Request for Proposals

Minnesota Accountable Health Model Practice Transformation Round Three Grant Program

September 1, 2015

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1. Overview

The Minnesota Department of Health (MDH) requests proposals for the Minnesota Accountable Health Model Practice Transformation [1] grant program. These grants will support organizations in the Behavioral Health Home First Implementers group to prepare for behavioral health home certification. The grant funding can only be used to support participation in practice transformation activities identified in the action plan developed in collaboration with the Behavioral Health Homes First Implementers Group. Activities may include:

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

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

2. Background

The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the Center for Medicare & Medicaid Innovation[2] and administered in partnership by the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH). The purpose of the Minnesota Accountable Health Model is to provide Minnesotans with better value in health care through integrated, accountable care using innovative payment and care delivery models that are responsive to local health needs. The funds will be used to help providers and communities work together to create healthier futures for Minnesotans, and drive health care reform in the State.

The vision of the Minnesota Accountable Health Model is:

- Every patient receives coordinated, patient-centered primary care.
- Providers are held accountable for the care provided to Medicaid enrollees and other populations, based on patient experience, patient health outcomes (population health), and cost performance measures.
- Financial incentives are fully aligned across payers and the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving
- Provider organizations effectively and sustainably partner and integrate with community organizations, engage consumers, and take responsibility for a population's health through accountable communities for health that integrate medical care, mental/chemical health, community health, public health, social services, schools and long term supports and services.

The Minnesota Accountable Health Model will test whether increasing the percentage of Medicaid enrollees and other populations (i.e. commercial, Medicare) in accountable care payment arrangements will improve

[1] Practice transformation, see attached glossary for definition of practice transformation, page 33.

[2] http://innovations.cms.gov

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[3].

The expanded focus will be on the development of integrated community service delivery models and use of coordinated care methods to integrate health care, behavioral health, long-term and post-acute care, local public health, and social services centered on patient needs. The model will also encourage addressing the non-clinical (social determinants) determinants of health at a community level.

To achieve the vision of shared cost and coordinated care, the Minnesota Accountable Health Model includes key investments in five drivers that are necessary for accountable care models to be successful.[4]

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

Driver-2 Providers have analytic tools to manage cost/risk and improve quality-Data Analytics.

Driver-3 Expanded numbers of patients are served by team-based integrated/coordinated care-Practice Transformation.

Driver-4 Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health-ACH.

Driver-5 ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations-Alignment.

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

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

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

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

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

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[5] is an interactive tool that allows organizations to answer questions to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and their status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve these goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress. For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit State Innovation Model Grant.[6]

3. Available Funding and Estimated Awards

A total of $390,000 is available for the grants to organizations that are participating in the behavioral health home first implementers group as recognized by the Minnesota Department of Human Services. The grant award range is up to $10,000 per grant, and up to 39 grants will be awarded during this funding cycle. Grants will be awarded for a six month period. A continuation of the grant period beyond six months with a no cost extension may be considered based on performance and needs identified, however, time extensions are not guaranteed.

MDH reserves the right to change the funding available for the current and future grant opportunities.

Funds may only be used to cover:
Practice transformation activities that support the action plan developed while participating in the first implementers group:

- Staff time and expenses for participating in the first implementers group.
- Staff time and expenses for making progress towards activities in the action plan developed with DHS vendor as a component of first implementers group.

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

[6] http://www.mn.gov/sim

4. Grant Timeline

RFP Activity	Date
RFP Posted	Tuesday, September 1, 2015
Informational webinar	Wednesday, September 9, 2015, 11:00am – 12:00 pm. CDT **To register for the Practice Transformation webinar visit:** https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=t0715641b8c59f485d0b2ef69c007a3f7 **Power point presentation will be emailed to participants and will be available:** http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_pt_round3# **Questions can be submitted on-line** https://survey.vovici.com/se.ashx?s=56206EE3587DF3AE
Proposals due to MDH	Thursday, October 15, 2015, 4:00 pm. CDT
Estimated notice of awards	November 16, 2015
Estimated grant start date	January 2016

5. Grant Applicants

The applicant for practice transformation grants must be an agency participating in the BHH first implementers group as recognized by the Minnesota Department of Human Services.

6. Goals and Outcomes

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

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

To successfully participate and achieve these goals and outcomes a grantee must complete a transformation project that supports the broad goals of the Minnesota Accountable Health Model related to preparing for behavioral health home certification. Recipients of this grant award must maintain ongoing participation in the first implementers group for the duration of the grant period.

7. Activities and Required Grant Elements

Types of project activities that could be funded include:

- Dedicated staff time and expenses for participation in the first implementers group
- Dedicated staff time and expenses for making progress towards the action plan developed with DHS vendor as a component of participation in the first implementers group.

- **Required Grant Elements -**Regardless of the activity identified, the applicant must include the following**:**

- First Implementer's Group Members.
- Work plan that includes the following deliverables:
    - Participation in the first implementers group.
    - Identify at least one project deliverable from the action plan developed in the first implementers group to be accomplished through practice transformation related to the BHH certification standards.
    - Process and outcome measures are required for all deliverables.

8. Review Process

Grant applicants must complete the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool, as part of the application process. This tool will help assess where applicants are moving towards greater accountability for quality, cost of care, and health of the populations served. The Continuum of Accountability Matrix Assessment Tool is required with the application; but is not considered in the grant review process.

The review panel will consist of staff from the Minnesota Department of Health and the Minnesota Department of Human Services. The panel will recommend selections to the Commissioners of Health and Human Services. In addition to panel recommendations, the commissioners may also take into account other relevant factors in making final awards, including 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, CDT, October 15, 2015, will be reviewed. Reviewers will determine which applications best meet the criteria as outlined in the RFP and make recommendations for funding. Grant award decisions are estimated to be made by November 16, 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 January 1, 2016, or the date upon which all signatures are obtained. Grant agreements will end June 30, 2016 or six months after the date the contract is fully executed. No work on grant activities can begin until a fully executed grant agreement is in place. (A sample grant agreement is located on page 43 in the Appendix).

9. Grant Application and Program Summary

Requirement	Description
Grant Applicant	To be eligible, the applicant organization must be **an agency or clinic participating in the BHH first implementers group as recognized by the Minnesota Department of Human Services**
Total Funds Available	$390,000 for this grant cycle.
Maximum Grant Amount	Up to 39 new grant awards for up to $10,000.
Duration of Funding	January 2016 through June 2016 or six months from contract execution date.
Grant Purpose	To provide resources to primary care clinics, behavioral health, and social service providers/organizations to facilitate provider-practice transformation in preparation for behavioral health home certification.
Application Requirements	• Applications must be written in a 12- point font with one inch margins. • Page limits are identified in Section 10, page 10. • All pages must be numbered consecutively. • Template forms must be used. If they are not used the application will not be accepted. Forms can be found on the Minnesota Accountable Health Model website. • http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_pt_round3# • Applicants must submit 7 copies of the proposal and an electronic version of the proposal on a USB drive. For the electronic copy include PDF and Word/Excel copies. Faxed or emailed applications will not be accepted. • Applications must meet application deadline requirements; late applications will not be reviewed. • An organization cannot submit more than one application per RFP grant cycle. • Applications must be complete and signed where noted. • Incomplete applications will not be considered for review.

Requirement	Description
Applicants must submit proposals in this order using forms provided in Word and Excel	1. Application Face Sheet (Form A) 2. Applicant Experience, Capacity, and Project Description (2 pages or less) (page 10) 3. Provider Application Form (Form B) (2 pages or less) 4. Work Plan and required deliverables (Form C) 5. Budget (Form D) 6. Budget Justification(Form E) 7. Continuum of Accountability Matrix Assessment (Form F)
Submitting the Proposal	Applicants must submit seven (7) copies of the proposal and an electronic proposal on a USB drive. For the electronic copy include PDF and Word/Excel copies. Proposals must be received by 4:00 p.m. CDT on Thursday, October 15, 2015.
Application Deadline	4:00 p.m. CDT October 15, 2015
Applications Sent	**Delivery Address:** Janet Howard Minnesota Department of Health Health Care Homes / SIM Unit 85 East 7th Place, Suite 220 Saint Paul, Minnesota 55101 **Mailing Address:** Janet Howard Minnesota Department of Health Health Care Homes / SIM Unit P.O. Box 64882 Saint Paul, Minnesota 55164-0882
Contact Information	Questions regarding this RFP must be submitted in writing by October 9, 2015 at https://survey.vovici.com/se.ashx?s=56206EE3587DF3AE through the State Innovation Model web site. 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_pt_round3#

10. Proposal Instructions

Required Elements:

Proposals for these grants must not exceed 4 pages of single-spaced 12-point type, this does not include forms to be included in the application. The 4 page limit includes the narrative sections of A and B.

A. Applicant Experience, Capacity and Project Description Narrative

Provide a brief summary, of the applicant's capacity and experience to complete the project, the type of provider you are, and the population you serve. Provide a brief description of the practice transformation focus and how it will support your efforts to become a Behavioral Health Home. Include the expected impact it will have on transforming your practice and the population you serve. (2 page limit)

A. Criteria for grant review: Applicant Experience, Capacity and Project Description Narrative(30 points)

- The applicant gives a clear picture of the history, structure, and capacity of the applicant agency to serve the identified population.
- The applicant provides a clear description of the proposed project and how it supports progress towards Behavioral Health Home certification.
- The applicant describes the impact on practice transformation and the population.
- The applicant has completed Minnesota Accountability Matrix Tool.

B. Provider Application for Practice Transformation Form B

- In the table below identify the members of your organization in the behavioral health home first implementers group and their role in the implementation of the practice transformation project. A project lead must be identified.
- Respond to the questions listed below. (2 page limit-does not include table)

Team Member Name	Team Role
	Project Lead

1. Describe how leadership, provider(s)/clinician(s), and administration are engaged in this project.

2. Describe the organization's goals to be achieved through this grant funding and how progress on meeting these goals will be measured.

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

- The applicant identifies the team members and clearly describes their role in project implementation and completion of the project.
- The applicant demonstrates a commitment of the leadership, the provider(s)/clinician(s) and administration to the project.
- The applicant clearly defines the goals and objectives of the project and the measurements to be used.

C. Work Plan and Deliverables Form C

Instructions: Complete the Work Plan Template. Include the grant elements, objectives, activities, timeline, tracking methods, measures, and deliverables or outcomes for the six month grant period**. Include process and outcome measures for each deliverable. (Use Form C on the RFP website**). The deliverables **must** include participation in the learning activities of the first implementers group and align with the action plan. Using the action plan developed in the first implementers group identify at least one action item to be accomplished through the practice transformation project directly related to the BHH certification standards. Key deliverables in Form C will be required to correspond to deliverables in Section 2 Deliverables (outcomes) of the Practice Transformation Budget Template-Form D. Form C Work Plan and Practice Transformation Budget Template will be the attachments in the grant contract and the documents used to monitor ongoing grant deliverables.

Deliverable: Participation in the First Implementers Group.					
OBJECTIVES	**ACTIVITIES and Names of Persons Responsible**	**TIMELINES (January 2016-June 2016)**	**TRACKING METHODS**	**MEASURES**	**OUTCOMES**

Deliverable: *Act*ion Plan Implementation (Select at least one action item to accomplish through this grant).					
OBJECTIVES	**ACTIVITIES**	**TIMELINES (January 2016—June 2016)**	**TRACKING METHODS**	**MEASURES**	**OUTCOMES**

C. Criteria for grant review: Work plan and deliverables: (30 points)

- The objectives for the project are clearly defined, realistic, and measurable within the work plan.
- The activities will enhance practice transformation in preparation for becoming a behavioral health home.
- The work plan has clear measures and outcomes tied to each deliverable.
- The applicant includes the key deliverables:
  - plan for participation in the first implementers group
  - at least one action item from the action plan developed in the first implementers group to be accomplished related to the BHH certification standards.
- Description of the work plan deliverables are supported by the proposed activities and are achievable.

D. Practice Transformation Budget Templates Form D and Form E

Budget Forms:

- **Practice Transformation Budget Template -Form D**
- **Budget Justification Narrative Template- Form E**

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

Include a budget for six months January 1, 2016-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 travel, and other allowable costs.

Ineligible Expenses:

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

Indirect Costs:

Indirect costs are not allowed in this proposal.

In-Kind:

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

Budget Template Section One:

The budget form includes two sections and must be completed for the six month grant period, January 1, 2016-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, the hourly rate, and the number of hours allocated to this project.

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

B. Fringe:

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

C. Consultant Cost:

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

D. Equipment:

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

E. Supplies:

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

- Include expected travel costs for hotels and meals for each trip and number of staff.
- 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.
    - As part of a per diem or subsistence allowance provided in conjunction with allowable travel *See HHS GPS Section II-42.*
- **Expense Reimbursement:** Generally speaking, members, clients, patients cannot be paid stipends, incentives, or be provided with food. 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.
- **Team Participation**: Allowable in accordance with applicable program proposal:
    - Reasonable and actual out-of-pocket costs incurred solely as a result of attending an approved scheduled meeting, including transportation, meals, babysitting fees, and lost wages for community partners without other sources of reimbursement as described in your budget narrative.

Section Two: Budget Deliverables:

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

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

- Participation in the first implementers group.
- Identification of at least one project deliverable that aligns with the action plan developed in the first implementers group that you will accomplish through practice transformation related to the BHH certification standards.

Budget Justification Narrative Template- Form E

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

Instructions: Provide a narrative justification where requested. The narrative justification must include a description of the funds requested and how their use will support the proposal. **See page 31 for specific instructions.**

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

- The Budget Form and Budget Justification Narrative are complete.
- The amounts on the Budget Form match what is in the Budget Justification Narrative.
- The information in the Budget Justification Narrative is consistent with what is proposed in the work plan.
- The projected costs are reasonable and sufficient to accomplish the proposed activity.

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

The Minnesota Accountable Health Model Practice Transformation applicant will be required to submit a completed **Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool** (http://www.health.state.mn.us/e-health/mahmassessmenttool.docx). This is an interactive tool that allows organizations to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and their status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve the goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress. (See Section 13-Page 20 for instructions on how to complete the form).

11. Grant Participation Requirements

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

Funded applicants will be required to:

- Submit and share copies of all tools, resources, documents, and other guidance.
- Submit written narrative progress report quarterly using a MDH template by April 30, 2016, and final report, July 31, 2016.
- Submit expenditure reports and invoices for the grant period at the end of the first quarter of activity, and a final report 30 days after the end of the six month contract period.
- Participate in conference calls or meetings as necessary to report on progress, barriers or lessons learned.
- Collaborate with any other contractors, grantees, or partners associated with the Minnesota Accountable Health Model as appropriate.

Contract requirements include:

- A final work plan and budget, if requested, to MDH.
- Three copies of grant agreement with original signature returned to MDH for final signature.
- Upon receipt of fully executed grant agreement, begin work. ***Note: Grantees cannot be reimbursed for work completed before the grant agreement is fully executed.***
- Completion of required deliverables and activities as outlined in grant agreement.
- Additional details that may be requested to comply with state and federal reporting requirements.
- Final 10 percent of the total grant award will be withheld until grant duties are completed.

12. Proposal Evaluation

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

Criteria	**Maximum Points**
Applicant Experience and Capacity	30 points
Provider application	25 points
Project Proposal/work plan	30 points
Budget	15 points
Total	**100 Points**

13. Required Forms

Below is a listing of forms required for the proposal submission of a Practice Transformation grant 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.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_pt_round3#

Form A: Application Face Sheet with Instructions

Form B: SIM Provider Application Form

Form C: Project Work Plan Form

Form D: Practice Transformation Budget Template

Form E: Budget Justification Narrative

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

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

Form A: Application Face Sheet

Practice Transformation

1.	**Legal name and address of the applicant agency with which grant agreement would be executed:** **Name:** **Address:**	
2.	**Is the organization a member of the Behavior Health Homes 1st Implementers Group? Yes No**	
3.	**Minnesota Tax I.D. Number**	
4.	**Federal Tax I.D. Number**	
5.	**Requested funding for the total grant period**	$
6.	**Director of applicant agency**	
	Name, Title and Address	Email Address:
		Telephone Number: ( )
		FAX Number: ()
7.	**Fiscal management officer of applicant agency**	
	Name, Title and Address	Email Address:
		Telephone Number: ( )
		FAX Number: ()
8.	**Operating agency** (if different from number 1 above)	
	Name, Title and Address	Email Address:
		Telephone Number: ( )
		FAX Number: ()
9.	**Contact person for applicant agency** (if different from number 4 above)	
	Name, Title and Address	Email Address:
		Telephone Number: ( )
		FAX Number: ()
10.	**Contact person for further information on grant application**	
	Name, Title Address	Email Address:
		Telephone Number: ( )
		FAX Number: ()
11.	**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. **Behavioral Health Home First Implementer**

3. **Applicant agency's Minnesota Tax I.D. number**

4. **Applicant agency's Federal Tax I.D. number**

5. **Requested funding for the total grant period**
   Amount the applicant agency is requesting in grant funding for the grant period. The grant period will be from January 1, 2016 - June 30, 2016 or six months from the date the contract is executed. The grantee must submit a budget for the six month period: January 1, 2016-June 30, 2016.

6. **Director of the applicant agency**
   Person responsible for direction at the applicant agency.

7. **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.

8. **Operating agency**
   Complete only if other than the applicant agency listed in 1 above.

9. **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.

10. **Contact person for further information**
    Person who may be contacted for detailed information concerning the application or the proposed program.

11. **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: Provider Application for Practice Transformation

- In the table below identify the members of your behavioral health home first implementers group and their role in the practice transformation project. A project lead must be identified.
- Respond to the questions listed below. (2 page limit-does not include table)

Team Member Name	Team Role
	Project Lead (Required)

1. Describe how leadership, provider(s)/clinicians, and administration are engaged in this project.

2. Describe the organization's goals to be achieved through this grant funding and how progress on meeting these goals will be measured.

Form C: Work Plan

- **Instructions:** Complete the Work Plan Template. Include the grant elements, objectives, activities, timeline, tracking methods, measures, and deliverables or outcomes for the six month grant period**. Include process and outcome measures for each deliverable. (Use Form C on the RFP website**). The deliverables **must** include participation in the learning activities of the first implementers group, and align with the action plan. Using the action plan developed in the first implementers group identify at least one action item to be accomplished through the practice transformation project directly related to the BHH certification standards. Key deliverables in Form C will be required to correspond to deliverables in Section 2 Deliverables (outcomes) of the Practice Transformation Budget Template-Form D. Form C Work Plan and Practice Transformation Budget Template will be the attachments in the grant contract and the documents used to monitor ongoing grant deliverables.

Deliverable: Participation in the First Implementers Group					
OBJECTIVES	**ACTIVITIES**	**TIMELINES (January 2016- June 2016)**	**TRACKING METHODS**	**MEASURES**	**OUTCOMES**

Deliverable: Action Plan Implementation (Select at least one action item to accomplish through this grant).					
OBJECTIVES	**ACTIVITIES**	**TIMELINES (January 2016-June 2016)**	**TRACKING METHODS**	**MEASURES**	**OUTCOMES**

Form D. Practice Transformation Budget Template

Applicant:

Total Contract Period: January 2016 – June 30, 2016

Budget Form Instructions for Practice Transformation Applicants:

1. Complete a budget for the grant period Include costs for the grant recipient in Salaries & Wages, Fringe, supplies, Travel, and Other categories.
2. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group facilitation, or consultation.) **in C. Consultant Costs.**
3. Enter information in cells highlighted in blue as applicable for your project.

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

Section One

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

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

C. CONSULTANT COSTS: Provide the following information for consultants/contractors: name of contractor or organization, hourly rate, number of hours, services to be provided. **In Form 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, 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 meetings. Include the estimated number of miles planned for project activities and the rate of reimbursement per mile. Out of state travel is not an eligible expense. Travel costs are not to exceed rates established in the Commissioner's Plan at http://www.mmd.admin.state.mn.us/commissionersplan.htm	
Item	**Total Cost**
Total Travel Costs:	**$**

G. OTHER: If applicable, list items not included in previous budget categories below. Include a detailed description of the proposed expenditures in Form E Budget Justification Narrative. Consult budget instructions under D pages 15- 17 of the RFP 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: Participation in behavioral health home first implementers group	**Avg by Hour**	**Estimated Hrs**	**Billable Amt**
			$
			$
TOTAL			**$**

Deliverable: Making progress towards the activities in the action plan developed with the DHS vendor as a component of the first implementers group.	**Avg by Hour**	**Estimated Hrs**	**Billable Amt**
			$
			$
TOTAL			**$**

GRAND PROJECT TOTAL	**$**

Form E: Budget Justification Narrative

The Budget Narrative provides additional information to justify costs in Form D Budget.
Instructions: Provide a narrative justification where requested. The narrative justification must include a description of the funds requested and how their use will support the proposal.

A. Salaries and Wages This should include all personnel whose work is tied to the proposal.
Narrative Justification *(enter a brief description of the roles, responsibilities, and unique qualifications of each position):*

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****):*

D. Supplies Describe costs related to each type of supply, either in Budget Form D or below.
Narrative Justification (*enter a description of the supplies requested and how their purchase will support the purpose and goals of this proposal*):

E. Travel Travel may include costs associated with travel for meetings, community engagement, and other items included in the work plan.
Narrative Justification (*describe the purpose and need of travel and how costs were determined for each line item in the budget):*

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

14. Appendixes

Appendix A: Minnesota Accountable Health Model Glossary

Appendix B: Resources

Appendix C: MDH Sample Contract

Accountable Care

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

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

Accountable Care Organizations (ACOs)

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

Source: Robert Wood Johnson Foundation Accountable Care Organizations or http://www.rwjf.org/en/library/research/2011/12/what-are-accountable-care-organizations-and-how-could-they-impro.html

Behavioral Health

The term "behavioral health" is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, and substance use disorders, mental illness, and/or mental disorders. Behavioral health includes the identification, treatment of, and recovery from mental health and substance use disorders. It also increasingly refers to lifestyle changes and actions which improve physical and emotional health, as well as the reduction or elimination of behaviors which create health risks.
Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

Behavioral Health Homes

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

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

Providers that wish to become a behavioral health home must meet federal and Minnesota state requirements and certification standards, currently under development.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177945

Care Coordination

Care coordination is a function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. The goal of coordination is to ensure that patients' needs and preferences are achieved and that care is efficient and of high quality. Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.
Source: U.S. Department of Health and Human Services, www.ncvhs.hhs.gov/091013p9.pdf

Care Coordinator

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

Care Manager

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

Care Plan

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

Community-based Prevention/Community-based Interventions/Community-based Programs are terms used interchangeably to refer to programs or policies within a community that seek to improve the health of a population by addressing non-medical factors, or social determinants of health. Such programs often include the application of non-clinical preventive methods in non-traditional health care settings by non-clinical providers.
Source: Financing Prevention: How states are balancing delivery system & public health roles
http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf
accessed 07.23.2014

Community Care Team is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations to provide citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services.
Source: MN Department of Health Request for Proposals, Health Care Homes: Community Care Team Grants April 15, 2011 https://www.statereforum.org/system/files/hchcareteamsrfp.pdf accessed 07/24/2014

Community Engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (Fawcett et al., 1995) http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

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

Continuum of care

The continuum of care is the full array of services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health and well-being of a population.
Source: Adapted from Alaska Health Care Commission (http://dhss.alaska.gov/ahcc/Documents/definitions.pdf)

Data Analytics

Data analytics is the systematic use of data and related business insights to drive fact-based decision making for planning, management, measurement and learning. Analytics may be descriptive, predictive or prescriptive.
Source: IBM Institute for Business Value Healthcare: The value of analytics in healthcare (http://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf)

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 or http://www.healthit.gov/providers-professionals/faqs/what-electronic-health-record-ehr

Emerging Health Professionals

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

Health Care Home

A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.
Source: Minnesota Department of Health Health Care Homes (aka Medical Homes) www.health.state.mn.us/healthreform/homes/ accessed 09.10.13

Health Equity

Exists when every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.
Source: in Minnesota: Report to the Legislature (http://www.health.state.mn.us/divs/chs/healthequity/) Minnesota Department of Health, accessed 07.30.14

Health Information Exchange (HIE)

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

Health Information Technology (HIT)

HIT is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
Source: Office of the National Coordinator for HIT Glossary (http://www.healthit.gov/policy-researchers-implementers/glossary) accessed 09.10.13

Integrated care

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

Interprofessional Team

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

Local Public Health

In Minnesota, local public health services are provided through Community Health Boards, which have statutory responsibilities for public health (MN Stat. Chapter 145A), and by Tribal Governments, which are sovereign nations. Local public health responsibilities include prevention and control of communicable disease; protection from environmental health hazards; promoting healthy communities and healthy behaviors (including maternal and child health); preparing for and responding to public health emergencies; and assessing, and sometimes addressing gaps in health services. Local public health professionals carry out these activities in collaboration with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate high quality, non-duplicative programs.
Source: Adapted from Minnesota Department of Health, Local Public Health Act (http://www.health.state.mn.us/divs/cfh/lph/) accessed 2.19.14

Long-Term and Post-Acute Care (LTPAC)

Long Term and Post-Acute Care is characterized by a variety of settings, from complex care in long-term acute-care hospitals to supportive services in the community or home-based care. Typical services include rehabilitation, medical management, skilled nursing services, and assistance with activities of daily living due physical and/or cognitive impairments. Common types of LTPAC providers include but are not limited to: nursing facilities or skilled nursing facilities; home health agencies; hospice providers; inpatient rehabilitation facilities (IRFS); long-term acute care hospitals; assisted living facilities; continuing care retirement communities; home and community-based services; and adult day service providers.
Source: U.S. Department of Health and Human Services, http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf, accessed 01.12.14

Patient and Family Centered Care

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

Population Health

An aim to optimize the health and well-being of an entire community and reduce inequalities in health and well-being between population groups. A "community" may be either geographic regions and/or groups of people who share attributes (e.g., elderly, minorities, employees, disabled persons, students). Population health requires collaboration across all sectors of a community to address factors such as public infrastructure, the environment, education systems, social supports, and the health care system, in order to address all social determinants of health. Population health within an accountable care organization requires collaboration between all health care providers in the community, social support services within the community, and local public health.
Adapted from: K Hacker, DK Walker. Achieving Population Health in Accountable Care Organizations, Am J Public Health. 2013; 103(7):1163-1167.
http://ajph.aphapublications.org/doi/ref/10.2105/AJPH.2013.301254 ; D Kindig, G Stoddart. What is population health? Am J Public Health. 2003; 93(3):380–383; and M Stoto. Population Health in the Affordable Care Act Era. Academy Health, February 2013.
http://www.academyhealth.org/files/AH2013pophealth.pdf

Practice Facilitation

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

Practice Transformation

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

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

- Intentional approach of practices to maximize the systematic engagement of patients and families
- Systematic efforts to reduce un-necessary diagnostic testing and procedures with little or no benefit.

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

Provider

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

Public Health

Public health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries. Public health also entails policy development and health surveillance. Public health professionals rely on policy and research strategies to understand issues such as infant mortality and chronic disease in particular populations. In Minnesota, Local public health departments partner with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate programs.
Source: American Public Health Association, http://www.apha.org/what-is-public-health Local Public Health Association of Minnesota, http://www.lpha-mn.org/FactSheets/MN_Local%20Public%20Health%20System_LPHAFacts.pdf

Quality improvement (QI)

Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The Institute of Medicine's (IOM) which is a recognized leader and advisor on improving the Nation's health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations
(1) http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

Social Services

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

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.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx) accessed 09.10.201

Appendix B: Resources

Behavioral Health

Web link for Behavioral Health Home:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177945

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

Primary Care

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

Social Needs

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

Clinician Champions

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

Care Coordination (Health Care Home Care Coordination Toolkit)

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

Additional resources: Fundamentals of Care Coordination within the Medical Home

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

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

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

MDH Sample Contract
Standard Grant Template Version 1.4, 6/14
Grant Agreement Number _____
Between the Minnesota Department of Health and *Insert Grantee's Name*

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

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

Minnesota Department of Health
Grant Agreement

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

Recitals

1. Under Minnesota Statutes 144.0742 and *Insert the program's specific statutory authority to enter into the grant*,
   the State is empowered to enter into this grant agreement.

2. The State is in need of *Add 1-2 sentences describing the overall purpose of the grant*.

3. The Grantee represents that it is duly qualified and will perform all the duties described in this agreement to the satisfaction of the State. Pursuant to Minnesota Statutes section 16B.98, subdivision 1, the Grantee agrees to minimize administrative costs as a condition of this grant.

Grant Agreement

1. Term of Agreement

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

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

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

2. ***Grantee's Duties*** The Grantee, who is not a state employee, shall: *Attach additional pages if needed, using the following language*, "complete to the satisfaction of the State all of the duties set forth in Exhibit A, which is attached and incorporated into this agreement."

3. Time The Grantee must comply with all the time requirements described in this grant agreement. In the performance of this grant agreement, time is of the essence, and failure to meet a deadline may be a basis

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

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

4. *Consideration and Payment*

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

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

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

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

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

OR

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

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

4.2 Terms of Payment

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

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

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

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

Authorized Representatives

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

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

7. Assignment, Amendments, Waiver, and Merger

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

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

7.3 Waiver If the State fails to enforce any provision of this agreement, that failure does not waive the provision or the State's right to enforce it.
7.4 Merger This agreement contains all the negotiations and agreements between the State and the Grantee. No other understanding regarding this agreement, whether written or oral, may be used to bind either party.

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

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

10. Government Data Practices and Data Disclosure

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

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

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

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

Option #1

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

Option #2:

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

12. Ownership of Materials and Intellectual Property Rights

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

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

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

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

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

14. Publicity and Endorsement

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

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

15. Termination

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

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

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

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

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

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

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

17.1 Contractor Debarment, Suspension and Responsibility Certification

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

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

(a) Are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency;

(b) Have not within a three-year period preceding this contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

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

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

17.2 Audit Requirements to be Included in Grant Agreements with Subrecipients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17.3 Drug-Free Workplace

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

17.4 Lobbying

The Grantee agrees to comply with the provisions of Untied 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

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

1. Grantee

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

By: _____
(with delegated authority)
Title: _____
Date: _____
By: _____
Title: _____
Date: _____

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

2. State Agency

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

By: _____

Title: _____
Date: _____

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.