2014

Community Engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (Fawcett et al., 1995)

http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Computerized Provider Order Entry (CPOE) is a computer application that allows a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.

Continuum of care

The continuum of care is the full array of services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health and well-being of a population.

Source: Adapted from [Alaska Health Care Commission](http://dhss.alaska.gov/ahcc/Documents/definitions.pdf) (<http://dhss.alaska.gov/ahcc/Documents/definitions.pdf>)

Data Analytics

Data analytics is the systematic use of data and related business insights to drive fact-based decision making for planning, management, measurement and learning. Analytics may be descriptive, predictive or prescriptive.

Source: [IBM Institute for Business Value Healthcare: The value of analytics in healthcare](http://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf) (http://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf)

Determinants of health:

Health is determined through the interaction of individual behaviors and social, economic, genetic and environmental factors. Health is also determined by the systems, policies, and processes encountered in everyday life. Examples of determinants of health include job opportunities, wages, transportation options, the quality of housing and neighborhoods, the food supply, access to health care, the quality of public schools and opportunities for higher education, racism and discrimination, civic engagement, and the availability of networks of social support.

Source: <http://www.health.state.mn.us/divs/chs/healthequity/definitions.html>

Electronic Health Records (EHR)

EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. EHR is considered more comprehensive than the concept of an Electronic Medical Record (EMR).

Source: [Office of the National Coordinator for HIT Health IT Glossary](http://www.hhs.gov/healthit/glossary.html) (<http://www.hhs.gov/healthit/glossary.html>) accessed 09.10.13

Emerging health professionals

Emerging health professionals include Community Health Workers, Community Paramedics, Dental Therapists and Advanced Dental Therapists, with possible future inclusion of other practitioners such as Doulas and Certified Peer Support Specialists.

Health Care Home

A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

Source: [Minnesota Department of Health Health Care Homes \(aka Medical Homes\)](http://www.health.state.mn.us/healthreform/homes/) (www.health.state.mn.us/healthreform/homes/) accessed 09.10.13

Health Equity

Exists when every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Source: [Advancing Health Equity in Minnesota: Report to the Legislature](http://www.health.state.mn.us/divs/chs/healthequity/) (<http://www.health.state.mn.us/divs/chs/healthequity/>) Minnesota Department of Health, accessed 07.30.14

Health Information Exchange (HIE)

Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards. Source: [Minnesota Statutes §62J.498 sub. 1\(f\)](http://www.revisor.mn.gov/statutes/?id=62J.498) (<http://www.revisor.mn.gov/statutes/?id=62J.498>) accessed 09.10.13

Health Information Technology (HIT)

HIT is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Source: [Office of the National Coordinator for HIT Glossary](http://www.healthit.gov/policy-researchers-implementers/glossary) (<http://www.healthit.gov/policy-researchers-implementers/glossary>) accessed 09.10.13

Integrated care

Integrated care covers a complex and comprehensive field and there are many different approaches to and definitions of the concept. One overarching definition (Grone, O. and Garcia-Barbero, M. 2002) is *integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.*

Interprofessional Team

Interprofessional Team, as defined in the Institute of Medicine's (IOM) Report, *Health Professions Education: A Bridge to Quality*, (2003) an interdisciplinary (Interprofessional) team is "composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods." (p. 54) Members of an Interprofessional team communicate and work together, as colleagues, to provide quality, individualized care for patients.

<http://www.iom.edu/Reports/2003/health-professions-education-a-bridge-to-quality.aspx>

Local Public Health

In Minnesota, local public health services are provided through Community Health Boards, which have statutory responsibilities for public health (MN Stat. Chapter 145A), and by Tribal Governments, which are sovereign nations. Local public health responsibilities include prevention and control of communicable disease; protection from environmental health hazards; promoting healthy communities and healthy behaviors (including maternal and child health); preparing for and responding to public health emergencies; and assessing, and sometimes addressing gaps in health services. Local public health professionals carry out these activities in collaboration with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate high quality, non-duplicative programs.

Source: Adapted from [Minnesota Department of Health, Local Public Health Act](http://www.health.state.mn.us/divs/cfh/lph/) (<http://www.health.state.mn.us/divs/cfh/lph/>) accessed 2.19.14

Long-Term and Post-Acute Care (LTPAC)

Long Term and Post-Acute Care is characterized by a variety of settings, from complex care in long-term acute-care hospitals to supportive services in the community or home-based care. Typical services include rehabilitation, medical management, skilled nursing services, and assistance with activities of daily living due physical and/or cognitive impairments. Common types of LTPAC providers include but are not limited to: nursing facilities or skilled nursing facilities; home health agencies; hospice providers; inpatient rehabilitation facilities (IRFS); long-term acute care hospitals; assisted living facilities; continuing care retirement communities; home and community-based services; and adult day service providers.

Source: U.S. Department of Health and Human Services, <http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf>, accessed 01.12.14

Patient and Family Centered Care

Patient and family centered care means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant's knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

Population

For purposes of ACH, “population” is defined broadly and can include the population in a geographic area, people in a location or setting such as a high rise apartment, a patient or other population group, a group with an identified community health need such as tobacco use, or a group of people who utilize many health resources.

Population Health

An aim to optimize the health and well-being of an entire community and reduce inequalities in health and well-being between population groups. A “community” may be either geographic regions and/or groups of people who share attributes (e.g., elderly, minorities, employees, disabled persons, students). Population health requires collaboration across all sectors of a community to address factors such as public infrastructure, the environment, education systems, social supports, and the health care system, in order to address all social determinants of health. Population health within an accountable care organization requires collaboration between all health care providers in the community, social support services within the community, and local public health.

Adapted from: K Hacker, DK Walker. Achieving Population Health in Accountable Care Organizations, *Am J Public Health*. 2013;103(7):1163-1167. <http://ajph.aphapublications.org/doi/ref/10.2105/AJPH.2013.301254>; D Kindig, G Stoddart. What is population health? *Am J Public Health*. 2003;93(3):380–383; and M Stoto. Population Health in the Affordable Care Act Era. *Academy Health*, February 2013. <http://www.academyhealth.org/files/AH2013pophealth.pdf>

Provider

For purposes of SIM, the term “provider” is meant to include the broad range of health care professionals within medicine, nursing, behavioral health, or allied health professions. Health care providers may also be a public/community health professional. Institutions include hospitals, clinics, primary care centers, long-term care organizations, mental health centers, and other service delivery points.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

Public Health

Public health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries. Public health also entails policy development and health surveillance. Public health professionals rely on policy and research strategies to understand issues such as infant mortality and chronic disease in particular populations. In Minnesota, Local public health departments partner with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate programs.

Source: American Public Health Association, http://www.apha.org/NR/rdonlyres/C57478B8-8682-4347-8DDF-A1E24E82B919/0/what_is_PH_May1_Final.pdf; Local Public Health

Association of Minnesota, http://www.lpha-mn.org/FactSheets/MN_Local%20Public%20Health%20System_LPHAfacts.pdf

Social Services

The system of programs, benefits and services made available by public, non-profit or private agencies that help people meet those social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services, for the purposes of SIM, include but are not limited to organizations that provide housing, transportation, or nutritional services to individuals or families.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

Teamwork

Teamwork is defined as the interaction and relationships between two or more health professionals who work interdependently to provide safe, quality patient care. Teamwork includes the interrelated set of specific knowledge (cognitive competencies), skills (affective competencies), and attitudes (behavioral competencies) required for an inter-professional team to function as a unit (Salas, Diaz Granados, Weaver, and King, 2008).

Triple Aim

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim": improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Source: [Institute for Healthcare Improvement Triple Aim](http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx) (www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx) accessed 09.10.201

Appendix C: MDH Sample Grant Agreement

Standard Grant Template Version 1.4, 6/14

Grant Agreement Number _____

Between the Minnesota Department of Health and *Insert Grantee's Name*

If you circulate this grant agreement internally, only offices that require access to the tax identification number AND all individuals/offices signing this grant agreement should have access to this document.

Instructions for completing this form are in blue and are italicized and bracketed. Fill in every blank and delete all instructions, including these instructions, before sending this document to Financial Management for review. Include an encumbrance worksheet to enable Financial Management to encumber the funds for this agreement.

Minnesota Department of Health Grant Agreement

This grant agreement is between the State of Minnesota, acting through its Commissioner of the Department of Health ("State") and *Insert name of Grantee* ("Grantee"). Grantee's address is *Insert complete address*.

Recitals

1. Under Minnesota Statutes 144.0742 and *Insert the program's specific statutory authority to enter into the grant*, the State is empowered to enter into this grant agreement.
2. The State is in need of *Add 1-2 sentences describing the overall purpose of the grant*.
3. The Grantee represents that it is duly qualified and will perform all the duties described in this agreement to the satisfaction of the State. Pursuant to Minnesota Statutes section 16B.98, subdivision 1, the Grantee agrees to minimize administrative costs as a condition of this grant.

Grant Agreement

1. *Term of Agreement*

1.1 *Effective date* *Spell out the full date, e.g., January 1, 2012*, or the date the State obtains all required signatures under Minnesota Statutes section 16C.05, subdivision 2, whichever is later. **The Grantee must not begin work until this contract is fully executed and the State's Authorized Representative has notified the Grantee that work may commence.**

1.2 *Expiration date* *Spell out the full date, e.g., December 31, 2012*, or until all obligations have been fulfilled to the satisfaction of the State, whichever occurs first.

1.3 *Survival of Terms* The following clauses survive the expiration or cancellation of this grant contract: 8. Liability; 9. State Audits; 10.1 Government Data Practices; 10.2 Data Disclosure; 12. Intellectual Property; 14.1 Publicity; 14.2 Endorsement; and 16. Governing Law, Jurisdiction, and Venue.

2. **Grantee's Duties** The Grantee, who is not a state employee, shall: *Attach additional pages if needed, using the following language, "complete to the satisfaction of the State all of the duties set forth in Exhibit A, which is attached and incorporated into this agreement."*
3. **Time** The Grantee must comply with all the time requirements described in this grant agreement. In the performance of this grant agreement, time is of the essence, and failure to meet a deadline may be a basis for a determination by the State's Authorized Representative that the Grantee has not complied with the terms of the grant.

The Grantee is required to perform all of the duties recited above within the grant period. The State is not obligated to extend the grant period.

4. **Consideration and Payment**

4.1 Consideration The State will pay for all services performed by the Grantee under this grant agreement as follows:

(a) Compensation. The Grantee will be paid *Explain how the Grantee will be paid— examples: "an hourly rate of \$0.00 up to a maximum of X hours, not to exceed \$0.00 and travel costs not to exceed \$0.00," Or, if you are using a breakdown of costs as an attachment, use the following language, "according to the breakdown of costs contained in Exhibit B, which is attached and incorporated into this agreement."*

(b) Total Obligation The total obligation of the State for all compensation and reimbursements to the Grantee under this agreement will not exceed *TOTAL AMOUNT OF GRANT AGREEMENT AWARD IN WORDS*] dollars [*(\$ INSERT AMOUNT IN NUMERALS)*].

(c) Travel Expenses *[Select the first paragraph for grants with any of Minnesota's 11 Tribal Nations. Select the second paragraph for all other grants. Delete the paragraph that isn't used.*

The Grantee will be reimbursed for travel and subsistence expenses in the same manner and in no greater amount than provided in the current "GSA Plan" promulgated by the United States General Services Administration. The current GSA Plan rates are available on the official U.S. General Services Administration website. The Grantee will not be reimbursed for travel and subsistence expenses incurred outside Minnesota unless it has received the State's prior written approval for out of state travel. Minnesota will be considered the home state for determining whether travel is out of state.

OR

The Grantee will be reimbursed for travel and subsistence expenses in the same manner and in no greater amount than provided in the current "Commissioner's Plan" promulgated by the Commissioner of Minnesota Management and Budget ("MMB"). The Grantee will not be reimbursed for travel and subsistence expenses incurred outside Minnesota unless it has received the State's prior written approval for out of state travel. Minnesota will be considered the home state for determining whether travel is out of state.

(d) Budget Modifications. Modifications greater than 10 percent of any budget line item in the most recently approved budget (listed in 4.1(a) and 4.1(b) or incorporated in Exhibit B) requires prior

written approval from the State and must be indicated on submitted reports. Failure to obtain prior written approval for modifications greater than 10 percent of any budget line item may result in denial of modification request and/or loss of funds. Modifications equal to or less than 10 percent of any budget line item are permitted without prior approval from the State provided that such modification is indicated on submitted reports and that the total obligation of the State for all compensation and reimbursements to the Grantee shall not exceed the total obligation listed in 4.1(b).

4.2 Terms of Payment

(a) Invoices The State will promptly pay the Grantee after the Grantee presents an itemized invoice for the services actually performed and the State's Authorized Representative accepts the invoiced services. Invoices must be submitted in a timely fashion and according to the following schedule: *Example: "Upon completion of the services," or if there are specific deliverables, list how much will be paid for each deliverable, and when. The State does not pay merely for the passage of time.*

(b) Matching Requirements *If applicable, insert the conditions of the matching requirement. If not applicable, please delete this entire matching paragraph.* Grantee certifies that the following matching requirement, for the grant will be met by Grantee:

(c) Federal Funds *Include this section for all federally funded grants; delete it if this section does not apply.* Payments under this agreement will be made from federal funds obtained by the State through Title *insert number*, CFDA number *insert number* of the *insert name of law* Act of *insert year*, including public law and all amendments. The Notice of Grant Award (NGA) number is _____. The Grantee is responsible for compliance with all federal requirements imposed on these funds and accepts full financial responsibility for any requirements imposed by the Grantee's failure to comply with federal requirements. If at any time federal funds become unavailable, this agreement shall be terminated immediately upon written notice of by the State to the Grantee. In the event of such a termination, Grantee is entitled to payment, determined on a pro rata basis, for services satisfactorily performed.

5. Conditions of Payment All services provided by Grantee pursuant to this agreement must be performed to the satisfaction of the State, as determined in the sole discretion of its Authorized Representative. Further, all services provided by the Grantee must be in accord with all applicable federal, state, and local laws, ordinances, rules and regulations. Requirements of receiving grant funds may include, but are not limited to: financial reconciliations of payments to Grantees, site visits of the Grantee, programmatic monitoring of work performed by the Grantee and program evaluation. The Grantee will not be paid for work that the State deems unsatisfactory, or performed in violation of federal, state or local law, ordinance, rule or regulation.

Authorized Representatives

6.1 State's Authorized Representative The State's Authorized Representative for purposes of administering this agreement is *insert name, title, address, telephone number, and e-mail, or select one: "his" or "her"* successor, and has the responsibility to monitor the Grantee's performance and the final authority to accept the services provided under this agreement. If the services are satisfactory, the State's Authorized Representative will certify acceptance on each invoice submitted for payment.

6.2 Grantee's Authorized Representative The Grantee's Authorized Representative is *insert name, title, address, telephone number, and e-mail, or select one: "his" or "her"* successor. The Grantee's Authorized Representative has full authority to represent the Grantee in fulfillment of the terms, conditions, and requirements of this agreement. If the Grantee selects a new Authorized Representative at any time during this agreement, the Grantee must immediately notify the State in writing, via e-mail or letter.

7. Assignment, Amendments, Waiver, and Merger

7.1 Assignment The Grantee shall neither assign nor transfer any rights or obligations under this agreement without the prior written consent of the State.

7.2 Amendments If there are any amendments to this agreement, they must be in writing. Amendments will not be effective until they have been executed and approved by the State and Grantee.

7.3 Waiver If the State fails to enforce any provision of this agreement, that failure does not waive the provision or the State's right to enforce it.

7.4 Merger This agreement contains all the negotiations and agreements between the State and the Grantee. No other understanding regarding this agreement, whether written or oral, may be used to bind either party.

8. Liability The Grantee must indemnify and hold harmless the State, its agents, and employees from all claims or causes of action, including attorneys' fees incurred by the State, arising from the performance of this agreement by the Grantee or the Grantee's agents or employees. This clause will not be construed to bar any legal remedies the Grantee may have for the State's failure to fulfill its obligations under this agreement. Nothing in this clause may be construed as a waiver by the Grantee of any immunities or limitations of liability to which Grantee may be entitled pursuant to Minnesota Statutes Chapter 466, or any other statute or law.

9. State Audits Under Minnesota Statutes section 16B.98, subdivision 8, the Grantee's books, records, documents, and accounting procedures and practices of the Grantee, or any other relevant party or transaction, are subject to examination by the State, the State Auditor, and the Legislative Auditor, as appropriate, for a minimum of six (6) years from the end of this grant agreement, receipt and approval of all final reports, or the required period of time to satisfy all state and program retention requirements, whichever is later.

10. Government Data Practices and Data Disclosure

10.1 Government Data Practices Pursuant to Minnesota Statutes Chapter 13.05, Subd. 11(a), the Grantee and the State must comply with the Minnesota Government Data Practices Act as it applies to all data provided by the State under this agreement, and as it applies to all data created, collected, received, stored, used, maintained, or disseminated by the Grantee under this agreement. The civil remedies of Minnesota Statutes section 13.08 apply to the release of the data referred to in this clause by either the Grantee or the State.

If the Grantee receives a request to release the data referred to in this clause, the Grantee must immediately notify the State. The State will give the Grantee instructions concerning the release of the data to the requesting party before any data is released. The Grantee's response to the request must comply with the applicable law.

10.2 Data Disclosure Pursuant to Minnesota Statutes section 270C.65, subdivision 3, and all other applicable laws, the Grantee consents to disclosure of its social security number, federal employee tax identification number, and Minnesota tax identification number, all of which have already been provided to the State, to federal and state tax agencies and state personnel involved in the payment of state obligations. These identification numbers may be used in the enforcement of federal and state tax laws which could result in action requiring the Grantee to file state tax returns and pay delinquent state tax liabilities, if any.

11. Ownership of Equipment *If this grant agreement disburses any federal funds, select option #1 and delete option #2. If this grant agreement disburses only state funds, select option #2 and delete option #1.*

Option #1

Disposition of all equipment purchased under this grant shall be in accordance with Code of Federal Regulations, Title 45, Part 74, Subpart C. For all equipment having a current per unit fair market value of \$5,000 or more, the State shall have the right to require transfer of the equipment, including title, to the Federal Government or to an eligible non-Federal party named by the STATE. This right will normally be exercised by the State only if the project or program for which the equipment was acquired is transferred from one grantee to another [Option #2](#):

The State shall have the right to require transfer of all equipment purchased with grant funds (including title) to the State or to an eligible non-State party named by the State. This right will normally be exercised by the State only if the project or program for which the equipment was acquired is transferred from one grantee to another.

12. Ownership of Materials and Intellectual Property Rights

12.1 Ownership of Materials The State shall own all rights, title and interest in all of the materials conceived or created by the Grantee, or its employees or subgrantees, either individually or jointly with others and which arise out of the performance of this grant agreement, including any inventions, reports, studies, designs, drawings, specifications, notes, documents, software and documentation, computer based training modules, electronically, magnetically or digitally recorded material, and other work in whatever form ("materials").

The Grantee hereby assigns to the State all rights, title and interest to the materials. The Grantee shall, upon request of the State, execute all papers and perform all other acts necessary to assist the State to obtain and register copyrights, patents or other forms of protection provided by law for the materials. The materials created under this grant agreement by the Grantee, its employees or subgrantees, individually or jointly with others, shall be considered "works made for hire" as defined by the United States Copyright Act. All of the materials, whether in paper, electronic, or other form, shall be remitted to the State by the Grantee. Its employees and any subgrantees shall not copy, reproduce, allow or cause to have the materials copied, reproduced or used for any purpose other than performance of the Grantee's obligations under this grant agreement without the prior written consent of the State's Authorized Representative.

12.2 Intellectual Property Rights Grantee represents and warrants that materials produced or used under this grant agreement do not and will not infringe upon any intellectual property rights of another including but not limited to patents, copyrights, trade secrets, trade names,

and service marks and names. Grantee shall indemnify and defend the State, at Grantee's expense, from any action or claim brought against the State to the extent that it is based on a claim that all or parts of the materials infringe upon the intellectual property rights of another. Grantee shall be responsible for payment of any and all such claims, demands, obligations, liabilities, costs, and damages including, but not limited to, reasonable attorney fees arising out of this grant agreement, amendments and supplements thereto, which are attributable to such claims or actions. If such a claim or action arises or in Grantee's or the State's opinion is likely to arise, Grantee shall at the State's discretion either procure for the State the right or license to continue using the materials at issue or replace or modify the allegedly infringing materials. This remedy shall be in addition to and shall not be exclusive of other remedies provided by law.

13. Workers' Compensation The Grantee certifies that it is in compliance with Minnesota Statutes section 176.181, subdivision 2, which pertains to workers' compensation insurance coverage. The Grantee's employees and agents, and any contractor hired by the Grantee to perform the work required by this Grant Agreement and its employees, will not be considered State employees. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees, and any claims made by any third party as a consequence of any act or omission on the part of these employees, are in no way the State's obligation or responsibility.

14. Publicity and Endorsement

14.1 Publicity Any publicity given to the program, publications, or services provided resulting from this grant agreement, including, but not limited to, notices, informational pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Grantee or its employees individually or jointly with others, or any subgrantees shall identify the State as the sponsoring agency and shall not be released without prior written approval by the State's Authorized Representative, unless such release is a specific part of an approved work plan included in this grant agreement.

14.2 Endorsement The Grantee must not claim that the State endorses its products or services.

15. Termination

15.1 Termination by the State or Grantee The State or Grantee may cancel this grant agreement at any time, with or without cause, upon thirty (30) days written notice to the other party.

15.2 Termination for Cause If the Grantee fails to comply with the provisions of this grant agreement, the State may terminate this grant agreement without prejudice to the right of the State to recover any money previously paid. The termination shall be effective five business days after the State mails, by certified mail, return receipt requested, written notice of termination to the Grantee at its last known address.

15.3 Termination for Insufficient Funding The State may immediately terminate this agreement if it does not obtain funding from the Minnesota legislature or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the work scope covered in this agreement. Termination must be by written or facsimile notice to the Grantee. The State is not obligated to pay for any work performed after notice and effective date of the termination. However, the Grantee will be entitled to payment,

determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available. The State will not be assessed any penalty if this agreement is terminated because of the decision of the Minnesota legislature, or other funding source, not to appropriate funds. The State must provide the Grantee notice of the lack of funding within a reasonable time of the State receiving notice of the same.

16. Governing Law, Jurisdiction, and Venue This grant agreement, and amendments and supplements to it, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this grant agreement, or for breach thereof, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

(If this grant agreement disburses any federal funds, delete the following section as Lobbying with federal funds is covered in Other Provisions. If this grant agreement disburses ONLY state funds, include the following section and delete Other Provisions.)

17. Lobbying (Ensure funds are not used for lobbying, which is defined as attempting to influence legislators or other public officials on behalf of or against proposed legislation. Providing education about the importance of policies as a public health strategy is allowed. Education includes providing facts, assessment of data, reports, program descriptions, and information about budget issues and population impacts, but stopping short of making a recommendation on a specific piece of legislation. Education may be provided to legislators, public policy makers, other decision makers, specific stakeholders, and the general community.

17. Other Provisions *If this grant agreement disburses any federal funds, all of the following provisions must be included. Delete this entire clause (#17) if the grant agreement disburses only state funds.*

17.1 Contractor Debarment, Suspension and Responsibility Certification

Federal regulation 45 CFR 92.35 prohibits the State from purchasing goods or services with federal money from vendors who have been suspended or debarred by the Federal Government. Similarly Minnesota Statute §16C.03, Subdivision 2, provides the Commissioner of Administration with the authority to debar and suspend vendors who seek to contract with the State.

Vendors may be suspended or debarred when it is determined, through a duly authorized hearing process, that they have abused the public trust in a serious manner. In particular, the Federal Government expects the State to have a process in place for determining whether a vendor has been suspended or debarred, and to prevent such vendors from receiving federal funds. By signing this contract, Grantee certifies that it and its principals:

- (a)** Are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency;
- (b)** Have not within a three-year period preceding this contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

(c) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement or receiving stolen property; and

(d) Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this grant/contract are in violation of any of the certifications set forth above.

17.2 Audit Requirements to be Included in Grant Agreements with Subrecipients

(a) For subrecipients (grantees) that are state or local governments, non-profit organizations, or Indian Tribes:

If the Grantee expends total federal assistance of \$500,000 or more per year, the grantee agrees to: a) obtain either a single audit or a program-specific audit made for the fiscal year in accordance with the terms of the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133; and, b) to comply with the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

Audits shall be made annually unless the grantee is a state or local government that has, by January 1, 1987, a constitutional or statutory requirement for less frequent audits. For those governments, the federal cognizant agency shall permit biennial audits, covering both years, if the government so requests. It shall also honor requests for biennial audits by state or local governments that have an administrative policy calling for audits less frequent than annual, but only audits prior to 1987 or administrative policies in place prior to January 1, 1987.

For subrecipients (grantees) that are institutions of higher education or hospitals:

If the Grantee expends total direct and indirect federal assistance of \$500,000 or more per year, the Grantee agrees to obtain a financial and compliance audit made in accordance with OMB Circular A-110, "Requirements for Grants and Agreements with Universities, Hospitals and Other Nonprofit Organization" as applicable. The audit shall cover either the entire organization or all federal funds of the organization.

The audit must determine whether the Grantee spent federal assistance funds in accordance with applicable laws and regulations.

(b) The audit shall be made by an independent auditor. An independent auditor is a state or local government auditor or a public accountant who meets the independence standards specified in the General Accounting Office's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

(c) The audit report shall state that the audit was performed in accordance with the provisions of OMB Circular A-133 (or A-110 as applicable).

The reporting requirements for audit reports shall be in accordance with the American Institute of Certified Public Accountants' (AICPA) audit guide, "Audits of State and Local Governmental Units," issued in 1986. The Federal Government has approved the use of the audit guide.

In addition to the audit report, the Grantee shall provide comments on the findings and recommendations in the report, including a plan for corrective action taken or planned and comments on the status of corrective action taken on prior findings. If corrective action is not necessary, a statement describing the reason it is not should accompany the audit report.

(d) The Grantee agrees that the grantor, the Legislative Auditor, the State Auditor, and any independent auditor designated by the grantor shall have such access to Grantee's records and financial statements as may be necessary for the grantor to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

(e) If payments under this grant agreement will be made from federal funds obtained by the State through the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), the Grantee is responsible for compliance with all federal requirements imposed on these funds. The Grantee must identify these funds separately on the schedule of expenditures of federal awards (SEFA), and must also accept full financial responsibility if it fails to comply with federal requirements. These requirements include, but are not limited to, Title III, part D, of the Energy Policy and Conservation Act (42 U.S.C. 6321 *et seq.* and amendments thereto); U.S. Department of Energy Financial Assistance Rules (10CFR600); and Title 2 of the Code of Federal Regulations.

(f) Grantees of federal financial assistance from subrecipients are also required to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

(g) The Statement of Expenditures form can be used for the schedule of federal assistance.

(h) The Grantee agrees to retain documentation to support the schedule of federal assistance for at least four (4) years.

(i) The Grantee agrees to file required audit reports with the State Auditor's Office, Single Audit Division, and with federal and state agencies providing federal assistance, within nine (9) months of the Grantee's fiscal year end.

OMB Circular A-133 requires recipients of more than \$500,000 in federal funds to submit one copy of the audit report within 30 days after issuance to the central clearinghouse at the following address:

Bureau of the Census
Data Preparation Division
1201 East 10th Street
Jeffersonville, Indiana 47132
Attn: Single Audit Clearinghouse

17.3 Drug-Free Workplace

Grantee agrees to comply with the Drug-Free Workplace Act of 1988, which is implemented at 34 CFR Part 85, Subpart F.

17.4 Lobbying

The Grantee agrees to comply with the provisions of United States Code, Title 31, Section 1352. The Grantee must not use any federal funds from the State to pay any person for influencing or attempting to influence an officer or employee of a federal agency, a member of Congress, an officer or employee of Congress, or any employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If the Grantee uses any funds other than the federal funds from the State to conduct any of the aforementioned activities, the Grantee must complete and submit to the State the disclosure form specified by the State. Further, the Grantee must include the language of this provision in all contracts and subcontracts and all contractors and subcontractors must comply accordingly.

17.5 Equal Employment Opportunity

Grantee agrees to comply with the Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and supplemented by regulations at 41 CFR Part 60.

17.6 Cost Principles

The Grantee agrees to comply with the provisions of the applicable OMB Circulars A-21, A-87 or A-122 regarding cost principles for administration of this grant award for educational institutions, state and local governments and Indian tribal governments or non-profit organizations.

17.7 Rights to Inventions – Experimental, Developmental or Research Work

The Grantee agrees to comply with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements" and any implementing regulations issued by the awarding agency.

17.8 Clean Air Act

The Grantee agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act as amended (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.). Violations shall be reported to the Federal Awarding Agency Regional Office of the Environmental Protection Agency (EPA).

17.9 Whistleblower Protection for Federally Funded Grants The "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections," 41 U.S.C. 4712, states, "employees of a contractor, grantee [or subgrantee] may not be discharged, demoted, or otherwise discriminated against as reprisal for "whistleblowing." In addition, whistleblowing protections cannot be waived by any agreement, policy, form or condition of employment.

The requirement to comply with, and inform all employees of, the “Pilot Program for Enhancement of Contractor Employee Whistleblower Protections” is in effect for all grants, contracts, subgrants, and subcontracts through January 1, 2017.

IN WITNESS WHEREOF, the parties have caused this grant agreement to be duly executed intending to be bound thereby.

APPROVED:

1. Grantee

The Grantee certifies that the appropriate persons(s) have executed the grant agreement on behalf of the Grantee as required by applicable articles, bylaws, resolutions, or ordinances.

By: _____
(with delegated authority)

Title: _____

Date: _____

By: _____

Title: _____

Date: _____

Distribution:

Agency – Original (fully executed) Grant Agreement

Grantee

State Authorized Representative

2. State Agency

Grant Agreement approval and certification that State funds have been encumbered as required by Minn. Stat. §§16A.15 and 16C.05.

By: _____

Title: _____

Date: _____