Request for Proposals

Release date: December 6, 2016
Due date: January 20, 2017

Minnesota Accountable Health Model
Learning Community Grant

Primary Care Public Health Partnership
Learning Community

Minnesota Department of Health
Division of Health Policy
# Table of Contents

Overview ......................................................................................................................................................... 2

Grant Timelines ............................................................................................................................................... 2

Available Funding and Estimated Awards ................................................................................................. 3

Background ..................................................................................................................................................... 3

Grant Applicant ............................................................................................................................................... 4

Required Deliverables .................................................................................................................................. 5

  Grant Application and Program Summary .................................................................................................. 7

  Proposal Instructions .................................................................................................................................. 8
  1. Signed Grant Application Face Sheet (Form A) ...................................................................................... 8
  2. Applicant Experience and Capacity (Limit 3 pages, 30 Points) ............................................................. 8
  3. Learning Community Project Proposal (Limit 6 pages, 30 Points) ......................................................... 9
  4. Learning Community Implementation Work Plan/Timeline of Activities (Form B, 25 Points) .............. 9
  5. Budget (15 Points) ................................................................................................................................ 10

Proposal Evaluation ................................................................................................................................... 12

Review Process .......................................................................................................................................... 12

Grant Participation Requirements ............................................................................................................. 13

Required Forms ........................................................................................................................................ 13

  Form A: Application Face Sheet .................................................................................................................. 14

  Form B: Learning Community Implementation Work Plan: ................................................................. 16

  Form C: Learning Community Budget Template ..................................................................................... 19

  Form D: Budget Justification Narrative .................................................................................................... 22

  Form E: Due Diligence ............................................................................................................................... 23

Appendix ....................................................................................................................................................... 26

  Appendix A: Minnesota Accountable Health Model Glossary .............................................................. 27

  Appendix B: MDH Sample Grant Agreement .......................................................................................... 34

  Appendix C: MDH EXAMPLE Invoice ....................................................................................................... 46

  Appendix D: Resources ............................................................................................................................. 48
Overview

The Minnesota Department of Health (MDH) is seeking proposals to advance the work of a Community Health Board – Primary Care Partnership through participation in the Primary Care Public Health Learning Community to address shared goals to improve the health and health outcomes of a community. The grants are intended to advance the Minnesota Accountable Health Model and expand participation with a broad range of stakeholders and providers in addressing local health needs, and is supported through the State Innovation Model (SIM). Applications may be submitted by Community Health Boards or Primary Care Practices on behalf of the partnership. The Primary Care Public Health Learning Community, established by the Minnesota Department of Health, will be guided by a State planning committee with a facilitator to lead the process.

For the purpose of this grant, a Learning Community is defined as learning teams who have common goals or interests, share best practice knowledge, focus on community health improvement and are actively engaged in building a relationship between a Community Health Board or Tribal Government and a primary care clinic to develop an action plan.

This grant funding will support participation of a Community Health Board and Primary Care Practice in a Learning Community to develop a shared narrative, advance knowledge of primary care public health partnership and create an implementation plan to improve community health. The strategy of the Learning Community will be to convene partners to identify shared priorities, use both population health and clinical data and engage the community to provide feedback on the implementation plan. The learning community is expected to identify how this work will address health disparities or inequities. Partners participating in this project must commit to continuing to move the work forward once funding has ended. While the focus of this grant is on public health and primary care partnership, grant funding may be used to support other community partners who may be engaged in the project.

Preference will be given to a community health board and primary care entities that have an existing working relationship, and involve certified health care home clinics. Priority will be given to those who demonstrate their capacity to expand and deepen their partnership.

The partners will be required to work with the State Facilitator in the Learning Community. Support available from the State Facilitator may include: building mutual understanding of roles and partnership benefits, identifying best practices, support for using data for decision making, work plan development, strategy and measure identification.

Grant Timelines

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

<table>
<thead>
<tr>
<th>RFP Activity</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for Proposal Posted</td>
<td>December 6, 2016</td>
</tr>
<tr>
<td>Direct Contact</td>
<td>Questions about the Learning Collaborative grant or the proposal process can be directed to: Janet Howard Minnesota Department of Health Health Care Homes / Health Policy Division- State Innovations Model Janet Howard at <a href="mailto:janet.howard@state.mn.us">janet.howard@state.mn.us</a>.</td>
</tr>
</tbody>
</table>
### Available Funding and Estimated Awards

#### Learning Community Grant

- Grant term is for eight (8) months from the start date, and is required to be completed by September 30, 2017.
- Total of up to $50,000 is available.

MDH reserves the right to not award grants. Funding is subject to availability of funds and dependent on approval by the Centers for Medicare and Medicaid Innovation.

#### Funding Restrictions

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

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

### 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](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...

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

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

<table>
<thead>
<tr>
<th>Driver</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver-1</td>
<td>Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement—Health Information Technology (HIT)/Health Information Exchange (HIE)</td>
</tr>
<tr>
<td>Driver-2</td>
<td>Providers have analytic tools to manage cost/risk and improve quality—Data Analytics</td>
</tr>
<tr>
<td>Driver-3</td>
<td>Expanded numbers of patients are served by team-based integrated/coordinated care—Practice Transformation</td>
</tr>
<tr>
<td>Driver-4</td>
<td>Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health—Accountable Communities of Health (ACH)</td>
</tr>
<tr>
<td>Driver-5</td>
<td>Accountable Care Organizations (ACO) performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations—ACO Alignment</td>
</tr>
</tbody>
</table>

The activities contained in this RFP are linked to **Driver 3 Learning Community** opportunities.

**Grant Applicant**

Eligible applicants include Community Health Boards, Tribal Governments and Primary Care practices. In order to be eligible for funding, applications must have at least one primary care partner and at least one community health board or tribal government partner. One of these partners must be designated as the lead agency. Non-profit or other organizations may be included in the grant application, but are not eligible to apply alone and may not be the lead agency. Learning teams shall be the primary recipients of the learning and implementation work. Work may be focused in a specific community or area and does not need to cover the entire geographic area included in the Community Health Board or Tribal Government’s jurisdiction.

Qualified applications will be from a partnership that includes at least one Community Health Board or Tribal Government and at least one primary care clinic. Applicants must demonstrate leadership commitment and sufficient capacity to engage in the project. Each participating agency should self-select at least two (2) individuals representing their organization. Staff representatives should include at least one administrator from each entity and one primary care provider (physician, nurse practitioner, nurse, social worker, etc.) and/or public health professional.

Applications can be submitted by either partner, and must include a commitment letter from the other partner. Funding decisions will be made on the ability of the applicant to meet the criteria established in this RFP, and priority will be given to applications that include an MDH-certified health care home.

Applicant must be located in the State of Minnesota, and meet the State’s fiscal requirements and other grant participation requirements, including the ability to collect and submit evaluation data, manage staff, communication, and other grant operations.
Required Deliverables

This grant opportunity is intended to support collaboration and partnership between a Community Health Board and primary care practices through the Primary Care and Public Health Learning Community (PCPH). The goal of the grant is the development and implementation of a plan that will increase partnership between a primary care practice and local public health that will improve the health and health outcomes of an identified population. Applicants for this grant funding will be required to meet the following deliverables:

1. Grantee entities will sign an agreement of participation of attendance and commitment.
2. Grantee and partners will attend Learning Community activities.
3. Grantee and partners will work with the State facilitator to identify learning needs, identify approaches and applicable best practices.
4. Grantee and partners will develop an implementation plan with the assistance of the State Facilitator by June 2017.
5. Grantee and partners will provide a sustainability plan to continue the work and health impact after the grant period ends.

The Learning Community grantee shall complete the following tasks:

Learning, Partnership and Planning Phase - February–June 2017
Led by the State facilitator, who will be responsible for convening all meetings and working with participants to develop a learning agenda, partners will participate in the Learning Community Activities:

- Attend three to five monthly meetings/and or activities.
- Work with State facilitator to develop a common narrative that will build upon existing relationships, share experiences in addressing community health needs, and advance understanding of primary care public health primary care partnership through literature, case studies and best practices.
- Use population health data, clinical data, utilization data, and community and patient experiences to identify actionable goals and strategies to collaboratively partner in improving community health.
- Engage community in identifying priority areas to be addressed.
- Review evidence-based, practice-based, and/or promising strategies to address the identified health priority.
- Develop a collaborative implementation plan for addressing the health priority, including fostering community partnerships and considering health equity in relation to the health priority.

Implementation Phase July-September 2017

- Share the implementation plan among partner staff and community stakeholders to gather further input and build support.
- Operationalize the implementation plan with a work plan outlining milestones, tasks, accountabilities and deadlines.
- Prepare and present a final project report which will include: lessons learned, successes, challenges, barriers, reflections, areas for improvement, opportunities for continuing partnership and sustainability plan.
- Participate in evaluation as requested.
Ongoing
Grantee shall:

- Make monthly progress reports to grant manager via conference call.
- Submit detailed invoices for payment at the conclusion of the Planning Phase and at the conclusion of the Implementation Phase, using the Invoice template supplied by MDH.
- Submit a written report, using the format provided by MDH, with each invoice that discusses progress on: building relationship and common narrative between public health and primary care, learning activities around best practice and selected areas of opportunity, selection of shared community health improvement goal(s), development and launch of implementation plan, and final report and evaluation.
- Actively participate in all activities regarding grant/Learning Community activities, as requested by state staff or facilitator.
- Respond to surveys as requested by State staff.
- Capitalize on the expertise of learning team members by capturing participant stories and reflections for inclusion in final report and presentation.
- Produce documentation to demonstrate progress on project and share any resulting innovations that would be helpful to others engaged in public health – primary care partnerships. For example, powerpoints, handouts, templates, forms, toolkits, etc.

Upon Completion

- Prepare and present an informative session on the Learning Community project during a Health Care Home or Minnesota Accountable Health Model learning event.
- Submit a final project report using the format the State will provide. Details to be included: overall evaluation results, measured qualitative and quantitative outcomes, lessons learned, successes, barriers, and challenges, how the learning team members plan to apply what they learned within their organizations and the team members’ next steps.
- Ensure that all materials (e.g., electronic documents, webpages, or other electronic materials) are made fully accessible in accordance with the applicable law. (Americans with Disabilities Act standards)
## Eligibility for Grant Funds
Eligible applicants include Community Health Boards, Tribal Governments and Primary Care Practices. To be eligible for funding, applications must have at least one primary care partner and one Community Health Board or tribal government partner. One of the partners must be designated as the lead agency. Non-profit or other organizations may be included in the grant application, but are not eligible to apply alone and may not be the lead agency. Learning teams shall be the primary recipients of the learning and implementation work.

## Total Funds Available
$50,000

## Grant Amount
Award of $50,000

## Duration of Funding
Eight months

## Grant Purpose
To plan and implement work to advance the partnership of an existing Community Health Board– primary care practice through participation in the Primary Care Public Health Learning Community to address shared goals to improve the health and health outcomes of a community.

## Application Requirements
- Narrative portions of the applications must be written in 12-point font, single spaced with one-inch margins.
- All pages must be numbered consecutively.
- Applicants must submit one (1) signed unbound original and four (4) unbound copies of the proposal as well as an electronic version of the proposal on a USB drive. Faxed or emailed applications will not be accepted.
- Applications must meet application deadline requirements
- Late applications will not be reviewed.
- Applications must be complete and signed where noted.
- Incomplete applications will not be considered for review.

## Order for Completed Application Submission
Each application must contain the following items in the order listed:
- Signed Application Face Sheet (Form A)
- Applicant Experience and Capacity (Limit 2 pages)
- Learning Community Description (Limit 6 pages)
- Learning Community Implementation Work Plan (Form B)
- Minnesota Accountable Health Model Contractor Budget (Form C)
- Project Budget Justification (Form D)
- Due Diligence Review Form (Form E) – (For Nongovernmental Organizations) submit only 1 copy of Due Diligence Review Form and any required documentation

## Submitting the Proposal
Applicants must submit one (1) signed unbound original and four (4) unbound copies of the proposal and an electronic version of the proposal on a USB drive. Faxed or emailed applications will not be accepted. Late applications will not be considered for review.

## Application Deadline
January 20, 2017
To meet the deadline, proposals must be either:
- hand delivered to the 2nd floor reception desk of the Golden Rule Building 85 East Seventh Place, Suite 220 on or before January 20, 2017 by 4:00 PM CST; or,
- Arrive by mail, Fed Ex, or courier service on or before January 20, 2017 by 4:00 PM CST.
- Late applications, applications lost in transit by courier, or faxed/emailed applications will not be considered for review.
| Applications Sent | Mailing Address:  
Janet Howard  
Minnesota Department of Health  
Health Care Homes / Health Policy Division- State Innovations Model  
PO Box 64882  
Saint Paul, MN 55164-0882  

Courier Address:  
Janet Howard  
Minnesota Department of Health  
Health Care Homes / Health Policy Division- State Innovations Model  
Golden Rule Building  
85 East Seventh Place, Suite 220  
Saint Paul, MN 55101  

| Contact Information | Questions about the Learning Collaborative grant and/or the proposal process can be directed to:  
Janet Howard  
Minnesota Department of Health  
Health Care Homes / Health Policy Division- State Innovations Model  
Janet.Howard@state.mn.us  

Other state staff are not allowed to respond to questions about this procurement, and may result in disqualification of application.  

| Grant Start Date | February 2017 or the date all required signatures on the grant agreement are obtained, whichever is later.  

Proposal Instructions  

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

1. Signed Grant Application Face Sheet (Form A)  
Include all applicable information required by the form.

2. Applicant Experience and Capacity (Limit 3 pages, 30 Points)  

In this section, applicant must provide:

a) A brief description of the relationship between the community health board or tribal government and the primary health clinic including the length of time the partnership has existed, the nature and scope of the relationship(s) and specific collaborative activities that are part of it, and successes and challenges in the relationship.

b) Describe the expected level of expansion as a result of participation in the Learning Community.

c) Description of the roles and responsibilities of the partners’ staff members that will participate, including their qualifications, skills, and experience.

d) Description or statement of leadership support for participating in the Learning Community from each partner organization.

e) Anticipated barriers and challenges in implementing this project and potential solutions.

f) Identify if the primary care provider is a certified Health Care Home.
Review Criteria:

a) Applicant described the relationship between the Community Health Board or Tribal Government and the primary care provider including length of time, focus of partnership and the successes and challenges.

b) Current level of partnership is described and participation in the Learning Community will support the partnership’s expansion.

c) Applicant has the capacity to participate in the Learning Community as described by roles and responsibilities of the participating partners’ staff members, including qualifications, skills and experience relative to the Learning Community.

d) Applicant included the partners’ leadership support for participation in the Learning Community.

e) Applicant described possible barriers and challenges for implementation and the potential solutions.

f) Priority will be given to applications that include a certified Health Care Home.

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

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

In this section, applicant must discuss:

a) The rationale for building on the partner relationship between selected public health and primary care partners.

b) Possible areas of opportunity for collaborating on an identified health priority area and the impact on community health improvement.

c) How the partnership will engage community in the planning and implementation phases, and how feedback will be utilized to change processes and activities in a timely manner.

d) Describe how health equity will be considered in the planning process using data, and community involvement in the implementation phase.

e) Describes a sustainability plan to continue the work and health impact after the grant is completed.

Review Criteria:

a) Applicant demonstrates understanding of the importance of partnership between public health and primary care and how it will impact community health.

b) Applicant includes possible areas of opportunity for collaborating on an identified health priority area and the expected impact on community health.

c) Applicant describes how they will engage community will be involved in the planning and implementation phase and how the feedback will be used to inform the plan.

d) Applicant describes how health equity will be supported by data and community input.

e) Applicants demonstrate a commitment to sustaining collaboration after the grant is over.

4. Learning Community Implementation Work Plan/Timeline of Activities (Form B, 25 Points)

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

a) Development of a timeline with State Facilitator.

b) Learning Community Objective/Activity: Brief description of the participation in learning activities/sessions and the type of staff involved from each partner agency.

c) Learning Outcome(s): Brief description of anticipated outcome(s) of the learning activities.

d) The applicant provides opportunities for sharing and discussion amongst its learning teams, staff, and stakeholders during the implementation process.

Review Criteria:

a) Applicant describes the work with the State Facilitator and the partner agency.
b) Applicant describes the objectives, activities, and timeline involved in the project.
c) Applicant describes the anticipated outcomes for the learning activities.
d) Applicant describes the opportunities for sharing and discussion with leadership, staff, and community stakeholders.

5. Budget (15 Points)

Budget Forms:
- **Minnesota Accountable Health Model Contractor Budget Template** Form C.
- **Budget Justification Narrative** see template Form D.
- **Due Diligence Review** Form E. Due Diligence Review Form (For Nongovernmental Organizations submit 1 copy of Due Diligence Review Form and required documentation) This form must be completed by the applicant organization’s administrative staff, for example, finance manager, accountant or executive director. It is a standard form MDH uses to determine the accounting system and financial capability of all grant applicants (submit only 1 copy of Due Diligence Review Form and any required documents)

**Section One:** Include a budget for eight months (February 2017 to September 30, 2017). 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)

**Section Two:** The amount paid for the deliverables in section two, is based upon the total dollars requested in section one.

Budget deliverables should cross reference your work plan and include key work plan deliverables for: Partnership, learning, and planning Phase and Implementation Phase

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

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

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

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

**Section One:**
The budget form includes two sections and must be completed for a nine month grant period. Section One provides a summary of the eligible expenses by line item. Section Two provides a summary of expenses for the deliverables. Provide information on how each line item in the budget was calculated.

A. **Salaries and Wages:**
For all positions proposed to be funded from this grant, provide the position title, the hourly rate, and the number of hours allocated to this project. In the budget narrative, provide a brief position description for each of the positions listed.
B. Fringe:
List the rate of fringe benefits calculated for the total salaries and wages for positions in 1A.

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

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

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

F. Travel:
Include the cost for any proposed in-state travel as it relates to the completion of the project. Provide the estimated number of miles planned for project activities and the rate of reimbursement per mile to be paid from project funds (not to exceed the current rate established by the Minnesota Management and Budget’s Commissioner’s Plan [http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf])
• Include expected travel costs for hotels and meals.
• Out of state travel is not an eligible expense.

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

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

• Expense Reimbursement: Travel and childcare expenses can be covered for consumers or other community members without a form of reimbursement to attend a schedule meeting. You must be specific on your budget form and budget narrative for travel and childcare expenses for consumers or community members without another form of reimbursement.

Review Criteria: The Budget section of the application will be reviewed and scored according to the following criteria.

a. Are the Budget Summary Form and the Budget Justification Sheet complete? Do the amounts on Budget Summary Form match what is in the Budget Justification Sheet?
b. Is the information contained in the Budget Justification Sheet consistent with what is proposed in the Project Narrative and Implementation Plan?
c. Are the projected costs reasonable and sufficient to accomplish the proposed activity? Budget Total Points
Proposal Evaluation

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

<table>
<thead>
<tr>
<th>Items</th>
<th>Points</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Experience and Capacity</td>
<td>30 points</td>
<td>30%</td>
</tr>
<tr>
<td>Learning Community Description</td>
<td>30 points</td>
<td>30%</td>
</tr>
<tr>
<td>Learning Community Implementation Plan</td>
<td>25 points</td>
<td>25%</td>
</tr>
<tr>
<td>Budget and Budget Justification</td>
<td>15 points</td>
<td>15%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100 points</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Review Process

The State will evaluate proposals based on the review criteria as set forth in this RFP. Reviewers will score proposals individually using a provided score sheet. Proposals and reviewer scores will be discussed by review teams. Reviewers are able to modify scores based on discussions at the review meetings. Funding decisions will consider capacity of the organizations to complete the project goals.

Grant proposals will be reviewed and evaluated by a panel familiar with the program. The panel will include staff from the Minnesota Department of Health’ Public Health Partnership and Health Care Home/SIM Section. 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 a final award, including geographic location and a cross section of target populations.

Only complete applications received on time according to the due date listed on or before January 20, 2017 at 4 pm Central Standard Time will be reviewed. Reviewers will use the criteria as outlined in the RFP and will make recommendations for funding. We anticipate that grant award decisions will be made by January 30, 2017. Applicants will be notified by letter whether or not their grant proposal was funded.

MDH reserves the right to negotiate changes to budgets and work plans submitted with the proposal. MDH reserves the right to waive minor irregularities or request additional information to further clarify or validate information submitted in a proposal, provided the proposal, as submitted, and substantially complies with the requirements of this RFP. There is, however, no guarantee MDH will look for information or clarification outside of the submitted written proposal. Therefore, it is important that all applicants ensure that all sections of their proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

A Grant agreement will be entered into with the applicant that is awarded grant funds. The anticipated effective date of the agreement is February 2017, or the date upon which all signatures are obtained. No work on grant activities can begin until a fully executed grant agreement is in place.
Grant Participation Requirements

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

Required Forms

Below is a list of forms required for submission with the Learning Community Grant proposal. Forms are included in the RFP for reference only. Do not use the forms in the RFP; instead use the version of the forms posted on the SIM website in completing the grant application. In some cases only the first part of the form is included in this RFP because of its length. The SIM website is available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_learning_communities

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

1. **Legal name and address of the applicant agency with which grant agreement would be executed**

2. **Minnesota Tax I.D. Number**

3. **Requested funding for the total grant period**

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

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

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

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

8. **Contact person for further information on grant application**
   - Name, Title and Address
   - Email Address:
   - Telephone Number: ( )
   - FAX Number: ()

9. **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  Title  Date
   Grant Agreement
Form A: Application Face Sheet Instructions

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

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

2. **Applicant agency’s Minnesota and Federal Tax I.D. number**

3. **Requested funding for the total grant period**
   Amount the applicant agency is requesting in grant funding for the grant period.

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

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

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

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

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

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

**Instructions:** Complete the Work Plan Template. Include the deliverables, learning objectives, learning activities, timeline, measurement, and outcomes for eight month grant period. Include process and outcome measures for each deliverable. *(Use Form B on the RFP website)*

Key deliverables in Form B will be required to correspond to deliverables in Section 2 Deliverables (outcomes) of Learning Community Budget Template-Form C. The Work Plan (Form B) and Learning Community Budget Template (Form C) will be the attachments in the grant contract and the documents used to monitor grant deliverables.

<table>
<thead>
<tr>
<th>Deliverable: Partnership, Learning, and Planning Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverable: Implementation Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Form B: Learning Community Implementation Work Plan: (Example)

**Instructions:** Complete the Work Plan Template. Include the deliverables, learning objectives, learning activities, timeline, measurement, and outcomes for eight month grant period. Include process and outcome measures for each deliverable. *(Use Form B on the RFP website)* Key deliverables in Form B will be required to correspond to deliverables in Section 2 Deliverables (outcomes) of Learning Community Budget Template-Form C. The Work Plan (Form B) and Learning Community Budget Template (Form C) will be the attachments in the grant contract and the documents used to monitor grant deliverables.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Timelines (Feb./March 2017 - June, 2017)</th>
<th>Measurement</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To work with a MDH facilitator to build relationship between community health board and primary care setting</td>
<td>Work with MDH facilitator in the process</td>
<td>Feb./March-June, 2017</td>
<td>Signed agreements between Community Health Board and primary care committing each agency to the project. Track attendance by agency. Document work in progress through minutes of meetings.</td>
<td>Community Health Board and primary care setting are committed to work on a priority health issue.</td>
</tr>
<tr>
<td></td>
<td>Get acquainted and share common experiences around working together</td>
<td>Feb-March, 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify the goals for the project with the MDH facilitator and partner agency.</td>
<td>Work with MDH facilitator in the process</td>
<td>Feb./March-June, 2017</td>
<td>Document work in progress through minutes of meetings. Track attendance by agency.</td>
<td>A priority community health issue is identified and worked on.</td>
</tr>
<tr>
<td></td>
<td>Look at clinical &amp; population health data &amp; Identify the priority health need.</td>
<td>April, 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work with the MDH facilitator to develop a work plan.</td>
<td>May-June, 2017</td>
<td>Work with MDH facilitator is completed.</td>
<td>A work plan is created. Report and recommendations are made.</td>
</tr>
<tr>
<td>Objective</td>
<td>Activities</td>
<td>Timeline (July, 2017 - Sept., 2017)</td>
<td>Measurement</td>
<td>Outcomes</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>-----------------------------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>Grantee will implement work plan with partner agency around the priority health need</td>
<td>Share plans with leadership of each agency partner agency.</td>
<td>July 2017</td>
<td>Plan shared with community</td>
<td>Leadership is committed to the project.</td>
</tr>
<tr>
<td></td>
<td>Bring plans to community stakeholders and gather input.</td>
<td>August, 2017</td>
<td>Document feedback from the community</td>
<td>Community insights are incorporated into the plan</td>
</tr>
<tr>
<td></td>
<td>Take initial steps to organize implementation of the project with community input.</td>
<td>August, 2017</td>
<td>Meetings in the community and attendance by community representatives.</td>
<td>Documented feedback from the community.</td>
</tr>
<tr>
<td></td>
<td>Develop sustainability plan for the project</td>
<td>September, 2017</td>
<td>Sustainability plan</td>
<td>Key community stakeholders are involved in the project.</td>
</tr>
</tbody>
</table>
For C: Learning Community Budget Template

Applicant: [Blank]

Total Contract Period: February 2017 to September 30, 2017 Eight Months

**Budget Form Instructions for Applicants:**

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

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

**Section One**

<table>
<thead>
<tr>
<th>Title</th>
<th>Hourly Rate</th>
<th>Hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Salaries and Wages:</td>
<td></td>
<td>0</td>
<td>$</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Hourly rate and number of hours</th>
<th>Hourly Rate</th>
<th>Hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Organization:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Consultant Costs:</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

D. EQUIPMENT: Equipment costs are not allowed.

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

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Total Supply Costs:</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Travel Costs:</td>
<td>$</td>
</tr>
</tbody>
</table>
G. OTHER: If applicable, list items not included in previous budget categories below. Include a detailed description of the proposed expenditures in Form D Budget Justification Narrative. Consult budget instructions in Section 11E for examples of allowable costs in this category.

<table>
<thead>
<tr>
<th>Item</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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: Partnership, Learning, and Planning Phase</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverable: Implementation Phase</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

**B. Fringe**

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

**C. Consultant Costs**

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

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

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

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

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

**G. Other**

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

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

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

Due Diligence Review Form

Instructions

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

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

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

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

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

Additional Documentation Requirements

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

Appendix A: Minnesota Accountable Health Model Glossary
Appendix B: MDH Sample Grant Agreement
Appendix C: MDH Sample Invoice
Appendix D: Resources
Appendix A: Minnesota Accountable Health Model Glossary

**Accountable Care**

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

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

**Accountable Care Organizations (ACOs)**

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


**Behavioral Health**

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

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

**Behavioral Health Homes**

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

DHS is developing a framework for “health homes” to serve the needs of complex populations covered by Medicaid. DHS, with input from stakeholders, is working to design a behavioral health services for adults and children with serious mental illness. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS may build on this framework to serve other complex populations in the future. Providers that wish to become a behavioral health home must meet federal and Minnesota state requirements and certification standards, currently under development.


**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).

**Community-based Prevention/Community-based Interventions/Community-based Programs** are terms used interchangeably to refer to programs or policies within a community that seek to improve the health of a population by addressing non-medical factors, or social determinants of health. Such programs often include the application of non-clinical preventive methods in non-traditional health care settings by non-clinical providers.


**Community Care Team** is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations to provide citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services.


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


**Computerized Provider Order Entry (CPOE)** is a computer application that allows a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.
Continuum of care
The continuum of care is the full array of services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health and well-being of a population.
Source: Adapted from Alaska Health Care Commission (http://dhss.alaska.gov/ahcc/Documents/definitions.pdf)

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

Determinants of health:
Health is determined through the interaction of individual behaviors and social, economic, genetic and environmental factors. Health is also determined by the systems, policies, and processes encountered in everyday life. Examples of determinants of health include job opportunities, wages, transportation options, the quality of housing and neighborhoods, the food supply, access to health care, the quality of public schools and opportunities for higher education, racism and discrimination, civic engagement, and the availability of networks of social support.
Source: http://www.health.state.mn.us/divs/chs/healthequity/definitions.htm

Electronic Health Records (EHR)
EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. EHR is considered more comprehensive than the concept of an Electronic Medical Record (EMR).
Source: Office of the National Coordinator for HIT Health IT Glossary http://www.healthit.gov/unintended-consequences/content/glossary.html accessed 10.23.14

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

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

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

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

Health Information Technology (HIT)

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

Integrated care

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

Interprofessional Team

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

Local Public Health

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

Long-Term and Post-Acute Care (LTPAC)

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

Patient and Family Centered Care

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

Population

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

Population Health

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


Practice Facilitation

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

Practice Transformation is a process that results in observable and measurable 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 unnecessary diagnostic testing and procedures with little or no benefit.


Provider

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

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

Public Health

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

Local Public Health Association of Minnesota, http://www.lpha-mn.org

Quality improvement (QI)

Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The Institute of Medicine’s (IOM) which is a recognized leader and advisor on improving the Nation’s health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations (1) http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
Social Services
The system of programs, benefits and services made available by public, non-profit or private agencies that help people meet those social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services, for the purposes of SIM, include but are not limited to organizations that provide housing, transportation, or nutritional services to individuals or families.
Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

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

Triple Aim
The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim"; improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.
Source: Institute for Healthcare Improvement Triple Aim (www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx) accessed 09.10.201
Appendix B: MDH Sample Grant 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 Grant ("Grantee"). Grantee’s address is Insert complete address.

Recitals

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

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

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

Grant Agreement

1. Term of Agreement

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

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

   1.3 Survival of Terms The following clauses survive the expiration or cancellation of this grant contract: 8. Liability; 9. State Audits; 10.1 Government Data Practices; 10.2 Data
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. Paragraph 1: 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. Paragraph 2: 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 insert number. 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.

6. Authorized Representatives

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

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

7. Assignment, Amendments, Waiver, and Merger

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

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

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

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

8. Liability The Grantee must indemnify and hold harmless the State, its agents, and employees from all claims or causes of action, including attorneys' fees incurred by the State, arising from the performance of this agreement by the Grantee or the Grantee's agents or employees. This clause will not be construed to bar any legal remedies the Grantee may have for the State's failure to fulfill its obligations under this agreement. Nothing in this clause may be construed as a waiver by the Grantee of any immunities or limitations of liability to which Grantee may be entitled pursuant to Minnesota Statutes Chapter 466, or any other statute or law.
9. **State Audits** Under Minnesota Statutes section 16B.98, subdivision 8, the Grantee's books, records, documents, and accounting procedures and practices of the Grantee, or any other relevant party or transaction, are subject to examination by the State, the State Auditor, and the Legislative Auditor, as appropriate, for a minimum of six (6) years from the end of this grant agreement, receipt and approval of all final reports, or the required period of time to satisfy all state and program retention requirements, whichever is later.

10. **Government Data Practices and Data Disclosure**

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

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

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

11. **Ownership of Equipment** If this grant agreement disburses any federal funds, select option #1 and delete option #2. If this grant agreement disburses only state funds, select option #2 and delete option #1. **Option #1:** Disposition of all equipment purchased under this grant shall be in accordance with 2 CFR 200. For all equipment having a current per unit fair market value of $5,000 or more, the State shall have the right to require transfer of the equipment, including title, to the Federal Government or to an eligible non-Federal party named by the State. This right will normally be exercised by the State only if the project or program for which the equipment was acquired is transferred from one grantee to another. **Option #2:** The State shall have the right to require transfer of all equipment purchased with grant funds (including title) to the State or to an eligible non-State party named by the State. This right will normally be exercised by the State only if the project or program for which the equipment was acquired is transferred from one grantee to another.
12. Ownership of Materials and Intellectual Property Rights

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

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

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

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

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

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

15. Termination

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

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

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

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

(If this grant agreement disburses any federal funds, delete the following section as Lobbying with federal funds is covered in Other Provisions. If this grant agreement disburses ONLY state funds, include the following section and delete Other Provisions.)
17. **Lobbying** Ensure funds are not used for lobbying, which is defined as attempting to influence legislators or other public officials on behalf of or against proposed legislation. Providing education about the importance of policies as a public health strategy is allowed. Education includes providing facts, assessment of data, reports, program descriptions, and information about budget issues and population impacts, but stopping short of making a recommendation on a specific piece of legislation. Education may be provided to legislators, public policy makers, other decision makers, specific stakeholders, and the general community.

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

17.1 **Contractor Debarment, Suspension and Responsibility Certification**

Federal regulation 2 CFR 200.12 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 $750,000 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 2 CFR 200; and, b) to comply with the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and 2 CFR 200.

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 $750,000 or more per year, the Grantee agrees to obtain a financial and compliance audit made in accordance with 2 CFR 200. 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 2 CFR 200.

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 2 CFR 200.

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

(f) Grantees of federal financial assistance from subrecipients are also required to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and 2 CFR 200.

(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 within nine (9) months of the Grantee's fiscal year end.

2 CFR 200 requires recipients of more than $750,000 in federal funds to submit one copy of the audit report within 30 days after issuance to the central clearinghouse at the following address:

Bureau of the Census
Data Preparation Division
1201 East 10th Street
Jeffersonville, Indiana 47132
Attn: Single Audit Clearinghouse
17.3 Drug-Free Workplace  Grantee agrees to comply with the Drug-Free Workplace Act of 1988, which is implemented at 34 CFR Part 85, Subpart F.

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

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

17.6 Cost Principles  The Grantee agrees to comply with the provisions 2 CFR 200 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
   The Grantee certifies that the appropriate persons(s) have executed the grant agreement on behalf of the Grantee as required by applicable articles, bylaws, resolutions, or ordinances.
   
   By: _______________________________________
   
   Title: _____________________________________
   
   Date: ______________________________________

   By: _______________________________________
   
   Title: _____________________________________
   
   Date: ______________________________________

2. State Agency
   Grant Agreement approval and certification that State funds have been encumbered as required by Minn. Stat. §§16A.15 and 16C.05.
   
   By: _______________________________________
   (with delegated authority)
   
   Title: _____________________________________
   
   Date: ______________________________________

Distribution:

Agency – Original (fully executed)
Grant Agreement Grantee
State Authorized Representative
Appendix C: MDH EXAMPLE Invoice

**Grant Name/Type:**

**MDH Division/Section:**

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Program Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Program Contact</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Contact Person for Invoice</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing Period for This Invoice</th>
<th>Contract Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line Item</th>
<th>Amount Spent in this Billing Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 1. Salary and Fringe Benefits</td>
<td>$</td>
</tr>
<tr>
<td>Line 2. Contractual Services</td>
<td>$</td>
</tr>
<tr>
<td>Line 3. Travel</td>
<td>$</td>
</tr>
<tr>
<td>Line 4. Supplies and Expenses</td>
<td>$</td>
</tr>
<tr>
<td>Line 5. Other</td>
<td>$</td>
</tr>
</tbody>
</table>

| Subtotal                        | $                                    |

| Total Expenses for this Invoice | $                                    |

| Total Reimbursement             | $                                    |

I declare that no part of this claim has been previously billed to MDH, and reflects only changes that conform and are consistent with the description and conditions of the grant agreement work plan and budget. I also declare that the data on this document is correct and all transactions that support this claim were made in accordance with all applicable Federal and State statutes and regulations.

Signature: ____________________________________________ Date: ________________________________

**FOR MDH USE ONLY**

<table>
<thead>
<tr>
<th>Approval/date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Org #:</th>
<th>PO #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SWIFT Vendor #:</th>
<th>Invoice Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Invoice Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Processed by: ___________________________________________

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

Invoice Instructions

1. Invoices may be submitted for reimbursement after all the following:
   a. grant project portion has been completed
   b. grantee has been invoiced
   c. grantee has paid invoice
   d. Match Requirement - if required match must also be documented before any payment is made.

2. Invoices are due according to the timeline provided above. Invoices that are received late may not be paid.

3. Enter your costs for the billing period related to each line item as per approved budget.
   a. In the column “Amount Awarded” this is the amount for each line item in your approved budget, and will be entered in by the grant manager.
   b. In the column “Actual Cost” enter the paid expenses for each line item based on the approved budget.

4. On the row labeled “Salary,” enter your costs for salary for staff members identified in the approved budget.

5. On the row labeled “Fringe Benefits,” enter your costs for fringe benefits related to staff salary.

6. On the row labeled “Contractual Services,” enter your costs for subcontractors.

7. On the row labeled “Travel,” enter your costs for travel, including mileage, hotels, and meals. Travel expenses are limited to the current Minnesota Management and Budget’s Commissioner’s Plan [http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf](http://beta.mmb.state.mn.us/doc/comp/contract/CommissionersPlan.pdf)

8. On the row labeled “Supplies,” enter your costs for such approved budget items as telephone, postage, printing, photocopying, office supplies, materials, and equipment costing less than $5,000.

9. On the row labeled “Other,” enter your costs for other items that were approved in your budget.

10. On the row labeled “Total,” enter the total of lines 1-6.

Unallowable Expenses

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

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

Advancing Health Equity in Minnesota: Report to the Legislature
http://www.health.state.mn.us/divs/chs/healthequity/

MN SIM website

MDH Health Care Homes: Learning Collaborative website
http://www.health.state.mn.us/healthreform/homes/collaborative/

MDH - Community Health Improvement Planning
http://www.health.state.mn.us/divs/opi/pm/lphap/chip/

The Practical Playbook
https://www.practicalplaybook.org/

NACCHO - Community Health Assessment and Health Reform
http://archived.naccho.org/topics/infrastructure/mapp/chahealthreform.cfm

Recommendations to Achieve Public Health 3.0

http://journals.lww.com/jphmp/Citation/2016/05000/The_3_Buckets_of_Prevention.1.aspx

Measuring Variation in the Integration of Primary Care and Public Health: A Multi-State PBRN Study of Local Integration and Health Outcomes