



# **Amendment to the Request for Proposals**

**Release date: November 6, 2014**

**Amended: November 24, 2014**

**Due date: December 30, 2014**

## **Minnesota Accountable Health Model Learning Community Grants**

General Learning Communities

Round 1: February – October 31, 2015

Accountable Communities for Health (ACH)

Learning Community: February 2015 –

December 2016

**Minnesota Department of Health**

**Division of Health Policy**

**PLEASE NOTE THE FOLLOWING AMENDMENT TO THE LEARNING  
COMMUNITY GRANT REQUEST FOR PROPOSAL**

**In the Proposal Instructions Section:**

On November 6, 2014:

**4. Learning Community Implementation Work Plan/Timeline of  
Activities (Form B, 30 Points) page 27**

In this section, the applicant must provide a work plan for February through December 2015 (See Form B and Example of Form B for more detail).

**Amendment November 24, 2014:**

**4. Learning Community Implementation Work Plan/Timeline of  
Activities (Form B, 30 Points) page 27**

In this section, the applicant must provide a work plan for the first 6 months of the grant period (See Form B and Example of Form B for more detail).

## Table of Contents

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Overview .....	3
Available Funding and Estimated Awards.....	3
Grant Timelines .....	4
Background .....	5
Minnesota Accountable Health Model Learning Collaborative Overview.....	6
Grant Applicant .....	7
General Learning Community Grant Applicant.....	8
Required Deliverables and Activities .....	10
Continuum of Accountability Matrix Assessment.....	12
Grant Application and Program Summary .....	12
Proposal Instructions .....	14
1. Signed Grant Application Face Sheet (Form A).....	14
2. Applicant Experience and Capacity (Limit 2 pages, 25 Points) .....	14
3. Learning Community Description (Limit 6 pages, 30 Points) .....	15
4. Learning Community Implementation Work Plan/Timeline of Activities (Form B, 30 Points) .....	15
5. Budget (15 Points).....	15
Proposal Evaluation.....	18
Review Process.....	18
Grant Participation Requirements .....	18
Required Forms.....	19
Accountable Communities for Health Learning Community Grant Applicant.....	20
Topics .....	20
Required Deliverables and Activities .....	22
Grant Application and Program Summary .....	24
Proposal Instructions .....	26
1. Signed Grant Application Face Sheet (Form A).....	26
2. Applicant Experience and Capacity (Limit 2 pages, 25 Points) .....	26
3. Learning Community Description (Limit 6 pages, 30 Points) .....	26
4. Learning Community Implementation Work Plan/Timeline of Activities (Form B, 30 Points) .....	27
5. Budget (15 Points).....	27
Proposal Evaluation.....	29
Review Process.....	29
Grant Participation Requirements .....	30
Required Forms.....	30
Form A: Application Face Sheet .....	31
Form B: Learning Community Implementation Work Plan/Timeline of Activities .....	33
Form B: Example Learning Community Implementation Work Plan/Timeline of Activities.....	34

Form C: General Learning Community Budget Template .....	35
Form D: ACH Learning Community Budget Template.....	38
Form E: Budget Justification Narrative .....	39
Form F: Due Diligence .....	41
Appendix .....	44
Appendix A: General Learning Communities Grant Application Scoring Sheet.....	45
Appendix B: Accountable Communities for Health Learning Communities Grant Application Scoring Sheet .....	47
Appendix C: Continuum of Accountability Matrix Count Sheet (example only).....	49
Appendix D: Minnesota Accountable Health Model Glossary.....	51
Appendix E: MDH Sample Grant Agreement.....	57
Appendix F: MDH EXAMPLE Invoice .....	68
Appendix G: Resources .....	70

## Overview

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The Minnesota Department of Health (MDH) is seeking proposals from qualified professionals or organizations to plan, implement, facilitate, and evaluate a **Learning Community**. Learning communities give care providers tools to improve quality, patient experience and health outcomes, while actively engaging communities and reducing health care expenditures as part of the Minnesota Accountable Health Model Grant.

This grant opportunity will provide funding to four Learning Communities to advance the Minnesota Accountable Health Model:

- Three General Learning Communities, which will be focused on a selected transformation topic.
- One Accountable Community for Health (ACH) Learning Community focused on topics specific to implementation of an ACH.

For the purpose of this grant, a Learning Community is defined as: learning teams who have common goals or interests, share best practice knowledge, and are actively engaged in implementing transformation in a focused, structured environment with the goal to advance patient centered, coordinated, and accountable care.

Each funded General Learning Community will comprise a minimum of five (5) learning teams that will be recruited by the grantee. The teams will engage in sharing experiences focusing on a specific transformation topic. Each team might include, but is not limited to: patients, families, caregivers, medical and dental practitioners, care coordinators, health educators, dietitians, social workers, public/community health workers, pharmacists, long term care providers, school nurses/counselors, behavioral health care providers, primary care clinic team, community paramedics, and other entities providing integrated care.

The Accountable Communities for Health (ACH) Learning Community will be comprised of up to 15 ACH grantee teams. ACH grant awards are scheduled to be announced November 2014. Accountable Communities for Health grants are to advance the Minnesota Accountable Health Model through implementation and expansion of broad community and provider partnerships to support readiness and participation in the [Minnesota Accountable Health Model](#) and achievement of the triple aim of improving the patient experience of care and the health of populations while reducing the per capita cost of health care.

The ACH Learning Community grant goal is to provide technical support and peer learning opportunities for ACH teams throughout the State. Specific goals are to implement best practices and support development of ACH leadership structures, community-clinical care partnerships, care coordination models and systems, and sustainability plans. A minimum of four members from each ACH team will be required to participate in ACH Learning Community activities as part of their ACH grant obligations.

Community and local public health resources should be accessed and incorporated into the learning environment, as appropriate.

## Available Funding and Estimated Awards

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### General Learning Community Grant

There will be two rounds of funding for the General Learning Community Grants. Each round will be for a grant term of 9 months. The second RFP for the General Learning Community Grants will be released in January 2015. The scheduled start dates for General Learning Community Grants are February 2015 for the first round and April 2015 for the second round.

General Learning Communities Round 1: February – October 31, 2015

- Grant term is for nine (9) months from the start date

- Total of up to \$150,000 available for first round
- Up to \$50,000 will be awarded per proposal for up to 3 awards

General Learning Communities Round 2: Approximate start date April – December 31, 2015

- The second RFP for the General Learning Community Grants will be released in January 2015
- Grant term is for nine (9) months from the start date
- Total of up to \$150,000 is available for second round
- Up to \$50,000 will be awarded per proposal for up to 3 awards

Applicants may apply or re-apply for more than one grant round. Applicants may submit proposals to convene more than one learning community during each grant round (eligible funding up to \$50,000 per award). Applicants are required to submit separate proposals for each Learning Community they are proposing to convene.

**ACH Learning Community Grant**

There will be one round for the ACH Learning Community for one award of up to \$200,000. Grantees can only apply for the ACH Learning Community grant during the first round of applications. The scheduled start date for the ACH Learning Community is February 2015 and the end date is December 31, 2016.

**Funding Restrictions**

Funds may not be used to pay for direct patient care service fees, purchase of computer or other equipment, building alterations or renovations, construction, fund raising activities, political education or lobbying, purchase of food, or out of state travel.

There is no requirement for matching funds. Indirect costs are not allowed in this proposal

**Grant Timelines**

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MDH staff expects to follow the tentative schedule below for both grant opportunities; however, the timelines are estimates and may be subject to change.

RFP Activity	Date/Time
Request for Proposal Posted	November 6 , 2014
Informational Q & A Webinar on RFP	November 18, 2014 11:00 AM – 12:30 PM CST  <b>To register for the Learning Community webinar visit:</b>  <a href="https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=t4d8ff6a43dd74ec8ee37d3a78799ecb7">https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=t4d8ff6a43dd74ec8ee37d3a78799ecb7</a>
Proposals Due	December 30, 2014 4:00 PM CST
Estimated Notice of Awards	January 30, 2015
Estimated Grant Start Date	February 2015

## Background

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The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the Center for Medicare & Medicaid Innovation <http://innovations.cms.gov> 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 quality, patient experience and cost performance measures.
- Financial incentives are fully aligned across payers and the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving quality of care.
- Provider organizations effectively and sustainably partner with community organizations, engage consumers, and take responsibility for a population's health through accountable communities for health that integrate medical care, mental/chemical health, community health, public health, social services, schools and long term supports and services.

The Minnesota Model will test whether increasing the percentage of Medicaid enrollees and other populations (i.e. commercial, Medicare) in accountable care payment arrangements will improve the health of communities and lower health care costs. To accomplish this, the state will expand the Integrated Health Partnerships (IHP) demonstration, formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services.

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_161441](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441)

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

To achieve the vision of shared cost and coordinated care, the Minnesota Accountable Health Model includes key investments in five Drivers that are necessary for accountable care models to be successful.

[http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16\\_182962.pdf](http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_182962.pdf)

- Driver-1** Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement—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—Accountable Communities of Health (ACH)
- Driver-5** Accountable Care Organizations (ACO) performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations--ACO Alignment

The activities contained in this RFP are linked to **Driver 3 Learning Community and Driver 4 Accountable Communities for Health** opportunities.

## 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.

In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool 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. The tool allows a broad range of providers to assess their current status and progress in moving toward accountable care.

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

## Minnesota Accountable Health Model Learning Collaborative Overview

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Learning Communities are one component within the overall Minnesota Accountable Health Model Learning Collaborative work.

The Minnesota Accountable Health Model Learning Collaborative work builds on the wide array of expertise within the state, such as the Health Care Home (HCH) Learning Collaborative that is mandated for certified health care home teams, the Health Information Technology education collaborative developed by Minnesota’s HIT Regional Extension Center (REACH), the Statewide Health Improvement Program (SHIP) and chronic disease education activities, and other initiatives established by the State or its stakeholder partners.

The intent is to provide support and training to improve the capacities of primary care clinics and other providers, as well as community partners, to provide coordinated care to patients with complex medical and behavioral health needs, leverage their EHRs and data analytic feeds to improve quality and reduce costs of care, participate in accountable care models, and meet the standards, criteria and expected outcomes of Accountable Communities for Health (ACH).

Learning Collaborative goals are to:

- Implement a variety of scientifically and experiential based learning collaboratives and learning community models as well as other technical training support tools & models.
- Organize learning collaborative models in a variety of methods including virtual, social media, conference calls, webinars, web-based, and in person face-to-face modalities.
- Facilitate efforts of interested small, independent practices to create learning communities to emphasize their special learning needs. For the purpose of this grant, a Learning Community is defined as: learning teams who have common goals or interests, share best practice knowledge, and are actively engaged in implementing transformation in a focused structured environment with the goal to advance patient centered, coordinated, and accountable care.
- Incorporate behavioral health integration training into learning collaborative activities.

- Utilize a stakeholder input process to focus on provider needs, such as topics that will help them improve quality and help them to be more effective partners/participants in an ACO.
- Ensure that learning collaborative topics and strategies include a focus on addressing health disparities and the effective collection and use of race, language and ethnicity data. This will involve integrating curriculum and learnings from existing efforts, and partnering with community organizations and stakeholders to develop new modules and approaches.

## Grant Applicant

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Eligible applicants for General and ACH Learning Communities may be community-based nonprofit and for-profit organizations; government entities or Tribal Government; clinics and hospitals; community health or public health organizations; quality improvement organizations: professional provider associations; and institutes of higher education. The applicant must meet the State’s fiscal requirements and other grant participation requirements, including the ability to collect and submit evaluation data, and manage staff, facilities, communication, and other grant operations.

### Qualifications of Applicant:

- Applicant must be located in the State of Minnesota.
- Applicants must have qualifications and/or relationships in place to recruit participants and implement a Learning Community. Relationships include, but are not limited to: primary care providers seeking HCH certification / recertification or practice transformation, behavioral health providers such as Community Mental Health Providers / others planning for Behavioral Health Homes (BHH), social services providers integrated with primary care / behavioral health, tribal primary care and behavioral health providers, and Accountable Communities for Health.

### Desired expertise of Applicant includes:

- Knowledge/expertise of proposed subject matter of Learning Community topic.
- Knowledge of principles of adult learning and framework of change/quality improvement processes.
- Experience designing and implementing curricula, video learning modules, tools, tool kits, etc. for a variety of audiences.
- Ability to effectively involve patient/family partners in curriculum development, learning sessions, evaluation, and sharing feedback.
- Ability to effectively support collaboration between organizations/entities.
- Demonstrated ability to implement a combination of face-to-face, virtual, and distance learning activities in a collaborative manner with a team.
- Experience with evaluating the process and outcomes of learning activities, including the progress of implementation and culture change.
- Ability to capitalize on the expertise of experienced team members and existing infrastructures.
- Experience in assessment of learning needs.

## **General Learning Community Grant Applicant**

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The following information applies only to those organizations applying for a General Learning Community grant. Details on the application processes for the ACH Learning Community Grant are found on page 20.

### **Topics:**

Grantees must consider the learning interests and needs of potential learning community teams. Grantees must choose from a variety of topics that increase learning teams' knowledge, skills, or abilities to advance patient-centered, coordinated care and accountable care. A priority of the grant is to have all Learning Communities demonstrate how the chosen topic area will support health equity. Topic areas are listed below:

### **Community Integration and Partnership:**

The Learning Community will focus on improving the coordination and integration of primary care and public health, social service providers (e.g. schools, non-profit, community organizations, etc.), behavioral health, and/ or long-term, post-acute care. Learning elements in this topic area may include: an assessment of current integration using the Continuum of Accountability Matrix ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Docs\\_Reps\\_Pres](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Docs_Reps_Pres)), to develop an inventory of resources for care and service integration; implementation of integration of care, services, or shared resources with other partners; or evaluation of referral patterns, transitions, and plan for follow up to public health, social service agencies, non-profit, community organizations and primary care. An example of a health equity approach may be to develop a strategy to increase partnerships with community organizations and leaders that represent populations most impacted by health disparities or that have been traditionally marginalized.

### **Integration with Behavioral Health:**

The Learning Community will focus on improving coordination and integration of health care services and behavioral health. Key concepts under this topic may include: creating organizational infrastructure to support greater integration; understanding population in order to create the appropriate integration approach; collecting data and tracking outcomes; connecting to individual, family, and other community supports; exchanging information between care providers; coordinating transitions between different levels of care or settings; and creating a financial model to support integration. A health equity consideration in this topic may be to review behavioral health assessments to ensure that policies and procedures that identify patients and provide support resources are consistently applied.

### **Expansion of Certified Health Care Homes:**

The Learning Community will focus on the implementation and development of certified health care homes with emphasis in areas of fewer resources or lower health care home penetration. Learning elements may include: review of standards and certification procedures; assessment of clinics current baseline for leadership and implementation of the standards; focus on implementation of the standards based on the assessment; and review of certification assessment tool and certification procedures.

### **Care Coordination:**

The Learning Community will focus on the role of care coordination and facilitation with patients/families and team members. Learning concepts may center on active patient engagement, implementation of motivational interviewing in setting patient-centered goals, reducing barriers, and establishing care planning strategies. In addition, a key learning element will be the importance of building community partnerships, identifying and using community resources, coordination of referrals, and coordinating with community/public agencies. One health equity approach may be to support and strengthen the role of patient-advocates and/or bilingual interpreters in the care coordination team so that patients are partners and not just recipients of care.

### **Quality Improvement Infrastructure:**

The Learning Community will focus on building a culture of quality, monitoring quality results and addressing improvements in quality outcomes (i.e., diabetes, cardiovascular measures) through systems changes. Concepts may include: focus on improved quality results through the use of registries, population management techniques, care coordination and care planning techniques, or other best practices. A key learning element and health equity approach should be developing an understanding of health disparities, and how to collect and monitor data on those populations most impacted by health disparities.

### **Culturally Appropriate Care:**

The Learning Community will focus on the policies, procedures, programs, and processes of the delivery system to address the values, beliefs, assumptions, cultural norms and customs of the client/community population. Learning concepts may include: use of interpreter services, creating and using culturally specific educational materials, offering staff trainings on topics with cultural sensitivity. Learning community topics include collecting and utilizing demographic data on cultural background, racial heritage, primary language and social and economic conditions. The approach may include information on community resources identification, referral, and use; address tracking, and measurement; health disparities; shared decision-making practices; using health assessments; and motivational interviewing.

### **Population Health:**

The Learning Community will focus on increasing preventive and health improvement activities and processes for populations served by the provider organizations. Focus areas may include: addressing tobacco cessation, weight management, hypertension, diabetes, and behavioral health (substance abuse, depression, anxiety, etc.), perinatal, etc. Topics addressed could include the use of current evidence-based guidelines, facilitating team self-assessment of current preventive practices and identifying need areas, exploring best practices in using EHRs; or exploring processes for primary prevention. Any of these focus areas should consider the array of socioeconomic factors that contribute to population health and target strategies and resources to particular demographics at highest risk. A health equity approach may be to include qualitative analysis of successful results-based practices in relation to socio-demographic indicators to better understand health outcomes in target populations.

### **Emerging Professions Integration:**

The Learning Community will focus on increasing the understanding and uptake of emerging professions practitioners (Community Health Worker, Community Paramedic or Dental Therapist/Advanced Dental Therapist) into care delivery systems. Key learning concepts may include: benefits of hiring an emerging profession practitioner; collaborative management or supervisory agreements; orientation and integration of the professional into team-based models of care; services that can be provided according to scope of practice; models for working across sectors; billing and reimbursement policies and procedures. The grantee should facilitate sharing of current challenges and solutions between provider types and organizations who could utilize emerging professionals. Learning teams may consider reviewing the potential impact emerging health professions could have on increasing access and/or culturally appropriate care in their area.

### **E-Health and Data Analytics:**

The Learning Community will focus on the workflow, management, coordination, governance, and policy with the electronic health record (EHR) and applying the use of data in assessing patient population needs specific to those patients/clients being served. Learning community concepts may include: population management tools such as registries, predictive modeling, problem list management, identification and documentation of primary care provider, interoperability and communication between other provider organizations, or the electronic exchange of information and data privacy needs. A focus on use of data in quality improvement processes should be included in the approach.

All learning topics should be facilitated in a manner that is conducive to peer learning and problem-solving across learning teams. The learning topics mentioned above should be both content-rich and process-improvement oriented.

## Required Deliverables and Activities

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State staff does not intend to prescribe the specific number of learning sessions that must occur or the methodology for these sessions. Applicants are encouraged to work with learning team members to design the best approach and innovative approaches/best practices to deliver curricula. However, applicants should provide evidence that the overall curriculum/work plan includes the following elements:

- A practical didactic learning component where the proposed topic is presented
- Discussion on the implementation of methods / strategies, including barriers, lessons learned and potential recommendations related to the identified topics
- Involvement of patients, family members, care givers and community partners as appropriate to the topic
- Opportunity for face to face interaction and engagement for participants
- A clear plan for evaluating participant learning and outcomes
- Evidence of health equity considerations

The Learning Community grantee shall complete the following tasks:

### **Planning Phase- within 60 days of grant start date:**

- Submit the Learning Community Implementation Work Plan and Timeline of Activities. Include identification of key content to be presented.
- Submit a schedule of the learning events and any speakers identified for content areas.
- Submit a list of organizations participating (include indication of accountable care organizations that are participating) and proposed number of the team members.
- Require participating organizations and/or members to sign an agreement of participation to ensure attendance and commitment.

### **Implementation Phase - 60 days- 9 months**

- Complete and submit the Matrix Count Sheet for each organization within 90 days of starting the grant.
- Develop content and materials for training sessions, including: learning opportunity announcements, PowerPoint slides, session handouts, and any audio-visual components.
- Develop and test implementation of learning using quality improvement models.
- Conduct content and sessions in a manner consistent with the evidence based change theory or using adult learning principles.
- Demonstrate patient and family involvement in learning sessions and sharing/feedback.
- Conduct an evaluation of the Learning Community, which measures both satisfaction and achievement of the goals and objectives. Evaluation of participant progress shall be conducted throughout the process, adapting learning according to the needs of participants.
- MDH staff will host a webinar to include presentations by all grantees. Grantee will prepare and present a section on their topic, which will include: lessons learned, successes, challenges, barriers, reflections and areas for improvement.

## Ongoing

- Submit detailed invoices for payment using the Invoice and following the Invoice due dates (Example Appendix F).
- Grantee shall submit a report with each invoice that discusses: curriculum development and delivery, learning community recruitment goals and outcomes, participation in learning events, observations and feedback on events, and evaluation outcomes, including participant satisfaction and process satisfaction data.
- Actively participate in all meetings regarding grant/Learning Community activities, as requested by state staff.
- State staff reserve the right to survey participants.
- Capitalize on the expertise of learning team members by capturing participant stories and reflections for inclusion in final report and presentation.

## Upon Completion

- Prepare and present an informative session on the Learning Community project during a Health Care Home or Minnesota Accountable Health Model learning event
- Provide materials and products created to the State for possible distribution (examples, power points, handouts, templates, forms, toolkits, etc.).
- Submit final syllabus, objectives, activities, assignments, questions, reflections, evaluation, list of resources and references used to create the materials.
- Submit a final project report using the format the State will provide. Details to be included: overall evaluation results, total clinic/patient/family participation, measured qualitative and quantitative outcomes, lessons learned, successes, barriers, and challenges, how the learning team members plan to apply what they learned within their organization and the team members' next steps.
- Ensure that all curriculum materials (e.g., electronic documents, webpages, or other electronic materials) are made fully accessible in accordance with the applicable law. (Americans with Disabilities Act standards)
- Describe how the Learning Community might be sustained.

## State staff shall complete the following tasks:

- Review and approve the list of learning community team members/organizations submitted by grantee within two weeks of receiving submission.
- Review and approve work plan for implementation and timeline of activities.
- Review and approve the Matrix Count Sheet.
- Review Learning Community curriculum work plan and updates upon receipt.
- Hold regular conference calls (minimum monthly) or meetings with the grantee. These calls/meetings will include monitoring of grantee activities, discussion of obstacles/issues, and evaluating progress towards reaching program goals.
- Review reports and invoices submitted by the grantee.

## Continuum of Accountability Matrix Assessment

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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.

In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool 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. The tool allows a broad range of providers to assess their current status and progress in moving toward accountable care.

The goal is for organizations/provider to complete a self-assessment of where the organization is currently at in the continuum of accountability.

General Learning Community grantees:

- Ensure individual organizations/providers participating in the learning teams complete the Continuum of Accountability Matrix Assessment Tool for their organization. For example, if an organization has three individual involved in learning team they would complete one Accountability Matrix Assessment Tool for their organization.
- Collect the organizations’/providers’ completed assessment(s).
- Input the organizations’/providers’ responses into the Accountability Matrix Count Sheet. The Accountability Matrix Count Sheet will be provided to the grantee after grant is started.
- Submit the completed Accountability Matrix Count Sheet to MDH within 90 days of the grant start date.

## Grant Application and Program Summary

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Eligibility for Grant Funds	The following organizations may apply for grant funding: community-based nonprofit and for-profit organizations; government entities or Tribal Government; clinics and hospitals; community health or public health organizations; quality improvement organizations; professional provider associations and institutes of higher education. Learning teams shall be the primary recipients of the learning and implementation work.
Total Funds Available	\$300,000 for up to 6 Learning Community Grant Up to \$150,000 available for two (2) rounds
Grant Amount	Awards up to \$50,000
Duration of Funding	First round of grants term: February 2015 through October 31, 2015
Grant Purpose	To plan, implement, and evaluate Learning Communities on topics that will advance patient-centered coordinated care and accountable care.

Application Requirements	<ul style="list-style-type: none"> <li>• Narrative portions of the applications must be written in 12-point font, single spaced with one-inch margins.</li> <li>• All pages must be numbered consecutively.</li> <li>• Applicants must submit one (1) signed unbound original and seven (7) unbound copies of the proposal as well as an electronic version of the proposal on a USB drive. Faxed or emailed applications will not be accepted.</li> <li>• Applications must meet application deadline requirements</li> <li>• Late applications will not be reviewed.</li> <li>• Applications must be complete and signed where noted.</li> <li>• Incomplete applications will not be considered for review.</li> </ul>
Order for Completed Application Submission	<p>Each application must contain the following items in the order listed:</p> <ul style="list-style-type: none"> <li>• Signed Application Face Sheet (Form A)</li> <li>• Applicant Experience and Capacity (Limit 2 pages)</li> <li>• General or ACH Learning Community Description (Limit 6 pages)</li> <li>• General or ACH Learning Community Implementation Work Plan (Form B)</li> <li>• Project Minnesota Accountable Health Model Contractor Budget General Learning Community (Form C)</li> <li>• Project Budget Justification (Form E)</li> <li>• Due Diligence Review Form (Form F) – For Nongovernmental Organizations)submit only 1 copy of Due Diligence Review Form and any required documentation</li> </ul>
Submitting the Proposal	<p>Applicants must submit one (1) signed unbound original and seven (7) unbound copies of the proposal and an electronic version of the proposal on a USB drive. Faxed or emailed applications will not be accepted. Late applications will not be considered for review.</p>
Application Deadline	<p><u>December 30, 2014, 4:00 PM Central Standard Time</u>  To meet the deadline, proposals must be either:</p> <ul style="list-style-type: none"> <li>• hand delivered to the 2nd floor reception desk of the Golden Rule Building 85 East Seventh Place, Suite 220 on or before December 30, 2014 by 4:00 PM CST; or,</li> <li>• Arrive by mail, Fed Ex, or courier service on or before December 30, 2014 by 4:00 PM CST.</li> <li>• Late applications, applications lost in transit by courier, or faxed/emailed applications will not be considered for review.</li> </ul>

Applications Sent	<p><b>Mailing Address:</b>          Shirley Schoening Scheuler          Health Educator          Minnesota Department of Health          Health Care Homes / Health Policy Division- State Innovations Model          PO Box 64882          Saint Paul, MN 55164-0882</p> <p><b>Courier Address:</b>          Shirley Schoening Scheuler          Health Educator          Minnesota Department of Health          Health Care Homes / Health Policy Division- State Innovations Model          Golden Rule Building          85 East Seventh Place, Suite 220          Saint Paul, MN 55101</p>
Contact Information	<p>Questions about Learning Collaborative grants and/or the proposal process can be directed to:          Shirley Schoening Scheuler          Minnesota Department of Health          Health Care Homes / Health Policy Division- State Innovations Model  <a href="mailto:shirley.scheuler@state.mn.us">shirley.scheuler@state.mn.us</a></p> <p>Other state staff are not allowed to respond to questions about this procurement.</p>
Grant Start Date	February 2015 or the date all required signatures on the grant agreement are obtained, whichever is later.

## Proposal Instructions

---

The following are the minimum required application components, listed in the order of documents to be submitted. Applicants should place emphasis on completeness and clarity of content.

### 1. Signed Grant Application Face Sheet (Form A)

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Include all applicable information required by the form.

### 2. Applicant Experience and Capacity (Limit 2 pages, 25 Points)

---

In this section, applicant must provide:

- a) A brief history of the entity and any notable accomplishments.
- b) A brief description of applicant's experience related to: collaborative learning, learning communities, quality improvement, collaborating with stakeholder groups, engaging and gathering input/feedback from health care consumers and family members.
- c) Description of knowledge and experience in the proposed subject matter of Learning Community.
- d) A brief overview of the agency's capacity and specifically how it is prepared to accomplish the grant objectives.
- e) Description of the roles and responsibilities of the project's staff members, including qualifications, skills, and experience of the project's lead staff (include CVs/resumes of lead staff in appendix. CVs are not included in the page limits).
- f) Anticipated barriers and challenges in implementing this project and potential solutions.

### 3. Learning Community Description (Limit 6 pages, 30 Points)

---

Proposals must address, in sufficient detail, how the applicant would fulfill the expected outcomes and features described below

In this section, applicant must provide:

- a) **Topic:** A description of the focus topic for the proposed Learning Community.
- b) **Goals and Objectives of Learning Community:** A description of the overall goals of the Learning Community (i.e. including the skills and/or knowledge to be learned), and objectives for meeting those goals.
- c) **Target Audience (learning teams):** A brief summary of the target audience and the recruitment plan for learning teams. Include types and number of learning team members that will be served by the Learning Community and a brief summary of the populations served by participating organizations (demographics, geographic location, general description of health status/needs).
- d) **Consumer and Family Involvement:** If applicable, describe of how applicant will involve consumer/family in the process, and how feedback will be utilized to change processes and activities in a timely manner.
- e) Describe how health equity will be addressed in the learning topic.
- f) **Evaluation Plan:** A description of the evaluation plan for the Learning Community. Grantee should measure the effectiveness of the Learning Community including skills/knowledge gained, and satisfaction of learning team members. To the greatest extent possible, the evaluation plan should also include outcome measures that show evidence of the impact of learning on the quality or cost of care. Evaluation plan should include:
  - **Measurement Tools:** Tools to be utilized in measuring whether goals and objectives were met.
  - **Timeframes:** When measurements will occur.
  - **Process for making changes to curriculum/work plan based on process outcomes or learning team feedback.**

### 4. Learning Community Implementation Work Plan/Timeline of Activities (Form B, 30 Points)

---

In this section, applicant must provide (See [Form B](#) and [Example of Form B](#) for more detail):

- a) **Timeline:** Anticipated date or timeframe of the learning activities.
- b) **Learning Community Objective/Activity:** Brief description of the learning activities/sessions.
- c) **Learning Method:** Learning methods that will be utilized (face-to-face learning, webinars, conference calls, etc.).
- d) **Learning Outcome(s):** Brief description of anticipated outcome(s) of the learning activities.
- e) **Measurement:** Description of tools that will be utilized to measure whether goals and objectives were met.

### 5. Budget (15 Points)

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#### **Budget Forms:**

- **Minnesota Accountable Health Model Contractor Budget Template** Form C.
- **Budget Justification Narrative** see template Form E.
- **Due Diligence Review** Form F. Due Diligence Review Form (For Nongovernmental Organizations submit 1 copy of Due Diligence Review Form and required documentation)

**General Learning Communities Round 1:** February – October 31, 2015

- Grant term is for nine (9) months from the start date
- Total of up to \$150,000 available for first round
- Up to \$50,000 will be awarded per proposal for up to 3 awards

Include a budget for nine months (February 2015 – October 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 service fees, purchase of computers or other equipment, building alterations or renovations, purchase of food, construction, fund raising activities, political education or lobbying, or out of state travel.

**Indirect Costs:**

Indirect costs are not allowed in this proposal.

**In-Kind:**

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

**Section One:**

The budget form includes two sections and must be completed for a nine 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 Costs:**

- Provide the name of contractors or organizations, the services to be provided, hourly rate, and projected costs.
- In the budget narrative, include brief background information about contractors, including how their previous experience relates to the project.
- If a contractor has not been selected, include a description of the availability of contractors for the services and/or products required and the method for choosing 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 Learning Communities project work and described in the budget justification narrative.

**F. Travel:**

Include the cost for any proposed in-state travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (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) (<http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf>))

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

**G. Other:**

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

- **Support Expenses:** Telephone equipment and services, internet connection costs, teleconferences, videoconferences, meeting space rental, and equipment rental.
- **Expense Reimbursement:** Travel and childcare expenses can be covered for consumers or other community members without a form of reimbursement to attend a schedule meeting. You must be specific on your budget form and budget narrative for travel and childcare expenses for consumers or community members without another form of reimbursement.

**Section Two:** The amount paid for the deliverables in 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: Planning Phase, Implementation Phase and Completion

**Due Diligence Review Form:**

This form must be completed by the applicant organization's administrative staff, for example, finance manager, accountant or executive director. It is a standard form MDH uses to determine the accounting system and financial capability of all grant applicants (submit only 1 copy of Due Diligence Review Form and any required documents)

## Proposal Evaluation

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

Items	Points	Percentage
Applicant Experience and Capacity	25 points	25%
Learning Community Description	30 points	30%
Learning Community Implementation Plan	30 points	30%
Budget and Budget Justification	15 points	15%
<b>TOTAL</b>	<b>100 points</b>	<b>100%</b>

## Review Process

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Grant proposals will be reviewed and evaluated by a panel familiar with the program. The panel may include staff from the Minnesota Department of Health, Minnesota Department of Human Services, and HCH/SIM Learning Collaborative Advisory Committee, which includes community stakeholders. 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 received on time according to the due date listed on or before **December 30, 2014, 4:00 PM Central Standard Time** will be reviewed. Reviewers will use the criteria as outlined in the RFP and will make recommendations for funding. We anticipate that grant award decisions will be made by January 30, 2015. 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 applicants that are awarded grant funds. The anticipated effective date of the agreement is February 2015, or the date upon which all signatures are obtained. No work on grant activities can begin until a fully executed grant agreement is in place.

## Grant Participation Requirements

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- Submit a final work plan and budget
- Submit three grant agreements with original signature to MDH for final signature.
- Grantee cannot start work or be reimbursed until a fully executed grant agreement is executed.
- Complete required deliverables and activities as outlined in grant agreement and agreed upon work plan.
- Participate in site visits or conference calls to report on progress, barriers or lessons learned.
- Provide additional details that may be requested to comply with state and federal reporting requirements.
- Provide ongoing progress reports submitted with each invoice.
- Final 10 percent of the total grant award will be withheld until grant duties are completed.

## Required Forms

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Below is a list of forms required for submission with the General Learning Community Grant proposal. Forms are included in the RFP for reference only. Do not use the forms in the RFP; instead use the version of the forms posted on the SIM website in completing the grant application. In some cases only the first part of the form is included in this RFP because of its length. The SIM website is available at:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Home](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home)

- Form A: Application Face Sheet with Instructions
- Form B: Learning Community Implementation Work Plan
- Form C: Project Minnesota Accountable Health Model Contractor Budget General Learning Community
- Form E: Budget Justification Narrative
- Form F: Due Diligence Review Form (submit only 1 copy of Due Diligence Review Form and any required documentation)

The Accountable Communities for Health (ACH) funding opportunity and instructions for applying are described below.

### Topics

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The ACH Learning Community grantee must consider the learning interests and needs of Accountable Communities for Health teams and facilitate learning on a variety of topics that increase ACH team knowledge, skills, and abilities to advance patient-centered, coordinated, and accountable care. The topics *Sustainability Planning* and *ACH Leadership Team* are required for the ACH Learning Community. Remaining topics represent priority areas for ACH teams that may be the focus of the Learning Community based upon identified needs. A priority of the grant is to demonstrate how chosen topic areas will support health equity.

The following two topics are required to be addressed in the applicant's work plan:

#### **Sustainability Planning**

The ACH Learning Community will focus on development of a sustainability plan including key elements necessary for sustainability of the ACH such as successful continuation of community partnerships, funding mechanisms, long term measurement, and resources necessary to continue and improve community based care coordination efforts after grant funding ends. Technical assistance from the grantee could include supporting the development of an effective and sustainable ACH leadership team and community care coordination system/team. Other learning areas might include identifying population health needs; building and maintaining the community partnerships needed for the ACH to be effective; developing effective governance structures; making use of available clinical/population health data for improvement efforts; establishing mechanisms for secure sharing of clinical data across settings; community engagement tools and strategies; quality improvement and transition management; and other topics identified through stakeholder engagement or community feedback.

#### **ACH Leadership Team**

The ACH Learning Community will focus on the leadership team structure of the ACH and how to include people who live in the community and are part of the target population and a broad range of providers and community partners. Key concepts include: how to implement partnerships with decision making that reflects the membership of the ACH team; how the ACH team ensures that community members and those providers responsible for services to the identified target population are included in the leadership team's decision-making processes; methods for facilitating understanding by the leadership team of health issues that impact the target population; and creating alignment for shared responsibility to develop and implement innovative strategies, e.g. operationalizing care teams and patient-centered care, population health initiatives, and other requirements.

Grantee will be expected to propose Learning Community activities in at least five of these areas, based on information obtained through an ACH learning community needs assessment that the Grantee will conduct.

#### **Community Integration and Partnership**

This topic focuses on improving the coordination and integration of primary care and public health, social service providers (e.g. schools, non-profit, community organizations, etc.), behavioral health, and/or long-term, post-acute care. Learning elements in this topic area may include: an assessment of current integration using the Continuum of Accountability Matrix

([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Docs\\_Reps\\_Pres](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Docs_Reps_Pres)), developing an inventory of resources for care and service integration; implementation of integration of care, services, or shared resources with other partners; or

evaluation of referral patterns, transitions, and plan for follow up to public health, social service agencies, non-profit, community organizations and primary care. One health equity approach may be to develop a strategy to increase partnerships with community organizations and leaders that represent populations most impacted by health disparities or that have been traditionally marginalized.

### **Integration with Behavioral Health**

Will focus on improving coordination and integration of health care services and behavioral health. Key concepts under this topic may include: creating organizational infrastructure to support greater integration; understanding population in order to create the appropriate integration approach; collecting data and tracking outcomes; connecting to individual, family, and other community supports; exchanging information between care providers; coordinating transitions between different levels of care or settings; and creating a financial model to support integration. A health equity consideration in this topic may be to review behavioral health assessments to ensure that policies and procedures that identify patients and provide support resources are consistently applied.

### **Care Coordination**

Learning will focus on the role of care coordination and facilitation with patients/families and team members. Learning concepts may center on active patient engagement, implementation of motivational interviewing in setting patient-centered goals, reducing barriers, and establishing care planning strategies. In addition, a key learning element will be the importance of building community partnerships, identifying and using community resources, coordination of referrals, and coordinating with community/public agencies. One health equity approach may be to support and strengthen the role of patient-advocates and/or bilingual interpreters in the care coordination team so that patients are partners and not just recipients of care.

### **Quality Improvement Infrastructure**

Focuses on building a culture of quality, monitoring quality results and addressing improvements in quality outcomes through systems changes. Concepts may include: focus on improved quality results through the use of registries, population management techniques, care coordination and care planning techniques, or other best practices. A key learning element and health equity approach should be developing an understanding of health disparities, and how to collect and monitor data on populations most impacted by health disparities.

### **Culturally Appropriate Care**

This topic will focus on the policies, procedures, programs, and processes of the delivery system to address the values, beliefs, assumptions, cultural norms and customs of the client/community population. Learning concepts may include: use of interpreter services, creating and using culturally specific educational materials, offering staff trainings on topics with cultural sensitivity. Learning community topics include collecting and utilizing demographic data on cultural background, racial heritage, primary language and social and economic conditions. The approach may include information on community resources identification, referral, and use; address tracking, and measurement; health disparities; shared decision- making practices; using health assessments; and motivational interviewing. The Learning Community will focus on increasing preventive and health improvement activities and processes for populations served by the provider organizations.

### **Population Health**

This topic covers increasing preventive and health improvement activities and processes for populations served by the provider organizations. Focus areas may include: addressing tobacco cessation, weight management, hypertension, diabetes, and behavioral health (substance abuse, depression, anxiety, etc.), perinatal, etc. Topics addressed could include the use of current evidence-based guidelines, facilitating team self-assessment of current preventive practices and identifying areas of need, exploring best practices in using EHRs; or exploring processes for primary prevention. Any of these focus areas should consider the array of socioeconomic factors that contribute to population health and target strategies and resources to particular demographics at highest risk. A health equity approach may be to include qualitative analysis of successful

results-based practices in relation to socio-demographic indicators to better understand health outcomes in target populations.

### **E-Health and Data Analytics**

The Learning Community will focus on the workflow, management, coordination, governance, and policy with the electronic health record (EHR) and applying the use of data in assessing patient population needs specific to those patients/clients being served. Learning community concepts may include: population management tools such as registries, predictive modeling, problem list management, identification and documentation of primary care provider, interoperability and communication between other provider organizations, or the electronic exchange of information and data privacy needs. A focus on use of data in quality improvement processes should be included in the approach.

All learning topics should be facilitated in a manner that is conducive to peer-to-peer learning and problem-solving across ACH teams. The learning topics mentioned above should be both content-rich and process-improvement oriented.

### **Required Deliverables and Activities**

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ACH learning community grant applicants are encouraged to use innovative approaches and best practices to deliver curricula and work with ACH team members to design the approach that will work best. However, applicants should provide evidence that the overall curriculum and work plan include the following elements:

- A practical didactic learning component with each proposed topic;
- Multiple opportunities for face-to-face discussion between ACH teams around implementation of methods/strategies, including barriers lessons learned and potential recommendations related to the identified topics;
- Involvement of patients, family members, care givers, and community partners as appropriate to the topic;
- Opportunity for face to face interaction and engagement for participants;
- A clear plan for evaluating participant learning and outcomes;
- Evidence of health equity considerations.

The ACH Learning Community grantee shall complete the following tasks:

#### **Planning Phase- within 60 days of grant start date**

- In collaboration with State staff, conduct a learning community needs assessment based on information from the Continuum of Accountability Matrix Assessment Tally Tool; interviews and/or surveys with ACH grantees; and other relevant information as recommended by SIM staff.
- Submit a copy of the ACH Learning Community Implementation Work Plan and timeline of activities for the first 6 months of the grant period.
- Develop content for learning sessions and identify presenters for the ACH team track for May 12-14, 2015, learning days in St. Cloud. This will include identification of key content to be presented on the topics of ACH Leadership Team and Sustainability Planning and must be coordinated with Learning Collaborative staff and conference organizers.

#### **Implementation Phase - months 3-23**

- Based on the learning community needs assessment and discussions with SIM staff, prepare a work plan for additional statewide learning community training activities.

- Coordinate technical assistance and just-in-time training with SIM state staff to focus on key deliverable areas in the ACH team work plans.
- Prepare and present at webinars, just-in-time training, regional training, and quarterly meetings to include: lessons learned stories, successes, challenges, barriers, reflections, and improvements.
- Plan, present and facilitate tracks at State Learning Collaborative day events during the grant period (1 per year).
- Develop and test implementation of learning using quality improvement models.
- Conduct content and sessions in a manner consistent with the evidence based change theory and using adult learning principles.
- Conduct an evaluation of the Learning Community, which measures both satisfaction and achievement of the goals and objectives. Evaluation of participant progress shall be conducted throughout the process, adapting learning according to the needs of participants. Coordinate evaluation planning and activities with SIM staff.

### Ongoing

- Collaborate with appropriate subject matter experts at the State in developing workplans, resources, and technical assistance materials.
- Submit detailed invoices for payment using the invoice and following the invoice due dates (Example Appendix F).
- Grantee shall submit a progress report with each invoice that updates progress on curriculum development and delivery, participation in learning events, observations and feedback on events, and evaluation outcomes including participant satisfaction and process satisfaction data.
- Actively participate in meetings regarding Learning Community grant activities, as requested by state staff.
- State staff reserves the right to survey participants.

### Upon Completion

- Prepare and present informative sessions on the ACH Learning Community to leadership as requested.
- Provide materials and products created to the State for possible distribution (examples, power points, handouts, templates, forms, toolkits, etc.).
- Submit a final project report which details: overall evaluation results; total organization/consumer/family participation; measured qualitative and quantitative outcomes, lessons learned, successes, barriers, and challenges; and, how ACH teams have applied or plan to apply what they learned within the ACH.
- Ensure that all curriculum materials (e.g., electronic documents, webpages, or other electronic materials) are made fully accessible in accordance with the applicable law ([Americans with Disabilities Act standards](#)).
- Capitalize on the expertise of learning team members by capturing participant stories and reflections for inclusion in final report and presentation.

**State staff shall complete the following tasks**

- Review and approve work plans and timelines for implementation of activities.
- Review Learning Community curriculum work plan and updates.
- Hold regular conference calls (minimum monthly) or meetings with the grantee. These calls/meetings will include monitoring of grantee activities, discussion of obstacles/issues, and evaluating progress towards reaching program goals.
- Review reports and invoices submitted by the grantee.
- Ensure the ACH Learning Community involves consumer/family team members in learning community activities.

Grant Application and Program Summary

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Eligibility for Grant Funds	The following organizations may apply for grant funding: community-based nonprofit and for-profit organizations; government entities or tribal government; clinics and hospitals; community health or public health organizations; quality improvement organizations; professional provider associations and institutes of higher education.  ACH teams shall be the primary recipients of the Learning Community work.
Total Funds Available	\$200,000 per proposal for 1 award
Duration of Funding	February 2015 – December 2016
Grant Purpose	To plan, implement, and evaluate an ACH Learning Community to advance patient-centered coordinated care and accountable care.
Application Requirements	<ul style="list-style-type: none"> <li>• Narrative portions of the application must be written in 12-point font, single spaced with one-inch margins.</li> <li>• All pages must be numbered consecutively.</li> <li>• Applicants must submit one (1) signed unbound original and seven (7) unbound copies of the proposal as well as an electronic version of the proposal on a USB drive. Faxed or emailed applications will <b>not</b> be accepted.</li> <li>• Applications must meet application deadline requirements.</li> <li>• Late applications will not be reviewed.</li> <li>• Applications must be complete and signed where noted.</li> <li>• Incomplete applications will not be considered for review.</li> </ul>
Order for Completed Application Submission	Each application must contain the following items in the order listed: <ul style="list-style-type: none"> <li>• Signed Application Face Sheet (Form A)</li> <li>• Applicant Experience and Capacity (Limit 2 pages)</li> <li>• General or ACH Learning Community Description (Limit 6 pages)</li> <li>• General or ACH Learning Community Implementation Work Plan (Form B)</li> <li>• Project ACH Minnesota Accountable Health Model Contractor Budget Learning Community (Form D)</li> <li>• Project Budget Justification (Form E)</li> <li>• Due Diligence Review Form (Form F) – For Nongovernmental Organizations)submit only 1 copy of Due Diligence Review Form and any required documentation</li> </ul>

Submitting the Proposal	<p>Applicants must submit one (1) signed unbound original and seven (7) unbound copies of the proposal and an electronic version of the proposal on a USB drive.</p> <p>Faxed or emailed applications will <b>not</b> be accepted.</p> <p>Late applications will not be considered for review.</p>
Application Deadline	<p><b>December 30, 2014, 4:00 PM Central Standard Time</b></p> <p>To meet the deadline, proposals must be either:</p> <ul style="list-style-type: none"> <li>• Hand delivered to the 2nd floor reception desk of the Golden Rule Building, 85 East Seventh Place, Suite 220 on or before December 30, 2014 by 4:00 PM CST; or,</li> <li>• Arrive by mail, Fed Ex, or courier service on or before December 30, 2014 by 4:00 PM CST.</li> <li>• Late applications, applications lost in transit by courier, or faxed/emailed applications will not be considered for review.</li> </ul>
Applications Sent	<p><b>Mailing Address:</b>          Shirley Schoening Scheuler          Health Educator          Minnesota Department of Health          Health Care Homes / Health Policy Division - State Innovations Model          PO Box 64882          Saint Paul, MN 55164-0882</p> <p><b>Courier Address:</b>          Shirley Schoening Scheuler          Health Educator          Minnesota Department of Health          Health Care Homes / Health Policy Division - State Innovations Model          Golden Rule Building          85 East Seventh Place, Suite 220          Saint Paul, MN 55101</p>
Contact Information	<p>Questions about Learning Collaborative grants and/or the proposal process can be directed to:</p> <p>Shirley Schoening Scheuler          Minnesota Department of Health          Health Care Homes / Health Policy Division- State Innovations Model  <a href="mailto:shirley.scheuler@state.mn.us">shirley.scheuler@state.mn.us</a></p> <p>Other state staff are not allowed to respond to questions about this procurement.</p>
Grant Start Date	<p>February 2015 or the date all required signatures on the grant agreement are obtained, whichever is later.</p>

## Proposal Instructions

---

The following are the minimum required application components, listed in the order of documents to be submitted. Applicants should place emphasis on completeness and clarity of content.

### 1. Signed Grant Application Face Sheet (Form A)

---

Include all applicable information required by the form.

### 2. Applicant Experience and Capacity (Limit 2 pages, 25 Points)

---

In this section, the ACH Learning Community applicant must provide:

- a) A brief history of the entity and any notable accomplishments.
- b) A brief description of experience of the applicant entity related to: collaborative learning, learning communities, quality improvement, collaborating with stakeholder groups, engaging and gathering input/feedback from health care consumers and family members.
- c) Description of knowledge and experience in the proposed subject matter of Learning Community.
- d) A brief overview of the capacity of the agency and specifically how it is prepared to accomplish the grant objectives.
- e) Description of the roles and responsibilities of the project's staff members, including qualifications, skills, and experience of the project's lead staff (include CVs/resumes of lead staff in appendix. CVs are not included in the page limits).
- f) Description of key partners or collaborators that the applicant proposes working with to complete project goals.
- g) Anticipated barriers and challenges in implementing this project and potential solutions.

### 3. Learning Community Description (Limit 6 pages, 30 Points)

---

Proposals must address, in sufficient detail, how the applicant would fulfill the expected outcomes and features described below.

In this section, the ACH Learning Community applicant must provide:

- a) Topics: A description of how the applicant would approach planning, presenting, and coordinating the learning community topics, ACH Leadership Team and Sustainability Planning, at the May 12-14, 2015, Learning Days in St. Cloud.
- b) Needs assessment: A description of how the applicant would conduct a learning needs assessment with ACH grantees.
- c) Goals and Objectives of Learning Community: A description of the overall goals of the ACH Learning Community and objectives for meeting those goals.
- d) Health equity: Describe how health equity will be addressed in the learning topics and activities.
- e) Evaluation Plan: A description of the evaluation plan for the ACH Learning Community. Grantee should measure the effectiveness of the Learning Community including skills/knowledge gained, and satisfaction of learning team members. To the greatest extent possible, the evaluation plan should also include outcome measures that show evidence of the impact of learning on quality or cost of care. Evaluation plan should include:
  - Measurement Tools: Tools to be utilized in measuring whether goals and objectives were met.
  - Timeframes: When measurements will occur.
  - Process for making changes to curriculum/work plan based on process outcomes or learning team feedback.

## 4. Learning Community Implementation Work Plan/Timeline of Activities (Form B, 30 Points)

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In this section, the applicant must provide a work plan for the first 6 months of the grant period (See [Form B](#) and [Example of Form B](#) for more detail):

- f) **Timeline:** Anticipated date or timeframe of the learning activities including the St. Cloud learning day and one additional learning day event in 2015.
- g) **Learning Community Objective/Activity:** Brief description of the learning activities/sessions.
- h) **Learning Method:** Learning methods that will be utilized (face-to-face learning, webinars, conference calls, etc.).
- i) **Learning Outcome(s):** Brief description of anticipated outcome(s) of the learning activities.
- j) **Measurement:** Description of tools that will be utilized to measure whether goals and objectives were met.

## 5. Budget (15 Points)

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### Budget Forms

- **Minnesota Accountable Health Model Contractor Budget Template** Form D.
- **Budget Justification Narrative** see template Form E.
- **Due Diligence Review** Form F. Due Diligence Review Form (For Nongovernmental Organizations submit 1 copy of Due Diligence Review Form and required documentation)

Applicants must use calendar year budget forms for 2015 and 2016.

- February – December 2015
- January – December 2016.

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, purchase of food, construction, fund raising activities, political education or lobbying, or out of state travel.

**Indirect Costs:** Indirect costs are not allowed in this proposal.

**In-Kind:** Matching Funds Requirement: There are no requirements for matching funds.

### Section One

The budget form includes two sections. Section One provides a summary of the eligible expenses by line item. 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 Costs:**

- Provide the name of contractors or organizations, the services to be provided, hourly rate, and projected costs.
- In the budget narrative, include brief background information about contractors, including how their previous experience relates to the project.
- If a contractor has not been selected, include a description of the availability of contractors for the services and/or products required and the method for choosing 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 Learning Communities project work and described in the budget justification narrative.

**F. Travel:**

Include the cost for any proposed in-state travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (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)  
(<http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf>)

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

**G. Other:**

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

- **Support Expenses:** Telephone equipment and services, internet connection costs, teleconferences, videoconferences, meeting space rental, and equipment rental.
- **Expense Reimbursement:** Travel, meals, and childcare expenses can be covered for consumers or other community members without a form of reimbursement to attend a schedule meeting. You must be specific on your budget form and budget narrative for travel, meal and childcare expenses for consumers or community members without another form of reimbursement.

## Section Two

Section Two provides a summary of expenses for the deliverables. The amount paid for the deliverables in 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 the Planning Phase, Implementation Phase, and Completion.

### Due Diligence Review Form

This form must be completed by the applicant organization's administrative staff, for example, finance manager, accountant, or executive director. It is a standard form MDH uses to determine the accounting system and financial capability of all grant applicants. Submit only 1 copy of Due Diligence Review Form and any required documents.

## Proposal Evaluation

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

Items	Points	Percentage
Applicant Experience and Capacity	25 points	25%
Learning Community Description	30 points	30%
Learning Community Implementation Plan	30 points	30%
Budget and Budget Justification	15 points	15%
<b>TOTAL</b>	<b>100 points</b>	<b>100%</b>

## Review Process

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Grant proposals will be reviewed and evaluated by a panel familiar with the program. The panel may include staff from the Minnesota Department of Health, Minnesota Department of Human Services, and HCH/SIM Learning Collaborative Advisory Committee, which includes community stakeholders. 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 received on time according to the due date listed on or before **December 30, 2014, 4:00 PM Central Standard Time** will be reviewed. Reviewers will use the criteria as outlined in the RFP and will make recommendations for funding. We anticipate that grant award decisions will be made by January 30, 2015. 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 applicants that are awarded grant funds. The anticipated effective date of the agreement is February 2015, or the date upon which all signatures are obtained. No work on grant activities can begin until a fully executed grant agreement is in place.

## Grant Participation Requirements

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- Submit a final work plan and budget.
- Execute original and two copies of grant agreement and return to MDH for final signature.
- Grantee cannot start work or be reimbursed until a fully executed grant agreement is executed.
- Complete required deliverables and activities as outlined in grant agreement.
- Participate in site visits or conference calls to report on progress, barriers or lessons learned.
- Final 10 percent of the total grant award will be withheld until grant duties are completed such as the final report.
- Provide additional details that may be requested to comply with state and federal reporting requirements.
- Provide ongoing reports submitted with each invoice

## Required Forms

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

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Home](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home)

- Form A: Application Face Sheet with Instructions
- Form B: Learning Community Implementation Work Plan
- Form D: ACH Minnesota Accountable Health Model Contractor Budget Learning Community Budget
- Form E: Budget Justification Narrative
- Form F: Due Diligence Review Form (submit only 1 copy of Due Diligence Review Form and any accompanying audit statements)

SIM Learning Community Grant

Check the Learning Community grant you are applying for:

- General Learning Community
- ACH Learning Community

<b>1. Legal name and address of the applicant agency with which grant agreement would be executed</b>	
<b>2. Minnesota Tax I.D. Number</b>	<b>Federal Tax I.D. Number</b>
<b>3. Requested funding for the total grant period</b>	\$
<b>4. Director of applicant agency</b>	
Name, Title and Address	Email Address:
	Telephone Number: ( )
	FAX Number: ( )
<b>5. Fiscal management officer of applicant agency</b>	
Name, Title and Address	Email Address:
	Telephone Number: ( )
	FAX Number: ( )
<b>6. Operating agency (if different from number 1 above)</b>	
Name, Title and Address	Email Address:
	Telephone Number: ( )
	FAX Number: ( )
<b>7. Contact person for applicant agency (if different from number 4 above)</b>	
Name, Title and Address	Email Address:
	Telephone Number: ( )
	FAX Number: ( )
<b>8. Contact person for further information on grant application</b>	
Name, Title Address	Email Address:
	Telephone Number: ( )
	FAX Number: ( )
<b>9. Certification</b>	
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 and Federal Tax I.D. number**
3. **Requested funding for the total grant period**  
Amount the applicant agency is requesting in grant funding for the grant period.
4. **Director of the applicant agency**  
Person responsible for direction at the applicant agency.
5. **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.
6. **Operating Agency**  
Complete only if other than the applicant agency listed in 1 above.
7. **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.
8. **Contact person for Further Information**  
Person who may be contacted for detailed information concerning the application or the proposed program.
9. **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: Learning Community Implementation Work Plan/Timeline of Activities

Check the Learning Community grant you are applying for:

- General Learning Community
- ACH Learning Community

Please list out each anticipated learning activity and evaluation plan in order of anticipated completion.

	Anticipated Date	Learning Objective/Activity	Learning Method	Learning Outcome(s)	Measurement	Anticipated # of Participants
1						
2						
3						
4						
5						
6						
7						
8						

Form B: Example Learning Community Implementation Work Plan/Timeline of Activities

Please list out each anticipated learning activity and evaluation plan in order of anticipated completion.

	Anticipated Date	Learning Objective/Activity	Learning Method	Learning Outcome(s)	Measurement	Anticipated # of Participants
<i>Example 1</i>	<i>January 2014</i>	<i>Learning day focused on new preventative toolkit (screening, brief intervention, and follow-up)</i>	<i>Face-to-face workshop</i>	<i>Participants will have better understanding of screening, brief intervention, and follow-up process. Participants will be able to implement toolkit.</i>	<i>1. Knowledge-based pre-test and post-test distributed day of training. 2. Satisfaction Survey to be distributed and collected at end of session.</i>	<i>20 (5 clinic teams, 4 participants each)</i>
<i>Example 2</i>	<i>Monthly (February – May 2014)</i>	<i>Monthly Follow-Up Phone calls</i>	<i>Webinars/Conference calls</i>	<i>Participants will be able to share experiences in implementing toolkit. Opportunity to discuss and problem solve through barriers to implementation.</i>	<i>Satisfaction survey following webinar to be emailed out.</i>	<i>5-10 (webinar is geared toward those in the care coordination role)</i>

Form C: General Learning Community Budget Template

**Applicant:**

**Total Contract Period: February, 2015 – October 31, 2015**

***Budget Form Instructions for Applicants:***

1. Complete a budget for the applications for the Learning Collaborative.
  2. Include costs for the grant recipient (fiscal agent) and Salaries & Wages, Fringe, Supplies, Travel, and Other categories for Learning Collaborative grant.
  3. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group facilitation, or consultation) in C.
  4. Enter information in cells highlighted in blue as applicable for your project.
- The amount paid for deliverables in section two is based on costs in section one.

***Section One***

<b>A. SALARIES &amp; WAGES: For each position, provide the following information: position title, hourly rate, and number of hours allocated to the project.</b>			
<b>In Form D Budget Justification Narrative, provide a brief position description for each position listed.</b>			
Title	Hourly Rate	Hours	Total
			\$
			\$
			\$
			\$
			\$
			\$
<b>Total Salaries and Wages:</b>		<b>0</b>	<b>\$</b>

<b>B. FRINGE: Provide information on the rate of fringe benefits calculated for the total salaries and wages for positions in 1A.</b>	
Enter the fringe benefit rate as a % of the total salaries and wages in decimal format.	
<b>Total Fringe:</b>	<b>\$</b>

**C. CONSULTANT COSTS:** Provide the following information for consultants/contractors: name of contractor or organization, hourly rate, number of hours, services to be provided.  
 In Form D provide a brief background about the contractor including how previous experience relates to the project. If the contractor has not been selected, include a description of the availability of contractors for the services or product, a description of the availability of contractors for the services or product, and the method that will be used for choosing a contractor.

		Hourly Rate	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 D Budget Justification Narrative. Consult budget instructions in Section 11E for examples of allowable costs in this category.

Item	Total
<b>Total Other Costs:</b>	<b>\$</b>

<b>GRAND PROJECT TOTAL</b>	<b>\$</b>
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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 B Work Plan and include key deliverables.

Deliverable: Planning Phase	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
<b>TOTAL</b>			<b>\$</b>
Deliverable: Implementation Phase	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
<b>TOTAL</b>			<b>\$</b>
Deliverable: Completion	Avg by Hour	Estimated Hrs	Billable Amt
			\$
			\$
<b>TOTAL</b>			<b>\$</b>

<b>GRAND PROJECT TOTAL</b>	<b>\$</b>
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## Form D: ACH Learning Community Budget Template

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Use the Excel budget template for the ACH Learning Community application at the SIM website. An example is not provided here because the two forms are identical.

## Form E: Budget Justification Narrative

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Check the Learning Community grant you are applying for:

- General Learning Community
- ACH Learning Community

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

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

### A. Salaries and Wages

This should include all personnel at the fiscal lead and partnering organizations whose work is tied to the proposal.

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

### B. Fringe

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

### C. Consultant Costs

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

### E. Supplies

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

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

### F. Travel

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

**F. Travel**

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

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

**G. Other**

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

**In-kind**

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

**(Submit only 1 copy of Due Diligence Review Form and any accompanying audit statements)**

**Check the Learning Community grant you are applying for:**

- General Learning Community**
- ACH Learning Community**

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

## *Due Diligence Review Form*

### *Instructions*

#### **Purpose**

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

#### **Definition**

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

#### **Restrictions**

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

#### **Instructions**

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

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

## Due Diligence Review Form

### Organization Information

1. How long has your organization been doing business?					
2. Does your organization have a current 501(c)3 status from the IRS? Circle Yes or No.			Yes	No	
3. How many employees does your organization have (both part time and full time)?					
4. Has your organization done business under any other name(s) within the last five years? Circle Yes or No. If yes, list name(s) used.			Yes	No	
5. Is your organization affiliated with or managed by any other organizations, such as a regional or national office? Circle Yes or No. If yes, provide details.			Yes	No	
6. Does your organization receive management or financial assistance from any other organizations? Circle Yes or No. If yes, provide details.			Yes	No	
7. What was your organization's total revenue in the most recent 12-month accounting period?					
8. How many different funding sources does the total revenue come from?					
9. Have you been a grantee of the Minnesota Department of Health within the last five years? Circle Yes or No. If yes, from which division(s)?			Yes	No	
10. Does your organization have written policies and procedures for accounting processes? Circle Yes or No. If yes, please attach a copy of the table of contents.			Yes	No	
11. Does your organization have written policies and procedures for purchasing processes? Circle Yes or No. If yes, please attach a copy of the table of contents.			Yes	No	
12. Does your organization have written policies and procedures for payroll processes? Circle Yes or No. If yes, please attach a copy of the table of contents.			Yes	No	
13. Which of the following best describes your organization's accounting system? Circle one response.		Manual	Automated	Both	
14. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately? Circle one response.		Yes	No	Not sure	
15. If your organization has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items? Circle one response.		Yes or Not applicable	No	Not sure	
16. Are time studies conducted for employees who receive funding from multiple sources? Circle one response.		Yes or Not applicable	No	Not sure	
17. Does the accounting system have a way to identify over-spending of grant funds? Circle one response.			Yes	No	Not sure
18. If grant funds are mixed with other funds, can the grant expenses be easily identified? Circle one response.			Yes	No	Not sure

19. Are the officials of the organization bonded? Circle one response.	Yes	No	Not sure
20. Did an independent certified public accountant (CPA) ever examine the organization's financial statements? Circle one response.	Yes	No	Not sure
21. Has any debt been incurred in the last six months? Circle Yes or No. If yes, what was the reason for the new debt? What is the funding source for paying back the new debt?		Yes	No
22. What is the current amount of unrestricted funds compared to total revenues?			
23. Are there any current or pending lawsuits against the organization? Circle Yes or No.		Yes	No
24. If yes, could there be an impact on the organization's financial position? Circle one response.		Yes	No or Not applicable
25. Has the organization lost any funding due to accountability issues, misuse, or fraud? Circle Yes or No. If yes, please describe the situation, including when it occurred and whether issues have been corrected.		Yes	No

**Additional Documentation Requirements**

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

## Appendix

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Appendix A:	General Learning Communities Grant Application Scoring Sheet
Appendix B:	Accountable Communities for Health Learning Communities Grant Application Scoring Sheet
Appendix C:	General Learning Community : Continuum of Accountability Matrix Assessment Tally Tool with Instructions
Appendix D:	Minnesota Accountable Health Model Glossary
Appendix E:	MDH Sample Grant Agreement
Appendix F:	MDH Sample Invoice
Appendix G:	Resources

## Appendix A: General Learning Communities Grant Application Scoring Sheet

Criteria	Possible Points
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### Applicant / Organizational Experience and Capacity

1. Does the description give a clear picture of the history, structure, services provided, and clientele served by the applicant? Does the applicant have a successful history of providing proposed services?	5
2. Does the applicant have the capacity (infrastructure, facilities) to develop the proposed Learning Community?	5
3. Does the applicant have adequate staffing for the proposed Learning Community? Do the qualifications, skills, and expertise of the project's staff align with the requirements of the Learning Community?	5
4. Does the applicant have any current partnerships/relationships or the ability to leverage partnerships with potential learning teams organizations?	5
5. What barriers does the applicant anticipate and what are the identified potential solutions	5
<b>Applicant Experience and Capacity Total Points</b>	<b>25</b>

### Learning Community Description

1. Does the applicant provide a sufficient description of the chosen topic for the Learning Community?	5
2. Does the applicant provide sufficient detail on the need for the Learning Community to focus on the chosen topic?	5
3. Is the target audience (learning teams): appropriate for the chosen topic?	5
4. Does the applicant provide sufficient opportunities for involvement of consumers and families?	5
5. Is the evaluation plan thorough; providing opportunities for feedback loops throughout the process? Are valid and robust evaluation tools/measures being utilized?	5
6. Will the processes or innovative practices that are taught be able to be sustainable even after the grant is over? Are they replicable in other settings statewide?	5
<b>Learning Community Description Total Points</b>	<b>30</b>

**Learning Community Implementation Work Plan**

1. Do the anticipated dates fall within the projected grant agreement timeline?	5
2. Does the applicant provide multiple innovative or non-traditional methods of learning?	5
3. Are the methods / strategies to be used best practices, or likely to be effective in providing learning opportunities for learning teams?	5
4. Does the applicant provide opportunities for sharing and discussion amongst learning teams?	5
5. Is there evaluation/measurement occurring with every learning activity to provide ample opportunity for participant feedback?	5
6. Does the applicant intend to facilitate the Learning Community with the correct estimated number of participants?	5
<b>Learning Community Implementation Plan Total Points</b>	<b>30</b>

**Budget**

1. Are the Budget Summary Form and the Budget Justification Sheet complete? Do the amounts on Budget Summary Form match what is in the Budget Justification Sheet?	5
2. Is the information contained in the Budget Justification Sheet consistent with what is proposed in the Project Narrative and Implementation Plan?	5
3. Are the projected costs reasonable and sufficient to accomplish the proposed activity?	5
<b>Budget Total Points</b>	<b>15</b>

**TOTAL POINTS****100**

## Appendix B: Accountable Communities for Health Learning Communities Grant Application Scoring Sheet

Criteria	Possible Points
<b>Applicant / Organizational Experience and Capacity</b>	
1. Does the description give a clear picture of the history, structure, services provided, and clientele served by the applicant? Does the applicant have a successful history of providing proposed services?	5
2. Does the applicant have the capacity (infrastructure, facilities) to develop the proposed Learning Community?	5
3. Does the applicant have adequate staffing for the proposed Learning Community? Do the qualifications, skills, and expertise of the project's staff align with the requirements of the Learning Community?	5
4. Does the applicant have any current partnerships/relationships or the ability to leverage partnerships with potential learning teams organizations?	5
5. What barriers does the applicant anticipate and what are the identified potential solutions	5
<b>Applicant Experience and Capacity Total Points</b>	<b>25</b>
<b>Learning Community Description</b>	
1. ACH: Does the applicant provide a sufficient description of how they would go about planning and presenting the learning community topics ACH Leadership Team and Sustainability Planning at May 12-14, 2015, Learning Days?	5
2. ACH: Does the applicant provide sufficient detail on how they would conduct a learning needs assessment with ACH grantees?	5
3. ACH: Is the description of the overall goals of the ACH Learning Community (i.e. including May 12-14 Learning Days skills and/or knowledge to be learned, learning needs assessment) and objectives for meeting those goals sufficient and appropriate?	5
4. Does the applicant provide sufficient opportunities for involvement of consumers and families?	5
5. Is the evaluation plan thorough; providing opportunities for feedback loops throughout the process? Are valid and robust evaluation tools/measures being utilized?	5
6. Will the processes or innovative practices that are taught be able to be sustainable even after the grant is over? Are they replicable in other settings statewide?	5
<b>Learning Community Description Total Points</b>	<b>30</b>

**Learning Community Implementation Work Plan**

1. Do the anticipated dates fall within the projected grant agreement timeline?	5
2. Does the applicant provide multiple innovative or non-traditional methods of learning?	5
3. Are the methods / strategies to be used best practices, or likely to be effective in providing learning opportunities for learning teams?	5
4. Does the applicant provide opportunities for sharing and discussion amongst learning teams?	5
5. Is there evaluation/measurement occurring with every learning activity to provide ample opportunity for participant feedback?	5
6. Does the applicant intend to facilitate the Learning Community with the correct estimated number of participants?	5
<b>Learning Community Implementation Plan Total Points</b>	<b>30</b>

**Budget**

1. Are the Budget Summary Form and the Budget Justification Sheet complete? Do the amounts on Budget Summary Form match what is in the Budget Justification Sheet?	5
2. Is the information contained in the Budget Justification Sheet consistent with what is proposed in the Project Narrative and Implementation Plan?	5
3. Are the projected costs reasonable and sufficient to accomplish the proposed activity?	5
<b>Budget Total Points</b>	<b>15</b>

**TOTAL POINTS****100**

## Appendix C: Continuum of Accountability Matrix Count Sheet (example only)

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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.

In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool6 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. The tool allows a broad range of providers to assess their current status and progress in moving toward accountable care.

The goal is for organizations/provider to complete a self-assessment of where the organization is currently at in the continuum of accountability.

### General Learning Community grantees:

- Ensure individual organizations/providers participating in the learning teams complete the Continuum of Accountability Matrix Assessment Tool for their organization. For example, if an organization has three individual involved in learning team they would complete one Accountability Matrix Assessment Tool for their organization.
- Collect the organizations’/providers’ completed assessment(s).
- Input the organizations’/providers’ responses into the Accountability Matrix Count Sheet. The Accountability Matrix Count Sheet will be provided to the grantee after grant is started.
- Submit the completed Accountability Matrix Count Sheet to MDH within 90 days of the grant start date.

EXAMPLE Appendix C: Example illustration below:

EXAMPLE Appendix C: Minnesota Accountable Health Model: Accountability Matrix Count Sheet								
Organization 1:	Clinic							
Organization 2:	Family Health Center							
Organization 3:	Community Center							
Organization 4:	Local Public Health							
Organization 5:	Public Schools							
Organization 6:	Hospital							
Organization 7:								
Organization 8:								
Grantee Name:	Our Care Community for Health							
<b>Delivery and Community Integration and Partnership Section</b>								
<b>3. Population Management: To what extent does your practice have a process to identify appropriate patients/clients for care coordination?</b>								
Level	Description	Org 1	Org 2	Org 3	Org 4	Org 5	Org 6	Count
Pre- Level	None							
A	We do not currently have a process in place but are planning or beginning to implement							
	Beginning							
	In progress			x				1
	Mostly done							
B	We have an informal process where care team members and providers identify patients/clients for care coordination.							
	Beginning					x		1
	In progress							
	Mostly done							
C	We routinely assess patients'/clients' needs for care coordination using methods such as pre-visit planning, use of registries and team / provider input.							
	Beginning							
	In progress	x						1
	Mostly done		x				x	2
D	We systematically assess the patient/client population for care coordination needs with use of data or screening tools, such as population based registry and community or payer data on a regular basis.							
	Beginning							
	In progress							
	Mostly done				x			1

### **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](http://www.rwjf.org/en/topics/search-topics/A/accountable-care-organizations-acos.html)) accessed 09.10.13

### **Behavioral Health**

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

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

### **Care Coordination**

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

Source: U.S. Department of Health and Human Services, [www.ncvhs.hhs.gov/091013p9.pdf](http://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/hchcareteamsrpf.pdf>

**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](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>

## 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.healthit.gov/unintended-consequences/content/glossary.html>) accessed 10.23.14

### **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) ([www.health.state.mn.us/healthreform/homes/](http://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>) 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>) 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/>) accessed 2.19.14

## **Long-Term and Post-Acute Care (LTPAC)**

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

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

## **Patient and Family Centered Care**

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

## **Population**

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

## **Population Health**

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

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

## **Provider**

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

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

## **Public Health**

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

Source: American Public Health Association, <https://www.apha.org/what-is-public-health>  
Local Public Health Association of Minnesota, <http://www.lpha-mn.org>

**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 E: MDH Sample Grant Agreement

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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 or local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement or receiving stolen property; and

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

### ***17.2 Audit Requirements to be Included in Grant Agreements with Subrecipients***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Bureau of the Census  
Data Preparation Division  
1201 East 10<sup>th</sup> 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

2. State Agency

*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.*

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

By: \_\_\_\_\_  
(with delegated authority)

By: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

*Distribution: Agency – Original (fully executed) Grant Agreement Grantee State Authorized Representative*

Appendix F: MDH EXAMPLE Invoice

**EXAMPLE INVOICE**

Minnesota Department of Health  
 (Program) Minnesota Accountable Health Model

**INVOICE**

Date:	Grant Manager: <b>Contact Information:</b>
Organization Name	Organization Address
<b>Name of Contact Person for Invoice</b>	<b>Phone Number</b>
Billing Period for This Invoice	From: To:

Only costs in the approved budget will be reimbursed, and only upon acceptance of any deliverables by the State. 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>

Line	Line Item	Amount Awarded	Actual Cost	Comments or Necessary Follow-up
1	Salary	\$	\$	
2	Fringe Benefits	\$	\$	
3	Contractual Services	\$	\$	
4	Travel	\$	\$	
5	Supplies and Expenses	\$	\$	
6	Other	\$	\$	
7	Total	\$	\$	

I declare that this claim is correct, that no part of it has previously been billed to MDH, and reflects only charges related to the (grant program) activities in the approved budget previously submitted.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR MDH USE ONLY**

<b>Approved by:</b>		
<b>Date:</b>	<b>Org #</b>	<b>FY:</b>
<b>PO #:</b>	<b>Org #</b>	<b>FY:</b>

## Invoice Due Dates

**NOTE: If we receive your invoice after the due date, we may not be able to pay it.**

Billing Period	Invoice Due Date
January 1, 2015 through March 31, 2015	April 30, 2015
April 1, 2015 through June 30, 2015	July 30, 2015
July 1, 2015 through September 30, 2015	October 30, 2015
October 1, 2015 through December 31, 2015	January 30, 2016
January 1, 2016 through March 31, 2016	April 30, 2016
April 1, 2016 through June 30, 2016	July 30, 2016
July 1, 2016 through September 30, 2016	October 30, 2016
October 1, 2016 through December 31, 2016	January 20, 2017

## Invoice Instructions

- Invoices may be submitted for reimbursement after all the following:
  - grant project portion has been completed
  - grantee has been invoiced
  - grantee has paid invoice
  - Match Requirement -if required match must also be documented before any payment is made.
- Invoices are due according to the timeline provided above. Invoices that are received late may not be paid.
- Enter your costs for the billing period related to each line item as per approved budget.
  - In the column "Amount Awarded" this is the amount for each line item in your approved budget, and will be entered in by the grant manager.
  - In the column "Actual Cost" enter the paid expenses for each line item based on the approved budget.
- On the row labeled "Salary," enter your costs for salary for staff members identified in the approved budget.
- On the row labeled "Fringe Benefits," enter your costs for fringe benefits related to staff salary.
- On the row labeled "Contractual Services," enter your costs for subcontractors.
- On the row labeled "Travel," enter your costs for travel, including mileage, hotels, and meals. Travel expenses are limited to the current [Minnesota Management and Budget's Commissioner's Plan](http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf) (<http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf>)
- On the row labeled "Supplies and Expenses," enter your costs for such approved budget items as telephone, postage, printing, photocopying, office supplies, materials, food at gatherings, and equipment costing less than \$5,000.
- On the row labeled "Other," enter your costs for other items that were approved in your budget.
- On the row labeled "Total," enter the total of lines 1-6.

## Unallowable Expenses

Funds may not be used to pay for direct patient care services fees, building alterations or renovations, construction, fund raising activities, political education or lobbying, purchase of equipment, or out of state travel.

## Appendix G: Resources

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The following resources are key references to understand the Minnesota landscape, and provide guidance for the Learning Community grant request for proposal requirements.

Advancing Health Equity in Minnesota: Report to the Legislature

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

Minnesota Accountable Health Model: Continuum of Accountability Matrix

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Docs\\_Reps\\_Pres](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Docs_Reps_Pres)

MN SIM website

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Home](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home)

SIM ACH Resources / Literature Review

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_RFPs](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs)

MDH Health Care Homes: Learning Collaborative website

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