



**Amendment to the
Request for Proposals**

***Minnesota Accountable Health Model
Practice Transformation
Grant Program***

Posted October 20, 2014

Amended November 5, 2014

As of October 23, 2014, the following changes in ineligible expenses for grant funding through the Center for Medicare and Medicaid have gone into effect.

PLEASE NOTE THE FOLLOWING AMENDMENT TO THE PRACTICE TRANSFORMATION REQUEST FOR PROPOSAL

Budget guidance on page 15 of the Practice Transformation RFP:

Food, stipends, and incentives are now considered Ineligible Expenses and are not allowed by the federal Center of Medicare and Medicaid Innovations grants for reimbursement.

Please see page 15 for full details.

Budget guidance on page 17 of the Practice Transformation RFP:

In Section F (Other, Meals), Meals are no longer a covered expense. Please see page 17 for full details.

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1. Overview

The Minnesota Department of Health (MDH) requests proposals for the Minnesota Accountable Health Model Practice Transformation¹ grant program. Many providers, including small, independent, rural, and safety net providers face financial barriers to implementation of practice transformation. These grants will support models that integrate primary care, behavioral health, social services, training, and coordination through practice facilitation.² This grant opportunity will support a range of providers and teams in primary care, social services, or behavioral health to allow team members to participate in practice transformation activities such as:

- redesign of clinical systems work
- development of new data collection or management tools
- implementation of new work flows
- expansion of quality improvement systems
- applicable provider training

Providers and clinical practices will learn to provide care within an interdisciplinary, team based, and coordinated care environment. This will support providers in achieving the goals of the triple aim: improving patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

2. Background

The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the Center for Medicare & Medicaid Innovation³ 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 care 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 patient experience, patient health outcomes (population health), 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

¹ Practice transformation, see attached glossary for definition of practice transformation, page 32.

² Practice facilitation, see attached glossary for definition of practice facilitation, page 32.

³ <http://innovations.cms.gov>

- Provider organizations effectively and sustainably partner and integrate 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 Accountable Health 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, formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services⁴.

The expanded focus will be on the development of integrated community service delivery models and use of 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. The model will also encourage addressing the non-clinical (social determinants) determinants of health at a community level.

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 care models to be successful.⁵

- Driver-1** Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement-Health Information Technology (HIT)/Health Information Exchange (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-Alignment.

The activities contained in this RFP are linked to Driver 3, the **Minnesota Accountable Health Model Practice Transformation Grant**. Many individuals, particularly those with multiple medical or behavioral health issues, face challenges getting the care they need. Patients with complex conditions often require health care, access to healthy food, physical safety, and supportive services (such as mental health or chemical dependency counseling, housing, home care, or rehabilitation services) from multiple entities; for these patients, it is easy to get lost in the cracks between systems, resulting in poor health outcomes and higher costs.

⁴

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441

⁵

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

Barriers on the provider side prevent most health care providers from partnering effectively with available community organizations, either because of lack of understanding of available services or lack of resources to coordinate with services beyond health care.

Within Driver 3, there is a significant goal to expand health care homes (HCH's). A "health care home, also called a medical home, is an approach to primary care transformation 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. The development of health care homes in Minnesota is part of the health reform legislation passed in May 2008. Primary care transformation using health care home standards as the transformation systems model is foundational to the success of primary care clinics in delivering high quality transformed services to the population. Minnesota has made significant progress in implementing HCH certification since July of 2010. However, there is significant geographic variation in the distribution of integrated care systems in Minnesota, and a wide variation in the mix of provider organizations that may be involved in a patient's care, particularly in urban versus rural areas. Small rural clinics, in particular, face special challenges in transforming themselves to operate health care homes or to implement integrated care coordination approaches and may also be challenged to form accountable care organization-like models. In addition, clinics such as Federally Qualified Health Centers (FQHC's), Community Mental Health Centers, and other small/medium sized independent practices may have similar challenges.⁶

Another important goal of Driver 3 is the integration of behavioral health and primary care. The Minnesota Department of Human Services Health Care and Chemical and Mental Health Services Administrations are working together to design a Behavioral Health Home (BHH) model which will operate under a "whole person" philosophy and assure access to and coordinated delivery of primary care and behavioral health services for children and youth with Serious Emotional Disorders and adults with Serious Mental Illness or Serious and Persistent Mental Illness. DHS is working closely with Health Care Homes in the Minnesota Department of Health and the State Innovations Model (SIM) Team to implement the objectives of both initiatives in areas such as practice transformation, implementation of community sub-grants, and stakeholder engagement to support and facilitate the adoption of this model.

Minnesota Accountable Health Model Continuum of Accountability Matrix

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 organizations readiness to expand the "triple aim". The Minnesota Accountable Health Model Continuum of Accountability Matrix 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 to lay out developmental milestones that indicate organizations or partnerships are making progress towards the vision.

⁶ <http://www.health.state.mn.us/healthreform/homes/standards/adoptedrule.html>

In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool⁷ 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 their status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve these 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.⁸

3. Available Funding and Estimated Awards

MDH will award grants of \$10,000 - \$20,000 per grant. We estimate that 10-20 primary care, behavioral health, or social service providers will be funded in the first cycle. Practice transformation grants will be awarded in four grant cycles with approximately \$200,000 for each cycle. Review in May 2015, November 2015, and May 2016.

Grants will be awarded for a six-month period. A continuation of the grant period beyond six months with a no cost extension may be considered based on performance and needs identified.

Applicants may apply or re-apply in more than one grant cycle.

Funds may be used to cover:

These grants will support models that integrate primary care, behavioral health, and social services. Funds could be utilized for the following:

- Preparation for health care home (HCH) certification or recertification, such as gap analysis, assessment of patient and family centered care, quality improvement(QI) infrastructure, assess workflow, or certification procedures.
- Support implementation activities and planning for behavioral health homes (BHH) and other social service integration activities.
- Salary support for provider/teams participating in the proposed project. Team members could be leadership &/or administration, project management, provider(s)/clinicians or quality improvement staff.
- Consultant contracts to support a proposed project. Examples of consultant roles could include health information technology (HIT), workflow/process redesign, and implementation of quality improvement infrastructure (Q1).

7

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836

8 <http://www.mn.gov/sim>

- Project staff time to support workflow redesign or process flow mapping within the setting.
- Involvement of consumers and their families in the provision of their care through consumer advisory committees, surveys, or focus groups.
- Patient and family engagement processes to enhance quality of patients' experience, participation in care coordination, and improve health outcomes.
- Process redesign for roles / responsibilities to increase efficiency of workforce utilization.
- Implementation of strategies to enhance team based skills or leadership skills.
- Staffing support through care coordination of high risk patients with chronic diseases such as diabetes or patients with hypertension, depression, or other chronic illnesses.
- Resources to improve cultural competency in staff and efficient use of interpreters.
- Implementation of quality improvement strategies to improve outcomes such as statewide quality reporting measures.
- Internal assessment to identify and expand existing programs and policies that address health disparities and advance health equity.
- Enhanced data analytic support to assist practices in managing cost and improving quality.
- Quality improvement strategies aimed at improving referrals to and transitions management between primary care and community partners or hospitals / long term care.
- Support for activities that are recommended by Practice Facilitators or professional coaches.

4. Grant Timeline

RFP Activity	Date
RFP Posted	Monday, October 20, 2014
Informational webinar	Wednesday, November 5, 2014, 11:00am – 12:30pm To register for the Practice Transformation webinar visit: https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=t3916aaa01c72f554245723169038deb6
Proposals due to MDH	Thursday, December 4, 2014, 4:00 PM CST.
Estimated notice of awards	Friday, December 19, 2014
Estimated grant start date	January 2015

5. Grant Applicants

The applicant for practice transformation grants must meet at least one of the following requirements:

- A primary care provider or primary care practice. This could be a health care home, rural health provider, Federally Qualified Health Center or a group of primary care providers seeking to transform their practice to a certified health care home or implement integration of services with social services or behavioral health.
- Social service providers working with primary care or behavioral health to implement integrated services.
- Behavioral health providers working with primary care providers to implement integrated services such as behavioral health homes.
- Tribal primary care and behavioral health providers.
- To be eligible, the applicant must be located in the State of Minnesota or serving residents of Minnesota⁹.

Priority will be given to organizations that provide services to underserved, rural health providers, organizations seeking health care home certification or recertification, organizations planning for development of behavioral health homes and organizations that are participating in, or preparing to participate in, an Accountable Care Organization (ACO) or similar health care delivery model that provides accountable care (including, but not limited to, the Medicare Shared Savings Program, the Medicare Pioneer ACO Program, or the Medicaid Integrated Health Partnerships program).

6. Goals and Outcomes

A specific goal of the SIM grant is to test how investments in infrastructure for data analytics, health information technology, practice transformation, and quality improvement can accelerate adoption of Accountable Care Organization (ACO) models and remove barriers to integration of care (including behavioral health and social services).

The goal of the Practice Transformation grants is to support a range of providers and teams in primary care, social services, or behavioral health to allow team members to participate in transformation activities that help remove barriers to the integration of care.

To successfully participate and help support achieving these goals and outcomes a grantee must complete a transformation project that support the broad goals of the Minnesota Affordable Health Model related to providing coordinated care, across settings, for complex patients, populations and models of accountable care.

⁹ Health care home rule, Sub.24 local trade area clinician, page 5. http://www.health.state.mn.us/health/reform/homes/standards/AdoptedRule_January2010.pdf

7. Activities and Required Deliverables

Types of project activities that could be funded include:

- Preparation for health care home certification, recertification, or planning activities for behavioral health home such as gap analysis, assessment of patient and family centered care, and quality improvement.
- Development of a care team that supports the provider in delivering patient and family centered care. Refining team roles and functions that support coordination of care.
- Activities that foster and improve skills in providing team based care, infrastructure, access, work flow, or certification procedures.
- Activities that improve cultural competency in staff and efficient use of interpreters.
- Activities that improve the skills of staff to better engage and activate patients/families in such ways as motivational interviewing, health coaching, development of patient centered action goals, trauma informed care approaches.
- Bringing together a quality improvement team that will establish a plan to monitor performance indicators and engage in quality improvement processes, including the ability to monitor, analyze, and track changes to improve health conditions of patients/consumers/clients with specific conditions such as diabetes, hypertension, depression, or other chronic illnesses.
- Utilization of data analytic tools to manage cost/risk and improve quality, access, and efficiency.
- Work flow redesign for effective implementation of HIT or meaningful use tools.
- Enhance reporting capabilities to support robust patient registries for population management.
- Utilizing electronic medical records for patient registries in the form of Health Information Exchange that support coordinated care, assess workflow, and scheduling to create efficiencies.
- Exchange of health information to coordinate care for patients.

Required Grant Elements -Regardless of the activity identified, the applicant must describe the following: **(deliverables):**

- Project management-key lead person identified and capacity to complete the project.
- Team members, team development, planning, and implementation.
- Quality Improvement-process and outcomes measures within the project.
- If applicable:
 - Care Coordination within the organization and with community services that can augment or support services.
 - Consumer/client or family participation in care planning, advisory committees, or focus groups.
- Other project specific elements.

8. Review Process

The State is requiring the completion of the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool, as part of the application process. This tool will help assess where applicants are at in moving towards greater accountability for quality, cost of care, and health of the populations served.

The review panel will consist of staff from the Minnesota Department of Health and the Minnesota Department of Human Services. The panel will recommend selections to the Commissioners of Health and Human Services. In addition to panel recommendations, the commissioners may also take into account other relevant factors in making final awards, including geographic location, number of grantees, and a cross section of target populations.

Only complete applications that meet eligibility and application requirements and are received on or before 4:00 pm, December 4, 2014, will be reviewed. Reviewers will determine which applications best meet the criteria as outlined in the RFP and make recommended for funding. Grant award decisions are estimated to be made by December 19, 2014. Applicants will be notified by letter whether or not their grant proposal was funded. MDH reserves the right to negotiate changes to budgets submitted with the proposal.

Grant agreements will be entered into with those organizations that are awarded grant funds. The anticipated effective date of the agreement is January 2015, or the date upon which all signatures are obtained. Grant agreements will end on June 2015 or six months after the date the contract is fully executed. No work on grant activities can begin until a fully executed grant agreement is in place.

9. Grant Application and Program Summary

Requirement	Description
Grant Applicant	To be eligible, the applicant organization must be located in the State of Minnesota. Proposals may be initiated by a primary care clinic, health care home, Tribal primary care or behavioral health provider, Federally Qualified Health Center, social service, or behavioral health provider who seeks to integrate.
Total Funds Available	\$200,000 for the first grant cycle.
Maximum Grant Amount	Up to 20 new grant awards for up to \$20,000 for first funding cycle in 2015.
Duration of Funding	January 2015 through June 2015 or six months from contract execution date.
Grant Purpose	To provide resources to primary care clinics, behavioral health, and social service providers/ organizations to facilitate provider-practice transformation.

Requirement	Description
Application Requirements	<ul style="list-style-type: none"> • Applications must be written in a 12- point font with one inch margins. • Page limits are identified in Section 10, page 12. • All pages must be numbered consecutively. • Applicants must submit 7 copies of the proposal and an electronic version of the proposal on a USB drive. Faxed or emailed applications will not be accepted. • Applications must meet application deadline requirements; late applications will not be reviewed. • Applications must be complete and signed where noted. • Incomplete applications will not be considered for review.
Applicants must submit proposals in this order using forms provided in Word and Excel	<ol style="list-style-type: none"> 1. Application Face Sheet (Form A) 2. Applicant Experience, Capacity, and Project Description (4 pages or less) (page 12.A) 3. Provider Application Form (Form B) (2 pages or less) 4. Work Plan and required deliverables (Form C) (Document referenced in grant contract) 5. Budget (Form D) 6. Budget Justification(Form E) 7. Continuum of Accountability Matrix Assessment (Form F)
Submitting the Proposal	<p>Applicants must submit seven (7) copies of the proposal and an electronic proposal on a USB drive.</p> <p>Proposals must be received by 4:00 p.m. on Thursday, December 4, 2014</p>
Application Deadline	4:00 p.m. CST December 4, 2014
Applications Sent	<p>Delivery Address: Minnesota Department of Health Health Care Homes / SIM Unit 85 East 7th Place, Suite 220 Saint Paul, Minnesota 55101</p> <p>Mailing Address: Minnesota Department of Health Health Care Homes / SIM Unit P.O. Box 64882 Saint Paul, Minnesota 55164-0882</p>
Contact Information	<p>Questions about Practice Transformation grants and the proposal process should be directed to:</p> <p>Janet Howard Minnesota Department of Health Health Care Homes / SIM Unit Janet.Howard@state.mn.us</p>

10. Proposal Instructions

Required Elements:

Proposals for these grants must not exceed 6 pages of single-spaced 12-point type. The 6 page limit includes:

- Application Experience, Capacity and Project Description Narrative
- Provider Application for Practice Transformation Form B.

A. Applicant Experience, Capacity, and Project Description Narrative

Provide a brief summary, of the applicant’s capacity and experience to complete the project, and the population you serve. Describe the practice transformation project goals, objectives, and outcomes. Discuss the need as identified by the Minnesota Accountability Matrix Tool. Include the expected impact it will have on transforming your practice and the population you serve. (4 page limit)

A. Criteria for grant review: Applicant Experience and Capacity (35 points)

- The applicant is a:
 - Primary care provider or primary care practice
 - Social service providers working with primary care or behavioral health to implement integrated services such as behavioral health homes.
 - Tribal primary care and behavioral health
The grant applicant serves rural and underserved communities.
- The applicant gives a clear picture of the history, structure, and capacity of the applicant agency to serve the identified population.
- The applicant describes the need for practice transformation based on the completion of the Minnesota Accountability Matrix Tool.

B. Provider Application for Practice Transformation Form B

- In the table below identify key provider practice team members and their role in the practice transformation project. A project lead must be identified.
- Respond to the questions listed below. (2 page limit-does not include table)

Team Member Name	Team Role
	Project Lead (Required)

1. Describe how leadership, provider(s)/clinicians, and administration are engaged in this project.
2. Do you plan on or are you hoping to utilize the services of a practice facilitator who can guide you through your practice transformation process?
3. Describe the goals your organization will achieve through this grant funding and how progress to these goals will be measured.
4. Describe your plan to involve patients, family members or consumers in planning or implementing this project. If this does not apply to your project tell us why it is not applicable.
5. Do you plan to apply for Health Care Home Certification, re-certification, or planning for behavioral health homes? Yes/No/Not Sure Projected date:
6. If applicable, describe how your organization is participating in, or preparing to participate in, an Accountable Care Organization (ACO) or similar health care delivery model that provides accountable care (including, but not limited to, the Medicare Shared Savings Program, the Medicare Pioneer ACO Program, or the Medicaid Integrated Health Partnerships program).

B. Criteria for grant review: Provider Application for Practice Transformation Form B (25 points)

- The applicant clearly describes a team leader and a team that will be involved in project implementation and completion of the project.
- The organization has committed the leadership, the provider(s)/clinicians and administration to the project.
- The applicant clearly describes how patients, family members or consumers will participate in the implementation of the project.
- The grant applicant is seeking health care home certification, re-certification, or planning for behavioral health homes, social services, or other integrated care models.
- The grant applicant is a participating or preparing to participate in an Accountable Care Organizations (ACO) or similar health care delivery model.

C. Work plan and Deliverables Form C

Instructions: Complete the Work Plan Template. Include the grant elements, objectives, activities, tracking methods, timeline, and deliverables or outcomes for the six month time period. **(Form C is Enclosed)**. Use the key deliverables in Form C to describe payment for corresponding deliverables in the Section 2 Deliverables (outcomes) in the Budget Minnesota Accountable Health Model Budget Template. Form C Work Plan and the Budget Minnesota Accountable Health Model Budget Template will be the work plan attachments in the grant contract and the documents used to monitor ongoing grant deliverables.

Work Plan Form C

<i>Required Grant Elements/Deliverables</i>	OBJECTIVES	ACTIVITIES	TRACKING METHODS	TIMELINES Jan-June, 2015	OUTCOMES
<i>Instructions</i>	<i>Focus on a specific activity for the time period What are you hoping to achieve?</i>	<i>Outline of what you will do & steps you will take:</i>	<i>Include how you will track your activity</i>	<i>Include a time line for each activity</i>	<i>Include your outcome for the activity</i>
<i>Example:</i> Quality Improvement Process & Outcomes Measures	<i>Example: QI Structure and identified Team</i>	<i>Example: Meet Quarterly Review Internal Data Implement Patient Experience Survey</i>	<i>Examples: Meeting minutes, Schedule of Data Analysis Patient Experience Findings</i>	<i>Examples: Quarterly Monthly 6 months</i>	<i>Examples: Processes in place, Improved outcomes in patient care, Consumer participation Reports, Data collection</i>
Project Management					
Team Members and Team Development					
Quality Improvement Process & Outcomes Measures					
If applicable: Care Coordination					
If applicable: Consumer/family participation					
Additional project activities					

C. Criteria for grant review: Work plan and deliverables: (25 points)

- The goals and objectives for the project are clearly defined, realistic, and measurable within the work plan.
- The applicant identifies activities that will enhance practice transformation in primary care, integration of care, becoming a health care home or behavioral health home, or other integrated care model.
- The applicant addresses the key deliverables of project management, team members and team development, quality improvement, if applicable care coordination, and consumer involvement.

D. Budget-Minnesota Accountable Health Model Budget Template Form D

Budget Forms:

- **Budget Minnesota Accountable Health Model Budget Template -Form D**
- **Budget Justification Narrative Template- Form E**

Practice Transformation Grants (from \$10-20,000 per six month grant cycle) identify your costs by category on the budget form that is provided.

Include a budget for six months (January 2015 –June 2015).

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.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf>

Eligible Expenses:

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

Ineligible Expenses:

Funds may not be used to pay for direct patient care services fees, purchase of computers or other equipment, building alterations or renovations, construction, fund raising activities, political education or lobbying, or out of state travel. Training will only be allowed when connected to the practice transformation project. **(Food, stipends, or incentives will not be allowed-added November 5, 2014)**

Indirect Costs:

Indirect costs are not allowed in this proposal.

In-Kind:

Matching Funds Requirement: There are no requirements for matching funds.

Budget Template Section One:

The budget form includes two sections and must be completed for a six month grant period. Section One provides a summary of the eligible expenses by line item. Section Two provides a summary of expenses for the deliverables. 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 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 Cost:

- 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 a 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 Practice Transformation project work and described in the budget justification narrative.

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 (not to exceed the current rate established by the

[Minnesota Management and Budget's Commissioner's Plan](#)

(<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.

F. 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.
- **Meals:**
 - ~~Consumer/Provider Board Participation, food is a covered expense for reasonable costs of necessary meals furnished by the recipient to consumer or provider participants during scheduled meetings. See HHS GPS page II-33.~~
(Food will not be allowed-added November 5, 2015)
 - As part of a per diem or subsistence allowance provided in conjunction with allowable travel See HHS GPS Section II-42.
- **Expense Reimbursement:** Travel, meals, and childcare expenses can be covered for consumers or other community members without a form of reimbursement to attend a scheduled meeting. Please be specific on your budget form and budget narrative about expenses for travel, meal and childcare expenses for consumers or community members without a form of reimbursement.
- **Team Participation:** Allowable in accordance with applicable program proposal:
 - Reasonable and actual out-of-pocket costs incurred solely as a result of attending an approved scheduled meeting, including transportation, meals, babysitting fees, and lost wages for community partners without other sources of reimbursement as described in your budget narrative.

Section Two: Budget Deliverables:

The amount paid for the deliverables in Form D section two, is based upon the total dollars requested in section one.

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

- Project Management-Key lead person identified-goals & objectives identified
- Team Development-Team members identified and their roles. Time commitment, frequency of meetings
- Quality Improvement/measurement/process-outcome measures, goals, objectives, and activities identified for the project
- If applicable:
 - Care Coordination-coordination within the clinic or health related organization and with community services involved in patient, consumer, or client care.
 - Consumer Participation-consumer/client or family participation in care planning, advisory committees, or focus groups.
- Other project specific activities.

Budget Justification Narrative Template- Form E

The Budget Narrative provides additional information to justify costs in Form D 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. **See page 29 for specific instructions.**

D. Criteria for grant review: The Budget section of the application will be reviewed and scored according to the following criteria (15 points):

- Are the Budget Form and Budget Justification Narrative complete?
- Do amounts on the Budget Form match what is in the Budget Justification Narrative?
- Is the information in the Budget Justification Narrative consistent with what is proposed in the work plan?
- Are the projected costs reasonable and sufficient to accomplish the proposed activity?

E. Minnesota Accountable Health Model: Continuum of Accountability Matrix Form F

The Minnesota Accountable Health Model Practice Transformation applicant will be required to submit a completed [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.health.state.mn.us/e-health/mahmassessmenttool.docx) (<http://www.health.state.mn.us/e-health/mahmassessmenttool.docx>). This is an interactive tool that allows organizations to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and their 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. (See Section 13-Page 21 for instructions on how to complete the form)

11. Grant Participation Requirements

Practice transformation grantees are required to submit a quarterly and final narrative and financial report, participate in conference calls, meetings or site visits, and participate in state or federal evaluation activities.

Funded applicants will be required to:

- Submit and share copies of all tools, resources, documents, and other guidance.
- Submit written narrative progress reports quarterly using a MDH template by April 30 and July 31, 2015.
- Submit expenditure reports and invoices for the grant period at the end of first quarter of activity and a final report after the end of six month contract period.
- Participate in MDH provided or identified trainings, meetings, and technical assistance, including participation in any state-funded activities.
- Collaborate with any other contractors, grantees, or partners associated with SIM grant and Minnesota Accountable Health Model as appropriate.

Contract requirements include:

- Submit a final work plan and budget, if requested, to MDH.
- Execute original and two copies of grant agreement and return to MDH for final signature.
- Upon receipt of fully executed grant agreement, begin work. ***Note: Grantees cannot be reimbursed for work completed before the grant agreement is fully executed.***
- Complete required deliverables and activities as outlined in grant agreement.
- Participate in conference calls or meetings with the grantee to report on progress, barriers or lessons learned.
- Additional details that may be requested to comply with state and federal reporting requirements.
- Final 10 percent of the total grant award will be withheld until grant duties are completed.

12. Proposal Evaluation

Grant proposals will be scored on a 100-point scale as listed in the following table:

Criteria	Maximum Points
Applicant Experience and Capacity	35 points
Project Implementation	25 points
Project Proposal/work plan	25 points
Budget	15 points
Total	100 Points

13. Required Forms

Below is a listing of forms required for submission of a Practice Transformation 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.

Form A: Application Face Sheet with Instructions

Form B: SIM Provider Application Form

Form C: Project Work Plan Form

Form D: Budget-Minnesota Accountable Health Model Budget Template

Form E: Budget Justification Narrative

Form F. Continuum of Accountability Matrix Assessment Tool - Please click on the link below and print the tool for completion as part of the application requirement.

<http://www.health.state.mn.us/e-health/mahmassessmenttool.docx>

Form A: Application Face Sheet

Practice Transformation

1. Legal name and address of the applicant agency with which grant agreement would be executed		
2. Minnesota Tax I.D. Number		
3. Federal Tax I.D. Number		
4. Requested funding for the total grant period	\$	
5. Director of applicant agency		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
6. Fiscal management officer of applicant agency		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
7. Operating agency (if different from number 1 above)		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
8. Contact person for applicant agency (if different from number 4 above)		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
9. Contact person for further information on grant application		
Name, Title Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
10. 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.

1. **Applicant agency**
Legal name of the agency authorized to enter into a grant contract with the Minnesota Department of Health.
2. **Applicant agency's Minnesota**
3. **Applicant agency's Federal Tax I.D. number**
4. **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 January 2015 –June 2015 or six months from the date the contract is executed. The grantee must submit a budget for the six month period starting with January 2015 –June 2015.
5. **Director of the applicant agency**
Person responsible for direction at the applicant agency.
6. **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.
7. **Operating agency**
Complete only if other than the applicant agency listed in 1 above.
8. **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.
9. **Contact person for further information**
Person who may be contacted for detailed information concerning the application or the proposed program.
10. **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. Provider Application for Practice Transformation

- In the table below identify key provider practice team members and their role in the practice transformation project. A project lead must be identified.
- Respond to the questions listed below. (2 page limit-does not include table)

Team Member Name	Team Role
	Project Lead (Required)

1. Describe how leadership, provider(s)/ clinicians, and administration are engaged in this project.
2. Do you plan on or are you hoping to utilize the services of a practice facilitator who can guide you through your practice transformation process?
3. Describe the goals your organization will achieve through this grant funding and how progress to these goals will be measured.
4. Describe your plan to involve patients, family members or consumers in planning or implementing this project. If this does not apply to your project tell us why it is not applicable.
5. Do you plan to apply for Health Care Home Certification, re-certification, or planning for behavioral health homes? Yes/No/Not Sure Projected date:
6. If applicable, describe how your organization is participating in, or preparing to participate in, an Accountable Care Organization (ACO) or similar health care delivery model that provides accountable care (including, but not limited to, the Medicare Shared Savings Program, the Medicare Pioneer ACO Program, or the Medicaid Integrated Health Partnerships program).

Form C. Work Plan

Applicant:

Instructions: Enter objectives, activities, tracking methods, timelines, and outcomes for six month grant period. Use the key objectives and deliverables in the work plan to crosswalk to Section 2 Deliverables of Budget Form D.

<i>Required Grant Elements/Deliverables</i>	OBJECTIVES	ACTIVITIES	TRACKING METHODS	TIMELINES Jan-June 2015	OUTCOMES
<i>Instructions</i>	<i>Focus on a specific activity for the time period What are you hoping to achieve?</i>	<i>Outline of what you will do & steps you will take:</i>	<i>Include how you will track your activity</i>	<i>Include a time line for each activity</i>	<i>Include your outcome for the activity</i>
<i>Example:</i> Quality Improvement Process & Outcomes Measures	<i>Example:</i> QI Structure and identified Team	<i>Example:</i> Meet Quarterly Review Internal Data Implement Patient experience Survey	<i>Examples: Meeting minutes, Schedule of Data Analysis Patient experience Findings</i>	<i>Examples:</i> Quarterly Monthly 6 months 1	<i>Examples:</i> Processes in place, Improved outcomes in patient care, Consumer participation, Reports, Data collection
Project Management					
Team Members and Team Development					
Quality Improvement Process & Outcomes Measures					
If applicable: Care Coordination					
If applicable: Consumer/family participation					
Additional project activities					

Form D. Budget Minnesota Accountable Health Model Budget Template

Applicant:

Total Contract Period: January 2015 –June 2015

Budget Form Instructions for Practice Transformation Applicants:

1. Complete a budget for a six month grant period (January – June 2015). Include costs for the grant recipient in Salaries & Wages, Fringe, Supplies, Travel, and Other categories.
2. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group facilitation, or consultation.) **in C. Consultant Costs.**
3. 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 E 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 1 A.	
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 E 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, and the method that will be used for choosing a contractor.			
	Hourly Rate	Hours	Total
Hourly rate and number of hours			\$
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 learning collaborative 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 E Budget Justification Narrative.			
Consult budget instructions in Section 11E for examples of allowable costs in this category.			
Item			Total
Total Other Costs:			\$

GRAND PROJECT TOTAL			\$
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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 C Work Plan and include key deliverables.

Deliverable: Applicant Project Management	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$

Deliverable: Team Members and Team Development	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$

Deliverable: Quality Improvement: process & outcome measures	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$

If applicable: Deliverable: Care Coordination	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$

If applicable: Deliverable: Consumer/client or family participation	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$

If applicable: Deliverable: Other project activities	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
TOTAL			\$

GRAND PROJECT TOTAL			\$
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Form E: Budget Justification Narrative

The Budget Narrative provides additional information to justify costs in Form D 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):*

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 or product and the method that will be used for choosing a contractor):*

D. Supplies

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

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

E. 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):*

F. 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):*

14. Appendixes

Appendix A: Minnesota Accountable Health Model Glossary

Appendix B: Resources

Appendix C: MDH Sample Contract

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

Behavioral Health Homes

Section 2703 of the Affordable Care Act defines health homes services as comprehensive and timely high-quality services provided by a designated provider or a team of providers and specifically include: care management; care coordination; health promotion; transitional care; patient and family support; referral to community and social support services; and improved exchange of health information.

DHS is developing a framework for “health homes” to serve the needs of complex populations covered by Medicaid. DHS, with input from stakeholders, is working to design a behavioral health services for adults and children with serious mental illness. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS may build on this framework to serve other complex populations in the future.

Providers that wish to become a behavioral health home must meet federal and Minnesota state requirements and certification standards, currently under development.

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177945

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.ncvhs.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.htm>

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: in Minnesota: Report to the Legislature (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\(f\)](https://www.revisor.mn.gov/statutes/?id=62J.498) (https://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/)

[\(http://www.health.state.mn.us/divs/cfh/lph/\)](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>

Practice facilitation

“Practice facilitation is a supportive service provided to primary care by a trained individual or team of individuals. These individuals use a range of organizational development, project management, QI, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits. In the research literature, PF sometimes is called quality improvement coaching or practice enhancement assistance.” **From Developing and Running a Primary care Practice Facilitation Program: A How to Guide. AHRQ-Agency for Health Care Research and Quality-www.ahrq.gov <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html>** Within the State Innovations Model (SIM), we will be open to applying practice facilitation to behavioral health, social services, long term care, and acute care services.

Practice Transformation

Practice Transformation is a process that results in observable and measureable changes to practice behavior. These behaviors include core competencies:

- Engaged leadership and quality improvement
- Empanelment and improved patient health outcomes
- Business and financial acumen
- Continuous, team-based relationships that incorporate culture, values, and beliefs
- Organized, evidence-based care
- Patient-centered interactions
- Enhanced access
- Progression toward population based care management
- State-of-the-art, results-linked, care
- Intentional approach of practices to maximize the systematic engagement of patients and families

- Systematic efforts to reduce un-necessary diagnostic testing and procedures with little or no benefit.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html?redirect=/QualityInitiativesGenInfo/>

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

Quality improvement (QI)

consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The [Institute of Medicine's \(IOM\)](#)  which is a recognized leader and advisor on improving the Nation's health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations

⁽¹⁾ <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>

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 \(www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx\)](http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx) accessed 09.10.201

Appendix B: Resources

Behavioral Health

- <http://www.nashp.org> State efforts to integrate primary care and behavior health in safety net settings.
- Evolving Care Models of Behavioral Health Integration in Primary Care <http://www.milbank.org>

Primary Care

- Patient-Centered Medical Homes-NCQA Fact Sheet <http://www.NCQA.org>
- Creating Capacity for Improvement in Primary Care: A case for Developing a Quality Improvement Infrastructure. (Decision maker Brief Primary Care Quality Improvement. No. 1) <http://www.ahrq.gov/>
- Enhancing the Primary Care Team to Provide Redesigned Care: The roles of Practice Facilitators and Care Managers. (Annals of Family Medicine, vol. 11, no. 1, Jan-Feb, 2013) <http://www.ANNFAMMED.org>
- Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions <http://www.commonwealthfund.org/publications/in-the-literature/2014/Aug/small-primary-care-practices>

Social Needs

- Addressing Patient Social Needs – An emerging Business Case for Provider Investment, May, 2014 <http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs>

Clinician Champions

- http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf
- <http://www.pcmhri.org/files/uploads/Brief%20-%20The%20Benefits%20of%20Implementing%20the%20Primary%20Care%20Patient.pdf>
- <http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home>

Care Coordination

Health Care Home Care Coordination Toolkit

- <http://www.health.state.mn.us/healthreform/homes/collaborative/carecoordtoolkit.html>

Additional resources: Fundamentals of Care Coordination within the Medical Home

- <http://www.ndcpd.org/ndis/pdf/Modules/MODULE%201%20Care%20Coordination%20Final.pdf>
- http://www.medicalhomeimprovement.org/pdf/MHPracticeBasedCC-Workbook_7-16-07.pdf

Steps to becoming a Health Care Home or Patient-Centered Medical Home: American College of Physicians

- http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/help.htm

American Academy of Family Physicians

- <http://www.aafp.org/practice-management/pcmh/overview.html>

Safety Net Medical Home Initiative

- <http://www.safetynetmedicalhome.org/change-concepts>

Appendix C: MDH Sample Contract Appendix C: MDH Sample Contract

MDH Sample Contract
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 adetermination 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 of 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: _____