Request for Proposals

Minnesota Accountable Health Model

*Practice Facilitation*

Grant Program

January 15, 2015
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1. Overview

The Minnesota Department of Health requests proposals for the Minnesota Accountable Health Model Practice Facilitation grant program to provide practice facilitation services to primary care clinics, behavioral health, social services, long term and post-acute care providers of services or sites seeking to become part of an accountable care model or a similar care delivery model. This grant opportunity will provide funding for a grantee(s) to use a range of organizational assessments, project management, quality improvement (QI), and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits. The applicant will use best practices and learning tools, perform gap analyses, provide financial and/or payment system analysis, employ process and outcome measures, and facilitate the transformation of the organization’s current care delivery system.

2. Background

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

The vision of the Minnesota Accountable Health Model is:

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

The Minnesota Model will test whether increasing the percentage of Medicaid enrollees and other populations (i.e. commercial, Medicare) in accountable care payment arrangements will improve the health of communities and lower health care costs. To accomplish this, the state will expand the Integrated Health Partnerships (IHP) demonstration (https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/) , formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services.

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*a Developing and Running a Primary Care Practice Facilitation Program: A How-To Guide, page 1.*
The expanded focus will be on the development of integrated community service delivery models and use of coordinated care methods to integrate health care, behavioral health, long-term and post-acute care, local public health, and social services centered on patient needs.

To achieve the vision of shared cost and coordinated care, the Minnesota Accountable Health Model includes key investments in five Drivers that are necessary for accountable care models to be successful. (see Minnesota Accountable Health Model Driver Diagram [http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_182962.pdf])

**Driver-1** Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement—HIT/HIE

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

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

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

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

The activities contained in this RFP are linked to Driver-3: Expanded number of patients served by team based integrated/coordinated care.

**Minnesota Accountable Health Model Continuum of Accountability Matrix**

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. The [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestRelease&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 identify criteria and priorities for investment, and lay out developmental milestones that demonstrate organizations or partnerships are making progress towards the vision.

In addition, the [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.health.state.mn.us/e-health/mahmassessmenttool.docx) 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.

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).
3. Goals and Outcomes

The goal of transforming primary care, behavioral health, social services, or long term and post-acute care services is to improve access to health services, improve the ability of organizations to participate in ACO or similar accountability-based payment arrangements, provide better coordination of care, improve quality, lower cost, and improve health of populations.

The goal of this grant program is to support a range of providers and teams, working in primary care, behavioral health, social services, or long term and post-acute care services, by allowing them to participate in practice facilitation activities that promote transformation including the integration of care with other service providers and successful participation in ACO or similar models.

To successfully participate and support this goal, a grantee(s) must complete a practice facilitation project that supports the broad goals of the Minnesota Accountable Health Model related to providing coordinated care across settings for complex populations and supporting models of accountable care. The priority for this grant is to fund practice facilitation strategies that will help:

- Primary care clinics transform into Health Care Homes
- Behavioral Health settings that are interested in becoming Behavioral Health Homes.
- Service providers working to integrate health care, behavioral health, social services, long term and post-acute care services, and/or organizations seeking to become part of an accountable care model or a similar care delivery model.
- Integration of non-physician healthcare team members such as community health workers, community paramedics, dental therapist/advanced dental therapists, health educators, nutritionists, and peer support specialists into health related organizations.
- Establish robust community partnerships to support broader accountability

4. RFP and Grant Timeline

<table>
<thead>
<tr>
<th>Key Dates</th>
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<tbody>
<tr>
<td>RFP Posted</td>
<td>Thursday, January 15, 2015</td>
</tr>
<tr>
<td>Notice/Letter of Intent Due (required)</td>
<td>Tuesday, February 3, 2015</td>
</tr>
<tr>
<td>Informational webinar (optional)</td>
<td>Thursday, January 29, 2015, 10-11 am CST</td>
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<tr>
<td></td>
<td>To register for the Practice Facilitation webinar visit:</td>
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<td><a href="https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=te07978e3879f8a3939cf8c302664d3a7">https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=te07978e3879f8a3939cf8c302664d3a7</a></td>
</tr>
<tr>
<td>Application deadline</td>
<td>Tuesday, March 3, 2015, 4 pm CST.</td>
</tr>
<tr>
<td>Estimated notice of awards</td>
<td>Friday, March 27, 2015</td>
</tr>
<tr>
<td>Estimated grant start date</td>
<td>May 2015</td>
</tr>
<tr>
<td>Grant end date</td>
<td>December 31, 2016</td>
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5. **Available Funding**

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<table>
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<tbody>
<tr>
<td><strong>Total Amount Available</strong></td>
<td>$1,016,000</td>
</tr>
<tr>
<td><strong>Number of Grant Awards</strong></td>
<td>2-5</td>
</tr>
<tr>
<td><strong>Grant Award Amounts</strong></td>
<td>$200,000-$500,000 MDH reserves the right to negotiate changes to budgets submitted with the proposal.</td>
</tr>
<tr>
<td><strong>Grant Timeline</strong></td>
<td>May 2015 through December 2016. Time line is dependent on contract execution.</td>
</tr>
<tr>
<td><strong>Applicants</strong></td>
<td>Each organization is only eligible to apply for one grant.</td>
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</table>

Two to five grants will be awarded to organizations which will provide a wide range of practice facilitation activities to primary care, behavioral health, social services, long term and post-acute care providers or accountable care organizations or organizations seeking to become part of an accountable care model. The grantee will be expected to provide practice facilitation services based on the needs and goals of the provider practice/integrated care team or organizations. Activities can include, but are not limited to, the following:

- Assessment of and feedback to practices regarding organizational, clinical, and business functions to drive change
- Use of practice-level data to drive change
- Training of staff in QI methods and specific transformation processes, such as team-based care
- Formation and facilitation of practice QI teams
- Executive coaching and leadership training
- Implementing/Training on best practices in QI structures and methods
- Support, encouragement, reinforcement, and recognition of successes
- Project and change management services
- Support the planning for resource identification and procurement
- Capacity building in the use of health information technology (HIT) to support improved clinical care and office efficiency
- Cross-pollination or peer to peer sharing of good ideas and best practices between primary care practices
- Capacity building for improved linkages to outside resources
- Technical assistance (TA) in implementing particular models of care, such as the chronic care model (CCM)
- Capacity building for financial and/or payment systems and analysis to reduce cost.

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Adapted from *Developing and Running a Primary Care Practice Facilitation Program: A How-To Guide, page 2-3*
The key elements to advancing primary care transformation historically has been a cornerstone of organizations serving the underserved and can be applied to transforming our health care delivery system in general. These key elements include:

- **Consistent access** to primary care, regardless of time of day or night.
- **Patient-centered care coordination** at the primary care provider level that effectively addresses chronic conditions and the unique needs of patients.
- **Emphasis on patient and organizational safety**
- **Patient engagement**, so patients become active partners in improving their health status and are better equipped to meet treatment goals.
- **Improved communication and education** between providers and patients, to address issues such as health literacy, cultural sensitivities, and language barriers.
- **Alignment of incentives for providers** such as using pay-for-performance and value-based payment arrangements.
- **Team-based care** which encourages a multi-disciplinary approach to care that allows all team members to practice at the top of their capacity/license.
- **Emphasis** on continuous quality improvement and outcomes measurement, using data analytics, E-health, and process workflows.

### 6. Eligible Applicants

The grantee(s) must have the qualifications to implement practice facilitation that is demonstrated through the organization’s capacity and experience and/or contracted relationships in place.

**Experience and skills the grantee(s) must have:**

- Knowledge and expertise of subject matter related to health care homes, leadership development, quality improvement, health information technology, transitions planning, primary care, behavioral health, social services, long-term care and post-acute care, accountable care organizations, or access to experts with this expertise through significant contract relationships.
- Knowledge of principles of adult learning and framework of change, quality and coaching improvement processes.
- Experience designing and implementing work plans with or for a variety of provider types and for practices of various sizes.
- Demonstrated ability to effectively involve patients and families in practice facilitation.
- Demonstrated ability to implement both face-to-face, virtual, and distance learning activities in a coaching relationship.
- Experience with evaluating the processes, goals and outcomes of learning activities, including the progress of implementation and culture change.
- Ability to capitalize on the expertise of experienced team members and existing infrastructures.

### Expected competencies for the practice facilitation grantees

It is expected that applicants are skilled and have competencies to provide practice facilitation services that include the following areas:

**Change Management**

- Foster practice, integrated care teams for improving patient care and changing the way the services are provided.
- Coach the practice in forming a multi-disciplinary quality improvement team that can measure and interpret the results of change.
- Work with the practice, integrated care team, and/or program to assess their performance and establish project goals and parameters.
- Use practice, integrated care team, and/or program level data to assist in establishing sequences and timelines for quality improvement initiatives, and to evaluate the impact of changes.
- Train practice, integrated care, and/or program teams in conducting PDSA (Plan-Do-Study-Act) cycles/model for improvement.
- Facilitate communication around evolving roles and relationships.
- Recognize, reinforce, and celebrate success.
- Provide feedback and coaching for practice, integrated care team, and/or organizational leaders.

**Technical Assistance and Training**
- Identify skills based training needs and recommend training for the team.
- Identify and implement models of care, innovative strategies and evidence based guidelines.
- Support practice, integrated care, and program teams in implementing shared decision making, self-management support, patient and family-centered care.

**Health Information Technology**
- Support the practice and integrated care teams in using technology to improve patient care and office efficiency.
- As appropriate, assist practice and integrated care teams in implementing data collection tools; using them to improve panel management, care coordination, care management, referrals, follow-up and other aspects of patient care.

**Connection with Community**
- Support the incorporation of integrated care teams into practice and organization workflow.
- Identify connections and support practice integrated care, and program teams with outside resources including behavioral health, social services, long term and post-acute care services, accountable health organizations, and public health.

7. **Required Deliverables and Activities**

**A. Recruitment Process:**

Grantee will develop a recruitment process that publicizes practice facilitation through the Minnesota State Innovations Model (SIM) Project, behavioral health homes advisory group and other relevant advisory bodies, primary care practices, and other associations representing public health, social services, long term care and acute care services. The recruitment process can include referrals from the State’s Health Care Home (HCH) capacity building staff. The grantee will submit a plan and timeline for this process to state staff, who must approve the process and timeline before any applications from providers are solicited.

Upon approval of the recruitment process, the grantee(s) will solicit applications from primary care, behavioral health, social services, long term and post-acute care organizations or sites seeking to become part of an accountable care model or a similar care delivery model to provide services for the duration of the grant with the State. These applications and/or agreements may be staggered over time so that not all project participants are being served at the same time.

The grantee is required to include the following in the recruitment process of practices seeking to receive services:
• An objective process for selecting organizations that serve individual practices in primary care, behavioral health, social services, long-term and post-acute care organizations, and integrated accountable care organizations or similar models.
• The grantee will also identify whether a recipient of services could apply for more than one project or cycle.
• Defined criteria for project participant duration. Project participants could potentially receive services from 3 to 12 months, depending on the size of the participant’s organization, complexity, and the goals of the practice facilitation project.
• A sample of participant agreement to be used with each organization that includes clear responsibilities for each party, a plan of approach, and a timeline for accomplishing the work.

B. Planning Process

The grantee will be required to complete the following activities in preparing to deliver practice facilitation services to an organization:

• Assess each organization’s leadership and quality improvement organizational structure and their ability to implement transformational change.
• Complete a gap analysis of each organization’s current operational processes, which include: access, registries, care planning, care coordination, quality improvement, data analytics, financial modeling, teamwork, partnerships, and patient/family-centered care.
• Utilize the Minnesota Accountable Health Model: Continuum of Care Accountability Matrix Tool for each organization to identify the current status for each standard element.
• Prepare a work plan with each organization that outlines next steps, strategies, time lines and resource requirements related to their needs for the time period of the project.

C. Work Plan

The grantee will create an overall work plan for the project, which must be approved by the MDH Practice Facilitation Grant Manager. The components listed below are required to be included in the Work Plan. Further information on how to complete the work plan are included in the Proposal Instructions Section.

• Recruitment Process
• Planning Process
• Assessments
• Evaluation

D. Reporting and Dissemination

The grantee will be required to perform the following activities:

• Implement an evaluation plan of the practice facilitation activities using 5-10% of project dollars to be reported to MDH.
• Attend regular meetings or conference calls with MDH to keep MDH informed on the progress of recruiting clinics, providers, or organizations; up-dating MDH on agreements with clinics, providers, or organizations; and reporting on progress and challenges with the project.
• Provide quarterly progress reports and a final report describing challenges, barriers, lessons, and successful strategies used in achieving transformation. Quarterly reports will include the type of practice facilitation support each recipient agency is receiving with the goals for the services
provided, frequency and types of services provided, challenges, progress made and evaluation of activities. MDH will provide a template for reporting.

- Submit expenditure reports and invoices monthly or quarterly, based on the approved budget and work plan.
- Provide recommendations and materials that MDH and clinics, providers, or health related organizations in transformation can use to further disseminate lessons learned.
- Prepare and give 4-8 presentations about this project, audiences may include other SIM projects involved in transformation, learning day conferences or other SIM learning collaborative activities.
- Collaborate with other contractors, grantees, or partners associated with the SIM grant and the Minnesota Accountable Health Model as appropriate.

8. Application Review Process

Grant proposals will be reviewed for experience and expertise in providing practice facilitation services, and the quality and effectiveness of the services they propose to provide. The State will evaluate proposals and the final selection will consider the ability to provide services and the ability to focus on the following priorities:

- Primary care clinics transforming into Health Care Homes
- Behavioral health settings interested in becoming behavioral health homes
- Service providers working to integrate health care, behavioral health, social services, long term and post-acute care services, or accountable care organizations or similar models
- Integration of non-physician healthcare team members such as community health workers, community paramedics, dental therapist/advanced dental therapists, health educators, nutritionists, and peer support specialists into health related organizations.
- Establish robust community partnerships to support broader accountability.

Grant proposals will be reviewed and evaluated by a panel familiar with practice facilitation programs. The panel may include staff from the Minnesota Department of Health and Minnesota Department of Human Services. The panel will recommend selections to the Commissioners of Health and Human Services. In addition to panel recommendations, the commissioners may also take into account other relevant factors in making final awards, including geographic service areas, number of grantees, and a cross section of practice facilitation services both in complexity and focus.

This request for proposals does not obligate the state to award a grant or complete the project, and the state reserves the right to cancel the solicitation if it is considered to be in its best interest. The state may award up to five grants for this RFP.

Only complete applications that meet eligibility and application requirements and are received on or before 4:00 pm CST on Tuesday, March 3, 2015, will be reviewed. Reviewers will determine which applications best meet the criteria for the RFP and should be recommended for funding. We anticipate that grant award decisions will be made by March 27, 2015. Applicants will be notified by letter whether or not their proposal was funded. MDH reserves the right to negotiate changes to budgets submitted with the proposal.

The anticipated effective date of the agreement is May 2015, or the date upon which all signatures are obtained. Grant agreements will end on December 31, 2016. No work on project activities can begin until a fully executed grant agreement is in place. Execution of the contract is dependent on Center of Medicare and Medicaid Innovation (CMMI) approval of the contractor, contractor’s budget, and the release of funds from CMMI.
9. Grant Application and Program Summary

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Applicant</td>
<td>Proposals may be initiated by individuals or organizations with experience in providing practice facilitation services to primary care clinics, behavioral health, social services, long term and post-acute care services or other integrated or accountable care organizations or similar models.</td>
</tr>
<tr>
<td>Total Funds Available</td>
<td>Up to $1,016,000 through December 31, 2016.</td>
</tr>
<tr>
<td>Maximum Award Amount</td>
<td>Up to 5 grants with a maximum award of $500,000. A total of $1,016,000 in funding is available through December 31, 2016. Award amounts will be considered in the amounts of $200,000-$500,000.</td>
</tr>
<tr>
<td>Duration of Funding</td>
<td>May 2015 through December 31, 2016, 20 months.</td>
</tr>
<tr>
<td>Grant Purpose</td>
<td>To provide practice facilitation services to primary care, behavioral health, social services, or long term and post-acute care organizations that are working towards integration of care, improved quality and satisfaction with care, and reduced cost.</td>
</tr>
<tr>
<td>Letter of Intent</td>
<td><strong>Required:</strong> Non-binding Letter of Intent to Respond required by <strong>February 3, 2015 at 4:00 pm CST.</strong> Use the template in <strong>Form E.</strong> Letters of Intent to Respond must be submitted via e-mail to: Janet Howard Minnesota Department of Health Health Care Homes / SIM Unit <a href="mailto:Janet.Howard@state.mn.us">Janet.Howard@state.mn.us</a></td>
</tr>
<tr>
<td>Application Requirements</td>
<td>• Applications must be written in 12-point font with one-inch margins with a maximum of 16 pages; Applicant Experience and Capacity-4 pages and Project Plan 12 pages. • Page limits are outlined in Section 10. • All pages must be numbered consecutively. • Applicants must submit 7 copies of the proposal and an electronic version of the proposal on a USB drive. • Faxed or emailed applications will not be accepted. • Applications must meet application deadline requirements; late applications will not be reviewed. • Applications must be complete (refer to section below for description of completed application) and signed where noted. • Incomplete applications will not be considered for review.</td>
</tr>
<tr>
<td>For an Application to be considered complete, applicants must include the following forms in the listed order</td>
<td>1. Application Face Sheet (Form A) 2. Description of the Applicant Experience and Capacity (4 page limit) 3. Project description and required deliverables (12 page limit) 4. Work plan (Form B) (Document will be referenced in grant agreement) 5. Budget (Form C) 6. Budget Justification (Form D) 7. Due Diligence (Form F) (Include only one copy with original copy.) 8. Practice Facilitation Contracts (Form G)</td>
</tr>
<tr>
<td>Submitting the Proposal</td>
<td>Applicants must submit seven (7) copies of the proposal and an electronic proposal on a USB drive.</td>
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<tr>
<td>Requirement</td>
<td>Description</td>
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</tr>
<tr>
<td>Requirement</td>
<td>Proposals must be received by 4:00 p.m. CST on Tuesday, March 3, 2015</td>
</tr>
<tr>
<td>Application Deadline</td>
<td>4:00 p.m. CST Tuesday, March 3, 2015</td>
</tr>
<tr>
<td>Applications Sent</td>
<td><strong>Delivery Address:</strong> Attn: Janet Howard Minnesota Department of Health Health Care Homes / SIM Unit 85 East 7th Place, Suite 220 Saint Paul, Minnesota 55101 <strong>Mailing Address:</strong> Attn: Janet Howard Minnesota Department of Health Health Care Homes / SIM Unit P.O. Box 64882 Saint Paul, Minnesota 55164-0882</td>
</tr>
<tr>
<td>Questions</td>
<td>Questions regarding this RFP must be submitted in writing by February 20, 2015 to <a href="mailto:Janet.Howard@state.mn.us">Janet.Howard@state.mn.us</a> Questions can be submitted through the State Innovation Model web site at <a href="http://www.mn.gov/sim">http://www.mn.gov/sim</a>. All written questions and answers that MDH has addressed will be posted on the State Innovation Model Grant (<a href="http://www.mn.gov/sim">http://www.mn.gov/sim</a>)</td>
</tr>
<tr>
<td>RFP Addenda</td>
<td>All addenda to this RFP will be posted on the Practice Facilitation RFP page of the Minnesota Accountable Health Model – SIM Minnesota website. It is the responders’ sole responsibility to periodically check the website for any addenda that may be posted.</td>
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### 10. Proposal Instructions

Following are the minimum requirements of the Proposal Narrative. Applicants should place emphasis on completeness and clarity of content.

**A. Description of the Applicant Experience and Capacity (Limit 4 pages)**

This section must include a brief description of the applicant in the following areas:

- Practice facilitation experience related to primary care, behavioral health, social services, long term and post-acute care services, or other integrated or accountable care organizations or similar models.
- Experience in building authentic partnerships across disciplines and settings.
- Experience and responsibilities for practice facilitation, practice transformation, systems redesign, and/or organizational culture change.
- The skills, qualifications and capacity of the project team that will provide practice facilitation. Include a description of the ability to provide services on a regional or statewide basis. **Include CVs of staff in an appendix.**
- Anticipated barriers and challenges to implementing this project and potential solutions.
• Using template Form G include a list of current and past clients the applicant has worked with related to practice facilitation. This should also include the experience of contractors included in this proposal. (The Form does not count towards the page limit)

A. **Criteria for Grant Review:** Description of the applicant experience and capacity section will be reviewed and scored according to the following criteria (35 points):

- The applicant has demonstrated experience in working with primary care, behavioral health, social services, long term and post-acute care services, other integrated accountable care organizations or similar models.
- The applicant has experience building authentic partnerships across professional disciplines and settings identified as primary care, behavioral health, social services, long term and post-acute care services or other integrated accountable care organizations or similar models.
- The description includes the applicant’s experience, capacity, and responsibility for providing practice facilitation services, practice transformation, systems redesign, and/or culture change.
- The applicant has included a clear description of the skills and qualifications of project team to provide the proposed practice facilitation services and the geographic location of the services.
- The applicant identifies potential barriers, such as recruitment or capacity to meet the need, and realistic solutions to identified barriers.
- The applicant included a list of current and past clients of practice facilitation of services.

B. **Project Plan (Limit 12 pages)**

This section must describe in detail how the project will carry out the following deliverables in an effective and efficient manner, including who will be involved, what resources are required, target dates for project activities, and the timeframe for completion.

- **Recruitment:** Include a description of the proposed strategy that will be used to recruit primary care clinics, or other integrated care models including behavioral health, social services, or long term care and post-acute care services, or sites seeking to become part of an accountable care model or similar care delivery model, for participation in this intensive transformation program. The description must include the following:
  ✓ An estimated number of organizations that will be recruited, as well as a description of the basis for the estimate.
  ✓ Process that will be used to solicit applications from potential recipients of services.
  ✓ Process for determining projects to be completed, time frame, and the types of services to be provided.
  ✓ A sample of participant agreement to be used with each organization that includes clear responsibilities for each party, a plan of approach, and a timeline for accomplishing the work.

- **Planning Process:** Describe the planning process you will use to develop the work plans for each organization receiving practice facilitation services. Include the following information:
  ✓ Planning process to establish each organization’s transformation plans.
  ✓ Monitoring and feedback process for transformation activities.
  ✓ Evaluation strategies to help organizations demonstrate and understand transformation successes.
  ✓ Description of strategies to engage members of the organization’s team to implement the transformation plan.
If applicable, describe how patients/consumers/clients and their families will be involved in the proposed transformation and the key considerations for involvement.

- **Assessment:** Describe proposed methods used to complete the required leadership and quality improvement assessments. Include in your description:
  - Proposed methodology and strategies on how you plan to work with primary care, behavioral health, social services, or long term and post-acute care services.
  - Methods to complete gap analysis and communication of results with the organization.
  - Proposed tools and data collection methods to conduct the assessments.

- **Evaluation:** Describe your proposed evaluation plan for this project.
  - Methods for evaluating proposed activities with the practices.
  - Staff/contractor responsible for conducting the evaluation.
  - Dissemination of evaluation findings.
  - Timeline for the evaluation.
  - Budget amount set aside for evaluation.

- **Work Plan and Deliverables (Form B):** For each of the four required deliverables in the project plan use Form B to outline the following for the 20 month grant period. You can include more than one objective for each grant deliverable. Use key objectives and deliverables in the work plan to crosswalk to Budget Form C, Section 2 Deliverables.

  Use Form B Work Plan to outline the following for the 20 month grant period. (Form B is not included in the 12 page limit.)

  - Key objectives for each of the deliverables and outcomes
  - Proposed strategies or activities and methods for accomplishing each objective
  - Personnel and Staff to be involved in the objective
  - How the Practice Facilitator will track progress toward meeting objectives
  - Timeline for achievement of objectives
  - Outcomes for completing objectives and activities and whether outcomes have been achieved.
Instructions: For each grant deliverable listed in the work plan: include: recruitment process, planning process, assessment, and evaluation. Enter objectives, activities, personnel/staff involved, tracking methods, timelines, and outcomes for 20 month grant period. You can include more than one objective for each grant deliverable. Use key objectives and deliverables in the work plan to crosswalk to Budget Form C, Section 2 Deliverables.

| Deliverable: Recruit up to twelve organizations interested in practice facilitation |
|-----------------------------------|-----------------------------------|-------------------------------|-----------------|----------------|
| **Objectives**                    | **Activities**                    | **Personnel/Staff involved**  | **Tracking Methods** | **Timeline**  | **Outcome**                  |
| Example                           | Develop selection Process for organizations to receive practice facilitation services. | Develop RFP to solicit applications. | Project staff | 6/30/15 | Recruitment of organizations. |
|                                  |                                    | Develop criteria for selection of organizations. | Lead facilitator | 9/30/15 |                              |
| Example                           | Identify organizational sites ready to participate in practice facilitation | Issue a solicitation for organizations to receive services. | Executive Director, lead provider, Quality Improvement lead | Records kept of organizations interested & assessments completed. | By 9/30/15 sites & readiness is complete | Organizations ready for practice facilitation have a completed assessment |
|                                  |                                    | Send solicitation to MDH/DHS SIM team; HCH advisory committee; SIM Task Force | | | | |
B. Criteria for Grant Review: The Project Plan section of the application will be reviewed and scored according to the following criteria (45 points):

- The applicant provides a clear description of the recruitment strategies and why these strategies will be effective.
- The applicant clearly describes the anticipated number of practices that will be recruited and effectively served, and provides a clear description of how the number was developed. The applicant provides clear goals for each proposed component of the work plan.
- The proposed objectives for each component are clearly described, measurable, and realistic.
- The applicant describes the methods and tools to complete gap analysis, leadership, and quality improvement assessments and why these assessments will be effective.
- The applicant provides a clear description of the planning process that will be used to develop work plans for each organization.
- The applicant provides a clear description of the proposed evaluation plan.
- The applicant includes a work plan that details the activities.

C. Budget Total budget may not exceed $500,000.

- Budget Forms:
  - Minnesota Accountable Health Model Contractor Budget Template (Form C) for budget period templates from May 2015 –December 31, 2016. Form C includes an example.
  - Budget Justification Narrative see template Form D.

The program budget must be complete and reasonable, must link to the proposed program activities, and must specify how the amounts for each budget item were determined. Responders are encouraged to apply for only the amount needed for their proposed programs. The selected applicants will not be guaranteed the entire amount requested.

All duties must be performed in accordance with the Federal Department of Health and Human Services Grants Policy Statement which is available at [http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf](http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf)

Eligible Expenses:
Grant funds may be used to cover costs of personnel, consultants, subcontracts, supplies, and grant related travel.

Ineligible Expenses:
Funds may not be used to pay for direct patient care services, purchase of computers, EHR software and hardware costs, purchase of equipment, building alterations or renovations, construction, purchase of food, fund raising activities, political education or lobbying, food, stipends, and incentives.
Indirect Costs:

Indirect costs are not allowed in this proposal.

Minnesota Accountable Health Model Grantee Budget Template:

Section One:
- The budget form must be completed for the 20 months in the grant period. Section One provides a summary of the eligible expenses by line item. Section Two provides a summary of expenses for the deliverables.
- Provide information on how each line item in the budget was calculated.

A. Salaries and Wages:
- For all positions proposed to be funded from this contract provide the position title, name of the employee if known, the hourly rate, and the number of worked hours allocated to this project.
- In the budget narrative, provide a brief position description for each of the positions listed.

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

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

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

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

F. Travel:
- Include the cost for any proposed in-state travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (not to exceed the current rate established by the Minnesota Management and Budget’s Commissioner’s Plan)
- As part of a per diem or subsistence allowance provided in conjunction with allowable travel See HHS GPS Section II-42.
- Include expected travel costs for hotels and meals.
G. Other:
• If it is necessary to include expenditures in the “Other” category, include a detailed description of the proposed expenditures as they relate to the project. Add additional “Other” lines to the budget form as needed.

Support Expenses:
• Telephone equipment and services, internet connection costs, teleconferences, videoconferences, meeting space rental, and equipment rental.

Expense Reimbursement:
• Travel, meals, lost wages, and childcare expenses can be covered for consumers or other community members without a form of reimbursement to attend a scheduled meeting. Please be specific on your budget form and budget narrative about expenses for travel, meals, lost wages and childcare expenses for consumers or community members without a form of reimbursement.

• Team Participation: Allowable in accordance with applicable program proposal:
  • Reasonable and actual out-of-pocket costs incurred solely as a result of attending an approved scheduled meeting, including transportation, meals, childcare expenses, and lost wages for community partners without other sources of reimbursement as described in your budget narrative.

Section Two: Budget Deliverables:

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

*Budget deliverables should cross reference your work plan and include key work plan deliverables for:*
• Recruitment Process
• Planning Process
• Assessment
• Evaluation

C. Criteria for grant review: The Budget section of the application will be reviewed and scored according to the following criteria (20 points):
• The Budget Form and Budget Justification Narrative are complete.
• The amounts on the Budget Form match what is in the Budget Justification Narrative.
• The information in the Budget Justification Narrative is consistent with what is proposed in the work plan.
• The projected costs are reasonable and sufficient to accomplish the proposed activity. Total budget may not exceed $500,000.
E. Due Diligence Review Form:

This form must be completed by the applicant organization’s administrative staff, for example, finance manager, accountant, or executive director. It is a standard form MDH uses to determine The accounting system and financial capability of all grant applicants that will be receiving at least $50,000.

F. Continuum of Accountability Matrix Assessment

If you receive this contract you will be required to collect Continuum of Accountability Matrix Assessment results from each provider or organization that receives your practice facilitation services and submit the completed matrixes to the MDH. Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool. This is an interactive tool that allows organizations to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and their status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve the goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress.

11. Proposal Evaluation

Proposals will be scored on a 100-point scale as listed below:

The factors and weighting for proposals are as follows:

1. Applicant Experience and Capacity 35%
2. Project Plan including recruitment, goals & objectives and work plan. 45%
3. Budget and Budget Justification 20%

12. Required Forms

Below is a listing of forms required for submission of the Practice Facilitation grant proposal. Forms are included in the RFP for reference only. Do not use the forms in the RFP; instead use the version of the forms posted on the SIM website in completing the grant application.

- Form A: Application Face Sheet with Instructions
- Form B: Project Work Plan
- Form C: Budget-Practice Facilitation Budget Template
- Form D: Budget Justification Narrative
- Form E: Letter of Intent
- Form F: Due Diligence
- Form G: Current and former Practice Facilitation clients
Form A: Application Face Sheet

1. Legal name and address of the applicant agency with which Grant agreement would be executed
   Name:
   Address:

2. Minnesota Tax I.D. Number

3. Federal Tax I.D. Number

4. Requested funding for the total grant period $

5. Director of applicant agency
   Name, Title and Address
   Email Address:
   Telephone Number: ( )
   FAX Number: ()

6. Fiscal management officer of applicant agency
   Name, Title and Address
   Email Address:
   Telephone Number: ( )
   FAX Number: ()

7. Operating agency (if different from number 1 above)
   Name, Title and Address
   Email Address:
   Telephone Number: ( )
   FAX Number: ()

8. Contact person for applicant agency (if different from number 4 above)
   Name, Title and Address
   Email Address:
   Telephone Number: ( )
   FAX Number: ()

9. Contact person for further information on Grant application
   Name, Title Address
   Email Address:
   Telephone Number: ( )
   FAX Number: ()

10. Certification
    I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant agency.

    ________________________________  ___________  __________
    Signature of Authorized Agent for Grant Agreement  Title  Date
Form A: Application Face Sheet Instructions
Please type or print all items on the Application Face Sheet.

1. **Applicant agency**
   Legal name of the agency authorized to enter into a Grant agreement with the Minnesota Department of Health.

2. **Applicant agency's Minnesota Tax I.D. Number**

3. **Federal Tax I.D. number**

4. **Requested funding for the total grant period**
   Amount the applicant agency is requesting in grant funding for the grant period. The grant period will be from May 2015 – December 31, 2016.

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

6. **Fiscal Management Officer of applicant agency**
   The chief fiscal officer for the applicant agency who would have primary responsibility for the grant agreement, grant funds expenditures, and reporting.

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

8. **Contact Person for Applicant Agency**
   The person who may be contacted concerning questions about implementation of this proposed program. Complete only if different from the individual listed in 5 above.

9. **Contact person for Further Information**
   Person who may be contacted for detailed information concerning the application or the proposed program.

10. **Signature of Authorized Agent of Applicant Agency**
    Provide an original signature of the director of the applicant agency, their title, and the date of signature.
Form B: Work Plan and Deliverables

Applicant Instructions:
For each grant deliverable listed in the work plan: include: recruitment process, planning process, assessment, and evaluation. Enter objectives, activities, personnel/staff involved, tracking methods, timelines, and outcomes for 20 month grant period. You can include more than one objective for each grant deliverable. Use key objectives and deliverables in the work plan to crosswalk to Budget Form C, Section 2 Deliverables.

<table>
<thead>
<tr>
<th>Deliverable:</th>
<th>OBJECTIVES</th>
<th>ACTIVITIES</th>
<th>PERSONNEL/STAFF INVOLVED</th>
<th>TRACKING METHODS</th>
<th>TIMELINES</th>
<th>OUTCOME</th>
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</tbody>
</table>
Form C: Practice Facilitation Budget Template
Applicant: ____________________________________________________________

Total Grant Period: May 2015 –December 31, 2016

Budget Form Instructions for Practice Facilitation Applicants:

2. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group facilitation, or consultation.) in C. Consultant Costs
3. Enter information in cells as applicable for your project. The amount paid for deliverables in section two is based on costs in section one.

Section One

A. SALARIES & WAGES: For each position, provide the following information: position title, hourly rate, and number of hours allocated to the project.

<table>
<thead>
<tr>
<th>Title</th>
<th>Hourly Rate</th>
<th>Hours</th>
<th>Total</th>
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<tbody>
<tr>
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<tr>
<td>Total Salaries and Wages:</td>
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</tr>
</tbody>
</table>

B. FRINGE: Provide information on the rate of fringe benefits calculated for the total salaries and wages for positions in 1 A.

Enter the fringe benefit rate as a % of the total salaries and wages in decimal format.

| Total Fringe: | $ |

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

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

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<thead>
<tr>
<th>Hourly Rate</th>
<th>Hours</th>
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</table>

| Name: | |
|-------| |
| Organization: | |
| Services: | |
| Total Consultant Costs: | $ |
**D. EQUIPMENT:** Equipment costs are not allowed.

<table>
<thead>
<tr>
<th>Item</th>
<th>Unit</th>
<th>Cost/Unit</th>
<th>Total Cost</th>
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Total Equipment Costs: $

**E. SUPPLIES:** List each item requested, the number needed, and cost per unit. Include expected costs for general operating expenses such as office supplies, postage, photocopying, and printing.

<table>
<thead>
<tr>
<th>Item</th>
<th>Unit</th>
<th>Cost/Unit</th>
<th>Total Cost</th>
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</table>

Total Supply Costs: $

**F. TRAVEL:** Provide estimated travel costs below for in-state travel. Include travel costs for hotels, meals, and attending learning collaborative meetings. Include the estimated number of miles planned for project activities and the rate of reimbursement per mile.

Out of state travel is not an eligible expense. Travel costs are not to exceed rates established in the Commissioner's Plan at [http://www.mmd.admin.state.mn.us/commissionersplan.htm](http://www.mmd.admin.state.mn.us/commissionersplan.htm)

<table>
<thead>
<tr>
<th>Item</th>
<th>Total Cost</th>
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</table>

Total Travel Costs: $

**G. OTHER:** If applicable, list items not included in previous budget categories below. Include a detailed description of the proposed expenditures in Form D Budget Justification Narrative. Consult budget instructions under G page 18 of RFP for examples of allowable costs in this category.

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<tr>
<th>Item</th>
<th>Total</th>
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Total Other Costs: $

**GRAND PROJECT TOTAL**

$
**Section Two**

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

<table>
<thead>
<tr>
<th>Deliverable: Recruitment process</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<thead>
<tr>
<th>Deliverable: Planning Process</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tr>
<th>Deliverable: Assessments</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tr>
<th>Deliverable: Evaluation</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tr>
<td>TOTAL</td>
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<table>
<thead>
<tr>
<th>Deliverable:</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tr>
<td>TOTAL</td>
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</table>

**GRAND PROJECT TOTAL** $
**Form D: Budget Justification Narrative**

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

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

### A. Salaries and Wages

This should include all personnel whose work is tied to the proposal.

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

### B. Fringe

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

### C. Consultant Costs

*(Include a brief description of services that will be provided and break down of the costs if you know them)*

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

### D. Supplies

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

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

### E. Travel

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

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

### F. Other

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

Place on Letterhead:

*Deadline February 3, 2015, 4:00 pm (CST)*

Practice Facilitation

(date)

This is written notification of the intent to submit an application to the Minnesota Department of Health for funding under the Minnesota Accountable Health Model Accountable Communities for Practice Facilitation. We understand that the application deadline for our proposal is March 3, 2015 at 4 pm CST. Information on our Practice Facilitation proposal is provided below.

**Applicant organization name:** ____________________________________________________________

**Contact person:** ________________________________

**Contact person email:** ________________________________

**Signature:** ____________________________________________________________

**Title:** ____________________________________________________________

Please submit the letter as an email attachment to Janet.Howard@state.mn.us

Or provide the letter via mail or courier to:

    Janet Howard
    Minnesota Department of Health
    Health Care Homes / SIM Unit

**Courier Address:**
85 East 7th Place, Suite 220
Saint Paul, Minnesota 55101

**Mailing Address (must arrive by the deadline to be accepted):**
P.O. Box 64882
Saint Paul, Minnesota 55164-0882
Form F: Due Diligence Review Form

The applicant organization’s administrative staff (finance manager, accountant, or executive director) must complete the due diligence form.

**Due Diligence Review Form**

*Instructions*

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

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

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

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

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

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

### Organization Information

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<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>How long has your organization been doing business?</td>
<td></td>
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<tr>
<td>2.</td>
<td>Does your organization have a current 501(c)3 status from the IRS? Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>3.</td>
<td>How many employees does your organization have (both part time and full time)?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Has your organization done business under any other name(s) within the last five years? Yes / No / Not sure</td>
<td>Yes / No</td>
</tr>
<tr>
<td>5.</td>
<td>Is your organization affiliated with or managed by any other organizations, such as a regional or national office? Yes / No / Not sure</td>
<td>Yes / No</td>
</tr>
<tr>
<td>6.</td>
<td>Does your organization receive management or financial assistance from any other organizations? Yes / No / Not sure</td>
<td>Yes / No</td>
</tr>
<tr>
<td>7.</td>
<td>What was your organization's total revenue in the most recent 12-month accounting period?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>How many different funding sources does the total revenue come from?</td>
<td></td>
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<tr>
<td>9.</td>
<td>Have you been a grantee of the Minnesota Department of Health within the last five years? Yes / No / Not sure</td>
<td>Yes / No</td>
</tr>
<tr>
<td>10.</td>
<td>Does your organization have written policies and procedures for accounting processes? Yes / No / Not sure</td>
<td>Yes / No</td>
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<tr>
<td>11.</td>
<td>Does your organization have written policies and procedures for purchasing processes? Yes / No / Not sure</td>
<td>Yes / No</td>
</tr>
<tr>
<td>12.</td>
<td>Does your organization have written policies and procedures for payroll processes? Yes / No / Not sure</td>
<td>Yes / No</td>
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<tr>
<td>13.</td>
<td>Which of the following best describes your organization's accounting system? Manual / Automated / Both</td>
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<tr>
<td>14.</td>
<td>Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately? Yes / No / Not sure</td>
<td>Yes / No</td>
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<tr>
<td>15.</td>
<td>If your organization has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items? Yes or Not applicable / No / Not sure</td>
<td>Yes or Not applicable / No / Not sure</td>
</tr>
</tbody>
</table>
16. Are time studies conducted for employees who receive funding from multiple sources? Circle one response. | Yes or Not applicable | No | Not sure
---|---|---|---
17. Does the accounting system have a way to identify overspending of grant funds? Circle one response. | Yes | No | Not sure
18. If grant funds are mixed with other funds, can the grant expenses be easily identified? Circle one response. | Yes | No | Not sure
19. Are the officials of the organization bonded? Circle one response. | Yes | No | Not sure
20. Did an independent certified public accountant (CPA) ever examine the organization's financial statements? Circle one response. | Yes | No | Not sure
21. Has any debt been incurred in the last six months? Circle Yes or No. If yes, what was the reason for the new debt? What is the funding source for paying back the new debt? | Yes | No |  
22. What is the current amount of unrestricted funds compared to total revenues? |  
23. Are there any current or pending lawsuits against the organization? Circle Yes or No. | Yes | No |  
24. If yes, could there be an impact on the organization's financial position? Circle one response. | Yes | No or Not applicable |  
25. Has the organization lost any funding due to accountability issues, misuse, or fraud? Circle Yes or No. If yes, please describe the situation, including when it occurred and whether issues have been corrected. | Yes | No |  

**Additional Documentation Requirements**

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

<table>
<thead>
<tr>
<th>Organization</th>
<th>Type of services provided</th>
<th>Date of Services provided</th>
<th>Length of time providing the services</th>
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</table>
Appendix A: Minnesota Accountable Health Model Glossary

Appendix B: Resources

Appendix C: Health Reform Policy Resources

Appendix D: MDH Sample Grant Agreement
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 (www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf)

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

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.


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

Behavioral Health Homes

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

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

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.


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.


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).
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.

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.

Health Information Exchange (HIE)
Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards.

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.

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 Glossary
http://www.healthit.gov/policy-researchers-implementers/technology-standards-certification-glossary
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.

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/)

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, Opportunities For Engaging Long-Term and Post-Acute Care Providers in Health Information Exchange Activities (http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf)

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)

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.

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:

Practice facilitation
“Practice facilitation is a supportive service provided to primary care by a trained individual or team of individuals. These individuals use a range of organizational development, project management, QI, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits. In the research literature, PF sometimes is called quality improvement coaching or practice enhancement assistance.”

From Developing and Running a Primary care Practice Facilitation Program:

Within the State Innovations Model (SiM), we will be open to applying practice facilitation to behavioral health, social services, long term care, and acute care services.

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

- Engaged leadership and quality improvement
- Empanelment and improved patient health outcomes
- Business and financial acumen
- Continuous, team-based relationships that incorporate culture, values, and beliefs
- Organized, evidence-based care
- Patient-centered interactions
- Enhanced access
- Progression toward population based care management
- State-of-the-art, results-linked, care
- Intentional approach of practices to maximize the systematic engagement of patients and families
- Systematic efforts to reduce un-necessary diagnostic testing and procedures with little or no benefit.


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

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:


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

http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

Social Services
The system of programs, benefits and services made available by public, non-profit or private agencies that help people meet those social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services, for the purposes of SIM, include but are not limited to organizations that provide housing, transportation, or nutritional services to individuals or families. Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models
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

Triple Aim
The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which we call the “Triple Aim”: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. Source: Institute for Healthcare Improvement Triple Aim (www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx)
Appendix B: Resources

Developing and Running a Primary Care Practice Facilitation Program, AHRQ, Agency for Health Care Research and Quality, http://www.ahrq.gov/


Case Studies of Leading Primary Care Practice Facilitation Programs, Lessons Learned From Leading Models of Practice Facilitation, AHRQ, Agency for Health Care Research and Quality, http://www.ahrq.gov/

Enhancing the Primary Care Team to Provide Redesigned Care: The Roles of Practice Facilitators and Care Managers, Annals of Family Medicine, Vol. 11, No. 1, January/February, 2013, http://www.annfammed.org/

Creating Capacity for Improvement in Primary Care: The Case for Developing A Quality Improvement Infrastructure, Decision maker Brief: Primary Care Quality Improvement No. 1, http://www.ahrq.gov


Cost Estimates for Operating a Primary Care Practice Facilitation Program, Annals of Family Medicine, Vol. 11, No 3-May/June 2013, http://www.annfammed.org


## Purchaser and payer

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<thead>
<tr>
<th>Minnesota Policy</th>
<th>Statutory Reference</th>
<th>Policy Description</th>
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| Integrated Health Partnerships Payment Reform/ACO contracting | **MN Stat. 256B.0755** Subdivisions 1 (b)(6) and 3 (b) | Integrated Health Partnership, formally an HCDS to demonstrate how it will coordinate with other services affecting its patient’s health, quality of care, and cost of care including counties, other provider types, and purchasers. Encourages projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care.  
| Health Care Home (HCH)                                | **MN Stat. 256B.0751**    | Rule published in 2008 requires patients and families to participate in a meaningful way in quality activities and for primary care providers to establish new quality and performance standards through HCH certification. Foundational to ACO models.  
[http://www.health.state.mn.us/healthreform/homes/index.html](http://www.health.state.mn.us/healthreform/homes/index.html) |
| In-Reach Care Coordination                            | **MN Stat. 256B.0625 Subd. 56** | Provides a new service for Medicaid enrollees who have high emergency department utilization to receive community-based coordination and navigation services (e.g. health care access, housing, transportation) immediately preceding and as part of a hospital discharge.  
## Promoter of wellness

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<td>Local Public Health Act</td>
<td>MN Stat. Chapter 145A</td>
<td>Developed an &quot;integrated system of community health services under local administration and within a system of state guidelines and standards&quot; (local public health); establishes SCHSAC; sets expectations for community needs assessment, community engagement and development of local health priorities. <a href="http://www.health.state.mn.us/divs/opi/gov/lphact/">http://www.health.state.mn.us/divs/opi/gov/lphact/</a></td>
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<tr>
<td>Statewide Health Improvement Program (SHIP)</td>
<td>MN Stat. 145.986</td>
<td>Requires the commissioner of health to award competitive grants to community health boards and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco. <a href="http://www.health.state.mn.us/ship/">http://www.health.state.mn.us/ship/</a></td>
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<tr>
<td>Community Transformation Grant (CTG)</td>
<td>Prevention and Public Health Fund of the Affordable Care Act, Pub. L. 111-148</td>
<td>Requires support to community-level efforts to reduce chronic diseases such as heart disease, hypertension, cancer, stroke and diabetes. <a href="http://www.health.state.mn.us/divs/oshii/ctg.html">http://www.health.state.mn.us/divs/oshii/ctg.html</a></td>
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## Provider

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<td>Preferred Integrated Network (PIN)</td>
<td>MN Stat. 245.4682 Subd. 3</td>
<td>Authorized DHS to implement up to three projects to demonstrate the integration of physical and mental health services within MCOs and coordination of these services with county social services. <a href="http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&amp;RevisionSelectionMethod=LatestReleased&amp;dDocName=dhs16_139287">http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&amp;RevisionSelectionMethod=LatestReleased&amp;dDocName=dhs16_139287</a></td>
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### Regulator

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<td>Health Plan Collaboration Plans</td>
<td>MN Stat. 62Q.075</td>
<td>Requires health plans to submit &quot;collaboration plans&quot; to commissioner of health describing how they will work with local health departments to achieve public health goals. <a href="http://www.health.state.mn.us/divs/opi/pm/collaboration-plans/">http://www.health.state.mn.us/divs/opi/pm/collaboration-plans/</a></td>
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### Federal Administrator

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<tr>
<td>IRS Rules for Community Needs Assessment</td>
<td>Internal Revenue Service 26CFR Parts 1 and 53 (Reg- 106499-12) RIN 1545-BL30</td>
<td>Draft rules to implement ACA requirement that hospitals conduct community needs assessments; develop plans to address identified needs; and requires engagement of community members and consultation with a state, regional or local public health authority. <a href="http://www.mnhospitals.org/data-reporting/mandatory-reporting/community-health-needs-assessment">http://www.mnhospitals.org/data-reporting/mandatory-reporting/community-health-needs-assessment</a></td>
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Appendix D: MDH Sample Grant Agreement

MDH Sample Contract

Standard Grant Template Version 1.4, 6/14
Grant Agreement Number ______________________
Between the Minnesota Department of Health and Insert Grantee's Name

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

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

Minnesota Department of Health
Grant Agreement

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

Recitals

1. Under Minnesota Statutes 144.0742 and Insert the program's specific statutory authority to enter into the grant, the State is empowered to enter into this grant agreement.
2. The State is in need of Add 1-2 sentences describing the overall purpose of the grant.
3. The Grantee represents that it is duly qualified and will perform all the duties described in this agreement to the satisfaction of the State. Pursuant to Minnesota Statutes section 16B.98, subdivision 1, the Grantee agrees to minimize administrative costs as a condition of this grant.

Grant Agreement

1. Term of Agreement

1.1 Effective date Spell out the full date, e.g., January 1, 2012, or the date the State obtains all required signatures under Minnesota Statutes section 16C.05, subdivision 2, whichever is later.

The Grantee must not begin work until this contract is fully executed and the State's Authorized Representative has notified the Grantee that work may commence.

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


2. Grantee's Duties The Grantee, who is not a state employee, shall: Attach additional pages if needed, using the following language, "complete to the satisfaction of the State all of the duties set forth in Exhibit A, which is attached and incorporated into this agreement."
3. **Time** The Grantee must comply with all the time requirements described in this grant agreement. In the performance of this grant agreement, time is of the essence, and failure to meet a deadline may be a basis for a determination by the State's Authorized Representative that the Grantee has not complied with the terms of the grant.

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

4. **Consideration and Payment**

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

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

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

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

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

**OR**

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

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

4.2 Terms of Payment

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

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

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

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

Authorized Representatives

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

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

7. Assignment, Amendments, Waiver, and Merger

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

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

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

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

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

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


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

If the Grantee receives a request to release the data referred to in this clause, the Grantee must immediately notify the State. The State will give the Grantee instructions concerning the release of the data to the requesting party before any data is released. The Grantee's response to the request must comply with the applicable law.
10.2 Data Disclosure Pursuant to Minnesota Statutes section 270C.65, subdivision 3, and all other applicable laws, the Grantee consents to disclosure of its social security number, federal employee tax identification number, and Minnesota tax identification number, all of which have already been provided to the State, to federal and state tax agencies and state personnel involved in the payment of state obligations. These identification numbers may be used in the enforcement of federal and state tax laws which could result in action requiring the Grantee to file state tax returns and pay delinquent state tax liabilities, if any.

11. Ownership of Equipment

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

12. Ownership of Materials and Intellectual Property Rights

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

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

12.2 Intellectual Property Rights Grantee represents and warrants that materials produced or used under this grant agreement do not and will not infringe upon any intellectual property rights of another including but not limited to patents, copyrights, trade secrets, trade names, and service marks and names. Grantee shall indemnify and defend the State, at Grantee's expense, from any action or claim brought against the State to the extent that it is based on a claim that all or parts of the materials infringe upon the intellectual property rights of another. Grantee shall be responsible for payment of any and all such claims, demands, obligations, liabilities, costs, and damages including, but not limited to, reasonable attorney fees arising out of this grant agreement, amendments and supplements thereto, which are attributable to such claims or actions. If such a claim or action arises
or in Grantee's or the State's opinion is likely to arise, Grantee shall at the State's discretion either procure for the State the right or license to continue using the materials at issue or replace or modify the allegedly infringing materials. This remedy shall be in addition to and shall not be exclusive of other remedies provided by law.

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

14. Publicity and Endorsement

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

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

15. Termination

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

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

15.3 Termination for Insufficient Funding The State may immediately terminate this agreement if it does not obtain funding from the Minnesota legislature or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the work scope covered in this agreement. Termination must be by written or facsimile notice to the Grantee. The State is not obligated to pay for any work performed after notice and effective date of the termination. However, the Grantee will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available. The State will not be assessed any penalty if this agreement is terminated because of the decision of the Minnesota legislature, or other funding source, not to appropriate funds. The State must provide the Grantee notice of the lack of funding within a reasonable time of the State receiving notice of the same.
16. Governing Law, Jurisdiction, and Venue This grant agreement, and amendments and supplements to it, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this grant agreement, or for breach thereof, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

17. Other Provisions

17.1 Contractor Debarment, Suspension and Responsibility Certification

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

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

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

17.2 Audit Requirements to be Included in Grant Agreements with Subrecipients

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

If the Grantee expends total federal assistance of $500,000 or more per year, the grantee agrees to: a) obtain either a single audit or a program-specific audit made for the fiscal year in accordance with the terms of the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133; and, b) to comply with the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.
Audits shall be made annually unless the grantee is a state or local government that has, by January 1, 1987, a constitutional or statutory requirement for less frequent audits. For those governments, the federal cognizant agency shall permit biennial audits, covering both years, if the government so requests. It shall also honor requests for biennial audits by state or local governments that have an administrative policy calling for audits less frequent than annual, but only audits prior to 1987 or administrative policies in place prior to January 1, 1987.

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

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

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

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

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

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

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

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

\( (e) \) If payments under this grant agreement will be made from federal funds obtained by the State through the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), the Grantee is responsible for compliance with all federal requirements imposed on these funds. The Grantee must identify these funds separately on the schedule of expenditures of federal awards (SEFA), and must also accept full financial responsibility if it fails to comply with federal requirements. These requirements include, but are not limited to, Title III, part D, of the Energy Policy and Conservation Act (42 U.S.C. 6321 et seq. and amendments thereto); U.S. Department of Energy Financial Assistance Rules (10CFR600); and Title 2 of the Code of Federal Regulations.
(j) Grantees of federal financial assistance from subrecipients are also required to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

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

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

(i) The Grantee agrees to file required audit reports with the State Auditor's Office, Single Audit Division, and with federal and state agencies providing federal assistance, within nine (9) months of the Grantee's fiscal year end. OMB Circular A-133 requires recipients of more than $500,000 in federal funds to submit one copy of the audit report within 30 days after issuance to the central clearinghouse at the following address:

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

17.3 Drug-Free Workplace

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

17.4 Lobbying

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

17.5 Equal Employment Opportunity

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

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

17.7 Rights to Inventions – Experimental, Developmental or Research Work

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

17.8 Clean Air Act

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

17.9 Whistleblower Protection for Federally Funded Grants

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

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

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

APPROVED: _______________________________________________________________

1. Grantee

2. State Agency

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

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

By: _____________________________________

(with delegated authority)

Title: ________________________________

Date: ________________________________

By: ___________________________________

Title: ________________________________

Date: ________________________________

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