



## **Request for Proposals**

*Minnesota Accountable Health Model  
e-Health Grant Program*

February 24, 2014

# TABLE OF CONTENTS

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|   |              |
|---|--------------|
| <b>General Information</b>  | <b>2-9</b>   |
| 1. Overview   | 2            |
| 2. Estimated grant awards and matching funds requirement  | 2            |
| 3. Grant timeline   | 2            |
| 4. Background   | 3-6          |
| 5. Goals and outcomes   | 7            |
| 6. Resources  | 8-9          |
| <br>  |              |
| <b>Eligibility and Review</b>   | <b>10-19</b> |
| 7. Eligible Applicants  | 10           |
| 8. Development Grants: Eligible Activities and Required Deliverables                                  | 11-12        |
| 9. Implementation Grants: Eligible Activities and Required Deliverables                               | 13-17        |
| 10. Proposal filing requirements  | 18           |
| 11. Contact information   | 18           |
| 12. Proposal review process   | 19           |
| <br>  |              |
| <b>Proposal Instructions</b>  | <b>20-29</b> |
| 13. Development grants  | 20-24        |
| 14. Implementation grants   | 25-29        |
| <br>  |              |
| <b>Appendices</b>   | <b>30-62</b> |
| Appendix A: Glossary  | 30-35        |
| Appendix B: Minnesota Accountable Health Model:<br>Continuum of Accountability Matrix Assessment Tool | 36-58        |
| Appendix C: Criteria for scoring grant proposals  | 59-60        |
| Appendix D: Use case template   | 61-62        |
| <br>  |              |
| <b>Attachments</b>  | <b>63-67</b> |
| Proposal Cover Form   | 64           |
| Suggested Budget Form   | 65           |
| Grant Proposal Checklist  | 66           |
| Accounting System and Financial Capability Questionnaire  | 67           |

## 1. Overview

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The Minnesota Department of Health (MDH) requests proposals for the Minnesota Accountable Health Model e-Health Grant Program. The grants are intended to support readiness to advance the Minnesota Accountable Health Model and to prepare for potential participation in accountable communities for health. This grant opportunity will provide funding to Community Collaboratives to advance the Minnesota Accountable Health Model through:

- Developing a plan to meet e-health requirements
- Implementing and expanding e-health capabilities

The Minnesota Accountable Health Model e-Health Grant Program will leverage the work of the Minnesota e-Health Initiative and will support:

- Readiness and participation in the [Minnesota Accountable Health Model](http://www.mn.gov/sim/) (<http://www.mn.gov/sim/>) and
- Achievement of the Triple Aim which includes: 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: [The Institute for Healthcare Improvement Triple Aim for Populations](http://www.ihl.org/explore/tripleaim/pages/default.aspx) (<http://www.ihl.org/explore/tripleaim/pages/default.aspx>).

## 2. Available Funding and Estimated Awards:

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**2014:** Up to \$4 million available for the following:

- Development (12-month projects): Up to \$75,000 per grant (estimated 3-5 grants)
- Implementation (12-18 month projects): Up to \$1,000,000 per grant (estimated 3-5 grants)

**2015:** Up to \$2 million available for implementation grants only

### Matching Funds Requirement

A 20 percent match is required. Match may be in the form of cash or in-kind services.

*The Minnesota Department of Health and Minnesota Department of Human Services reserves the right to award more than \$4 million in 2014 and decrease the amount available in 2015.*

## 3. Grant Timeline

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|  |  |
|--|--|
| RFP posted:  | Monday, February 24, 2014  |
| RFP informational call:                              | Wednesday, March 12, 2014<br>10:00 a.m. – 12:00 p.m. CST <ul style="list-style-type: none"><li>• Call-in number: 1-888-742-5095</li><li>• Passcode: 4477200226</li></ul> |
| Non-binding Letters of Intent to Respond due to MDH: | Thursday, March 27, 2014, 4:00 p.m. CST  |
| Proposals due to MDH:                                | Monday, May 5, 2014, 4:00 p.m. CST   |
| Estimated notice of awards:                          | June 9, 2014   |
| Estimated grant start date range:                    | July 1, 2014 – October 1, 2014   |
| Estimated grant end date range:                      | June 30, 2015 – December 31, 2015  |

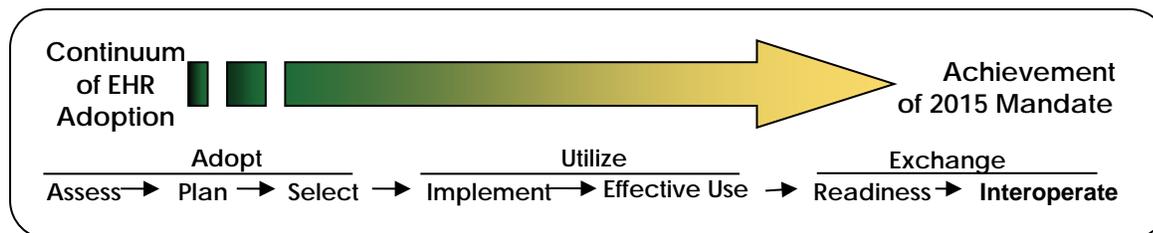
## 4. Background

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange (HIE) to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.

Minnesota has been a leader in e-health through the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) (<http://www.health.state.mn.us/e-health/abouthome.html>). Established in 2004, the Initiative was established as a public-private collaboration to pursue strong policies and practices to accelerate e-health with a focus on achieving interoperability (the ability to share information seamlessly) across the continuum of care. Policy makers in Minnesota have recognized that more effective use of health information technology – including timely exchange of information – is needed to improve quality and safety of care, as well as to help control costs. Toward that end, Minnesota enacted legislation in 2007 that requires all health and health care providers in the state to implement an interoperable electronic EHR system by January 1, 2015. [Minn. Stat. §62J.495](https://www.revisor.mn.gov/statutes/?id=62j.495) (<https://www.revisor.mn.gov/statutes/?id=62j.495>)

In order to help providers achieve the 2015 interoperable EHR mandate, the Initiative developed the Minnesota Model for Adopting Interoperable EHRs (Figure 1) in 2008 to outline seven practical steps leading up to and including EHR interoperability. This model groups each of the steps into three major categories that apply to all aspects of the Initiative’s work and policy development.

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



In recent years, federal funding has supported Minnesota’s e-health efforts and contributed to high rates of EHR adoption and growing rates of effective use and health information exchange (see [Minnesota e-Health Assessment Reports, Factsheets and Briefs](http://www.health.state.mn.us/e-health/assessment.html#brief) (<http://www.health.state.mn.us/e-health/assessment.html#brief>). However, this support ends in 2014, and e-health challenges and disparities still exist in settings such as long-term and post-acute care, local public health, behavioral health, social services, and other settings. In addition, there is a need for e-health technical assistance and education in the areas such as privacy and security, standards and interoperability, and health information exchange sustainability.

The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the [Center for Medicare & Medicaid Innovation](http://innovations.cms.gov) (<http://innovations.cms.gov>) to the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH) in 2013. The purpose of the SIM-Minnesota project is to provide Minnesotans with better value in health care through integrated, accountable care using innovative payment and care delivery models that are responsive to local health needs. The funds will be used to help providers and communities work together to create healthier futures for Minnesotans, and drive health care reform in the state.

The vision of the Minnesota Accountable Health Model is:

- Every patient receives coordinated, patient-centered primary care.

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

The Minnesota Accountable Health Model will test whether increasing the percentage of Medicaid enrollees and other populations in accountable care payment arrangements will improve the health of communities and lower costs of health care delivery. To accomplish this, the state will expand the [Integrated Health Partnerships \(IHP\)](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441) demonstration, formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services. ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_161441](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441))

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

To achieve the vision of shared cost and coordinated care, the Minnesota Accountable Health Model includes key investments in drivers that are necessary for accountable care models to be successful. E-health is one of these areas of investment. The e-health driver outlines foundational requirements for health information technology, stating that “providers will have the ability to exchange clinical data in a secure manner for treatment, care coordination, quality improvement and population health,” acknowledging that investments to achieve this driver include:

- Providing funding, technical assistance and other resources to increase engagement in secure health information exchange.
- Developing roadmaps for the exchange of health information in new settings and providing tools/resources to promote EHR adoption and effective use.

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. The [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) is designed to illustrate the basic capabilities, relationships, and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It will help the state to 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](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) is an interactive tool that allows organizations to answer questions to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to

achieve the goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress.

In the Assessment Tool, the terms ‘organization’ and ‘provider’ are meant to include a broad range of health and health care providers and support services providers that may or may not formally be part of an existing ACO, but that are moving towards greater accountability for quality, cost of care and health of the populations they serve. Many types of organizations, including not only providers of medical care but also organizations that operate in the behavioral health, social services, local public health, long term care/post-acute care settings, community organizations, and other public/private sector partners that provide supportive services to individuals and families, can all have a role in convening, leading or participating in these models.

The Minnesota Accountable Health Model will further test and evaluate whether investments in e-health, data analytics used for population health, and HIE can be used to accelerate the movement of health care providers and organizations to shared cost, shared savings or Total Cost of Care (TCOC) arrangements. In addition, these investments build upon and align with the vision of the Minnesota e-Health Initiative to accelerate the adoption and use of HIT in order to improve health care quality, increase patient safety, reduce health care costs and improve public health. Built on the 2015 Interoperable Electronic Health Record (EHR) Mandate, these e-health investments can move all providers to adopt and use e-health to support participation in the Minnesota Accountable Health Model.

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

The Minnesota Department of Health will be releasing three e-health RPFs for the SIM funding:

1. Minnesota e-Health Roadmaps to Advance the Minnesota Accountable Health Model.
2. Minnesota Accountable Health Model e-Health Grant Program.
3. Minnesota Technical Assistance and Education: Privacy, Security and Consent Management.

This RFP is for the ***Minnesota Accountable Health Model e-Health Grant Program***.

## 5. Goals and Outcomes

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The specific goal of this grant program is to support the secure exchange of medical or health-related information (see table below) between organizations participating in, or preparing to participate in, accountable care models so that it occurs in a more seamless/real time way across settings (clinic/hospital/long-term and post-acute care/behavioral health/local public health/ social services), for the purpose of more effectively identifying opportunities for improvement and coordination, to improve health and health care.

### **Examples of medical information needed by health care providers**

- Medication history and current medications
- Lab result information
- Current problem lists and diagnoses
- Immunization history and immunization forecasting
- Care/treatment plans
- Past hospitalizations
- History of psychiatric/ chemical health treatment
- Allergies

### **Examples of non-medical health-related information desired by health care providers**

- Patient information adjusted to demographic data (e.g., income, education, race, language, immigrant or refugee status, neighborhood or zip code)
- Social supports (e.g., whether the patient has unstable housing or is homeless, use of food support or cash assistance, transportation needs)
- Information on all providers who are treating the patient
- Patient goals for their health
- Health care quality indicators by socioeconomic factors such as: race, language and/or ethnicity, insurance status, gender
- Current or upcoming stressors
- Spiritual or cultural values

## 6. Resources

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

1. [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) ( <http://www.health.state.mn.us/e-health/abouthome.html>)
2. [Minnesota e-Health Advisory Committee](http://www.health.state.mn.us/e-health/advcommittee/index.html) (<http://www.health.state.mn.us/e-health/advcommittee/index.html>) and [Minnesota e-Health Workgroups](http://www.health.state.mn.us/e-health/wgshome.html) (<http://www.health.state.mn.us/e-health/wgshome.html>)
3. [Minnesota e-Health Assessment Reports, Factsheets and Briefs](http://www.health.state.mn.us/e-health/assessment.html) (<http://www.health.state.mn.us/e-health/assessment.html>)
4. [EHR/HIT toolkits](http://www.stratishealth.org/expertise/healthit/index.html) (<http://www.stratishealth.org/expertise/healthit/index.html>)
5. [Health Information Technology and Infrastructure \(2015 Interoperable Electronic Health Record Mandate\)](https://www.revisor.mn.gov/statutes/?id=62J.495) (<https://www.revisor.mn.gov/statutes/?id=62J.495>) and [MDH's Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate](http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf) (<http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf>)
6. [Electronic Prescription Drug Program](https://www.revisor.mn.gov/statutes/?id=62J.497) (<https://www.revisor.mn.gov/statutes/?id=62J.497>) and [MDH's Guidance for Understanding the 2011 e-Prescribing Mandate](http://www.health.state.mn.us/e-health/eprescribing/erx032011guidance.pdf) (<http://www.health.state.mn.us/e-health/eprescribing/erx032011guidance.pdf>)
7. [Health Information Exchange Oversight](https://www.revisor.mn.gov/statutes/?id=62J.498) (<https://www.revisor.mn.gov/statutes/?id=62J.498>) [Health Information Exchange \(HIE\) Oversight: Overview of Minnesota Law](http://www.health.state.mn.us/divs/hpsc/ohit/hieoversightlaw.pdf) (<http://www.health.state.mn.us/divs/hpsc/ohit/hieoversightlaw.pdf>)
8. ONC Beacon Program findings, including those from the Southeast Minnesota Beacon Program:
  - [Southeast Minnesota Beacon Program](http://semnbeacon.wordpress.com) ( <http://semnbeacon.wordpress.com>)
  - [Driving Clinical Transformation in a Practice Setting with Health Information Technology- A Learning Guide](http://www.healthit.gov/sites/default/files/onc-beacon-lg5-enabling-community-level-hie.pdf) (<http://www.healthit.gov/sites/default/files/onc-beacon-lg5-enabling-community-level-hie.pdf>)
  - [Enabling Health Information Exchange to Support Community Goals- A Learning Guide](http://www.healthit.gov/sites/default/files/onc-beacon-lg4-clinical-transformation-via-hit.pdf) (<http://www.healthit.gov/sites/default/files/onc-beacon-lg4-clinical-transformation-via-hit.pdf>)
9. [Regional Extension Center for Health IT- REACH](http://www.khareach.org/) (<http://www.khareach.org/>)
10. [Substance Abuse Mental Health Services Administration](http://www.samhsa.gov/healthIT/) (<http://www.samhsa.gov/healthIT/>)
11. [Minnesota Health Records Act](https://www.revisor.mn.gov/statutes/?id=144.291) (<https://www.revisor.mn.gov/statutes/?id=144.291>) and [MDH's Health Records Act Fact Sheet](http://www.health.state.mn.us/e-health/mpsp/hrfactsheet2007.pdf) (<http://www.health.state.mn.us/e-health/mpsp/hrfactsheet2007.pdf>)
12. [Minnesota Health Records Access Study legislative report](http://www.health.state.mn.us/e-health/hras/hras2012.html) (<http://www.health.state.mn.us/e-health/hras/hras2012.html>)

13. [Uniform Electronic Transactions & Implementation Guide Standards](https://www.revisor.mn.gov/statutes/?id=62J.536) (https://www.revisor.mn.gov/statutes/?id=62J.536) Minnesota's requirements for the standard, electronic exchange of health care administrative transactions)
14. [MDH's Health Care Administrative Simplification resources](http://www.health.state.mn.us/asa/index.html) (http://www.health.state.mn.us/asa/index.html).
15. [Health Information Technology for Economic and Clinical Health \(HITECH\) Act](http://www.healthit.gov/policy-researchers-implementers/hitech-act-0) (http://www.healthit.gov/policy-researchers-implementers/hitech-act-0)
16. [Administrative Data Standards and Related Requirements](http://www.ecfr.gov/cgi-bin/text-idx?SID=2e7dc674e5f28683aab627ae1e1e7b31&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1_02.tpl) (http://www.ecfr.gov/cgi-bin/text-idx?SID=2e7dc674e5f28683aab627ae1e1e7b31&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1\_02.tpl) HIPAA administrative simplification and privacy and security rules- see Subchapter C
17. [Health Information Exchange Governance](http://www.healthit.gov/policy-researchers-implementers/health-information-exchange-governance) (http://www.healthit.gov/policy-researchers-implementers/health-information-exchange-governance) resources from the National eHealth Collaborative.
18. [Resources for Implementing the Community Health Needs Assessment Process](http://www.cdc.gov/policy/chna/) (http://www.cdc.gov/policy/chna/)
19. [Minnesota State-Certified Health Information Exchange Service Providers](http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) (http://www.health.state.mn.us/divs/hpsc/ohit/certified.html)
20. [Office of National Coordinator for Health IT \(ONC\), Standards and Interoperability \(S&I\) Framework](http://wiki.siframework.org/CET+-+Use+Case+and+Functional+Requirements+Development) ( http://wiki.siframework.org/CET+-+Use+Case+and+Functional+Requirements+Development)
21. [S&I framework Public Health Reporting Initiative User Story Template](http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx) (http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx)
22. [Advancing Health Equity in Minnesota: Report to the Legislature](http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf) (http://www.health.state.mn.us/divs/chs/healthequity/ahe\_leg\_report\_020414.pdf)
23. [Center for Medicare and Medicaid Innovation](http://innovations.cms.gov) (http://innovations.cms.gov)
24. [Integrated Health Partnerships](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441) (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\_DYNAMIC\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\_161441) (formerly known as Health Care Delivery System (HCDS) demonstrations)
25. [A Health IT Framework for Accountable Care.](https://www.cchit.org/hitframework)( https://www.cchit.org/hitframework)
26. [American Medical Association's ACOs and other options: A "how-to" manual for physicians navigating a post-health reform world](http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf) (http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf) (ACO-Governance)

## 7. ELIGIBLE APPLICANTS

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Applicants must be Community Collaboratives. Individual organizations are not eligible for this grant. A Community Collaborative must have at least two or more organizations participating in or planning to participate in an accountable care organization (ACO) or similar health care delivery model that provides accountable care. Examples include, but are not limited to, the following:

- [Medicare Shared Savings Program](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/) (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/)—a program that helps a Medicare fee-for-service program providers become an ACO.
- [Pioneer ACO Model](http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/) (http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/)—a program designed for early adopters of coordinated care.
- [Integrated Health Partnerships \(IHP\)](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441) demonstration formerly called the Health Care Delivery Systems (HCDS) demonstrations administered by the Department of Human Services. (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\_DYNAMIC\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\_161441)

Community Collaboratives must be developing or have a plan in place with at least one payer (e.g., letter of commitment) for payment arrangements involving shared risk, shared savings or total cost of care. The [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\_181836 ).

Every Community Collaborative must include a partner organization from at least one of the four priority settings of the Minnesota Accountable Health Model/SIM grant:

- local public health departments
- long-term and post-acute care (e.g., skilled nursing facilities, assisted living, home health)
- behavioral health
- social services.

*Note: Priority will be given to Community Collaboratives that include two or more of the four priority settings listed above in their proposal.*

Community Collaboratives are expected to engage a combination of partner organizations that cross the continuum of health and health care including, but not limited to:

- Primary care clinics
- Community clinics
- Rural Health Clinics
- Federally Qualified Health Centers
- Health care homes
- Specialty clinics
- Behavioral health clinics/facilities
- Hospitals
- Pharmacies
- Dental offices
- Other providers of health or health care services for which HIE would improve care (see providers listed on page 3 of [Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate](http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf) (http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf )
- Emergency medical services
- Chiropractic offices
- Skilled nursing facilities
- Assisted living facilities
- Home health organizations
- Community health boards/ local health departments
- Social services or social supports
- Health plans or payers
- Accountable care organizations

## 8. DEVELOPMENT GRANTS

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### Eligible Activities and Required Deliverables

Development grants should focus on creating a detailed development action plan (*Development Plan*) for implementation of e-health (adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange (HIE)) that will advance the Community Collaborative along the Minnesota Accountable Health Model: Continuum of Accountability Matrix.

### Eligible Activities

- Plan for implementation of collaborative and governance structures (e.g., data use agreements)
- Plan for establishing connectivity to a [State-Certified HIE Service Provider](http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/certified.html>) or other exchange option. *Note: the Minnesota Accountable Health Model e-Health Grant Program recognizes there are many different health information exchange options available to potential grantees. The funding for this grant program will only cover HIE subscription costs associated with State-Certified HIE Service Providers consistent with Minnesota's 2015 mandate for interoperable EHR requirements. If a grantee chooses to plan for a non-State-Certified HIE option, they will need to cover those investments as part of their funding match requirement for implementation.*
- Identify EHR upgrades/enhancements needed and develop plan for transition
- Plan for using [e-health toolkits](http://www.stratishealth.org/expertise/healthit/) (<http://www.stratishealth.org/expertise/healthit/>) and roadmaps, as appropriate and available.
- Plan for using e-health for quality measurement reporting and quality improvement.
- Plan for developing framework or capability for data analytics.
- Plan for using e-health to engage consumers/patients and/or the community.
- Plan for using e-health to address population health in the community.
- Plan for using e-health to address health disparities in the community.
- Plan for integrating telehealth with EHRs, HIT and HIE.

### Ineligible Activities and Expenses

- Purchase of proprietary interfaces (interfaces that do not go through State-Certified HIE Service Provider) for HIE.
- Purchase of EHR hardware or software.
- Purchase of broadband infrastructure or service.
- Capital improvements, including but not limited to roads and buildings.

### Required Deliverables and Activities

1. Development Plan for e-Health (Development Plan details are outlined below)
2. Submit an evaluation plan to MDH for approval. The evaluation plan should include objectives developed using the SMART approach to measure and report on grant goals. [SMART Objectives](http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx) (<http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx>)
3. Submit quarterly written progress reports, content and detail to be described by MDH, to the MDH- Office of Health Information Technology.
4. Submit final report, content and detail to be described by MDH, to MDH- Office of Health Information Technology.

### ***Development Plan***

The key deliverable for this grant is a Development Plan for e-Health (*Development Plan*). The *Development Plan* should provide sufficient detail on how the collaborative can advance through the Minnesota Accountable Health Model: Continuum of Accountability Matrix. It should identify partners to engage, proposed actions, a timeline for implementation and resources needed to implement successfully. The development plan must include, but is not limited to, the following:

- a) Describe the Community Collaborative’s current and proposed “location” on the overall [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) using the [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_RFPs](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs)). The description should include where the Community Collaborative will be after the development plan is implemented. In particular, the plan should include an assessment of governance and e-health (EHR, related HIT and HIE) gaps and opportunities as outlined in the EHR and HIE rows of the matrix. It may also include an assessment of data analytics capability and /or capacity. (For information on developing collaborative guidance structures see the Resources section).
- b) Create a strategy, based on assessment results and including a timeline, to move along the Minnesota Accountable Health Model: Continuum of Accountability Matrix. The plan should include the collaborative governance process and strategy for EHR adoption, effective use and HIE across all health and health care settings in the collaborative. The plan should also include a timeline for assessing HIE options and selecting a [State-Certified HIE Service Provider](http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/certified.html>) or other exchange option. *Note: the Minnesota Accountable Health Model e-Health Grant Program recognizes there are many different HIE options available to potential grantees. The funding for this grant program will only cover health information exchange subscription costs associated with State-Certified HIE Service Providers consistent with Minnesota’s 2015 mandate for interoperable EHR requirements. If a grantee chooses to plan for a non-State-Certified HIE option, they will need to cover those investments as part of their funding match requirement for implementation.*
- c) If applicable, include a plan for implementing e-health toolkits and/or roadmaps for priority settings.
- d) Identify and describe, in consultation with MDH and DHS, one (or more) use case for using e-health to advance the Minnesota Accountable Health Model. A use case is a list of steps defining interactions or workflow between providers (business actors) and EHR or other HIT systems (technical actors), to achieve a specific health or health care goal. Use cases should include, but are not limited to, the components included in the formats outlined below.

One use case must involve care coordination, including but not limited to examples listed here:

- A patient/client who is transitioning between settings of care (e.g., hospital to a skilled nursing facility or to home health care).
- A patient/client with multiple chronic conditions, including behavioral health as well as physiological health conditions.

- A patient/client who resides in a rural area, as defined by the Office of Rural Health and Primary Care, MDH; and receives services in urban locations in addition to rural.
- An individual, client and/or patient that is part of a medical home and/or behavioral health home and that is receiving county social services.
- A patient in a Health Professional Shortage Area or Medically Underserved Area in Minnesota, as defined by the Office of Rural Health and Primary Care, MDH.
- A patient where smoking, obesity and/or diabetes is being treated or addressed through care of a provider.
- A patient/client who is receiving social services in addition to medical care services.
- A patient transitioning between another setting and the patient's health care home.
- A patient/client needing primary prevention. Primary prevention may be defined as a method used before a person/population gets a disease and aims to prevent the disease from occurring to reduce both the incidence and prevalence of a disease (e.g., screenings, immunizations). Reference: National Public Health Partnership, [http://www.nphp.gov.au/publications/language\\_of\\_prevention.pdf](http://www.nphp.gov.au/publications/language_of_prevention.pdf)

Other use cases may include:

- health information exchange between the setting and the MDH, DHS or other state agency

More information on use case development is available from the [Office of National Coordinator for Health IT \(ONC\), Standards and Interoperability \(S&I\) Framework](#)

(<http://wiki.siframework.org/CET+-+Use+Case+and+Functional+Requirements+Development>) or the S&I framework Public Health Reporting Initiative User Story Template in Appendix B.

### **Use Case Format 1:**

#### **1. *Data Reporting/Exchange Participants and Events***

Describe participants in data reporting or exchange: people (Business Actors) and information systems (Technical Actors). Also describe the workflow process (flow of events) in which data are collected and/or exchanged now and your vision for how data can be reported / exchanged in the future.

#### **2. *Data***

Provide a list of data elements for the report or a dataset to be exchanged. You may submit a sample report form from the EHR or other form with the data elements. Indicate the required and optional data elements on the report / dataset.

#### **3. *Standards***

Describe HIT standards that support data reporting/exchange.

### **Use Case Format 2:**

1. Identify the type of protected health information that must be exchanged.
2. Define the care coordination activity that must be accomplished, and determine each sharing partner at the setting level.
3. Identify the available electronic processes that currently exist and any work-around or paper processes that may be used to accomplish each care coordination activity.
4. Identify potential and/or perceived barriers to sharing electronic health information exchange.
5. Complete a review and analysis of the available policies and procedures for privacy, security and consent management preferences for electronic health information exchange Identify available policies and procedures, and document any gaps and/or opportunities that would improve the flow of information between health care providers and settings.
6. Identify gaps in practice, process and knowledge by health care setting; propose solutions to address each unique opportunity.

7. Identify strategies to improve workflow as it relates to protecting electronic health information and privacy. Focus strategies on people, process and technology to improve information exchange and care coordination efforts.

**Note:** Development Plan may also include these optional elements as noted here:

- Plan for integrating telehealth/telemedicine with EHRs, HIT and HIE
- Plan for implementation of broadband infrastructure
- Plan for e-health related consumer/community/patient engagement
- Plan for using e-health to address health disparities or advance health equity in a community

In addition to the Required Deliverables and Activities, the grantee shall:

1. Engage and incorporate feedback from the MDH on methodology, engagement strategies, use cases and all other activities.
2. Participate in overall Minnesota Accountable Health Model/SIM grant evaluation with MDH, DHS and other staff.
3. Participate in MDH provided or identified trainings, meetings and technical assistance, including participation in any state-funded activities to develop e-health roadmaps for the SIM priority settings that are applicable to the collaborative development plans.
4. Collaborate with any other contractors, grantees or partners associated with SIM grant and Minnesota Accountable Health Model as appropriate.
5. Participate in state-provided or identified e-health assessment activities.

**For proposal instructions see section 13.**

## 9. IMPLEMENTATION GRANTS

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Implementation grants should focus on implementing and using e-health (adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange) that will advance the Minnesota Accountable Health Model: Continuum of Accountability Matrix.

### Eligible Activities

- Implement collaborative governance structure(s) (e.g., data use agreements)
- Update and implement a *Development Plan for e-Health*
- Establish connectivity with a [State-Certified HIE Service Provider](http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/certified.html>) or other exchange option. *Note: the Minnesota Accountable Health Model e-Health Grant Program recognizes there are many different health information exchange options available to potential grantees. The funding for this grant program will only cover HIE subscription costs associated with State-Certified HIE Service Providers consistent with Minnesota's 2015 mandate for interoperable EHR requirements. If a grantee chooses to plan for a non-State-Certified HIE option, they will need to cover those investments as part of their funding match requirement for implementation.*
- Implement e-health toolkits and roadmaps
- Incorporate e-health for quality measurement reporting and quality improvement
- Develop data analytics capability plan or framework
- Use e-health to engage consumers/patients and/or the community
- Use e-health to address population health in the community
- Use e-health to address health disparities in the community
- Integrating telehealth with EHRs, HIT and HIE.

### Ineligible Activities and Expenses

- Purchase of proprietary interfaces (interfaces that do not go through State-Certified HIE Service Provider) for HIE.
- Purchase of EHR hardware or software.
- Purchase of broadband infrastructure or service.
- Capital improvements, including but not limited to roads and buildings.

### Required Deliverables and Activities

1. Submit proposed implementation plan to MDH for approval (see Development Plan for e-Health in section 8 for guidance on what this may include).
2. Submit pre-grant and post-grant descriptions of the Community Collaborative “location” on the [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) including the Assessment Tool results [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_RFPs](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs)). Include detailed descriptions of how Community Collaborative capabilities improved as a result of grant funding.
3. Describe current use of HIE among collaborative partners, including identification of the State-Certified HIE Service Provider or other exchange option, a list of HIE services currently provided, an estimate of the number of transactions currently exchanged (paper and electronic) annually, and detailed list of sharing partners with whom patient data are being exchanged.

4. Identify and describe, in consultation with MDH and DHS, one (or more) use case for using e-health to advance the Minnesota Accountable Health Model. A use case is a list of steps defining interactions or workflow between providers (business actors) and EHR or other HIT systems (technical actors), to achieve a specific health or health care goal. Use cases should include, but are not limited to, the components included in the formats outlined below.
5. Implement one (or more) use case, for using e-health to advance the Minnesota Accountable Health Model.

One use case must involve care coordination including, but not limited to, examples listed here:

- A patient/client who is transitioning between settings of care (e.g., hospital to a skilled nursing facility or to home health care).
- A patient/client with multiple chronic conditions, including behavioral health as well as physiological health conditions.
- A patient/client who resides in a rural area, as defined by the Office of Rural Health and Primary Care, MDH; and receives services in urban locations in addition to rural.
- An individual, client and/or patient that is part of a medical home and/or behavioral health home and that is receiving county social services.
- A patient in a Health Professional Shortage Area or Medically Underserved Area in Minnesota, as defined by the Office of Rural Health and Primary Care, MDH.
- A patient where smoking, obesity and/or diabetes is being treated or addressed through care of a provider.
- A patient/client who is receiving social services in addition to medical care services.
- A patient transitioning between another setting and the patient's health care home.
- A patient/client needing primary prevention. Primary prevention may be defined as a method used before a person/population gets a disease and aims to prevent the disease from occurring to reduce both the incidence and prevalence of a disease (e.g., screenings, immunizations).  
Reference: [National Public Health Partnership –The Language of Prevention](http://www.nphp.gov.au/publications/language_of_prevention.pdf)  
([http://www.nphp.gov.au/publications/language\\_of\\_prevention.pdf](http://www.nphp.gov.au/publications/language_of_prevention.pdf))

Other use cases may include:

- health information exchange between the setting and the MDH, DHS or other state agency

#### **Use Case Format 1:**

1. ***Data Reporting/Exchange Participants and Events***

Describe participants in data reporting or exchange: people (Business Actors) and information systems (Technical Actors). Also describe the workflow process (flow of events) in which data are collected and/or exchanged now and your vision for how data can be reported / exchanged in the future.

2. ***Data***

Provide a list of data elements for the report or a dataset to be exchanged. You may submit a sample report form from the EHR or other form with the data elements. Indicate the required and optional data elements on the report / dataset.

3. ***Standards***

Describe HIT standards that support data reporting/exchange.

#### **Use Case Format 2:**

1. Identify the type of protected health information that must be exchanged.

2. Define the care coordination activity that must be accomplished, and determine each sharing partner at the setting level.

3. Identify the available electronic processes that currently exist and any work-around or paper processes that may be used to accomplish each care coordination activity.
4. Identify potential and/or perceived barriers to sharing electronic health information exchange.
5. Complete a review and analysis of the available policies and procedures for privacy, security and consent management preferences for electronic health information exchange Identify available policies and procedures, and document any gaps and/or opportunities that would improve the flow of information between health care providers and settings.
6. Identify gaps in practice, process and knowledge by health care setting; propose solutions to address each unique opportunity.
7. Identify strategies to improve workflow as it relates to protecting electronic health information and privacy. Focus strategies on people, process and technology to improve information exchange and care coordination efforts.

More information on use case development is available from the [Office of National Coordinator for Health IT \(ONC\), Standards and Interoperability \(S&I\) Framework](http://wiki.siframework.org/CET+-+Use+Case+and+Functional+Requirements+Development) (<http://wiki.siframework.org/CET+-+Use+Case+and+Functional+Requirements+Development>) or the S&I framework Public Health Reporting Initiative User Story Template in Appendix B.

#### **Other Required Deliverables and Activities (continued from Page 12)**

6. Submit evaluation plan to MDH for approval. Evaluation plan should include objectives developed using the SMART approach to measure and report on grant goals and outcomes (e.g., tracking number of HIE partners, number of transactions/type etc). For more information see [SMART Objectives](http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx) (<http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx>)
7. Submit copies of all tools, resources or other guidance
8. Submit quarterly written progress reports, (content and detail to be described by MDH) to the MDH- Office of Health Information Technology.
9. Submit final report, (content and detail to be described by MDH including lessons learned) to MDH- Office of Health Information Technology.

In addition to Required Deliverables and Activities, the grantee shall:

1. Engage and incorporate feedback from the MDH on methodology, engagement strategies, use cases and all other activities.
2. Participate in overall SIM grant evaluation with MDH, DHS and other staff.
3. Participate in MDH provided or identified trainings, meetings and technical assistance, including participation in any state-funded activities to develop e-health roadmaps for SIM priority settings that are applicable to collaborative development plans.
4. Collaborate with any other contractors, grantees or partners associated with SIM grant and Minnesota Accountable Health Model as appropriate.

**For proposal instructions see section 14.**

## 10. Proposal Filing Requirements

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### INTENT TO RESPOND

MDH requests that potential applicants submit a written Intent to Respond via e-mail to MDH by March 27, 2014. The Intent to Respond should indicate for which grant type the Applicant intends to submit a proposal. If a written Intent to Respond is not sent, a proposal may still be submitted; however, any further notices issued by MDH will only be sent to Responders that have an Intent to Respond on file. Any updates will be posted at [State Innovation Model Grant- Minnesota](http://mn.gov/sim) (<http://mn.gov/sim>)

Letters of Intent to Respond should be submitted by March 27, 2014, via e-mail to:

Anne Schloegel  
Minnesota Department of Health  
Office of Health Information Technology  
[Anne.Schloegel@state.mn.us](mailto:Anne.Schloegel@state.mn.us)

### APPLICANT REQUIREMENTS

Applicants must:

1. Meet the minimum requirements of eligible applicants and activities.
2. Designate whether applying for either a *Development* or *Implementation* grant.
3. Include all required elements as detailed for each grant type in proposal instructions.
4. All proposals must be typed, using a single-spaced 12-point font and have no more than 20 pages of narrative.
5. Applicants are encouraged to be concise and to closely follow the grant proposal outline and guidance. Limit any additional documentation to information relevant to the specific scope and purpose of proposed project.

### SUBMISSION OF FULL PROPOSAL

Ten copies of the proposal and an electronic copy of the proposal on a USB drive are required. Proposals must be received by 4:00 p.m. on May 5, 2014, at the following address:

Minnesota Department of Health  
Office of Health Information Technology

**Courier Address:**  
85 East 7<sup>th</sup> Place  
Saint Paul, Minnesota 55101

**Mailing Address:**  
P.O. Box 64882  
Saint Paul, Minnesota 55164-0882

*Proposals must be mailed or delivered. No e-mailed or faxed proposals will be accepted.*

## 11. Contact Information

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Questions about these grants and the proposal process should be directed to:

Anne Schloegel  
Office of Health Information Technology  
Phone: 651-201-4846  
Email: [Anne.schloegel@state.mn.us](mailto:Anne.schloegel@state.mn.us)

## 12. Proposal Review Process

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### Scoring Criteria

Grant proposals will be reviewed and evaluated by a panel familiar with the program. The panel may include staff from the Minnesota Department of Health, Minnesota Department of Human Services, SIM Advisory Task Force members and the community at large. 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.

The grant proposals will be scored on a 100-point scale as listed in the following table and according to *Appendix C: Criteria for Scoring Grant Proposals*

| <b>Criteria</b>                              | <b>Maximum Points</b> |
|--|-----------------------|
| Community Collaborative Description          | 15 points             |
| Needs Assessment                             | 15 points             |
| Project Description                          | 15 points             |
| Work Plan and Evaluation                     | 30 points             |
| Project Team/Resources                       | 10 points             |
| Budget                                       | 10 points             |
| Evidence of Community Commitment and Support | 5 points              |
| <b>Total</b>                                 | <b>100 points</b>     |

### Award Process

Applicants awarded a grant award will be expected to:

1. Submit a final work plan and budget, if requested, to MDH.
2. Execute original and two copies of grant agreement and return to MDH for final signature.
3. Upon receipt of fully executed grant agreement, begin work. **Note: Grantees cannot be reimbursed for work completed before the grant agreement is fully executed.**
4. Complete required deliverables and activities as outlined in grant agreement.
5. Participate in site visits or conference calls to report on progress, barriers or lessons learned.
6. Submit quarterly written narrative progress reports and final narrative and expenditure reports for the grant period within 30 days of the grant agreement ending.
7. Additional details that may be requested to comply with federal reporting requirements.
8. Final 10 percent of the total grant award will be withheld until grant duties are completed.

## 13. Proposal Instructions

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### ***Development Grants (limit \$75,000)***

#### **Required Elements**

Proposals for these grants must not exceed 20 pages of single-spaced 12-point type. The 20-page limit includes only items 2-6 below.

**1. Proposal Cover Form** (see Attachments)

**2. Project Summary** (abstract)

Brief summary of the project including major goals, timeline, desired outcomes, the areas/populations served, and any collaborating organizations.

**3. Community Collaborative Description**

- a. Brief organizational description of each collaborative partner (e.g., history, structure, services provided, patients/clients served)
- b. History as collaborators on previous projects, if any. If so, describe the relationships including how they have evolved, successes, and challenges
- c. Brief description of each collaborative partner's current use of EHRs, HIT and health information exchange (paper or electronic) within each organization, including information about the number and type of transactions exchanged (paper or electronic) per year. If not using EHRs, describe partners' plans for implementing e-health tools. If applicable, please include information on exchange within the collaborative and with others outside the collaborative.
- d. Description of the location on the [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) for each participating organization and collaborative in total (estimated). Include a copy of Assessment Tool results [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_RFPs](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs))  
**Note: The Minnesota Accountable Health Model: Continuum of Accountability Matrix location and /or specific assessment results will not be part of the criteria for grant award or funding decisions.**
- e. Estimated payer mix including number of Medicaid, Medicare and commercial enrollees for each organization and for the collaborative as a whole.
- f. Description of any current or proposed ACO or ACO-like arrangements that collaborative partners are involved in, including participation in the Integrated Health Partnerships (formerly Health Care Delivery System (HCDS) demonstration), the Medicare Shared Savings Program, the Pioneer ACO program, or other payment arrangements with at least one payer involving shared risk/shared savings or total cost of care. If no collaborating partners are currently participating in ACO or ACO-like arrangements, describe the plan and timeline under which at least two collaborating partners will meet this requirement.

**4. Needs Assessment**

This section should describe the health environment and *needs* that can be addressed through e-health activities. Cite sources for data whenever possible.

- a. Geographic area and demographics of population(s) to be served. Include references to community needs assessments (see Resources section for more information on community health needs assessments) where appropriate, and show evidence of engagement of the

local health department, patients/consumers, and other social or community service agencies to provide a comprehensive view. Please include the following categories:

- Population - Describe the population of county (ies), neighborhoods or entire community to be served. Demographic data should be used and cited whenever possible to support the information provided. Include a geographic map of service area if possible.
  - Health Status - Describe the general health status of your population. This geographic data should be compared to regional and state data, where possible, and should include a description of health disparities relevant for your population and project. Relevant factors such as age, poverty, disparities, substance abuse and other social problems should be included.
  - Health and Healthcare Delivery System - Describe the health infrastructure (e.g., hospitals, solo and group practices, primary care and specialty clinics, community health centers, health care homes and emergency medical services. Describe the availability, distribution and any shortages within the health workforce.
- b. Problem statement of unmet e-health needs in the community to be served. Describe how unmet needs impact health outcomes
- c. Financial and other resource considerations of organizations and the community, including the reason(s) why grant funds are needed. Include a statement of financial need of collaborative partner organizations and community, including how grant funds will support care coordination.

#### **5. Project Description**

- a. Identify the target population and communities the project will serve and why this collaborative is suited to provide services to this population. If applicable, describe how this project meets the needs of the community in rural and/or underserved areas or populations.
- b. Describe what the project will accomplish (goals/outcomes/objectives) with respect to community e-health needs and coordination of health and health care services.
- c. Describe how this project may improve health outcomes of the community. Include a description of the potential of this project to impact health disparities in the community.

#### **6. Project Work Plan (may not extend beyond June 30, 2015)**

- a. Describe the work plan to achieve all of the goals/objectives proposed in the project description section. As appropriate, identify meaningful support and collaborations with key partners / stakeholders (including patients/consumers) in planning, designing and implementing activities. To accomplish this, applicants are strongly encouraged to include a table that illustrates the following:
- Goals/outcomes and expectations for the project (see Required Deliverables and Activities)
  - Time-specific objectives to achieve each stated outcome/goal
  - Methods for accomplishing each objective and metrics for measuring the successful achievement of the objectives
  - Staff (or responsible entity, partners)
  - Progress or process measures
  - Outcome or impact
- b. Describe a communications plan to ensure all stakeholders (including patients/consumers) are kept informed of project goals and progress, and are engaged
- c. Describe the formal process used for obtaining the governing boards of each collaborating organization's approval to commit to the grant duties and conditions of funding. Describe how the present project will advance and expand HIE capabilities.

- d. Identify and describe one or more possible use cases for using e-health to advance the Minnesota Accountable Health Model. A use case is generally defined as a list of steps, typically defining interactions or workflow between providers (business actors) and EHR or other HIT systems (technical actors), to achieve a specific health or health care goal. (See detailed use case information in Section 8)

One use case must involve care coordination, including but not limited to examples here:

- a patient/client who is transitioning between settings of care (e.g., hospital to a skilled nursing facility or to home health care)
- a patient/client with multiple chronic conditions, including behavioral health as well as physiological health conditions;
- a patient/client who resides in a rural area, as defined by the Office of Rural Health and Primary Care, MDH; and receives services in urban locations in addition to rural;
- an individual, client and/or patient that is part of a medical home and/or behavioral health home and that is receiving county social services
- a patient in Health Professional Shortage Area or Medically Underserved Area in Minnesota, as defined by the Office of Rural Health and Primary Care, MDH;
- a patient where smoking, obesity and/or diabetes is being treated or addressed through care of a provider;
- a patient/client who is receiving social services in addition to medical care services
- a patient transitioning between another setting and the patient's health care home;
- a patient/client needing primary prevention. Primary prevention may be defined as a method used before a person/population gets a disease and aims to prevent the disease from occurring to reduce both the incidence and prevalence of a disease (e.g., screenings, immunizations). [National Public Health Partnership –The Language of Prevention](http://www.nphp.gov.au/publications/language_of_prevention.pdf) ([http://www.nphp.gov.au/publications/language\\_of\\_prevention.pdf](http://www.nphp.gov.au/publications/language_of_prevention.pdf))

Other use cases may include:

- health information exchange between the setting and the Minnesota Department of Health or Minnesota Department of Human Services or other state agency

#### **7. Evaluation Plan:**

The evaluation plan should include objectives developed using the SMART approach to measure and report on grant goals and outcomes (e.g., tracking number of HIE partners, number of transactions/type etc). For more information see [SMART Objectives](http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx) (<http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx>). Applicant must describe the strategies and measures that will be used to evaluate performance during the project period. The applicant should describe how progress toward meeting grant-funded goals will be tracked, measured, and evaluated. Explain any assumptions made in developing the project work plan and discuss the anticipated performance measures and desired outcomes of grant-funded activities. Describe the data collection strategy to collect, analyze and track data to measure performance and determine impact or outcomes. Explain how the data will be used to improve performance.

#### **8. Project Team**

- a. Name(s), title(s), organization(s), and qualifications of the project lead or co-leads.
- b. Names, titles and organizations of primary project team members and their project roles. Include information on any clinicians involved in the project.

- c. Description of the source of any in-kind technical support, internal and/or external, for the project.

**9. Line Item Budget** (please use Suggested Budget Form in the Attachments)

All reasonable costs for completing project are eligible. Insert a line item budget into the narrative or attach as a separate document.

*Note: Grant funds may not be used for construction of buildings or facilities.*

- a. **Direct costs** (see categories in section 10 below)
- b. **Indirect costs.** If requested, limited to 10 percent of the total funding request.
- c. **Match. A 20 percent match is required for this grant.** Include the amounts and sources of financial or in-kind resources used for the required match. It is not necessary to have a match for each line item; however, the total match must equal at least twenty percent of the total grant dollars being applied for. Match should be expressed in dollars, and can include, but is not limited to, staff time (the value of salaries and fringe) spent by collaborating organizations on the project (for example, staff time spent in planning, governance or IT support), communications and mileage costs related to planning or governance meetings, and equipment needed to enable health information exchange or adoption of an interoperable EHR.

**10. Budget Justification.**

Provide information on how each of the line items shown in the budget was calculated.

- a. **Salary and Fringe.** For any positions funded by this grant, provide the position title, amount of salary and fringe benefits paid for by the grant, and percent of time on the project. Include a brief description of the activities of each position as it relates to the project. The budget form need only reflect the totals for salaries and fringe.
  - b. **Travel.** Describe any proposed travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (not to exceed the current rate established by the [Minnesota Management and Budget's Commissioner's Plan](http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf) (<http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf>))
  - c. **HIE costs.** Describe any vendor selection costs for [State-Certified HIE Service Provider](http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/certified.html>). Include quotes where possible
- Ineligible expenses:**
- Costs for proprietary software interfaces (not through state-certified HIE service provider) for health information exchange
  - Costs for electronic health record hardware or software
  - Costs for broadband infrastructure
- d. **Supplies.** Describe any supplies needed for completion of the project.
  - e. **Contracted services/Consultants.** Provide the name of contractors, the services to be provided and projected costs. Include brief background information about contractors, including how their previous experience relates to the project. If no contractor has been chosen, include a description of the availability of contractors for the services and/or products required and the method for choosing a contractor.
  - f. **Other.** If it is necessary to include expenditures in the "Other" category, include a detailed description of the proposed expenditures as they relate to the project. Add additional "Other" lines to the budget form as needed.
  - g. **Match.** (see section 9c above)
  - h. **Indirect costs.** If requested, may not exceed 10 percent of the total funding request.

**11. Project Contact Information**

Name and qualifications of the person or persons leading or co-leading the project.

**12. Fiscal Agent**

There must also be a letter from the organization agreeing to serve as fiscal agent. The letter must state that organization's willingness to accept and account for grant funds under this program.

**13. Letters of commitment and support.**

- a. Letters of commitment are required from all collaborating organizations. The letter of commitment from the organization agreeing to serve as fiscal agent must state their willingness to accept and account for grant funds under this program. The letters of commitment and support must also declare plans to participate in an accountable care organization (ACO) or similar health care delivery model and have a plan for financial risk sharing among participants.
- b. Letters of support from other organizations participating in the grant are allowed but not required.

**14. Accounting System and Financial Capability Questionnaire (see Attachments)**

## 14. Proposal Instructions

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### ***Implementation Grants (limit \$1,000,000)***

#### **Required Elements**

Proposals for these grants must not exceed 20 pages of single-spaced 12-point type. The 20-page limit includes only items 2-6 below.

**1. Proposal Cover Form** (see Attachments)

**2. Project Summary** (abstract)

Brief summary of the project including desired outcomes, the areas/populations served, and the collaborating organizations.

**3. Community Collaborative Description**

- a. Brief organizational descriptions, including current use of EHRs, HIT and health information exchange (paper or electronic) within each organization. If not using EHRs, describe partners' plans for implementing e-health tools. If applicable, please include information on exchange within the collaborative and with others outside the collaborative.
- b. History as collaborators on previous projects, if any (can be other than health IT projects). If so, describe the relationships including how they have evolved, successes, and challenges
- c. Description of collaborative location on the [Minnesota Accountable Health Model: Continuum of Accountability Matrix](#) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) for each participating organization and collaborative in total (estimated). Include a copy of Assessment Tool results [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](#) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_RFPs](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_RFPs)). ***Note: The Minnesota Accountable Health Model: Continuum of Accountability Matrix location and /or specific assessment results will not be part of the criteria for grant award or funding decisions.***
- d. Estimated payer mix including number of Medicaid, Medicare and commercial enrollees for each organization and for the collaborative as a whole.
- e. Description of any current or proposed ACO or ACO-like arrangements that collaborative partners are involved in, including participation in the Integrated Health Partnerships (formerly known as Health Care Delivery System (HCDS) demonstrations, the Medicare Shared Savings Program, the Pioneer ACO program, or other payment arrangements with at least one payer involving shared risk/shared savings or total cost of care. If no collaborating partners are currently participating in ACO or ACO-like arrangements, describe the plan and timeline under which at least two collaborating partners will meet this requirement.

**4. Needs Assessment**

This section should describe the health environment and *needs* that can be addressed through e-health activities, Cite sources for data if possible.

- a. Geographic area and demographics of population(s) to be served. Include community needs assessments where appropriate (see Resources section for more information on community health needs assessments). Engage the local health department and other social or community service agencies to provide a comprehensive view. Please include the following categories:

- Population - Describe the population of county (ies), neighborhoods or entire community to be served. Demographic data should be used and cited whenever possible to support the information provided. Include a geographic map of service area if possible.
  - Health Status - Describe the general health status of your population. This geographic data should be compared to regional and state data where possible. Relevant factors such as age, poverty, disparities, substance abuse and other social problems should be included.
  - Health and Healthcare Delivery System - Describe the health infrastructure (e.g., hospitals, solo and group practices, primary care and specialty clinics, community health centers, health care homes and emergency medical services. Describe the availability, distribution and any shortages within the health workforce.
- b. Problem statement of unmet e-health needs in the community to be served. Describe how unmet needs impact health outcomes
  - c. Financial and other resource considerations of organizations and the community, including the reason(s) why grant funds are needed. Include a statement of financial need of collaborative partner organizations and community, including how grant funds will support care coordination

## **5. Project Description**

- a. Identify the target population and communities the project will serve and why this collaborative is suited to provide services to this population. If applicable, describe how this project meets the needs of the community in rural and/or underserved areas or populations.
- b. Describe what the project will accomplish (goals/outcomes/objectives) with respect to community e-health needs and coordination of health and health care services, as well as specific goals related to number and type of HIE transactions that are anticipated among collaborative partners.
- c. Describe how this project may improve health outcomes of the community, including the impact on health disparities as appropriate, and how these outcomes will be measured.
- d. Indicate where Community Collaborative will be on the Minnesota Accountable Health Model: Continuum of Accountability Matrix (using Assessment Tool) with successful implementation of this grant project.

## **6. Project Work Plan (may not extend beyond December 30, 2015)**

Describe the work plan to achieve all of the goals/objectives proposed in the project description section. As appropriate, identify meaningful support and collaborations with key partners and stakeholders, (including patients/consumers) in planning, designing and implementing activities. To accomplish this, applicants are strongly encouraged to include a table that illustrates the following:

- Goals/outcomes and expectations for the project (see Required Deliverables and Activities)
  - Time-specific objectives to achieve each stated outcome/goal
  - Methods for accomplishing each objective and metrics for measuring the successful achievement of the objectives
  - Staff (or responsible entity, partners)
  - Progress or process measures
  - Outcome or Impact (anticipated or actual)
- a. Goals/outcomes and expectations for the project as related to advancing Minnesota Accountable Health Model: Continuum of Accountability Matrix (specifically EHR and HIE rows) (see Required Deliverables and Activities)

- b. Include evidence that project is part of the Community Collaborative's long term strategic plan
- c. Document planning activities have been completed including due diligence, workflow analysis, clinician and consumer involvement (if applicable), etc.
- d. Include information, if applicable, on State-Certified HIE Service Provider selection process such that the product selected includes essential key features to improve patient care and health of the population identified. This may include registry functions, decision support tools, and population based health outcomes system reports capability
- e. Plans for staff training for implementation and continuous evaluation
- f. Plans for system operation and maintenance and technical support resources.
- g. Plans for sustainability beyond state funding.
- h. Describe a communications plan to ensure all stakeholders (including patients/consumers) are kept informed of project goals and progress, and are engaged
- i. Brief description of the formal process used for obtaining the governing boards of each collaborating organization's approval to commit to the grant duties and conditions of funding. Describe how the present project will advance and expand HIE capabilities.
- j. Identify, describe, and implement at least one or more, use cases for using e-health for the Minnesota Accountable Health Model. A use case is generally defined as a list of steps, typically defining interactions or workflow between providers (business actors) and EHR or other HIT systems (technical actors), to achieve a specific health or health care goal. (for more detailed information see Section 9)

One use case must involve care coordination, including but not limited to examples here:

- a patient/client who is transitioning between settings of care (e.g., hospital to a skilled nursing facility or to home health care)
- a patient/client with multiple chronic conditions, including behavioral health as well as physiological health conditions;
- a patient/client who resides in a rural area, as defined by the Office of Rural Health and Primary Care, MDH; and receives services in urban locations in addition to rural;
- an individual, client and/or patient that is part of a medical home and/or behavioral health home and that is receiving county social services
- a patient in Health Professional Shortage Area or Medically Underserved Area in Minnesota, as defined by the Office of Rural Health and Primary Care, MDH;
- a patient where smoking, obesity and/or diabetes is being treated or addressed through care of a provider;
- a patient/client who is receiving social services in addition to medical care services
- a patient transitioning between another setting and the patient's health care home;
- a patient/client needing primary prevention. Primary prevention may be defined as a method used before a person/population gets a disease and aims to prevent the disease from occurring to reduce both the incidence and prevalence of a disease (e.g., screenings, immunizations). [National Public Health Partnership –The Language of Prevention](http://www.nphp.gov.au/publications/language_of_prevention.pdf) ([http://www.nphp.gov.au/publications/language\\_of\\_prevention.pdf](http://www.nphp.gov.au/publications/language_of_prevention.pdf))

Other use cases may include:

- health information exchange between the setting and the Minnesota Department of Health or Minnesota Department of Human Services or other state agency

## 7. Evaluation Plan

The evaluation plan should include objectives developed using the SMART approach to measure and report on grant goals and outcomes (e.g., tracking number of HIE partners, number of transactions/type etc). For more information see [SMART Objectives](http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx) (<http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx>). Applicant must describe the strategies and measures that will be used to evaluate performance during the project period. The applicant should describe how progress toward meeting grant-funded goals will be tracked, measured, and evaluated. Explain any assumptions made in developing the project work plan and discuss the anticipated performance measures and desired outcomes of grant-funded activities. Describe the data collection strategy to collect, analyze and track data to measure performance and determine impact or outcomes. Explain how the data will be used to improve performance.

## 8. Project Team

- a. Name(s), title(s), organization(s), and qualifications of the project lead or co-leads.
- b. Names, titles and organizations of the primary project team members and their roles in the project. Include information on any clinicians involved in the planning or implementation processes.
- c. Description of the source of any in-kind technical support, internal and/or external, for the project.

## 9. Line Item Budget (please use Suggested Budget Form from the Attachments)

All reasonable costs for completing project are eligible. Insert a line item budget into the narrative or attach as a separate document.

- a. **Direct costs** (see categories in section 10 below)
- b. **Indirect costs.** If requested, limited to 10 percent of the total funding request.
- c. **Match. A 20 percent match is required for this grant.** Include the amounts and sources of financial or in-kind resources used for the required match. It is not necessary to have a match for each line item; however, the total match must equal at least twenty percent of the total grant dollars being applied for. In-kind match should be expressed in dollars, and can include, but is not limited to, staff time (the value of salaries and fringe) spent by collaborating organizations on the project (for example, staff time spent in planning, governance, or IT support), communications and mileage costs related to planning or governance meetings, and equipment needed to enable health information exchange or adoption of an interoperable EHR.

## 10. Budget Justification.

Provide information on how each of the line items shown in the budget was calculated.

- a. Salary and Fringe. For any positions proposed to be funded from this project, provide the position title, the amount of salary and fringe benefits paid for by the grant, and percent of time on the project. Include a brief description of the activities of each position as it relates to the project. The budget form need only reflect the totals for salaries and fringe.
- b. Travel. Describe any proposed travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (not to exceed the current rate established by the [Minnesota Management and Budget's Commissioner's Plan](http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf) (<http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf>))
- c. Software. Include a description and projected costs of any proposed software.

### **Ineligible expenses:**

- Costs for proprietary software interfaces (not through state-certified HIE service provider) for health information exchange
- Costs for electronic health record hardware or software

- Costs for broadband infrastructure
- d. HIE costs. Describe costs related to implementation and subscription (up to one year) for [State-Certified HIE Service Provider](http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) (<http://www.health.state.mn.us/divs/hpsc/ohit/certified.html>). Include quotes where possible.
  - e. Supplies. Describe any supplies needed for the completion of the project.
  - f. Consultants/Contracted services. Provide the name of contractors, the services to be provided and projected costs. Include brief background information about contractors, including how their previous experience relates to the project. If no contractor has been chosen, include a description of the availability of contractors for the services and/or products required and the method for choosing a contractor.
  - 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.
  - h. Match. (see section 9c above)
  - i. Indirect charges. If requested, may not exceed 10 percent of the total funding request.
- 11. Project Contact Information**  
Name(s) and qualifications of the person or persons leading or co-leading the project.
  - 12. Fiscal Agent**  
There must also be a letter from the organization agreeing to serve as fiscal agent. The letter must state that organization’s willingness to accept and account for grant funds under this program.
  - 13. Letters of Commitment**
    - a. Letters of commitment are required from all collaborating organizations. The letters of commitment must also declare plans to participate in an accountable care organization (ACO) or similar health care delivery model that has a plan for financial risk sharing among participants.
    - b. Letters of support from other organizations participating in the grant are allowed but not required.
  - 14. Letters of Support**  
Letters of support from other organizations not participating directly in the grant are allowed but not required.13.
  - 15. Accounting System and Financial Capability Questionnaire** (see Attachments)

## Appendix A

### Minnesota Accountable Health Model Glossary

#### 2015 Mandate for Interoperable EHR

The 2007 Minnesota Legislature mandated in Minnesota Statute §62J.495 (Electronic Health Record Technology), that “By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems.”

Source: [Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate](http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf), (www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf) accessed 09.10.13

#### Accountable Care

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

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

#### Accountable Care Organizations (ACOs)

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

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

#### Behavioral Health

The term “behavioral health” is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

Behavioral health includes the identification, treatment of, and recovery from mental health and substance use disorders. It also increasingly refers to lifestyle changes and actions which improve physical and emotional health, as well as the reduction or elimination of behaviors which create health risks.

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

#### Care Coordination

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

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

**Care Coordinator**

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

**Care Manager**

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

**Care Plan**

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

**Continuum of care**

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

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

**Data Analytics**

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

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

**Electronic Health Records (EHR)**

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

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

**Emerging professionals-**

Emerging 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.

## **E-health**

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.

Source: [Minnesota e-Health](http://www.health.state.mn.us/e-health/) (http://www.health.state.mn.us/e-health/) accessed 2.19.14

## **Health Care Home**

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

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

(www.health.state.mn.us/healthreform/homes/) accessed 09.10.13

## **Health Information Exchange (HIE)**

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

## **Health Information Technology (HIT)**

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

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

## **Integrated care**

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

## **Interoperability**

The ability of two or more information systems or components to exchange information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed.

Source: Office of the National Coordinator for HIT, <http://www.hhs.gov/healthit/glossary.html>, accessed 09.10.13

## **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.ttuhs.edu/qjp/teamwork.aspx>

## **Local Public Health**

In Minnesota, local public health services are provided through Community Health Boards, which have statutory responsibilities for public health (MN Stat. Chapter 145A), and by Tribal

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

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

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

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

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

### **Minnesota e-Health Initiative**

The Minnesota e-Health Initiative is a public-private collaborative whose Vision is to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health.

Source: Minnesota Department of Health, [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html), (<http://www.health.state.mn.us/e-health/abouthome.html>) accessed 09.11.13

### **Minnesota Model for EHR Adoption**

In 2008, the Minnesota e-Health Initiative developed the Minnesota Model for Adopting Interoperable EHRs that is applied to all aspects of the Initiative's work and policy development. The model has seven steps which are grouped into three major categories:

- Adopt, which includes the sequential steps of Assess, Plan and Select.
- Utilize, which involves implementing an EHR product and learning how to use it effectively.
- Exchange, including readiness to exchange information electronically with other partners, and implementing regular, ongoing exchange between interoperable EHR systems

Source: Minnesota Department of Health, [www.health.state.mn.us/e-health/legrpt2013.pdf](http://www.health.state.mn.us/e-health/legrpt2013.pdf), accessed 09.11.13

### **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. AcademyHealth, February 2013.

<http://www.academyhealth.org/files/AH2013pophealth.pdf>

### **Provider**

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

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

### **Public Health**

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

Source: American Public Health Association, [http://www.apha.org/NR/rdonlyres/C57478B8-8682-4347-8DDF-A1E24E82B919/0/what\\_is\\_PH\\_May1\\_Final.pdf](http://www.apha.org/NR/rdonlyres/C57478B8-8682-4347-8DDF-A1E24E82B919/0/what_is_PH_May1_Final.pdf); Local Public Health Association of Minnesota, [http://www.lpha-](http://www.lpha-mn.org/FactSheets/MN_Local%20Public%20Health%20System_LPHAFacts.pdf)

[mn.org/FactSheets/MN\\_Local%20Public%20Health%20System\\_LPHAFacts.pdf](http://www.lpha-mn.org/FactSheets/MN_Local%20Public%20Health%20System_LPHAFacts.pdf)

### **Social Services**

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

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

### **Summary of Care Record**

A summary of care record may include the following elements:

- Patient name
- Referring or transitioning provider's name and office contact information
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results

- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral
- Current problem list (a list of current, active and historical diagnoses)
- Current medication list (a list of medications that a given patient is currently taking), and
- Current medication allergy list (a list of medications to which a given patient has known allergies)
- Diagnosis lists
- Advance directives
- Contact information; guardianship information
- Critical incident information relating to physical and/or mental/behavioral health.

### **Transitions of Care**

The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Source: [CMS/EHR Incentive Program Menu Set Measures Measure 8 of 10-Transition of Care Summary](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf) (www.cms.gov/Regulations-and

Guidance/Legislation/EHRIncentivePrograms/downloads/8\_Transition\_of\_Care\_Summary.pdf) accessed 09.11.13

### **Triple Aim**

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

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

(www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx) accessed 09.10.20

## Appendix B

### Minnesota Accountable Health Model: Continuum of Accountability Assessment Tool

The Minnesota Accountable Health Model is working to support organizations participation in accountable care models in order to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. This tool is designed to help organizations assess where they are now in achieving the basic capabilities, relationships, and functions they need to have in place in order to achieve these goals, and to provide guideposts that will allow them to track their progress as they continue to evolve in their work.

At the State level, the Minnesota Department of Health (MDH) and Department of Human Services (DHS) will use this tool to better understand SIM-Minnesota participants (grantees, TA recipients, Accountable Communities for Health, and others) status in achieving the goals of the Minnesota Accountable Health Model, what supports are needed from SIM-Minnesota to achieve the goals, and how we may be able to provide additional tools or resources. An organization's self-assessment will **NOT** be used to make funding decisions; rather, this tool will be used to help us develop targets and goals for participating organizations, and to assess their progress.

***In this document, the terms 'organization' and 'provider' are meant to include a broad range of health and health care providers and support services providers that may or may not formally be part of an existing ACO, but that are moving towards greater accountability for quality, cost of care and health of the populations they serve. Many types of organizations, including not only providers of medical care but also organizations that operate in the behavioral health, social services, local public health, long term care/post-acute care settings, community organizations, and other public/private sector partners that provide supportive services to individuals and families, can all have a role in convening, leading or participating in these models.***

While there are multiple examples of how an organization may achieve the goals of the Minnesota Accountable Health Model, this assessment tool describes the components necessary to demonstrate movement toward this long-term vision. As you work through this assessment, remember that:

- Organizations or partnerships may be at different levels of development on different issues.
- It is not necessary for an organization to have achieved capabilities in all areas in order to be eligible for support or technical assistance under the Minnesota Accountable Health Model. The goal is to help organizations or providers move onto this grid, or move further to the right, in as many areas as possible.
- Organizations may move along this continuum at different rates and use different approaches.

**Directions:**

This assessment is designed to help organizations understand where they are on the continuum of Minnesota's Accountable Health Model. The results will help identify areas for improvement, and track changes over time.

*Instructions:*

1. Each facility or physical site should complete an assessment (e.g., a practice, clinic, hospital, organization, or provider).
2. Fill out the organization's name, date it is being completed, name of individual(s) completing the assessment tool and their title(s).
3. For each question, select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box: *Beginning, In-Progress, Mostly Done*. In some cases you may be in more than one level and therefore can select responses for each level.
4. A glossary of terms and resources can be found at the end of the document. Not all terms may apply to all providers or organizations.
5. If you determine that you have not yet met Level A requirements for a particular row (i.e. you are at the 'pre-level' for that capability), check the pre-level box.
6. If you determine that you have fully met the expectations for a certain level within a row, move to the next level.
7. Use comment fields at the end of each section to provide additional information or context as needed.
8. Save and print a copy of this assessment for your records when you are finished.

Within each level you should choose where your organization is in implementing:

**Beginning**—your organization is at the initial stages of implementing this process or activity

**In Progress** — your organization is moving forward and making steady advances toward the goal of full implementation

**Mostly done** — your organization is generally complete in implementing this process or activity

**Name of Organization:** [Click here to enter text.](#)

**Date:** [Click here to enter a date.](#)

**Name of Person Completing:** [Click here to enter text.](#)

**Title:** [Click here to enter text.](#)

*(If more than one person is completing the form, enter information for each person completing the form.)*

**Model Spread and Multi-Payer Participation Section**

| 1. What type of payment arrangements do you participate in?   |  |  |  |  |
|---|--|--|--|--|
| <i>Pre-Level</i>  | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>   | <i>Level D</i>   |
| We only receive payment for delivered services in the form of fee-for-service or capitation payments without any incentives | We have alternative types of payment arrangements with at least one payer that represents less than 20% of our total consumer base, OR participation in at least one performance-based or value-based incentive system representing less than 5% of our total revenue. | We have alternative types of payment arrangements with at least one payer that represents 20% to 50% of our total consumer base, OR participation in at least one performance-based or value-based incentive system representing 5% to 15% of our total revenue. | We have alternative types of payment arrangements with at least one payer that represents 50% to 75% of our total consumer base, OR participation in a performance-based or value-based incentive system representing 15% to 30% of our total revenue. | We have alternative types of payment arrangements with at least one payer that represents greater than 75% of our total consumer base, OR participation in a performance-based or value-based incentive system representing greater than 30% of our total revenue. |
| <b>Select which is applicable for your organization.</b>  |  |  |  |  |
| <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| <b>Briefly describe any alternative payment arrangements you participate in.</b> <a href="#">Click here to enter text.</a>  |  |  |  |  |

**Payment Transformation Section**

| <b>2. What types of alternatives to fee-for-service (FFS) payment arrangement(s) do you participate in?</b>                                   |   |  |   |   |
|---|---|--|---|---|
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>   | <i>Level C</i>  | <i>Level D</i>  |
| We only receive payment for delivered services in the form of fee-for-service without any incentives.   | We have little or no readiness to manage global costs, but may be willing to assume fixed payment for some ancillary services. Examples include: Health care home or similar coordination fees, quality improvement/incentive payments. | We are ready to manage global costs with upside risk. We participate in shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk (e.g. episode-based payments). | We are ready to manage global cost with upside and downside risk. We participate in shared savings and some arrangements moving toward risk sharing through Total Cost of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization. | We are ready to accept global capitation payments. Community partners are sharing in accountability for cost, quality and population health are included in the financial model in some form. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b> |   |  |   |   |
| <input type="checkbox"/>  | Choose an item  | Choose an item   | Choose an item  | Choose an item  |
| <b>Comments- Payment Transformation:</b> <a href="#">Click here to enter text.</a>  |   |  |   |   |

**Delivery and Community Integration and Partnership Section**

|  |   |  |  |   |
|--|---|--|--|---|
| <b>3. Population Management: To what extent does your practice have a process to identify appropriate patients/clients for care coordination?</b>            |   |  |  |   |
| <i>Pre-Level</i>   | <i>Level A</i>  | <i>Level B</i>   | <i>Level C</i>   | <i>Level D</i>  |
| None   | We do not currently have a process in place but are planning or beginning to implement this.  | We have an informal process where care team members and providers identify patients/clients for care coordination.   | We routinely assess patients'/clients' needs for care coordination using methods such as pre-visit planning, use of registries and team / provider input.  | We systematically assess the patient/client population for care coordination needs with use of data or screening tools, such as population based registry and community or payer data on a regular basis.   |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>                |   |  |  |   |
| <input type="checkbox"/>   | Choose an item  | Choose an item   | Choose an item   | Choose an item.   |
| <b>4. Care Coordination: To what extent are external care coordinators or care managers identified and collaborative integrated relationships developed?</b> |   |  |  |   |
| <i>Pre-Level</i>   | <i>Level A</i>  | <i>Level B</i>   | <i>Level C</i>   | <i>Level D</i>  |
| None   | We have internal care coordination or management (within clinics, services or co-located) where patients/clients and families have direct involvement in establishing patient centered goals. | We regularly ask our patients/clients if they have external care coordinators or managers by service provider. Names of external care coordinators or managers and other service providers such as specialists, or schools are included on the patients'/clients' care plan and staff members communicate across locations with patient/client and family as partners. | We have developed collaborative relationships with external care coordinators or managers, and appropriate components of external care plans are incorporated into the patients'/clients' care plan and families understand who is involved in their care and participate as partners. | External care managers (including health plan case managers), care coordinators, and patients/clients and families are working together in partnership in a patient centered, coordinated care environment. Roles are defined, communication systems are in place and information is shared and updated in a shared care plan. There is integration on all levels of care coordination. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>                |   |  |  |   |
| <input type="checkbox"/>   | Choose an item  | Choose an item   | Choose an item   | Choose an item  |

| <b>5. Team Based Work: To what extent has your organization addressed how team members implement work functions as a team?</b>                                     |  |  |   |  |
|--|--|--|---|--|
| <i>Pre-Level</i>   | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>  | <i>Level D</i>   |
| None   | Our organization defines who is on the team, identifies roles and functions of team members.     | Our organization has actively worked to define and reorganize roles and responsibilities in team-building based services including the patient/client and family (clients) as an active partner on the team. | Our organization has redesigned roles and responsibilities and established trusting relationships among team members that allow team members to function at the top of their license, education or scope of work.                 | Our organization is actively working to integrate teams with defined roles and responsibilities broadly with a range of services beyond a single provider organization.  |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>                      |  |  |   |  |
| <input type="checkbox"/>   | Choose an item   | Choose an item   | Choose an item  | Choose an item   |
| <b>6. Referral Processes: To what extent are referrals documented, tracked for participation and does the referring provider know the results of the referral?</b> |  |  |   |  |
| <i>Pre-Level</i>   | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>  | <i>Level D</i>   |
| We do not make referrals to providers or community resources.  | Our referral system is informal and staff generally has limited knowledge of referral resources. | Our referral system is somewhat formal and involves providing patients/clients with contact information for referral resources however this does not include follow up.                                      | Our referral processes are established. Referrals are made to providers or to community resources and there is a record maintained of the referral, whether and when the patient/client was seen, and the result of the referral. | Our referral process is formal, well established, referrals are completed in partnership with the patient/client, and includes follow up with the patient/client and referred entity. Data is systematically collected on referrals and used for data analytics such as quality improvement. There is ongoing problem solving with referral resources. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>                      |  |  |   |  |
| <input type="checkbox"/>   | Choose an item   | Choose an item   | Choose an item  | Choose an item   |

|  |  |  |  |  |
|--|--|--|--|--|
| <b>7. Transitions Planning: To what extent is there a formal process for transitioning patients/clients to or from another provider or organization?</b> |  |  |  |  |
| <i>Pre-Level</i>   | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>   | <i>Level D</i>   |
| None   | We have an informal process and it is not done systematically.   | Our process is well-established for some but not all transitions in care provider(s). Assistance is provided on an as-needed basis in response to requests from patient/client and/or family.                      | Our process is well-established for most care provider transitions, and includes post-transition follow-up with patients/clients and caregivers.   | Our process is well-established for transitions between all usual care providers, and care givers. The EHR provides prompts and templates for health care transition activities.   |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>            |  |  |  |  |
| <input type="checkbox"/>   | Choose an item   | Choose an item   | Choose an item   | Choose an item   |
| <b>8. Transitions Communication: Is there care transitions communication?</b>  |  |  |  |  |
| <i>Pre-Level</i>   | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>   | <i>Level D</i>   |
| It is not done systematically.   | Our communication on care transitions and expectations are variable and dependent on each individual provider's interest and usual practice. | We inform patient/client or care giver to call the provider with questions. Team communicates with patients/clients or care givers when there are requests for information, but there is not deliberate follow-up. | We have implemented standardized methods to assess patient's transition. There is monitoring of communication between providers, scheduling follow up appointments by protocol. There may be some difficulty transferring and / or obtaining service records for continued care. | We have ongoing communication by skilled team members that includes written goal setting and care planning with the patient/client and care giver regarding the transition with information and resources. There is minimal difficulty transferring and / or obtaining service records for continued care. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>            |  |  |  |  |
| <input type="checkbox"/>   | Choose an item   | Choose an item   | Choose an item   | Choose an item   |

| <b>9. Quality Improvement: To what extent does your practice have quality improvement (QI) processes in place?</b>  |  |   |   |  |
|---|--|---|---|--|
| <i>Pre-Level</i>  | <i>Level A</i>   | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| None  | We have established a quality improvement team that can measure data, and has a structured quality improvement process in place. | Our quality improvement team meets regularly and includes operations staff. It has a well- developed quality improvement plan that includes the triple aim (clinical, patient/client experience and cost). There is a mechanism in place for input and feedback on quality metrics. | We are transparent in how quality data is shared with providers and team members, and an environment of team collaboration in addressing quality results, including direct input from consumers and partners. | Our administrative team and providers are held accountable for quality improvement, through regular performance assessments linked to QI goals or targets, and possibly individual compensation. |
| <i>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</i>                             |  |   |   |  |
| <input type="checkbox"/>  | Choose an item   | Choose an item  | Choose an item  | Choose an item   |
| <b>10. Training: To what extent does your organization provide access to trainings and other resources on, effective, sustainable communication for care integration?</b> |  |   |   |  |
| <i>Pre-Level</i>  | <i>Level A</i>   | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| None  | We have limited training for our staff.  | We have training available to our staff and it is formally promoted by our leadership.  | We have training widely available to our staff. It is utilized/modeled by our leadership, and is required by our policies.  | Our training is widely used in an inter-professional team or integrated work team.   |
| <i>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</i>                             |  |   |   |  |
| <input type="checkbox"/>  | Choose an item   | Choose an item  | Choose an item  | Choose an item   |

| <b>11. Community Resources: To what extent do you have knowledge of community agencies and resources within the area you serve or have developed partnerships?</b> |   |   |   |  |
|--|---|---|---|--|
| <i>Pre-Level</i>   | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| None   | We have limited knowledge or working relationships with community resources or agencies.  | We make referrals to community resources but have limited knowledge of how community they operate.  | We have established mutually beneficial community partnerships for referrals and we work actively with partners in problem solving and communications.                | We have formalized partnerships supported by an infrastructure where partners plan together, measure outcomes together and share information together. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>                      |   |   |   |  |
| <input type="checkbox"/>   | Choose an item  | Choose an item  | Choose an item  | Choose an item   |
| <b>12. Culturally Appropriate Care Delivery: To what extent is the care delivered sensitive to values, customs and cultures of individuals?</b>                    |   |   |   |  |
| <i>Pre-Level</i>   | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| Not at all.  | We have a basic understanding of the cultural needs of people receiving care or services. | We address the needs of individuals receiving services or care by providing interpreter services, culturally specific educational materials, and staff training on providing culturally appropriate services. | We collect cultural background, racial heritage and primary language information in a systematic way and use this information in providing care delivery or services. | We use demographic data such as race, language and ethnicity for our patient/client population to address disparities.                                 |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>                      |   |   |   |  |
| <input type="checkbox"/>   | Choose an item  | Choose an item  | Choose an item  | Choose an item   |

|   |   |   |   |  |
|---|---|---|---|--|
| <b>13. Emerging Workforce Roles: Does your organization employ emerging professionals (including but not limited to, community health workers, community paramedics, dental therapists)</b> |   |   |   |  |
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| We have never considered, or may be non-applicable to service.  | We are interested in, have done initial research and have begun the planning process to integrate one or more of these roles into our service delivery model. | We've considered and we are redesigning current team member work roles at this time to implement or we're considering bringing on a new role. | We've been implementing but are still unsure if new skills and time are being utilized effectively.   | We have employed "emerging professionals" for some time and we understand how to ensure that new skills and time are utilized efficiently.   |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |   |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item  | Choose an item   |
| <b>14. Patient and Family Centered Care: To what extent has your practice implemented principles of patient and family centered care (that includes family values and preferences)?</b>     |   |   |   |  |
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| None  | We have included these principles as part of our organization's vision and mission statement.   | These principles are a key priority for our organization and are included in training and orientation.  | We include these principles in job descriptions and performance metrics for all staff and providers and incorporate into planning and organization of care. | We consistently and systematically use these principles to guide organization changes, plan care delivery and measure system performance. It is consistently demonstrated in care or services interactions at the person and organization level. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |   |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item  | Choose an item   |

| 15. Patient Centered Care: To what extent is input solicited from patients/clients for organizational improvement activities?                 |   |   |   |  |
|---|---|---|---|--|
| Pre-Level   | Level A   | Level B   | Level C   | Level D  |
| None  | We have an informal process in place collecting patient/client input.   | We regularly solicit patient/client input through patient/client experience surveys and results are shared with clinic teams and acted on.  | We receive frequent input from patients/clients and families using survey methods, point of care information, focus groups or participation on patient/client advisory groups; results are shared with clinic teams and acted on.     | We receive frequent and actionable input from patients/clients and families who participate on interdisciplinary clinic level quality improvement teams to provide input into quality improvement.   |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b> |   |   |   |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item  | Choose an item   |
| 16. Self-Management Support: To what extent are patients/clients provided support in self-management and decision making?                     |   |   |   |  |
| Pre-Level   | Level A   | Level B   | Level C   | Level D  |
| None  | We provide limited self-management by distributing educational materials (e.g., pamphlets, booklets, web pages); information is usually suggested to patients/clients and families without discussions. | Providers and/or staff members, such as a health educator or peer coach, provide patients/clients with education information. We often make referrals to self-management classes or educators with limited instruction, referral, or follow up. | We provide self-management support by goal setting and action planning with members of our service team. Evidence based documents for shared decision making are used by team members or we make referrals to an established partner. | We provide self-management support systematically supported and provided by members of our trained service team in patient empowerment, motivational interviewing techniques, problem solving methods and decision making techniques. Shared decision making with decision aids activities are tracked and evaluated through QI processes. |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item  | Choose an item   |
| <b>Comments- Delivery and Community Integration and Partnership</b> <a href="#">Click here to enter text.</a>                                 |   |   |   |  |

**Infrastructure to Support Shared Accountability Organizations Section**

|   |   |   |   |  |
|---|---|---|---|--|
| <b>17. Infrastructure: To what extent has your organization participated in establishing governance for managing business, legal and financial arrangements with partnering organization?</b> |   |   |   |  |
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| We do not have any partnerships or relationships at this time.  | We have identified partners and have begun the planning process for establishing formal business relationships. | We and our partners have established an oversight body (a group of individuals representing the partners) to set a vision, strategic and business plans, and data sharing agreements that meet regularly. | Our governing body has established a formal legal structure that includes the strategic and business plans and is overseeing the implementation of the plans, approving annual budgets, monitoring financial and operational performance, sharing some aspects of financial gain/risk and related activities. | Our governing body actively responds to changes in the marketplace, reimbursement rates and policy to ensure sustainability of the partnerships. Key aspects of our governance assure that our communities are represented.      |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |   |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item  | Choose an item   |
| <b>18. Governing Body: To what extent does your governing body represent the composition of your community?</b>   |   |   |   |  |
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>  | <i>Level D</i>   |
| No formal governing body exists   | No formal governing body exists, but stakeholder groups are convened based on input from the community.         | A standing membership list based on role is created to advise the organization.   | Governing body composition is representative of the community served, patient family representatives, providers, payers, behavioral health social services, local public health, and education. Formal composition is proposed.   | Governing body composition is representative of the community served, patient family representatives, providers, payers, behavioral health social services, local public health, and education. Composition is formally defined. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |   |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item  | Choose an item   |
| <b>Comments: Infrastructure to Support Shared Accountability</b>  |   |   |   |  |

**Health Information Technology Capabilities Section**

**19. Indicate your practice's implementation of an electronic health record (EHR) system or similar interoperable information system (not including stand-alone practice management systems)**

| <i>Pre-Level</i>  | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>  | <i>Level D</i>  |
|---|--|--|---|---|
| We are not yet using or planning for an EHR<br><b>(Skip to question 33)</b> | We do not use an EHR but are in the planning and/or implementation process | We have an EHR in use for 1%-50% of staff and providers at our practice. | We have an EHR in use for 51%-80% of staff and providers at our practice. | We have an EHR in use for more than 80% of staff and providers at our practice. |

**Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.**

|                          |                                |                                |                                |                                |
|--------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> | <a href="#">Choose an item</a> |
|--------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|

**20. What is the name of the EHR software you use or plan to use? (enter text here)**

**21. To what extent does your practice use your EHR for Computerized Provider Order Entry (CPOE)?**

| <i>Pre-Level</i>                    | <i>Level A</i>   | <i>Level B</i>  | <i>Level C</i>                             | <i>Level D</i>                                   |
|-------------------------------------|--|---|--|--|
| Our practice does not enter orders. | We do not use our EHR for CPOE but are in the planning and/or implementation process | The CPOE function is enabled and in use as part of workflow for 1%-50% of provider orders | We use CPOE for 51%-80% of provider orders | We use CPOE for more than 80% of provider orders |

**Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.**

|                          |                                |                                |                                |                                |
|--------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> | <a href="#">Choose an item</a> |
|--------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|

| <b>22. To what extent does your practice use your EHR for clinical decision support tools, such as: reminders; care plans and flow sheets; guidelines based on conditions specific to the patient/ client or condition?</b> |   |   |  |  |
|---|---|---|--|--|
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>   | <i>Level D</i>   |
| Our practice is not yet using or planning to use clinical decision support tools.   | We do not use clinical decision support tools in our EHR but are in the planning and/or implementation process. | We use the clinical decision support tools in our EHR for 1%-50% of our patients/clients who need it. | We use the clinical decision support tools in our EHR for 51%-80% of our patients/clients who need it. | We use the clinical decision support tools in our EHR for more than 80% of our patients/clients who need it. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |  |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item   | Choose an item   |
| <b>23. To what extent does your practice use your EHR for summary care records?</b>   |   |   |  |  |
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>   | <i>Level D</i>   |
| Our practice is not yet using or planning to use summary care records   | We do not use the EHR to create summary care records but are in the planning and/or implementing process.       | We use the EHR to create summary care records for 1%-50% of our patients/clients.                     | We use EHR to create summary care records 51%-80% of our patients/clients.                             | We use the EHR to create summary care records more than 80% of our patients/clients.                         |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |  |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item   | Choose an item   |

| <b>24. To what extent does your practice electronically track patient/client consent to release health information using your EHR?</b>  |   |   |  |  |
|---|---|---|--|--|
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>   | <i>Level D</i>   |
| Our practice is not yet using or planning to use the EHR or a Health Information Exchange Service Provider (HIESP) to electronically manage patient/client consent.   | We do not currently use the EHR or a HIESP to electronically manage patient/client consent but are in the planning and/or implementation process. | We use our EHR or a HIESP to manage consent for 1%-50% of our patients/clients.                     | We use the EHR or a HIESP to manage consent for 51%-80% of our patients/clients. | We use the EHR or a HIESP for more than 80% of our patients/clients.     |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |  |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item   | Choose an item   |
| <b>25. How does your practice use your EHR to monitor immunization information for your patients/ clients?(For example, accessing the Minnesota Immunization Information Connection to review patients' past vaccination to ensure proper administration for next does or getting alerts or reminders for vaccines)</b> |   |   |  |  |
| <i>Pre-Level</i>  | <i>Level A</i>  | <i>Level B</i>  | <i>Level C</i>   | <i>Level D</i>   |
| Our practice is not yet using or planning to use summary care records.  | We do not monitor immunization information.   | We do not use the EHR to monitor immunizations but are in the planning and/or implementing process. | We use the EHR to monitor immunizations for 1%-50% of patients/clients.          | We use the EHR to monitor immunizations for 51%-80% of patients/clients. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>   |   |   |  |  |
| <input type="checkbox"/>  | Choose an item  | Choose an item  | Choose an item   | Choose an item   |

| 26. How does your practice use data from your EHR for quality improvement? E.g. reporting to the State of Minnesota and/or payers, not including billing |  |  |   |   |
|--|--|--|---|---|
| Pre-Level  | Level A  | Level B  | Level C   | Level D   |
| Our practice is not yet using or planning to use data from the EHR system for quality improvement.   | We do not currently use data from the EHR for quality improvement but are in the planning and/or implementing process. | We use data from the EHR to measure internal quality improvement, such as to create benchmarks, goals or priorities. | We use data from the EHR to support improving the quality of our care delivery. | We use data from the EHR to improve health outcomes for our patients/clients. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>            |  |  |   |   |
| <input type="checkbox"/>   | Choose an item   | Choose an item   | Choose an item  | Choose an item  |
| <b>Comments Health Information Technology</b> <a href="#">Click here to enter text.</a>  |  |  |   |   |

**Health Information Exchange Capabilities Section**

| <b>27. How does your practice electronically exchange clinical information with other organizations (e.g., lab or test results, care plans)? This does not include using fax or unsecure e-mail.</b>   |  |   |  |  |
|--|--|---|--|--|
| <i>Pre-Level</i>   | <i>Level A</i>   | <i>Level B</i>  | <i>Level C</i>   | <i>Level D</i>   |
| Our practice is not yet using or planning to exchange health information electronically  | We do not currently exchange health information electronically but are in the planning and/or implementing process (e.g., identifying use cases) | We electronically push (send) information (i.e., test results, care plan) to affiliated organizations (e.g., practicing within the same health system). | We electronically push (send) information (i.e., test results, care plan) to unaffiliated organizations (e.g., not practicing within the same health system) | We electronically pull (query) information from organizations.   |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>  |  |   |  |  |
| <input type="checkbox"/>   | Choose an item   | Choose an item  | Choose an item   | Choose an item   |
| <b>28. To what extent does your practice electronically exchange a patient's summary of care record, or similar documentation such as a discharge summary or transfer form that has information for continuity of care to other settings or providers? Does not include using fax or unsecure email.</b> |  |   |  |  |
| <i>Pre-Level</i>   | <i>Level A</i>   | <i>Level B</i>  | <i>Level C</i>   | <i>Level D</i>   |
| Our practice is not yet exchanging or planning to exchange the summary care record   | We are not electronically exchanging the summary care records but are in the planning and/or implementing process                                | We electronically exchange the summary care records for 1%-50% of patients/ clients who require transition, referral or sharing with another provider   | We electronically exchange the summary care records for 51%-80% of patients/ clients who require transition, referral or sharing with another provider       | We electronically exchange the summary care records for more than 80% of patients/ clients who require transition, referral or sharing with another provider |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b>  |  |   |  |  |
| <input type="checkbox"/>   | Choose an item   | Choose an item  | Choose an item   | Choose an item   |

| <b>29. To what extent does your practice electronically prescribe non-controlled substances?</b>  |  |  |   |   |
|---|--|--|---|---|
| <i>Pre-Level</i>  | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>  | <i>Level D</i>  |
| We do not prescribe medications.  | Do not e-prescribe but are beginning the planning and/or implementation process. | Use for 1%-50% of prescriptions for non-controlled substances. | Use for 51%-80% of prescriptions for non-controlled substances. | Use for more than 80% of prescriptions for non-controlled substances. |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b> |  |  |   |   |
| <input type="checkbox"/>  | Choose an item   | Choose an item   | Choose an item  | Choose an item  |
| <b>30. To what extent does your practice electronically prescribe controlled substances?</b>  |  |  |   |   |
| <i>Pre-Level</i>  | <i>Level A</i>   | <i>Level B</i>   | <i>Level C</i>  | <i>Level D</i>  |
| We do not prescribe medications.  | Do not e-prescribe but are beginning the planning and/or implementation process  | Use for 1%-50% of prescriptions for controlled substances      | Use for 51%-80% of prescriptions for controlled substances      | Use for more than 80% of prescriptions for controlled substances      |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b> |  |  |   |   |
| <input type="checkbox"/>  | Choose an item   | Choose an item   | Choose an item  | Choose an item  |

31. **No EHR Planned**

*Not Applicable*

32. **Are you currently using an electronic system such as a practice management system or computerized database to manage patient/client information? These do not include billing systems.**

Yes  No

33. **Describe your practice's plans for implementing an EHR, including expected timeframes for planning to actively use the EHR, needs, and expected barriers**

[Click here to enter text.](#)

**Comments-Health Information Exchange** [Click here to enter text.](#)

**Data Analytics Capabilities Section**

| 34. How does your practice approach the topic of data analysis and organization of information?   |  |   |  |   |
|---|--|---|--|---|
| Pre-Level   | Level A  | Level B   | Level C  | Level D   |
| Our practice does not have a strategy for managing information.   | We are beginning to organize information about patients when specific needs or questions arise using tools such as spreadsheets or simple databases. | We are establishing common and reliable source(s) of information to understand our patients/clients and inform practice decisions.  | We have begun to coordinate or integrate data from multiple sources including clinical and financial.  | We have a robust data strategy and reliable data sources to inform practice decisions. Our practice has established data warehouse(s) and analysis software that can aggregate information from multiple sources, including external data sources.  |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b> |  |   |  |   |
| <input type="checkbox"/>  | Choose an item   | Choose an item  | Choose an item   | Choose an item  |
| 35. How is information used by your practice?   |  |   |  |   |
| Pre-Level   | Level A  | Level B   | Level C  | Level D   |
| Our practice is primarily paper based.  | We can view and easily use information about an individual patient's/client's history to identify risk factors.                                      | We use information across patient/client populations to prepare descriptive reports about our common conditions, services or costs. | Our practice uses data to inform strategies or establish clinical or financial targets. We can analyze information from ancillary providers and major partners to allow patient risk profiling, provider assessment, and analysis of defined subpopulations (patients by chronic status, race/ethnicity, compliance level, etc.) We have dedicated staff whose primary responsibilities include interpreting and understanding our data. | We use data to understand our population and how it compares to similar or related practices. We regularly update information to understand how our population and costs are changing. Data is used for predictive or prescriptive analysis. We are beginning to work with community partners to identify opportunities to engage community resources to manage subpopulations with specific needs (engagement of behavioral health/social service, emerging public health threat, etc.). |
| <b>Select the level that best represents your organization, and within that level choose the appropriate response from the drop-down box.</b> |  |   |  |   |
| <input type="checkbox"/>  | Choose an item   | Choose an item  | Choose an item   | Choose an item  |
| <b>Comments Data Analytics Capabilities</b> <a href="#">Click here to enter text.</a>   |  |   |  |   |

**Glossary:**

**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: US. Department of Health and Human Services, [Meaningful Measures of Care Coordination, NCVHS, 2009](#)

**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** 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** 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).

**Clinical Decision Support (CDS)** refers broadly to providing clinicians or patients with clinical knowledge and patient-related information, intelligently filtered or presented at appropriate times, to enhance patient care.

**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.

**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.  
[http://www.ibm.com/smarterplanet/global/files/the\\_value\\_of\\_analytics\\_in\\_healthcare.pdf](http://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf)

**Electronic Health Record (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. An EHR requires the capacity that information be interoperable, or able to send information electronically to other providers within and outside of the treatment setting. 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) or Practice Management System (PMS).

**Emerging 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

**e-prescribing** means secure bidirectional electronic information exchange between prescribers (providers), dispensers (pharmacies), Pharmacy Benefits Managers, or health plans, directly or through an intermediary network. E-prescribing encompasses exchanging prescriptions, checking the prescribed drug against the patient's health plan formulary of eligible drugs, checking for any patient allergy to drug or drug-drug interactions, access to patient medication history, and sending or receiving an acknowledgement that the prescription was filled.

**Health information exchange** or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

**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.*

**Interoperability:** The ability of two or more information systems or components to exchange information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed. **Reference:** [ehealth initiative, DC](#)

**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. [Texas Tech University, Interprofessional Teamwork](#)

**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.

**Push:** This is a secure sending of information between two known entities with an established business relationship, such as a primary care provider and a specialist. These types of transactions typically relate to routine workflow and processes. A non-health care example of a push transaction would be sending an email.

**Pull:** This is a secure accessing of information that involves a query and a response. The query is the request for information about a patient, and the response is the retrieval of clinical information on the patient or information on where the clinical data can be found. For example, conducting a Google web search is a non-health care example of a pull transaction.

**Summary of Care Record**— a summary of care record may include the following elements:

- Patient name
- Referring or transitioning provider's name and office contact information
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Care plan field, including goals and instructions
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Reason for referral
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Current problem list (a list of current, active and historical diagnoses)
- Current medication list (a list of medications that a given patient is currently taking), and
- Current medication allergy list (a list of medications to which a given patient has known allergies)
- Diagnosis lists
- Advance directives
- Contact information; guardianship information
- Critical incident information relating to physical and/or mental/behavioral health

**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 interprofessional team to function as a unit (Salas, DiazGranados, Weaver, and King, 2008).

#### **Resources:**

**Transitions of Care:** The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. [CMS, EHR incentive program, Meaningful Use Menu](#)

**Care Integration:** Evidence shows that this is the most effective component for providing team based/ integrated care. (SAMSHA-HRSA, 2013; Thielke, et al, 2007) [Standard Framework for Levels of Integrated Healthcare, SAMHSA](#)

**ACO-Governance** [How-to Manual for Physicians, AMA](#)

## **Appendix C**

### **Criteria for Scoring Grant Proposals**

#### **Community Collaborative Description (15 points)**

- Does the applicant clearly describe the history, structure, services provided, and patients/clients served by the collaborative organizations?
- Does the applicant provide a clear description of prior collaborations or linkages with other providers and/or organizations? (Are these collaborative relationships effective, well-established, and likely to assure coordination?)
- Does the applicant's description give a clear picture of the EHR, HIT and health information exchange used by the collaborative organizations?
- Does the applicant's description give a clear indication of where organizations are located on the Minnesota Accountable Health Model: Continuum of Accountability Matrix?
- Does the applicant's description give a clear picture of the Medicaid population and current payer mix of the collaborative organizations?
- Does the applicant's give a clear picture of any current or proposed ACO arrangements, and show evidence of meeting requirements related to the number of partners participating in, or planning to participate in, ACO or ACO-like arrangements?

#### **Needs Assessment (15 points)**

- Does the applicant provide a clear description of the geographic area they intend to serve including information from any community health needs assessments?
- Does the applicant provide a clear description of the health status of the population to be served? If applicable, is there comparison to regional and state information? Is there information on health factors such as age, poverty, disparities, substance abuse and other social problems?
- Does the applicant provide a clear description of the health and health care delivery system - (e.g., hospitals, solo and group practices, primary care and specialty clinics, Community Health Centers and Emergency Medical Services) including any health workforce issues? If applicable, does the applicant include any health reform activities such as Health Care Homes?
- Does the applicant provide a strong statement of the unmet e-health needs and potential impact on health outcomes?
- Does the applicant clearly identify why they need grant funding for this project?

#### **Project Description (15 points)**

- Does the applicant clearly identify their target population and why the collaborative is suited to provide services to that target population? If applicable, does the applicant clearly identify how this project meets the needs of the community in rural and/or underserved areas or populations?
- Does the applicant provide a clear description of how this project (goals/objectives) will meet the e-health needs of the community – including coordination of health and health care services?
- Does the applicant provide a clear description of the how this project may improve community health outcomes?

### **Work Plan and Evaluation Plan (30 points)**

- Does the applicant provide clear measures and outcomes for each proposed objective?
- Does the applicant provide clear objectives and time frame for each proposed component?
- Are the proposed methods for each objective for each component clearly described, measurable, and realistic?
- Is the use case clearly identified and described?
- Is the proposed communication plan adequate for the proposed activities/strategies for each objective?
- To what extent does the proposed evaluation plan effectively measure the project's progress toward meeting their objectives?

*For implementation grants only:*

- Does the applicant include evidence that the project is part of the collaborative long term strategic plan?
- Does the applicant include documentation that development planning activities have been completed including due diligence, workflow analysis, clinician and consumer involvement (if applicable), etc.?
- Is the applicant's plan for implementation, staff training, maintenance and technical support reasonable?
- Is the formal process for governance clearly described?

### **Project Team (10 points)**

- Does the applicant show they have well-trained and experienced staff to complete the proposed project?
- Are the project leads or co-leads and qualifications clearly identified and described?
- Are the project team members, project roles and qualifications clearly identified and described, including any clinicians involved with the project?
- Is the source of any in-kind support (internal or external) clearly described?

### **Budget (10 points)**

- Are the (suggested) Budget Summary Form and the Budget Justification complete?
- Do the amounts on Budget Form match what is in the Budget Justification?
- Is the Budget Justification information consistent with what is in the proposed Work Plan?
- Are the projected costs reasonable, cost-effective, and sufficient to accomplish the proposed activities?
- Is the proposed match reasonable and adequately described?

### **Evidence of Commitment and Support (5 points)**

- Does the proposal include Letters of Commitment from all collaborating organizations?
- Do the letters of commitment must also declare plans to participate in an accountable care organization (ACO) or similar health care delivery model that have a plan for financial risk sharing among participants?
- Does the proposal include Letters of Support from other organizations participating in the grant are allowed but not required?

## Appendix D

**Note: This is a not a required format for use case or user story. It is a template created for public health that may be used or adapted as applicable.**

### 1.1.1.1 Office of National Coordinator for Health IT (ONC)

#### Standards and Interoperability (S&I) Framework

#### Public Health Reporting Initiative

#### User Story Template

*Using this template, please describe (a) scenario(s) of data reporting to your program from clinical information systems, e.g., Electronic Health Records (EHR) systems, Laboratory Information Management Systems (LIMS) and others, and/or (b) scenario(s) of data exchanges between clinical and public health information systems to support your program's activities.*

#### User Story Narrative

*This section will be used to identify key components and requirements of public health reporting that may be standardized.*

##### 1.1.2 Goal

*Please describe the overall goals of the public health reporting/data exchange with clinical systems for your program. Please describe how these data are used by your programs or clinicians involved in the data exchange.*

##### 1.1.3 Data Reporting/Exchange Participants (Actors) and Events (Workflow)

*Please describe participants in data reporting or exchange: people (Business Actors) and information systems (Technical Actors). Please also describe the workflow process (flow of events) in which data are collected and/or exchanged now as well as your vision for how data can be reported / exchanged in the future. Please use the template in Attachment 1 to describe the Actors and Workflow.*

##### 1.1.4 Data

*Please provide a list of data elements for the report or a dataset to be exchanged. You may submit a sample report form or an excel spreadsheet with the data elements. Please indicate the required and optional data elements on the report / dataset.*

##### 1.1.5 Standards

*Please describe health information technology (HIT) standards that support data reporting/exchange. Please also describe participation of your program in the national HIT standardization activities.*

1.1.6 Other Information

Please provide other information that could support selection of this user story for the PHRI Phase 2.

1.2 Stakeholder Commitment

Please describe the level of stakeholder readiness and commitment to participate in PHRI.

1.3 Story Submitter Contact Information

Please provide contact information for the Story Submitter (Name, Organization, Position, Address, Phone, E-mail), so we could contact you regarding your User Story.

**Attachment 1: User Story: Actors and Workflow Template**

Please complete sections *in red* by providing information from your User Story.

|  |  |   |
|--|--|---|
| <b>Name:</b>   | <i>Name of Your User Story</i>   |   |
| <b>Actors:</b>   | <b>Business Actors (people):</b> <i>List participants in data reporting/exchange</i><br><b>Technical Actors (information systems):</b> <i>List information systems involved in data reporting/exchange</i> |   |
| <b>Flow of Events</b><br><i>Describe activities of Business Actors in reporting or data exchanges:</i>                           |  | <b>Data Categories</b><br><i>List types of documents/forms/ datasets by event:</i>  |
| <i>1.Patient visits Provider. Provider enters visit data into EHR.</i><br><br><i>2.Provider orders Test</i><br><br><i>3.etc.</i> |  | <i>1.Patient, provider demographics, Medical Summary</i><br><i>2. Consent or Consent Refusal, Test order</i><br><i>3. etc</i> |
| <b>Pre-Conditions:</b>   | <i>Sender - List Technical Actor(s), i.e., system(s) that creates/sends reports</i>  |   |
| <b>Post-Conditions:</b>  | <i>Receiver - List Technical Actor(s), i.e., system(s) that receives reports</i>   |   |
| <b>Preferred Timing:</b>   | <i>Identify the desired frequency of reporting/data exchange</i>   |   |

## **Attachments**

1. Proposal Cover Form
2. Suggested Budget Form
3. Grant Proposal Checklist
4. Accounting System and Financial Capability Questionnaire

**2014 Minnesota Accountable Health Model e-Health Grant Program  
Proposal Cover Form**

1. Type of grant being applied for:

Development  
Implementation

2. Lead Applicant Organization: organization that will serve as the collaborative fiscal agent for project. Grant agreement will be executed with this organization.

Legal Name

Federal Tax ID #

State Tax ID #

3. Names and addresses of the collaborating organizations:

4. Total amount of state grant funds applied for: \$

Total dollar value of match (cash or in-kind): \$

5. Contact person for further information on proposal:

Name

Title

Organization:

Address:

Phone:

E-mail:

I certify that the information contained herein is true and accurate to the best of my knowledge, and I have been authorized to submit this proposal on behalf of the applicant organizations listed above.

*Signature of Authorized Official*

*Title of Authorized Official*

*Date*

# Minnesota Accountable Health Model e-Health Grant Program

## Suggested Budget Form

Note: The grant narrative must include a budget justification narrative explaining each line item below.

| Categories  | State Funding Requested | Financial Match* | In-kind match* | Total |
|---|-------------------------|------------------|----------------|-------|
| Total Personnel   |                         |                  |                |       |
| Salaries  |                         |                  |                |       |
| Fringe  |                         |                  |                |       |
| Travel  |                         |                  |                |       |
| Software (implementation grants only)                   |                         |                  |                |       |
| State-Certified HIE Service Provider Subscription Costs |                         |                  |                |       |
| Supplies  |                         |                  |                |       |
| Consultants/ Contractors**                              |                         |                  |                |       |
| Other   |                         |                  |                |       |
| <b>Sub-Total</b>  |                         |                  |                |       |
| Indirect (no more than 10% of the sub-total)            |                         |                  |                |       |
| <b>TOTAL</b>  |                         |                  |                |       |

\* The 20 percent match can be either in financial or in-kind services. It is not necessary to have either or both types of match for each line item. The only requirement is that the total of the financial match and the in-kind match must be at least one-third of the total grant dollars being applied for. In-kind match should be expressed in dollars, and can include, but is not limited to, staff time (the value of salaries and fringe) spent by collaborating organizations on the project (for example, staff time spent in planning, governance, or IT support), communications and mileage costs related to planning or governance meetings, and equipment needed to enable exchange or adoption of HIT.

\*\* Contractors must be identified. If contractors have not yet been identified, explain the selection process your collaborative will use.

## 2014 Minnesota Accountable Health Model e-Health Grant Program

### Proposal Checklist

- This form is for your purposes only, and does not need to be submitted with your grant proposal.
- Grant proposal cover form is completely filled out.
- Grant proposal form is signed by an authorized agent of the collaborative.
- Excluding cover form, budget forms and letters of commitment and support narrative does not exceed 20 pages.
- Proposal narrative is at least 12-point type.
- Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool results
- Budget form is enclosed.
- Accounting System and Financial Capability Questionnaire form is enclosed.
- Letters of commitment are enclosed from each of the collaborative organizations listed.
- Ten plain white paper copies and an electronic copy of the proposal on a USB drive must be received before 4:00 p.m. on May 5, 2014.

Anne Schloegel  
Office of Health Information Technology  
Minnesota Department of Health

|   |  |
|---|--|
| Courier delivery:   | Postal address:                                    |
| 85 East 7 <sup>th</sup> Place, Suite 220<br>Saint Paul, Minnesota 55101 | P.O. Box 64882<br>Saint Paul, Minnesota 55164-0882 |



## ACCOUNTING SYSTEM AND FINANCIAL CAPABILITY QUESTIONNAIRE

*This is the standard form to be used in order to determine the financial capacity of grant applicants. The creation and implementation of this form is in response to the best practices stated in the Office of Legislative Auditor's report "State Grants to Nonprofit Organizations," January 2007.*

**No applicants will be excluded from receiving funding based solely on the answers to these questions.**

| SECTION A: APPLICANT INFORMATION   |  |   |
|--|--|---|
| 1. Organization Name and Address   | 2. Employer Identification Number  | 3. Number of Employees<br>Full Time: _____ Part Time: _____   |
| 4. When did the applicant receive its 501(c)3 status? (MM/DD/YYYY)?  |  |   |
| 5. Is the applicant affiliated with or managed by any other organizations (Ex. regional or national offices)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," provide details:<br><br>5b. Does the applicant receive management or financial assistance from any other organizations? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," provide details: |  | 6a. Total revenue in most recent accounting period (organization's 12 month fiscal year).<br><br>6b. How many different funding sources does the total revenue come from? |
| 7. Does the applicant have written policies and procedures for the following business processes?   |  |   |
| a. Accounting  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   | If yes please attach a copy of the table of contents  |
| b. Purchasing  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   | If yes please attach a copy of the table of contents  |
| c. Payroll   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   | If yes please attach a copy of the table of contents  |
| SECTION B: ACCOUNTING SYSTEM   |  |   |
| 1. Has a Federal or State Agency issued an official opinion regarding the adequacy of the applicants accounting system for the collection, identification and allocation of costs for grants <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| <i>Note: If a financial review occurred within the past three years, omit Questions 2 – 6 of this Section and 1-3 of Section C.</i>  |  |   |
| a. If yes, provide the name and address of the reviewing agency:   | b. Attach a copy of the latest review and any subsequent documents.  |   |
| 2. Which of the following best describes the accounting system? <input type="checkbox"/> Manual <input type="checkbox"/> Automated <input type="checkbox"/> Combination  |  |   |
| 3. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   |   |
| 4. If the applicant has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure<br><input type="checkbox"/> Not Applicable      |   |
| 5. Are time studies conducted for an employee(s) who receives funding from multiple sources?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure<br><input type="checkbox"/> No Multiple Sources |   |
| 6. Does the accounting system have a way to identify over spending of grant funds?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   |   |
| SECTION C: FUND CONTROL  |  |   |
| 1. Is a separate bank account maintained for grant funds?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   |   |
| 2. If grant funds are mixed with other funds, can the grants expenses be easily identified?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   |   |
| 3. Are the officials of the organization bonded?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   |   |
| SECTION D: FINANCIAL STATEMENTS  |  |   |
| 1. Did an independent certified public accountant (CPA) ever examine the organization's financial statements?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure   |   |
| SECTION E: CERTIFICATION   |  |   |
| I certify that the above information is complete and correct to the best of my knowledge.  |  |   |
| 1. Signature   | 2. Date     /     /  |   |
| 3. Title   |  |   |