



Request for Proposals

Release date: June 9, 2015

Due date: July 28, 2015

Minnesota Accountable Health Model Learning Community Grants

**Minnesota Department of Health
Division of Health Policy**

Table of Contents

A.	Overview	3
B.	Available Funding and Estimated Awards.....	3
C.	Grant Timelines.....	4
D.	Background	5
E.	Eligible Grant Applicants for Learning Community	7
F.	Learning Community Grant Applicant.....	7
G.	Required Grant Elements.....	10
H.	Continuum of Accountability Matrix Assessment.....	10
I.	Review Process.....	11
J.	Grant Application and Program Summary	12
K.	Proposal Instructions	14
1.	Signed Grant Application Face Sheet (Form A).....	14
2.	Applicant Experience and Capacity (Limit 3 pages, 25 Points)	14
3.	Learning Community Description (Limit 6 pages, 30 Points)	14
4.	Learning Community Implementation Work Plan (Form B, 30 Points)	15
5.	Budget (15 Points).....	17
L.	Proposal Evaluation.....	19
M.	Grant Participation Requirements	19
	Required Forms	19
	Form A: Application Face Sheet.....	20
	Form B: Learning Community Implementation Work Plan	22
	Form C: Year 1 Learning Community Budget Template	26
	Form C: Year 2 Learning Community Budget Template	29
	Form D: Budget Justification Narrative	32
	Form E: Due Diligence	33
	Form F: Letter of Intent to Respond.....	36
N.	Appendix	37
	Appendix A: Learning Communities Grant Application Scoring Sheet	38
	Appendix B: Continuum of Accountability Matrix Count Sheet (example only)	40
	Appendix C1: Example Project Form for Quality Improvement	41
	Appendix C2: Project Form for Quality Improvement PDSA Worksheet for Testing Change	42
	Appendix D: Minnesota Accountable Health Model Glossary	43
	Appendix E: MDH Sample Grant Agreement.....	49
	Appendix F: MDH EXAMPLE Invoice	59
	Appendix G: Resources.....	61

A. Overview

The Minnesota Department of Health (MDH) is seeking proposals from qualified professionals or organizations to plan, implement, facilitate and evaluate a small focused quality improvement **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.

This grant opportunity will provide funding to five (5) Learning Communities to advance the Minnesota Accountable Health Model. The Learning Community grants will focus on a quality improvement project that supports the advancement of provider organizations and community partners along a continuum of practice transformation and community care integration efforts in the following areas:

- Building the Foundation for implementation of a Health Care Home (HCH) Model of Care Delivery in Primary Care
- Sustaining and Enhancing the HCH Model of Care Delivery in Primary Care
- Advancing Community Health

Learning communities can serve as a powerful forum for dialogue and sharing of tools and best practices among clinic/community teams seeking to improve the care of patients and families. 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.

The primary recipient of the learning and implementation work is: primary care, behavioral health, long-term and post-acute care, local public health and social services. Each funded Learning Community will comprise a minimum of five (5) learning teams that will be recruited by the grantee, with four (4) to six (6) participants per team. 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 goal of the Learning Community Grant is to provide teams with education, assistance and support to implement a quality improvement project using rapid learning cycles. Rapid learning cycles include four steps: Plan, Do, Study and Act.

B. Available Funding and Estimated Awards

Learning Community Grant

Round 2: October 1, 2015 – June 30, 2016

- Total amount available up to \$250,000
- Grant award amounts up to \$50,000 will be awarded per proposal for up to 5 awards
- Grant timeline is for nine (9) months from the start date

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. Applicants are required to submit separate proposals for each Learning Community they are proposing to convene. MDH reserves the right to change the funding available for the current and future grant opportunities.

Funding Restrictions

Funds may not be used to pay for direct patient care service fees, childcare, 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

C. Grant Timelines

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

RFP Activity	Date/Time
Request for Proposal Posted	Tuesday, June 9 , 2015
Notice/Letter of Intent (Required)	Thursday, June 25, 2015, 4:00 PM CST
Optional Informational Q & A Webinar on RFP	<p>Date: June 22, 2015, 9:00 AM – 10:00 AM CST</p> <p>To register for the Learning Community webinar visit:</p> <p>https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=t6c4a54e4ddaf3458b4730ca794cefbfb</p> <p>Power point presentation will be emailed to participants and will be available:</p> <p>http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_learning_communities</p> <p>Questions can be submitted on-line:</p> <p>https://survey.vovici.com/se.ashx?s=56206EE3458C6533</p>
Application Deadline	Tuesday, July 28, 2015 4:00 PM CST
Estimated Notice of Awards	September 2015
Estimated Grant Start Date	October 2015 or the date all required signatures on the grant agreement are obtained, whichever is later.

D. Background

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 consumer sand 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

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

- 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** 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 ([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)) 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. See page 11 and 43 for more information about the Minnesota Accountable Health Model Continuum of Accountability Matrix Assessment as it pertains to the Learning Community Grant. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Docs_Reps_Pres

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

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 and participate in accountable care models.

Health Care Homes/SIM 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, and 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.

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

E. Eligible Grant Applicants for Learning Community

Eligible applicants for Learning Communities may be community-based nonprofit and for-profit organizations; local 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, 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.

Desired expertise of Applicant includes:

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

F. Learning Community Grant Applicant

Topics:

Grantees must consider the learning interests and needs of potential learning community teams since they will represent a broad range of progression along the continuum of practice transformation and community care integration efforts. In order to support these entities in making advancements along this continuum, grantees are required to choose **one topic** from areas I, II, or III from the list below. The topics are designed to increase learning teams’ knowledge, skills, or abilities to advance patient-centered, coordinated care and accountable care and to bring together cohorts

with similar learning needs. A priority of the grant is to have all Learning Communities demonstrate how the chosen topic area will support health equity and the certification or recertification of Health Care Homes (HCH).

I. Building the Foundation for Implementation of a Health Care Home (HCH) Model of Care Delivery in Primary Care

- **Principles of Team Based and Patient- and Family-Centered Care:**

The Learning Community will focus on implementing the culture of patient- and family-centered, team based-care into the everyday work of the primary care practice. Key learning concepts grantee can include: learning to incorporate patient and family-centered care into job descriptions, team competencies and communication techniques, such as: partnership in quality teams/advisory committees where patients provide meaningful input; interpreting and understanding patient experience results; and patient centered measures and tools (e.g., walk-about). The grantee should also include cultural competencies in establishing patient- and family-centered care.

- **Quality Improvement Infrastructure:**

The Learning Community will focus on the organization's ability to measure, analyze and track quality measures. Key learning concepts grantee can include: establishing a quality improvement team that reflects the structure of the clinic, establishing procedures that the team uses to share their work and elicit feedback about quality improvement activities, development of a quality improvement plan and implement ways to measure, analyze and track performance measures. Key learning concepts grantee can include 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.

- **Health Care Homes the Model of Care Delivery:**

The Learning Community will focus on the implementation and development of certified health care homes. Key learning concepts grantee can include: review of standards and certification procedures; assessment of clinics capacity to implement the HCH standards; and address identified gaps and barriers to implementation of the standards based on the assessment. (Health Care Homes five Standards: Access and Communication; Access and Communication; Care Coordination; Care Planning; Performance Reporting/Quality Improvement) Certification/Recertification Resource page: <http://www.health.state.mn.us/healthreform/homes/certification/index.html> Certification Assessment Tool with standards language/intent/requirements can be downloaded from this page refer to Getting Started Health Care Home Resource Guide: <http://www.health.state.mn.us/healthreform/homes/resources/getstarted/index.html>

II. Sustain and Enhance the HCH Model of Care Delivery in Primary Care

- **Improve Coordinated Care:**

The Learning Community will focus on care coordination and patient activation. Key learning concepts grantee can include: tools to enhance patient engagement and development of patient centered goals including motivational interviewing, shared decision making and the identification of patient barriers, transition management and care planning strategies including the integration of external plans of care and external care team members. This could also include the addition of bilingual, culturally sensitive staff on the care teams as a way to increase patient engagement or improving referral patterns and follow up to community resources that are appropriate patient resources.

- Disease Prevention and Health Improvement:**

The Learning Community will focus on increasing clinical preventive and health improvement services systems or processes. Key learning concepts grantee can include: addressing tobacco cessation, weight management, hypertension and/or hyperlipidemia. Using current evidence-based clinical guidelines, the grantee will facilitate clinic self-assessment of current preventive practices and identify need areas; hold learning activities to introduce a process for clinical preventive services based on the Screen, Counsel, Refer and Follow-up model; include information on community resources identification, referral and use; address tracking, measurement and evaluating outcomes; use of EMR; health disparities; shared decision- making practices; using health assessments; and motivational interviewing.
- 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 grantee can 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.
- Integrated Care and Community Partnerships:**

The Learning Community will focus on the integration of primary care with public health, social service providers (e.g. schools, non-profit, community organizations, etc.), behavioral health and/ or long-term, post-acute care and the formation of active community partnerships that serve the unmet needs of patients or enhance the patient's quality of life. Key learning concepts grantee can include: an assessment of current integration using the Continuum of Accountability Matrix (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectonMethod=LatestReleased&dDocName=SIM_Docs_Reps_Pres) and the implementation of processes to advance a clinic's location along the continuum of integration and the provision of integrated services. Key learning concepts grantee can include as 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.

III. Advance Community Health

- Integration with Behavioral Health:**

The Learning Community will focus on improving coordination and integration of health care services and behavioral health. Key learning concepts grantee can 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.

- **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. Key learning concepts grantee can 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.

Required:

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.

G. Required Grant Elements

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 community team members to design the most effective best approach and innovative approaches/best practices to deliver curricula. However, applicants should include in their application the overall curriculum/work plan with the following elements:

- A practical didactic learning component where the proposed topic is presented.
- Discussion on the implementation of methods /strategies including adult learning and quality improvement action-learning approach – Rapid learning cycles include four steps: Plan, Do, Study and Act, including barriers, lessons learned and potential recommendations related to the identified topics.
- Staff for the Project-including roles and responsibilities.
- 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.
- Work Plan that includes Activities, Learning Methods, Responsibility/Roles, Timeline, Measures, and Outcomes for deliverables (see proposal instructions section for details on each deliverable).
- A clear plan for evaluating participant learning and outcomes.
- Evidence of health equity considerations.

H. Continuum of Accountability Matrix Assessment

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/providers to complete a self-assessment of where the organization is currently at in the continuum of accountability.

Learning Community grantees will be responsible for collecting completed matrixes from each participating organization.

Requirement:

- Individual organizations/providers participating in the learning teams must complete the Continuum of Accountability Matrix Assessment Tool for their organization. For example, if an organization has three individuals involved in a learning team they would complete one Accountability Matrix Assessment Tool for their organization.
- 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 60 days of the grant start date.

I. Review Process

The review panel will consist of staff from the Minnesota Department of Health, the Minnesota Department of Human Services and members of the community. 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 the priorities of the grant program, geographic location, number of grantees and a cross section of target populations.

Only complete applications that meet eligibility and application requirements and are received on or before 4:00 pm, CST, July 28, 2015, will be reviewed. Reviewers will determine which applications best meet the criteria as outlined in the RFP and make recommendations for funding. (Criteria Score sheet can be found in Appendix A). Grant award decisions are estimated to be made by September 2015. Applicants will be notified by email 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 organizations that are awarded grant funds. The anticipated effective date of the agreement is October 1, 2015, or the date upon which all signatures are obtained. Grant agreements will end June 2016 or nine (9) months after the date the contract is fully executed. No work on grant activities can begin until a fully executed grant agreement is in place. (A sample grant agreement is located in the Appendix).

J. Grant Application and Program Summary

Eligibility for Grant Funds	The following organizations may apply for grant funding: community-based nonprofit and for-profit organizations; local 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	\$250,000 for this grant cycle
Grant Amount	Up to 5 new grant awards for up to \$50,000
Duration of Funding	October 1, 2015 through June 30, 2016 or nine months from the contract execution date.
Grant Purpose and Goal	To plan, implement and evaluate Learning Communities on topics that will advance patient-centered coordinated and accountable care. The goal of the Learning Community Grant is to provide teams with education, assistance and support to implement a quality improvement project using rapid learning cycles. Rapid learning cycles include four steps: Plan, Do, Study and Act.
Letter of Intent	Required: Non-binding Letter of Intent (Form F) to Respond required by Thursday, June 25, 2015, 4:00 pm (CST) Letters of Intent to Respond must be submitted via e-mail to: Shirley Schoening Scheuler Minnesota Department of Health Health Care Homes / Health Policy Division- State Innovations Model Shirley.scheuler@state.mn.us
Application Requirements	<ul style="list-style-type: none"> • Letter of intent is required. • Narrative portions of the applications must be written in 12-point font, single spaced with one-inch margins. • All pages must be numbered consecutively. • Template forms must be used. If they are not used, the application will not be accepted. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelect ionMethod=LatestReleased&dDocName=sim_learning_communities# • Applicants must submit one (1) signed unbound original and seven (7) copies of the signed original proposal and an electronic version of the proposal on a USB drive. For the electronic copy include PDF and non-PDF Word/Excel copies. • Applications must meet application deadline requirements. • Late applications will not be reviewed. • Applications must be complete and signed where noted. • Incomplete applications will not be considered for review.

Order for Completed Application Submission	<p>Each application must contain the following items in the order listed using forms provided in Word and Excel: Template forms must be used.</p> <ul style="list-style-type: none"> • Signed Application Face Sheet (Form A) • Applicant Experience and Capacity (Limit 3 pages) • Learning Community Description (Limit 6 pages) • Learning Community Implementation Work Plan (Form B) • Learning Community Budget <ul style="list-style-type: none"> ○ Year 1 Budget (Form C) ○ Year 2 Budget (Form C) • Budget Justification Narrative (Form D) • Due Diligence (Form E) – For Non-governmental Organizations should submit only 1 copy of Due Diligence form and any required documentation
Submitting the Proposal	<p>Applicants must submit one (1) signed unbound original and seven (7) copies of the original signed proposal and an electronic version of the proposal on a USB drive. For the electronic copy include PDF and non-PDF Word/Excel copies. Faxed or emailed applications will not be accepted. Late and incomplete applications will not be considered for review.</p>
Application Deadline	<p>July 28, 2015, 4:00 PM Central Standard Time To meet the deadline, proposals must be either:</p> <ul style="list-style-type: none"> • Hand delivered to the 2nd floor reception desk of the Golden Rule Building 85 East Seventh Place, Suite 220 on or before July 28, 2015 by 4:00 PM CST; or, • Arrive by mail, Fed Ex, or courier service on or before July 28, 2015 by 4:00 PM CST. • Late applications, applications lost in transit by courier, or faxed/emailed applications will not be considered for review.
Applications Sent	<p>Mailing Address: Shirley Schoening Scheuler Minnesota Department of Health Health Care Homes / Health Policy Division- State Innovations Model PO Box 64882 Saint Paul, MN 55164-0882</p> <p>Courier/Delivery Address: Shirley Schoening Scheuler 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>
Grant Start Date	<p>October 2015 or the date all required signatures on the grant agreement are obtained, whichever is later.</p>
Questions	<p>Questions regarding this RFP must be submitted on line by July 24, 2015 https://survey.vovici.com/se.ashx?s=56206EE3458C6533 through the State Innovation Model website. All written questions and answers will be posted on the website. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_learning_communities#</p>

K. Proposal Instructions

The following are the minimum required application components, listed in the order of documents to be submitted. Proposals must address, in sufficient detail, how the applicant would fulfill the expected outcomes, deliverables and activities described below. 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 3 pages, 25 Points)

In this section, applicant must

- a) Provide a brief summary of the applicant's structure, capacity and experience to complete the project.
- b) Provide brief description of applicant's experience related to collaborative learning and/or learning communities and quality improvement process.
- c) Provide the applicants experience to gather input/feedback from health care consumers and family members. Discuss current partnerships/relationships or the ability to leverage partnerships with potential learning teams organizations.
- d) Anticipated barriers and challenges in implementing this project and potential solutions.
- e) Discuss the skills and qualifications of applicant staff involved in the Learning Community project. Discuss the roles and responsibilities of staff involved in the proposed Learning Community. (Include one page resume/CVs in appendix. Resumes/CV's are not included in the page limits).

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

In this section, applicant must provide:

- a) Topic: A description of the focus topic for the proposed Learning Community to improve quality. Include rationale for how and why the topic was chosen to be a focus of a Learning Community (i.e., needs assessment data, baseline data and a couple references from best practice or peer reviewed literature).
- b) Purpose: The applicant will provide the overall goals and objectives of Learning Community topic (i.e. including the skills and/or knowledge to be learned/what will be changed) and activities for meeting those goals.
- c) Learning Teams: Discuss the proposed learning teams including: A brief summary of the team and the recruitment plan for learning teams. Identify the types and number of learning team members (minimum of five (5) learning teams) that will be served by the Learning Community. The role of the learning teams in the quality improvement process (what will be done, who will do it and by when?).
- d) Participants: The applicant will describe how there will be will involvement of consumer/family in the process and how feedback will be utilized to change processes and activities in a timely manner.
- e) Health Equity: 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. 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 (Form B, 30 Points)

Instructions: Applicant will complete the Learning Community Implementation Work Plan Template (Form B). The following key deliverables are required for the work plan. Key deliverables will be required to correspond to deliverables in Section 2 Deliverables (outcomes) of the Budget Template.

Key Deliverables

1. Recruitment of Participants:

- a. **Deliverable: Submit a list of clinics/organizations (indicate participating accountable care organizations) within 30 days of starting the grant.**
 - Identify the recruitment process of the Learning Community organizations; a minimum of five (5) learning teams with four (4) to six (6) participants per team are required.
 - Include team roles and responsibilities.
 - Require participating organizations and/or members to sign an agreement of participation to ensure attendance and commitment.
 - Include involvement of patients, family members, care givers and community partners as appropriate to the topic.
- b. **Deliverable: Grantee will complete and submit the Matrix Count Sheet (Appendix B) for each organization within 60 days of starting the grant.**
 - Provide technical assistance to organizations completing the assessment.
 - Enter results for all participating organizations into Matrix Count Sheet.

2. Planning Process

- a. **Deliverable: Submit a schedule of the learning events and materials for training sessions within 45 days of starting the grant.**
 - Include learning opportunity announcements, PowerPoint slides, session handouts and any audio-visual components.
 - Include identification of key content to be presented.
- b. **Deliverable: Submit a clear plan for evaluating participant learning and outcomes within 30 days starting the grant.**
 - 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.

3. Quality Improvement Project:

- a. **Deliverable: Submit Project Form for Quality Improvement Project (Appendix C) for a minimum of five (5) learning teams within 60 days of starting the grant.**
 - Develop action plan utilizing the Institute for Healthcare Improvement (IHI) Project Planning Form. <http://www.ihl.org/resources/Pages/Tools/ProjectPlanningForm.aspx>
 - Assessment of each team for quality improvement structure and their ability to implement the project.
- b. **Deliverable: Facilitate Quality Improvement Project for minimum of five (5) learning teams within 60 days of starting the grant – conclude two weeks before end of the grant period. (Appendix C)**
 - Schedule meetings, ideally monthly or more often to track progress
 - Conduct the session in a manner using adult learning principles and learning methods to lead the learning sessions Performs assessment and collect Baseline data to determine priority or focus area

- Train and coach teams through Plan-Do-Study-Act (PDSA) utilize IHI PDSA Worksheet <http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>
- Review results and change process based on lessons learned
- Re-evaluate the process
- Finalize the process

4. **Reporting and Dissemination:**

- a. **Deliverable: Submit a progress report and invoice according to the due dates on the invoice form. (Example Appendix F).**
- Discuss curriculum development and delivery.
 - Include participation in learning events, observations and feedback on events and evaluation outcomes, including participant satisfaction and process satisfaction data.
 - Actively participate in monthly and all other meetings regarding grant/Learning Community activities, as requested by state staff.
 - Follow the invoice schedule to submit expenses according to approved budget.
 - Capitalize on the expertise of learning team members by capturing participant stories and reflections for inclusion in final report and presentation.
- b. **Deliverable: Participate in MDH hosted Minnesota Accountable Health Model learning event webinar to include presentations by all grantees within the last two months of the grant period.**
- Prepare and present a section on focus topic and include: lessons learned, successes, challenges, barriers, reflections and areas for improvement. Submit power point to MDH.

5. **Final Report and Invoice**

- a. **Deliverable: Submit a final project report using the format the State will provide, invoice and other materials listed in the RFP.**
- 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.
 - Final syllabus including list of resources and reference to create the materials.
 - 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 and approve reports and invoices submitted by the grantee.
- State staff reserve the right to survey participants.

5. Budget (15 Points)

Budget Forms:

- Learning Community Budget Template Form C.
- Budget Justification Narrative Template Form D. The Budget Justification Narrative provides additional information to justify costs in Form C Budget
- Due Diligence Review Form E. Due Diligence Review Form (For Nongovernmental Organizations submit 1 copy of Due Diligence Review Form and required documentation)

Include a budget for nine months (October 1, 2015 – June 30, 2016). First Year October 1, 2015 to December 31, 2015; Second Year January 1, 2016 to June 30, 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 in state 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. All expense will only be allowed when connected to the Learning Community project.

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. First Year October 1, 2015 to December 31, 2015; Second Year January 1, 2016 to June 30, 2016. 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, hourly rate and 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 consultant or organizations, the services to be provided, hourly rate and projected costs. Consultants must be named and approved by the Center for Medicare Medicaid Innovation (CMMI); if consultants are not identified at time of application or budget approval the amount allocated for the consultants will not be released until identified and approved by CMMI.

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

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. (Purchase of data analytic software is not allowed in this grant).

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:** Stipends, incentives and food are not covered expenses. Please be specific on your budget form and budget narrative about expenses for team members or other grant project participants without a 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:

1. Recruitment of Participants
2. Planning Process
3. Quality Improvement Project
4. Reporting and Dissemination
5. Final Report and Invoice

Due Diligence 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 non – governmental grant applicants (submit only 1 copy of Due Diligence Review Form and any required documents).

L. Proposal Evaluation

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 Narrative	15 points	15%
TOTAL	100 points	100%

M. Grant Participation Requirements

- 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

Below is a list 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. **Template forms must be used.** The SIM website is available at:

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

- Form A: Application Face Sheet
- Form B: Learning Community Implementation Work Plan
- Form C: Learning Community Budget
- Year 1 (October 2015 – December 2015)
 - Year 2 (January 2016 – June 2016)
- Form D: Budget Justification Narrative
- Form E: Due Diligence
- (Submit only one (1) copy of Due Diligence Form and any required documentation)
- Form F: Letter of Intent to Respond

SIM Learning Community Grant

1. Legal name and address of the applicant agency with which grant agreement would be executed:		
Name of Organization:		
Address:		
Phone:		
2. Minnesota Tax I.D. Number		
3. Federal Tax I.D. Number		
4. Requested funding for the total grant period	\$	
5. Director of applicant agency		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
6. Fiscal management officer of applicant agency		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
7. Operating agency (if different from number 1 above)		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
8. Contact person for applicant agency (if different from number 4 above)		
Name, Title and Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
9. Contact person for further information on grant application		
Name, Title Address	Email Address:	
	Telephone Number: ()	
	FAX Number: ()	
10. Certification		
I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant agency.		
_____	_____	_____
Signature of Authorized Agent for Grant Agreement	Title	Date

Form A: Application Face Sheet Instructions

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

1. **Applicant agency**
Legal name of the agency authorized to enter into a grant contract with the Minnesota Department of Health.
2. **Applicant agency's Minnesota Tax I.D. number**
3. **Applicant agency's Federal Tax I.D. number**
4. **Requested funding for the total grant period**
Amount the applicant agency is requesting in grant funding for the grant period. The grant period will be from October 2015 -June 2016 or nine (9) months from the date the contract is executed. The grantee must submit a budget for the nine (9) months period starting with October 2015 - June 2016. Prepare budget within two (2) calendar years: Year 1-October 1, 2015-December 31, 2015 and Year 2-January 1, 2016-June 30, 2016.
5. **Director of the applicant agency**
Person responsible for direction at the applicant agency.
6. **Fiscal management officer of applicant agency**
The chief fiscal officer for the applicant agency who would have primary responsibility for the grant agreement, grant funds expenditures and reporting.
7. **Operating agency**
Complete only if other than the applicant agency listed in 1 above.
8. **Contact person for applicant agency**
The person who may be contacted concerning questions about implementation of this proposed program. Complete only if different from the individual listed in 5 above.
9. **Contact person for further information**
Person who may be contacted for detailed information concerning the application or the proposed program.
10. **Signature of authorized agent of applicant agency**
Provide an original signature of the director of the applicant agency, their title and the date of signature on the original application.

Form B: Learning Community Implementation Work Plan

Instructions: Complete the Work Plan Template. Include the grant elements: activities, learning method, responsibilities/roles, timeline, measures and outcomes for nine (9) months grant period. **(Use Form B on the RFP website)**. Refer to proposal instructions on page 16 – 18 for specifics on each key deliverables in the Work Plan (Form B) will be required to correspond to deliverables in Section 2 Deliverables of Budget (Form C). The Work Plan (Form B) and Budget (Form C) will be attachments in the grant contract and the documents used to monitor grant deliverables. **Add additional rows as needed, per deliverable section.**

- a. Activities – Identify what will be done and steps to accomplish the deliverable.
- b. Learning Methods (if applicable) Identify the methods to be used (face-to-face learning, webinars, conference calls, etc.)
- c. Responsibilities/Roles- Identify staff and/or learning team member responsibilities for the activities.
- d. Timeline- Anticipated timeframe of the activities.
- e. Measures - Include the measure indicators and the methods to be used to meet your outcomes.
- f. Outcomes- Include the expected results of the activity.

DELIVERABLE: Example					
ACTIVITIES	LEARNING METHOD	<u>RESPONSIBILITIES/ ROLES</u>	TIMELINE	MEASURES	OUTCOMES
What are you hoping to achieve? Outline of what you will do & steps you will take	Face-to-face learning, webinars, conference calls, etc.	Identify staff and/or learning team member responsibilities for the activities.	Include a time line for each activity.	Include the measure indicators you and the methods to be used to meet the outcomes.	Include your outcome for the activity.

Key Deliverables

1. Recruitment Process a. Deliverable: Submit a list of clinics/organizations (indicate participating accountable care organizations) within 30 days of starting the grant. b. Deliverable: Grantee will complete and submit the Matrix Count Sheet (Appendix B) for each organization within 60 days of starting the grant.					
<i>ACTIVITIES</i>	<i>LEARNING METHOD</i>	<i>RESPONSIBILITIES/ROLES</i>	<i>TIMELINE</i>	<i>MEASURES</i>	<i>OUTCOMES</i>

2. Planning Process:

- a. Deliverable: Submit a schedule of the learning events and materials for training sessions within 45 days of starting the grant.
- b. Deliverable: Submit a clear plan for evaluating participant learning and outcomes within 30 days of starting the grant.

<i>ACTIVITIES</i>	<i>LEARNING METHOD</i>	<i>RESPONSIBILITIES/ROLES</i>	<i>TIMELINE</i>	<i>MEASURES</i>	<i>OUTCOMES</i>

3. Deliverable: Quality Improvement Project Performance Improvement

- a. Deliverable: Submit Project Form for Quality Improvement Project (Appendix C) for a minimum of five (5) learning teams within 60 days of starting the grant.
- b. Deliverable: Facilitate Quality Improvement Project for minimum of five (5) learning teams within 60 days of starting the grant – conclude two weeks before end of the grant period.

<i>ACTIVITIES</i>	<i>LEARNING METHOD</i>	<i>RESPONSIBILITIES/ROLES</i>	<i>TIMELINE</i>	<i>MEASURES</i>	<i>OUTCOMES</i>

4. Deliverable: Reporting and Dissemination a. Deliverable: Submit a progress report and invoice according to the due dates on the invoice form. (Example Appendix F). b. Deliverable: Participate in MDH hosted Minnesota Accountable Health Model learning event webinar to include presentations by all grantees within the last two months of the grant period.					
<i>ACTIVITIES</i>	<i>LEARNING METHOD</i>	<i>RESPONSIBILITIES/ROLES</i>	<i>TIMELINE</i>	<i>MEASURES</i>	<i>OUTCOMES</i>

5. Deliverable: Final Report and Invoice a. Deliverable: Submit a final project report using the format the State will provide, invoice and other materials listed in the RFP.					
<i>ACTIVITIES</i>	<i>LEARNING METHOD</i>	<i>RESPONSIBILITIES/ROLES</i>	<i>TIMELINE</i>	<i>MEASURES</i>	<i>OUTCOMES</i>

Form C: Year 1 Learning Community Budget Template

Applicant:

Total Contract Period: October 1, 2015 – December 31, 2015

Budget Form Instructions for Applicants:

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

Section One

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

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

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

		Hourly Rate	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
Total Other Costs:	\$

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

Section Two

DELIVERABLES: The amount paid for deliverables in section two is based upon the total dollars requested in section one. Budget deliverables are to cross reference Form B Work Plan and include key deliverables.

Deliverable: Recruitment Process	Avg by Hour	Estimated Hrs	Billable Amt
Submit a list of clinics/organizations			\$
Grantee will complete and submit the Matrix Count Sheet			\$
TOTAL			\$

Deliverable: Planning Process	Avg by Hour	Estimated Hrs	Billable Amt
Submit a schedule of the learning events and materials for training sessions			\$
Submit a clear plan for evaluating participant learning and outcomes			\$
TOTAL			\$

Deliverable: Quality Improvement Project	Avg by Hour	Estimated Hrs	Billable Amt
Submit Project Form for Quality Improvement Project			\$
TOTAL			\$

Deliverable: Reporting and Dissemination	Avg by Hour	Estimated Hrs	Billable Amt
Submit a progress report and invoice			\$
TOTAL			\$

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

Applicant:

Total Contract Period: January 1, 2016 – June 30, 2016

Budget Form Instructions for Applicants:

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

Section One

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

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

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

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

	Hourly Rate	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
Total Other Costs:	\$

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

Section Two

DELIVERABLES: The amount paid for deliverables in section two is based upon the total dollars requested in section one. Budget deliverables are to cross reference Form B Work Plan and include key deliverables.

Deliverable: Quality Improvement Project	Avg by Hour	Estimated Hrs	Billable Amt
Facilitate Quality Improvement Project			\$
TOTAL			\$

Deliverable: Reporting and Dissemination	Avg by Hour	Estimated Hrs	Billable Amt
Submit a progress report and invoice			\$
Participate in MDH hosted learning event webinar			\$
TOTAL			\$

Deliverable: Final Report and Invoice	Avg by Hour	Estimated Hrs	Billable Amt
Submit a final report and invoice			\$
TOTAL			\$

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

Form D: Budget Justification Narrative

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

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

A. Salaries and Wages

This should include all personnel 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. **Consultants should be identified by name to avoid restriction of funds by CMMI**):

E. Supplies

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

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

F. Travel

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

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

G. Other

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

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

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

Due Diligence Form

Instructions

Purpose

The Minnesota Department of Health (MDH) must conduct due diligence form 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.

Form E. Due Diligence Review Form

Due Diligence (submit only 1 copy of Due Diligence Review Form and any accompanying audit statements and include with the original copy):

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.

Form F: Letter of Intent to Respond

1. Place on Letterhead
2. Deadline: Thursday, June 25, 2015, 4:00 PM (CST)

Learning Community

(Date)

This is written notification of the intent to submit an application to the Minnesota Department of Health for funding under the Minnesota Accountable Health Model Accountable Communities for Learning Community. We understand that the application deadline for our proposal is July 28 at 4 PM (CST). Information on the proposed Learning Community is provided below.

Applicant organization name: _____

Contact person: _____

Contact person email: _____

Signature: _____

Title: _____

Please submit the letter as an email attachment to shirley.scheuler@state.mn.us
Or provide the letter via mail or courier/delivery to:

Mailing Address:

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

Courier/Delivery Address:

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

N. Appendix

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

Appendix A: Learning Communities Grant Application Scoring Sheet

Criteria	Possible Points
Applicant Experience and Capacity	
1. Does applicant provide a summary of the applicant's structure, capacity and experience to complete the project?	5
2. Does the applicant provide a description of experience related to collaborative learning and/or learning communities and quality improvement process?	5
3. Does the applicant discuss the experience to gather input/feedback from health care consumers and family members? Does the applicant have current partnerships/relationships or the ability to leverage partnerships with potential learning team organizations?	5
4. Does the applicant discuss the anticipated barriers and challenges and identify potential solutions?	5
5. Does the applicant discuss the skills and qualifications of applicant staff involved in the Learning Community project? Do they discuss the roles and responsibilities for the proposed Learning Community? (Are resumes in appendix? Resumes/CV's are not included in the page limits.)	5
Applicant Experience and Capacity Total Points	25

Criteria	Possible Points
Learning Community Description	
1. Does the applicant provide a sufficient description of the chosen topic for the Learning Community? Does the applicant Include rationale for why the topic should be a focus of a Learning?	5
2. Does the applicant provide a description of the overall goals of the Learning Community (i.e. including the skills and/or knowledge to be learned/what change) and objectives for meeting those goals?	5
3. Does the applicant clearly describes the recruitment plan, types and number of learning teams that will be recruited?	5
4. Does the applicant discuss opportunities for involvement of consumers and families?	5
5. Does the applicant discuss how health equity will be addressed in the learning topic?	5
6. Does the grantee evaluation of the Learning Community include skills/knowledge gained and satisfaction of learning team members? Does the applicant provide a clear description of the proposed evaluation plan (what measurement tools used, when evaluation occurs and (timeline) and process for changing curriculum or work plan based on evaluation?	5
Learning Community Description Total Points	30

Criteria	Possible Points
Learning Community Implementation Work Plan	
1. The proposed activities for each deliverable are clearly described.	5
2. Does the applicant use a variety combination of learning methods? (Face-to-face, virtual and distance learning, etc.).	5
3. Did the applicant identify the responsibilities and roles for each deliverable, if applicable?	5
4. Do the anticipated dates of the work plan fall within the projected grant agreement timeline?	5
5. The work plan has clear measures and outcomes tied to each deliverable?	5
6. The applicant addresses each key deliverable in the work plan.	5
Learning Community Implementation Plan Total Points	30

Criteria	Possible Points
Budget	
1. Are the Budget Form and the Budget Justification Narrative complete? Do the amounts on Budget Form match what is in the Budget Justification Sheet?	5
2. The information in the Budget Justification Narrative is consistent with what is proposed in the work plan.	5
3. Are the projected costs reasonable and sufficient to accomplish the proposed activity?	5
Budget Total Points	15
TOTAL POINTS	100

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

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

In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tools 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.

EXAMPLE Appendix B: 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							
Delivery and Community Integration and Partnership Section								
3. Population Management: To what extent does your practice have a process to identify appropriate patients/clients for care coordination?								
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

Appendix C2: Project Form for Quality Improvement PDSA Worksheet for Testing Change

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller test of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change:	Person responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do *Describe what actually happened when you ran the test*

Study Describe the measured results and how they compared to the predictions

Act Describe what modifications to the plan will be made for the next cycle from what you learned

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](http://www.rwjf.org/en/search-results.html?u=&k=accountable+care+organization), <http://www.rwjf.org/en/search-results.html?u=&k=accountable+care+organization> accessed 09.10.13

Behavioral Health

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

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

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

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

Care Coordination

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

Source: [U.S. Department of Health and Human Services](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177945) or <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/05/091013p9.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

A 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.statereforum.org/system/files/hchcareteamsrfp.pdf> accessed 07.23.2014.

Community Engagement

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

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

Computerized Provider Order Entry (CPOE)

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

Continuum of care

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

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

Data Analytics

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

Source: [IBM Institute for Business Value Healthcare](http://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf): The value of analytics in healthcare (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) (<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 \(aka Medical Homes\)](http://www.health.state.mn.us/healthreform/homes/) (www.health.state.mn.us/healthreform/homes/) accessed 09.10.13

Health Equity

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

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

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.

Source: [Institute of Medicine's \(IOM\) Report, Health Professions Education: A Bridge to Quality](#) or <http://www.iom.edu/Reports/2003/health-professions-education-a-bridge-to-quality.aspx>

Local Public Health

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

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

Long-Term and Post-Acute Care (LTPAC)

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

Source: [U.S. Department of Health and Human Services, http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf](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](http://ajph.aphapublications.org/doi/ref/10.2105/AJPH.2013.301254), 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](http://www.academyhealth.org/files/AH2013pophealth.pdf). 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](#) or <https://www.apha.org/what-is-public-health> and [Local Public Health Association of Minnesota](#) or http://www.lpha-mn.org/FactSheets/MN_Local%20Public%20Health%20System_LPHAFacts.pdf

Social Services

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

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

Teamwork

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

Triple Aim

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

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

Appendix E: MDH Sample Grant Agreement

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 programs 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 determination by the State's Authorized Representative that the Grantee has not complied with the terms of the grant.

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

4. **Consideration and Payment**

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

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

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

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

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

OR

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

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

4.2 Terms of Payment

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

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

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

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

Authorized Representatives

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

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

7. Assignment, Amendments, Waiver and Merger

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

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

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

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

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

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

10. Government Data Practices and Data Disclosure

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

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

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

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

Option #1

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

Option #2:

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

12. Ownership of Materials and Intellectual Property Rights

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

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

12.2 Intellectual Property Rights: Grantee represents and warrants that materials produced or used under this grant agreement do not and will not infringe upon any intellectual property rights of another including but not limited to patents, copyrights, trade secrets, trade names and service marks and names. Grantee shall indemnify and defend the State, at Grantee's expense, from any action or claim brought against the State to the extent that it is based on a claim that all or parts of the materials infringe upon the intellectual property rights of another. Grantee shall be responsible for payment of any and all such claims, demands, obligations, liabilities, costs and damages including, but not limited to, reasonable attorney fees arising out of this grant agreement, amendments and supplements thereto, which are attributable to such claims or actions. If such a claim or action arises or in Grantee's or the State's

opinion is likely to arise, Grantee shall at the State's discretion either procure for the State the right or license to continue using the materials at issue or replace or modify the allegedly infringing materials. This remedy shall be in addition to and shall not be exclusive of other remedies provided by law.

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

14. Publicity and Endorsement

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

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

15. Termination

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

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

15.3 Termination for Insufficient Funding: The State may immediately terminate this agreement if it does not obtain funding from the Minnesota legislature or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the work scope covered in this agreement. Termination must be by written or facsimile notice to the Grantee. The State is not obligated to pay for any work performed after notice and effective date of the termination. However, the Grantee will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available. The State will not be assessed any penalty if this agreement is terminated because of the decision of the Minnesota legislature, or other funding source, not to appropriate funds. The State must provide the Grantee notice of the lack of funding within a reasonable time of the State receiving notice of the same.

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

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

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

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

17.1 Contractor Debarment, Suspension and Responsibility Certification

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

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

- (a)** Are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency;
- (b)** Have not within a three-year period preceding this contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;
- (c)** Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state of local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement or receiving stolen property; and
- (d)** Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this grant/contract are in violation of any of the certifications set forth above.

17.2 Audit Requirements to be Included in Grant Agreements with Sub recipients

- (a)** For sub recipients (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 sub recipients (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 sub recipients are also required to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

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

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

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

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

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

17.3 Drug-Free Workplace

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

17.4 Lobbying

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

17.5 Equal Employment Opportunity

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

17.6 Cost Principles

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

17.7 Rights to Inventions – Experimental, Developmental or Research Work

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

17.8 Clean Air Act

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

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

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

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

APPROVED: _____

1. Grantee 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: _____
Date: _____
By: _____
Title: _____
Date: _____

Title: _____
Date: _____

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

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 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

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/>

MDH Health Care Homes: Learning Collaborative website

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

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

Minnesota Department of Health Statewide Health Improvement Program Clinical-Community Linkages for Prevention Guide for Implementation FY2014-15

http://www.health.state.mn.us/healthreform/ship/2013rfp/docs/healthcare_SHIP_3.pdf

MN SIM website

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

Quality Improvement at MDH

PDSA: Plan-Do-Study-Act

<http://www.health.state.mn.us/divs/opi/qi/toolbox/pdsa.html>

Quality Improvement Template

<http://www.cdc.gov/nphsp/performanceimprovement.html>

Safety Net Medical Home Initiative

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

SIM ACH Resources / Literature Review

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

Standards: Performance reporting and quality improvement

Tools and Tips for Success - Resource Guide

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