Request for Proposals

Minnesota Accountable Health Model e-Health Grant Program- Round 2

April 6, 2015
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1. Overview

The Minnesota Department of Health (MDH) requests proposals for the Minnesota Accountable Health Model e-Health Grant Program. The grants are intended to support readiness to advance the Minnesota Accountable Health Model. This grant opportunity will provide funding to Community Collaboratives to advance the Minnesota Accountable Health Model through implementing and expanding e-health capabilities.

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

- Readiness and participation in the Minnesota Accountable Health Model (http://www.mn.gov/sim/), and
- Achievement of the Triple Aim which includes: improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. Source: The Institute for Healthcare Improvement Triple Aim for Populations (http://www.ihi.org/explore/tripleaim/pages/default.aspx).

2. Available Funding and Estimated Awards:

Up to $2 million available for HIE implementation grants. The range of awards is estimated to be from between $200,000 to $500,000 per grant award.

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

The commissioners shall award grants to community collaboratives in metropolitan and rural areas of the state, and shall ensure geographic representation in awards among all regions of the state.

3. Grant Timeline

RFP posted: Monday, April 6, 2015
RFP informational call: Thursday April 16, 2015
10:30 a.m. – 12:00 p.m. CST
Call-in number: 1-888-742-5095
Passcode: 4477200226

Required Non-binding Letters of Intent to Respond due to MDH: Thursday, April 23, 2015, 4:00 p.m. Central Time

Proposals due to MDH: Monday, May 18, 2015, 4:00 p.m. Central Time

Estimated notice of awards: June 19, 2015

Estimated grant period: July 1, 2015 – December 31, 2016
4. Background

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

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

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

![Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records](image)

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

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

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

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

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

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

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

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. The Minnesota Accountable Health Model: Continuum of Accountability Matrix (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_188556) is designed to illustrate the basic capabilities, relationships, and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It will help the state to identify criteria and priorities for investment, and to lay out developmental milestones that indicate organizations or partnerships are making progress towards the vision.
In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool (http://www.health.state.mn.us/e-health/mahmassessmenttool.docx) is an interactive tool that allows organizations to answer questions to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and their status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve the goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress.

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

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

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

This RFP is for the Minnesota Accountable Health Model e-Health Grant Program.
5. Goals and Outcomes

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

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

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

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

1. Minnesota e-Health Initiative (http://www.health.state.mn.us/e-health/abouthome.html)

2. Minnesota e-Health Advisory Committee (http://www.health.state.mn.us/e-health/advcommittee/index.html) and Minnesota e-Health Workgroups (http://www.health.state.mn.us/e-health/wgshome.html)

3. Minnesota e-Health Assessment Reports, Factsheets and Briefs (http://www.health.state.mn.us/e-health/assessment.html)


7. ONC Beacon Program findings, including those from the Southeast Minnesota Beacon Program:
   - Southeast Minnesota Beacon Program (http://semnbeacon.wordpress.com)

8. Regional Extension Center for Health IT- REACH (http://www.khareach.org/)


13. **MDH’s Health Care Administrative Simplification resources**
   (http://www.health.state.mn.us/asa/index.html).

14. **Health Information Technology for Economic and Clinical Health (HITECH) Act**
    (http://www.healthit.gov/policy-researchers-implementers/hitech-act-0)

15. **Administrative Data Standards and Related Requirements**
    (http://www.ecfr.gov/cgi-bin/text-idx?SID=2e7dc674e5f28683aab627ae1e1e7b31&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1_02.tpl)
    HIPAA administrative simplification and privacy and security rules- see Subchapter C

16. **Health Information Exchange Governance**
    (http://www.healthit.gov/policy-researchers-implementers/health-information-exchange-governance)
    resources from the National eHealth Collaborative.

17. **Resources for Implementing the Community Health Needs Assessment Process**
    (http://www.cdc.gov/policy/chna/)

18. **Minnesota State-Certified Health Information Exchange Service Providers**
    (http://www.health.state.mn.us/divs/hpsc/ohit/certified.html)

19. **Office of National Coordinator for Health IT (ONC), Standards and Interoperability (S&I) Framework**
    (http://wiki.siframework.org/CET+-+Use+Case+and+Functional+Requirements+Development)

20. **S&I framework Public Health Reporting Initiative User Story Template**
    (http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx)

21. **Advancing Health Equity in Minnesota: Report to the Legislature**
    (http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf)

22. **Center for Medicare and Medicaid Innovation**
    (http://innovations.cms.gov)

23. **Integrated Health Partnerships**

24. **A Health IT Framework for Accountable Care: CCHIT.**
    (http://www.healthit.gov/FACAS/sites/faca/files/a_health_it_framework_for_accountable_care_1.pdf)
7. ELIGIBLE APPLICANTS

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

- Medicare Shared Savings Program (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram)—a program that helps a Medicare fee-for-service program providers become an ACO.
- Pioneer ACO Model (http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/)—a program designed for early adopters of coordinated care.
- Other ACO-type arrangements with other payers or commercial ACO products (i.e., a financial arrangement where a provider or group of providers payment is based on achieving targets related to reducing health care costs and meeting certain quality and patient experience benchmarks). For example, the Integrated Care System Partnerships (ICSP) arrangements under Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC).

Community Collaboratives must have a plan in place with at least one payer (e.g., letter of commitment) for payment arrangements involving shared risk, shared savings or total cost of care.

Community Collaboratives must include a partner organization from at least two of the four priority settings of the Minnesota Accountable Health Model/SIM grant with priority given to Community Collaboratives that include three or more priority settings:

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

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

- Primary care and specialty clinics
- Community clinics
- Rural Health Clinics
- Federally Qualified Health Centers
- Health care homes
- Behavioral health clinics or facilities
- Hospitals or Critical Access Hospitals
- Pharmacies
- Skilled nursing facilities
- Chiropractic offices
- Dental offices (including those with dental therapists or advanced dental therapists)
- Emergency medical services (including those with Community Paramedics)
- Assisted living facilities
- Home health organizations
- Community health boards/ local health departments
- Social service or social support providers (including those with Community Health Workers)
- Health plans, payers or Accountable Care Organizations
- Other providers of health or health care services for which HIE would improve care (see page three of Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate (http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf).
8. ELIGIBLE ACTIVITIES

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

Eligible Activities:

- Establish connectivity with a State-Certified HIE Service Provider (http://www.health.state.mn.us/divs/hpsc/ohit/certified.html) or other exchange option including implementing collaborative governance structure(s) (e.g., data use agreements, business associate agreements).

  Note: While the Minnesota Accountable Health Model e-Health Grant Program recognizes there are many different health information exchange options available to potential grantees, the funding for this grant program will only cover HIE subscription costs associated with State-Certified HIE Service Providers consistent with Minnesota's 2015 mandate for interoperable EHR requirements. If a grantee chooses to plan for a non-State-Certified HIE option, they will need to cover those investments as part of their funding match requirement for implementation.

- Implement e-health toolkits and roadmaps for HIE.
- Incorporate HIE for quality measurement reporting and quality improvement.
- Use e-health (including HIE) to engage consumers/patients and/or the community
- Use HIE to address population health in the community.
- Use HIE to address health disparities in the community.
- Integrate telehealth programs with EHRs, HIT and HIE (Note: funds may not be used for telehealth equipment).

Ineligible Activities and Expenses:

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

Required Deliverables and Activities

1. Submit a proposed implementation plan to MDH for review and approval.
2. Submit pre-grant and post-grant descriptions of the Community Collaborative “location” on the Minnesota Accountable Health Model: Continuum of Accountability Matrix (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) including the Assessment Tool results Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool (http://www.health.state.mn.us/e-
Include detailed descriptions of how Community Collaborative capabilities improved as a result of grant funding.

3. Submit, as part of quarterly report, a description of current use of HIE among collaborative partners, including identification of the State-Certified HIE Service Provider or other exchange option, a list of HIE services currently provided, an estimate of the number of transactions currently exchanged (paper and electronic) annually, and detailed list of sharing partners with whom patient data are being exchanged.

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

5. Implement one (or more) use case, for using e-health to advance the Minnesota Accountable Health Model.

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

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

6. Submit evaluation plan to MDH for approval. Evaluation plan should include objectives developed using the SMART (http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~/media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx) approach to measure and report on grant goals and outcomes (e.g., tracking number of HIE partners, number of transactions/type etc.).

7. Submit copies of all tools, resources or other guidance.

8. Submit quarterly written progress reports, (content and detail to be described by MDH) to the MDH- Office of Health Information Technology.

9. Submit final report, (content and detail to be described by MDH including lessons learned) to MDH- Office of Health Information Technology.
In addition to Required Deliverables and Activities, the grant participation requirements include:

1. Engage with and incorporate direction and feedback from MDH on methodology, engagement strategies, and use cases. The actual hours required for these reviews/adjustments are estimated to be within the total allocated time for reporting.

2. Participate in the overall Minnesota Accountable Health Model-SIM Minnesota grant evaluation with State including MDH, DHS and other staff or evaluation partners. All SIM-Minnesota funded projects are required to participate in the SIM-Minnesota project evaluation. MDH, DHS and Center for Medicare & Medicaid Innovation (CMMI) are identifying the components of the SIM-Minnesota project evaluation necessary to evaluate the Minnesota Accountable Health Model and SIM-Minnesota Grant. It is expected that the SIM-Minnesota project evaluation activities are not expected to exceed a total of 10 hours for the entire grant period.

3. Participate in State provided or identified trainings, meetings and technical assistance, including participation in any state-funded activities to develop e-health roadmaps for the Minnesota Accountable Health Model-SIM Minnesota priority settings that are applicable to the collaborative development plans.

4. Collaborate with any other contractors, grantees or partners associated with Minnesota Accountable Health Model-SIM Minnesota grant and Minnesota Accountable Health Model as appropriate. The State and its grantees, contractors and partners will leverage the learnings from each other through all the SIM-Minnesota Grant activities. It is expected that lessons learned from one activity could be of use to or influence the direction of another activity. For example, processes and lessons learned from the Minnesota Accountable Health Model e-Health Roadmaps could be beneficial to the development of the e-Health Grant Program. Participate in State-provided or identified e-health assessment activities. This may include activities related to the SIM-Minnesota evaluation (see 2 above) or other health information technology or health information exchange assessment surveys the State may conduct during the grant period that may or may not be part of the quarterly reporting requirements in Section 2.3. It is expected that the SIM-Minnesota project evaluation activities are not expected to exceed a total of 10 hours for the entire grant period.
9. Proposal Filing Requirements

INTENT TO RESPOND (Required)

Potential applicants must submit a written Intent to Respond to MDH by **April 23, 2015**. The non-binding Letter of Intent to Respond must use the Form F template. The letter should include the following: applicant organization; key partners; potential Accountable Care Organization (ACO) partner; and the planned target population. Letters of Intent to Respond should be submitted via e-mail to: Anne Schloegel at Anne.Schloegel@state.mn.us

APPLICATION REQUIREMENTS

Applicants must:

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

PROPOSAL SUBMISSION

Ten copies of the proposal and an electronic copy of the proposal on a USB drive are required. Proposals must be received by 4:00 p.m. on **May 18, 2015**, at the following address:

Minnesota Department of Health
Office of Health Information Technology
Attention: Anne Schloegel

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

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

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

All submitted grant application materials become public information once grant agreements have been executed.

9. Contact Information

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

Anne Schloegel
Office of Health Information Technology
Phone: 651-201-4846
Email: Anne.schloegel@state.mn.us
10. Proposal Review Process

Scoring Criteria

Grant proposals will be reviewed and evaluated by a panel familiar with the program. The panel may include staff from the Minnesota Department of Health, Minnesota Department of Human Services, SIM Advisory Task Force members and the community at large. The panel will recommend selections to the Commissioners of Health and Human Services. In addition to panel recommendations, the commissioners may also take into account other relevant factors in making final awards.

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Collaborative Description</td>
<td>15 points</td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>15 points</td>
</tr>
<tr>
<td>Project Description</td>
<td>10 points</td>
</tr>
<tr>
<td>Work Plan and Evaluation</td>
<td>25 points</td>
</tr>
<tr>
<td>Project Team/Resources</td>
<td>10 points</td>
</tr>
<tr>
<td>Budget</td>
<td>20 points</td>
</tr>
<tr>
<td>Evidence of Community Commitment and Support</td>
<td>5 points</td>
</tr>
</tbody>
</table>

**Total** 100 points

Award Process

Applicants awarded a grant will be expected to:

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

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

Required Elements

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

1. **Application Cover Form (Form A)**

2. **Project Summary (Abstract)**

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

3. **Community Collaborative Description**
   a. Brief organizational descriptions, including current use of EHRs, HIT and health information exchange (paper or electronic) within each organization. If not using EHRs, describe partners’ plans for implementing e-health tools. If applicable, please include information on exchange within the collaborative and with others outside the collaborative.
   b. History as collaborators on previous projects, if any (can be other than health IT projects). If so, describe the relationships including how they have evolved, successes, and challenges
   c. Estimated payer mix including number of Medicaid, Medicare and commercial enrollees for each organization and for the collaborative as a whole.
   d. Description of current ACO or ACO-like arrangements that collaborative partners are involved in, including participation in the Integrated Health Partnerships the Medicare Shared Savings Program, the Pioneer ACO program, or other payment arrangements with at least one payer involving shared risk/shared savings or total cost of care.
   e. **Letters of Commitment and Support** *(attach at back of application- not included in page limit).*

   Letters of commitment are required from all collaborating organizations. The letters of commitment must also declare participation in an accountable care organization (ACO) or similar health care payment model that has a plan for financial reward and/or risk sharing among participants. Letters of support from other organizations participating in the grant are allowed but not required.
   f. **Minnesota Accountable Health Model: Continuum of Accountability Matrix Location**

   Description of each organization’s and overall collaborative’s location on the Minnesota Accountable Health Model: Continuum of Accountability Matrix Tool (use Form G: Minnesota Accountable Health Model: Continuum of Accountability Matrix Tally Sheet).

Individual organizations / providers must complete the Continuum of Accountability Matrix Assessment Tool for their organization. In addition, community collaborative partners must come together collectively and complete the Matrix Assessment Tool to reflect one single score for the partnership.

After the assessments have been completed, use **Form G: Minnesota Accountable Health Model: Continuum of Accountability Matrix Tally Sheet** to enter results for entire collaborative. This is the only from required; individual organization assessment tool results are not required.
• List individual organizations on Form G and enter results for each organization following instructions in the tally form.
• Enter the name of the collaborative and collective results in the final column.

In the Assessment Tool, the terms ‘organization’ and ‘provider’ are meant to include a broad range of health and health care providers and support services providers that are part of an existing ACO, or similar arrangement moving towards greater accountability for quality, cost of care, and health of the populations they serve. Besides health care providers, organizations such as behavioral health, social services, local public health, long-term care/post-acute care, community organizations, and other public/private sector partners that provide supportive services to individuals and families have a role in convening, leading, or participating in these models.

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

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

a. Geographic area and demographics of population(s) to be served. Include community needs assessments where appropriate (see Resources section for more information on community health needs assessments). Engage the local health department and other social or community service agencies to provide a comprehensive view. Please include the following categories:
• Population - Describe the population of county(ies), neighborhoods or entire community to be served. Demographic data should be used and cited whenever possible to support the information provided. Include a geographic map of service area if possible.
• Health Status - Describe the general health status of your population. This geographic data should be compared to regional and state data where possible. Relevant factors such as age, poverty, disparities, substance abuse and other social problems should be included.
• Health and Healthcare Delivery System - Describe the health infrastructure (e.g., hospitals, solo and group practices, primary care and specialty clinics, community health centers, health care homes and emergency medical services. Describe the availability, distribution and any shortages within the health workforce.

b. Problem statement of unmet e-health needs in the community to be served. Describe how unmet needs impact health outcomes

c. Financial and other resource considerations of organizations and the community, including the reason(s) why grant funds are needed. Include a statement of financial need of collaborative partner organizations and community, including how grant funds will support care coordination

5. Project Description
a. Identify the target population and communities the project will serve and why this collaborative is suited to provide services to this population. If applicable, describe how this project meets the needs of the community in rural and/or underserved areas or populations.

b. Describe what the project will accomplish (goals/outcomes/objectives) with respect to community e-health needs and coordination of health and health care services, as well as specific goals related to number and type of HIE transactions that are anticipated among collaborative partners.

c. Describe how this project may improve health outcomes of the community, including the impact on health disparities as appropriate, and how these outcomes will be measured.

d. Indicate where Community Collaborative will be on the Minnesota Accountable Health Model: Continuum of Accountability Matrix (using Assessment Tool) with successful implementation of this grant project.

6. Project Work Plan and Evaluation (project may not extend beyond December 31, 2016)

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

- Project Goals/outcomes and expectations (see Required Deliverables and Activities)
- Time-specific objectives to achieve each stated outcome/goal
- Methods for accomplishing objectives; metrics for measuring the achievement of objectives
- Staff (or responsible entity, partners)
- Progress or process measures
- Outcome or Impact (anticipated or actual)

a. Goals/outcomes and expectations for the project as related to advancing Minnesota Accountable Health Model: Continuum of Accountability Matrix (specifically EHR and HIE rows) (see Required Deliverables and Activities).

b. Include evidence that project is part of the Community Collaborative’s long term strategic plan

c. Document planning activities have been completed including due diligence, workflow analysis, clinician and consumer involvement (if applicable), etc.

d. Include information, if applicable, on State-Certified HIE Service Provider selection process such that the product selected includes essential key features to improve patient care and health of the population identified. This may include registry functions, decision support tools, and population based health outcomes system reports capability.

e. Plans for staff training for implementation and continuous evaluation.

f. Plans for system operation and maintenance and technical support resources.

g. Plans for sustainability beyond state funding.

h. Describe a communications plan to ensure all stakeholders (including patients/consumers) are kept informed of project goals and progress, and are engaged.

i. Brief description of the formal process used for obtaining the governing boards of each collaborating organization’s approval to commit to the grant duties and conditions of funding. Describe how the present project will advance and expand HIE capabilities.

ej. Identify, describe, and implement at least one or more, use cases for using e-health for the Minnesota Accountable Health Model. A use case is generally defined as a list of steps, typically defining interactions or workflow between providers (business actors) and EHR or other HIT systems (technical actors), to achieve a specific health or health care goal. (for more detailed information see Appendix C)

One use case must involve care coordination, including but not limited to examples here:
- a patient/client who is transitioning between settings of care (e.g., hospital to a skilled nursing facility or to home health care)
- a patient/client with multiple chronic conditions, including behavioral health as well as physiological health conditions;
- a patient/client who resides in a rural area, as defined by the Office of Rural Health and Primary Care, MDH; and receives services in urban locations in addition to rural;
- an individual, client and/or patient that is part of a medical home and/or behavioral health home and that is receiving county social services
- a patient where smoking, obesity and/or diabetes is being treated or addressed through care of a provider and community supports;
- a patient/client who is receiving social services in addition to medical care services;
- a patient transitioning between another setting and the patient’s health care home;
- a patient/client needing primary prevention. Primary prevention may be defined as a method used before a person/population gets a disease and aims to prevent the disease from occurring to reduce both the incidence and prevalence of a disease (e.g., screenings, immunizations).

National Public Health Partnership – The Language of Prevention

Other use cases may include:
- health information exchange between the setting and the Minnesota Department of Health or Minnesota Department of Human Services or other state agency.

Evaluation Notes:
The evaluation portion should include objectives developed using the SMART approach to measure grant goals and outcomes (e.g., tracking number of HIE partners, number/type of transactions). For more information see SMART Objectives (http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx).

Applicant must describe the strategies and measures that will be used to evaluate performance during the project period. The applicant should describe how progress toward meeting grant-funded goals will be tracked, measured, and evaluated. Explain any assumptions made in developing the project work plan and discuss the anticipated performance measures and desired outcomes of grant-funded activities. Describe the data collection strategy to collect, analyze and track data to measure performance and determine impact or outcomes. Explain how the data will be used to improve performance.

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

Only costs in the approved budget will be reimbursed, and only upon acceptance of any deliverables by the State.

**e-Health Implementation Grants (up to $500,000 per grant)**

Include a budget for:
- Year one (July 1, 2015 – December 31, 2015)
- Year two (January 1, 2016 – December 31, 2016)

Grant funds may be used to cover costs of personnel, consultants, HIE subscription and installation costs, supplies, grant-related travel, and some other costs. Note: Ineligible Activities and Expenses:
- (proprietary interfaces (interfaces that do not go through State-Certified HIE Service Providers for HIE, EHR hardware or software, broadband infrastructure or service costs, telehealth equipment or services, capital improvements, including but not limited to roads and buildings.

Applicants must use the Minnesota Accountable Health Model Contractor Budget Template. (See Form F and the Example tab). The budget must be written for each year in Section One eligible expenses and for Section Two Deliverables.

- a. Direct costs (see categories below)
- b. Indirect costs. There are no indirect costs allowed in this proposal.
- c. Match. A 20 percent match is required for this grant. Include the amounts and sources of financial or in-kind resources used for the required match. It is not necessary to have a match for each line item; however, the total match must equal at least twenty percent of the total grant dollars being applied for. In-kind match should be expressed in dollars, and can include, but is not limited to, staff time (the value of salaries and fringe) spent by collaborating organizations on the project (for example, staff time spent in planning, governance, or IT support), communications and mileage costs related to planning or governance meetings, and equipment needed to enable health information exchange or adoption of an interoperable EHR.

Use the Minnesota Accountable Health Model Contractor Budget Template (Form C) for Years 1 and 2 budget templates. Form C includes an example.

- **Budget Justification Narrative** see template Form D.
- **Due Diligence Review** Form E.

**Minnesota Accountable Health Model Contractor Budget Template: (Form C)**

**Section One:**
- The budget form includes two sections and must be completed for each year. 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 worked hours allocated to this project (not supplanting, not full-time care coordinators).
- 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 A.

C. Consultant Costs.
Provide the name of contractors or organizations, the services to be provided, hourly rate, and projected costs. If a contractor has not been selected, include a description of the anticipated contractor by type of service.

- In the budget narrative, include brief background information about contractors, including how their previous experience relates to the project.
- 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 ACH 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:
Include HIE costs here. Describe costs related to implementation and subscription (up to one year) for State-Certified HIE Service Provider (http://www.health.state.mn.us/divs/hsfc/ohit/certified.html). Include quotes where possible.

If it is necessary to include additional 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.
- Reimbursement for committee member expenses: Travel, meals, and childcare expenses can be covered for consumers or other community members without a form of reimbursement to attend a scheduled meeting. Please be specific on your budget form and budget narrative about stipends for travel, meal and childcare expenses for consumers or community members without a form of reimbursement. These may be allowable in accordance with applicable program proposal:
- Reasonable and actual out-of-pocket costs incurred solely as a result of attending an approved scheduled meeting, including transportation, meals, babysitting fees, and lost wages for community partners without other sources of reimbursement as described in your budget narrative.
- The reasonable costs of necessary meals furnished by the recipient to consumer or provider participants during scheduled meetings if not reimbursed to participants as per diem or otherwise.

Section Two: Budget Deliverables:

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

_Budget deliverables should cross reference your work plan and include key work plan deliverables. The budget deliverable total for each year must equal the line-item total for that year._

_In addition, the total for the two years (line-item and deliverables) must equal the requested total grant amount._

Note: Ineligible Activities and Expenses: (proprietary interfaces (interfaces that do not go through State-Certified HIE Service Providers for HIE, EHR hardware or software, broadband infrastructure or service costs, telehealth equipment or services, capital improvements, including but not limited to roads and buildings.

9. Due Diligence Form (Form E)

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

Below is a listing of forms required for submission of the 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.

Form A: Application Cover Sheet with Instructions
Form B: Sample Project Work Plan
Form C: Budget Form, Minnesota Accountable Health Model Contractor Budget Template
Form D: Budget Justification Narrative
Form E: Due Diligence Review Form
Form F: Letter of Intent to Respond Template
Form G: Minnesota Accountable Health Model Continuum of Accountability Matrix Tally Sheet
Form A: Application Cover Sheet

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

2. Minnesota Tax I.D. Number:  

3. Federal Tax I.D. Number:  

4. Requested funding for the total grant period $  

5. Director of applicant agency

<table>
<thead>
<tr>
<th>Name, Title and Address</th>
<th>Email Address:</th>
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<tbody>
<tr>
<td></td>
<td>Telephone Number: ( )</td>
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<td>FAX Number: ()</td>
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6. Fiscal management officer of applicant agency

<table>
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<tr>
<th>Name, Title and Address</th>
<th>Email Address:</th>
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<tr>
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<td>Telephone Number: ( )</td>
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<td>FAX Number: ()</td>
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7. Contact person for applicant agency (if different from number 4 above)

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<tr>
<th>Name, Title and Address</th>
<th>Email Address:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Telephone Number: ( )</td>
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<tr>
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<td>FAX Number: ()</td>
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8. Contact person for further information on grant application

<table>
<thead>
<tr>
<th>Name, Title Address</th>
<th>Email Address:</th>
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<tbody>
<tr>
<td></td>
<td>Telephone Number: ( )</td>
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<td>FAX Number: ()</td>
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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 Grant Agreement  Title  Date

Please note that all submitted grant application materials become public information once grant agreements have been executed.
Form A: Application Cover 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. The estimated grant period will be from July 1, 2015 – December 31, 2016. The grantee must submit a budget for each year, starting with July 1, 2015 – December 31, 2015 and January 1, 2016 – December 31, 2016. The budget for each year will be based on deliverables being met the previous year.

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. 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.

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

8. 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: Sample Project Work Plan

Applicant:

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Activities and/or Tasks</th>
<th>Measurement and/or Tracking Methods</th>
<th>Milestones or/and Deliverables</th>
<th>Timeline and/or Completion Date</th>
</tr>
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</table>
Form C: Minnesota Accountable Health Model Budget Template

Applicant:  

Total Contract Period: Estimated July 1, 2015 - December 31, 2016

Budget Form Instructions for Applicants:
1. Complete a separate budget for each grant year - Year 1 (2015) and Year 2 (2016) (see tabs).
2. Include costs for the grant recipient (fiscal agent) and partners in Salaries & Wages, Fringe, Supplies, Travel, and
   Other categories.
3. Include contractor costs (contracts with vendors that will be providing a specific service such as IT, group
   facilitation, or consultation) in C. Consultant Costs.
4. Enter information in cells highlighted in blue as applicable for your project.

The amount paid for deliverables in section two is based on costs in section one (section totals must be equal).

Section One

A. SALARIES & WAGES: For each position, provide the following information: position title, hourly rate, and number of
   hours allocated to the project. In Form D Budget Justification Narrative, provide a brief position description for each
   position listed.

<table>
<thead>
<tr>
<th>Title</th>
<th>Hourly Rate</th>
<th>Hours</th>
<th>Total</th>
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<tbody>
<tr>
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</tbody>
</table>

Total Salaries and Wages: $ 0

B. FRINGE: Provide information on the rate of fringe benefits calculated for the total salaries and wages for positions in 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</th>
<th>Hours</th>
<th>Total</th>
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<tbody>
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</tbody>
</table>

Hourly rate and number of hours

Name: 
Organization: 
Services: 

Total Consultant Costs: $ 

### D. EQUIPMENT

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

Total Equipment Costs: $ 

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### E. SUPPLIES

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

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

Total Supply Costs: $ 

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### F. TRAVEL

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

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

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

Total Travel Costs: $ 

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### 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.

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

Total Other Costs: $ 

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**GRAND PROJECT TOTAL** $ 

---
Form D: Budget Justification Narrative

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

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

<table>
<thead>
<tr>
<th>A. Salaries and Wages</th>
<th>This should include all personnel at the fiscal lead and partnering organizations whose work is tied to the proposal.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrative Justification</strong> (enter a brief description of the roles, responsibilities, and unique qualifications of each position):</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Fringe</th>
<th></th>
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<tbody>
<tr>
<td><strong>Narrative Justification</strong> (provide information on the rate of fringe benefits calculated for salaries and wages):</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Consultant Costs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrative Justification</strong> (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):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Supplies</th>
<th>Describe costs related to each type of supply, either in Budget Form C or below.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrative Justification</strong> (enter a description of the supplies requested and how their purchase will support the purpose and goals of this proposal):</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>F. Travel</th>
<th>Travel may include costs associated with travel for meetings, community engagement, and other items included in the work plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrative Justification</strong> (describe the purpose and need of travel and how costs were determined for each line item in the budget):</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>G. Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrative Justification</strong> (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):</td>
<td></td>
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<table>
<thead>
<tr>
<th>In-kind</th>
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<tbody>
<tr>
<td><strong>Narrative Justification</strong> (describe in-kind contributions that will be provided. Include sources and types of in-kind such as staff time, communications, mileage, and other project costs for which grant funding is not being requested):</td>
<td></td>
</tr>
</tbody>
</table>

Minnesota Accountable Health Model -SIM Minnesota

2015 e-Health Grant Program

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April 6, 2015
Form E: Due Diligence Review Form Instructions

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

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

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

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

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

1. How long has your organization been doing business?  

2. Does your organization have a current 501(c)3 status from the IRS? Circle Yes or No.  
   Yes | No

3. How many employees does your organization have (both part time and full time)?

4. Has your organization done business under any other name(s) within the last five years? Circle Yes or No. If yes, list name(s) used.  
   Yes | No

5. Is your organization affiliated with or managed by any other organizations, such as a regional or national office? Circle Yes or No. If yes, provide details.  
   Yes | No

6. Does your organization receive management or financial assistance from any other organizations? Circle Yes or No.  
   Yes | No

7. What was your organization's total revenue in the most recent 12-month accounting period?

8. How many different funding sources does the total revenue come from?

9. Have you been a grantee of the Minnesota Department of Health within the last five years? Circle Yes or No. If yes, from which division(s)?  
   Yes | No

10. Does your organization have written policies and procedures for accounting processes? Circle Yes or No. If yes, please attach a copy of the table of contents.  
    Yes | No

11. Does your organization have written policies and procedures for purchasing processes? Circle Yes or No. If yes, please attach a copy of the table of contents.  
    Yes | No

12. Does your organization have written policies and procedures for payroll processes? Circle Yes or No. If yes, please attach a copy of the table of contents.  
    Yes | No

13. Which of the following best describes your organization's accounting system? Circle one response.  
   Manual | Automated | Both

14. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately? Circle one response.  
   Yes | No | Not sure
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Response Options</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>If your organization has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items? Circle one response.</td>
<td>Yes or Not applicable</td>
<td></td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>16.</td>
<td>Are time studies conducted for employees who receive funding from multiple sources? Circle one response.</td>
<td>Yes or Not applicable</td>
<td></td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>17.</td>
<td>Does the accounting system have a way to identify overspending of grant funds? Circle one response.</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>If grant funds are mixed with other funds, can the grant expenses be easily identified? Circle one response.</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Are the officials of the organization bonded? Circle one response.</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Did an independent certified public accountant (CPA) ever examine the organization's financial statements? Circle one response.</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Has any debt been incurred in the last six months? Circle Yes or No. If yes, what was the reason for the new debt? What is the funding source for paying back the new debt?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>What is the current amount of unrestricted funds compared to total revenues?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Are there any current or pending lawsuits against the organization? Circle Yes or No.</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>If yes, could there be an impact on the organization’s financial position? Circle one response.</td>
<td>Yes</td>
<td>No or Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Has the organization lost any funding due to accountability issues, misuse, or fraud? Circle Yes or No. If yes, please describe the situation, including when it occurred and whether issues have been corrected.</td>
<td>Yes</td>
<td>No</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.
Form F: Template: Required Non-binding Letter of Intent to Respond

Place on Letterhead:
**Deadline April 23, 2015, 4:00 pm Central Time**

(date)

This is written notification of the intent to submit an application to the Minnesota Department of Health for funding under the Minnesota Accountable Health Model e-Health grant program. We understand that the application deadline for our proposal is May 18, 2015, at 4:00 pm Central Time. Information on our community collaborative is provided below.

**Applicant organization name:**

**Contact person:**

**Contact person email:**

**Key collaborative partners/proposed leadership structure:**

**ACO partner:**

**Signature:**

Please submit the letter as an email attachment to Anne.schloegel@state.mn.us
Or provide the letter via mail or courier to:

Minnesota Department of Health
Office of Health Information Technology
Attention: Anne Schloegel

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

**Mailing Address (must arrive by the deadline to be accepted):**
P.O. Box 64882
Saint Paul, Minnesota 55164-0882
Form G: Minnesota Accountable Health Model: Continuum of Accountability Matrix Tally Sheet

Individual organizations / providers must complete the Continuum of Accountability Matrix Assessment Tool for their organization. In addition, community collaborative partners must come together collectively and complete the Matrix Assessment Tool to reflect one single score for the partnership. Use this form to document assessment results and submit it with your proposal.

Instructions for completing Form G (see Example tab for illustration):

1. Enter the name of each organization and the name of the community collaborative in the spaces below. The form allows for up to 3 organizations but that number is not required.
2. Place an x in the box that represents the score for each individual agency and the collaborative overall.

Enter Organizations and Community Collaborative name:

<table>
<thead>
<tr>
<th>Organization 1:</th>
<th>Organization 2:</th>
<th>Organization 3:</th>
<th>Collaborative Name</th>
</tr>
</thead>
</table>

Model Spread and Multi-Payer Participation Section

<table>
<thead>
<tr>
<th>Level</th>
<th>1. What type of payment arrangements do you participate in?</th>
<th>Org 1</th>
<th>Org 2</th>
<th>Org 3</th>
<th>Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre- Level</td>
<td>We only receive payment for delivered services in the form of fee-for-service or capitation payments without any incentives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>We have alternative types of payment arrangements with at least one payer that represents less than 20% of our total consumer base, OR participation in at least one performance-based or value-based incentive system representing less than 5% of our total revenue.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>We have alternative types of payment arrangements with at least one payer that represents 20% to 50% of our total consumer base, OR participation in at least one performance-based or value-based incentive system representing 5% to 15% of our total revenue.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>We have alternative types of payment arrangements with at least one payer that represents greater than 75% of our total consumer base, OR participation in a performance-based or value-based incentive system representing greater than 30% of our total revenue.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A: Minnesota Accountable Health Model Glossary

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

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)
Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Medicare offers several ACO programs:
• Medicare Shared Savings Program—a program that helps a Medicare fee-for-service program providers become an ACO. Apply Now.
• Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.
• Pioneer ACO Model—a program designed for early adopters of coordinated care. No longer accepting applications.
Source: Centers for Medicare and Medicaid Services (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/ accessed 03.30.2015

Accountable Care Organization (ACO)
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.
Admit/Discharge/Transfer (ADT) messages
Admission, Discharge and Transfer (ADT) messages are used to communicate episode details. ADT messages carry patient demographic information for HL7 communications, but also provide important information about trigger events (such as patient admit, discharge, transfer, registration, etc.). ADT messages are extremely common in HL7 processing and are among the most widely used of all message types.

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.
DHS Behavioral Health Home webpage
(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177945)

Business Associate Agreement (BAA)
A contract between a covered entity and its business associate or a business associate and its subcontractor that must contain the elements specified at 45 CFR 164.504(e). For example, the contract must: Describe the permitted and required uses of protected health information by the business associate; Provide that the business associate will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law; and Require the business associate to use appropriate safeguards to prevent a use or disclosure of the protected health information other than as provided for by the contract.
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.
Source: [Financing Prevention: How states are balancing delivery system & public health roles](http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf)

Community Engagement
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.
Source: [Fawcett et al., 1995](http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf)

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 Use and Reciprocal Support Agreement (DURSA)
The Data Use and Reciprocal Support Agreement (DURSA) is a comprehensive, multi-party trust agreement that was signed by all Nationwide Health Information Network participants, both public and private, wishing to
participate in the NwHIN Exchange, now referred to as the eHealth Exchange. The DURSA provides the legal framework governing participation in the eHealth Exchange by requiring the signatories to abide by a common set of terms and conditions.  
(Excerpted from: Office of the National Coordinator for Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0 Appendix G: HIT Glossary  
(http://www.healthit.gov/policy-researchers-implementers/interoperability)

**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: MDH Health Equity Terminology webpage  
(http://www.health.state.mn.us/divs/chs/healthequity/definitions.htm)

**Direct Protocol**

Direct uses established standards and protocols to enable secure health information exchange through a simple, scalable approach. Direct allows authorized users to send authenticated, encrypted health information directly to known recipients via the Internet. Direct offers a means of transmitting health information in support of core Stage 2 meaningful use measures including the communication of summary care records, referrals, discharge summaries and other clinical documents.  
http://www.healthit.gov/policy-researchers-implementers/direct-project  
http://wiki.directproject.org/  
(Excerpted from: Office of the National Coordinator for Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0 Appendix G: HIT Glossary  
(http://www.healthit.gov/policy-researchers-implementers/interoperability)

**Directed Exchange (push)**

Organizations need to send information to one another, often in an unsolicited manner (i.e., without the recipient specifically asking for the information). The Direct protocol was developed by the S&I Framework and utilizes email standards, but in a secure manner, with the primary protocol utilizing secure mail transport (SMTP). Direct supports a secure e-mail transaction that is appropriate for many different uses, including provider-to-provider, provider-to-consumer, provider-to-payer and many other types of transactions. The Direct protocol is an all-purpose protocol; it does not care what type of information is transported. To be used effectively, however, a trust relationship must exist between participants to ensure that a message reaches the intended party and not someone else. Other technologies have also been in use for some time to support unsolicited transmission of information including, secure File Transfer Protocol (sFTP) and Simple Object Access protocol [SOAP] and Representational State Transfer (REST).  
http://www.healthit.gov/policy-researchers-implementers/direct-project  
http://wiki.directproject.org/  
(Excerpted from: Office of the National Coordinator for Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0 Appendix G: HIT Glossary  
(http://www.healthit.gov/policy-researchers-implementers/interoperability)
DirectTrust
DirectTrust is an independent, non-profit trade association created by and for participants in the Direct community. It has established a set of technical, legal and business standards, expressed as policy and best practice recommendations, which members of the trust community agree to follow, uphold and enforce. DirectTrust offers an accreditation program that assesses organizations’ adherence to these standards. http://www.directtrust.org/

E-Health
E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.
Source: Minnesota Department of Health (http://www.health.state.mn.us/e-health/) accessed 2.19.14

Electronic Health Record (EHR)
EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. EHR is considered more comprehensive than the concept of an Electronic Medical Record (EMR). Source: Office of the National Coordinator for HIT Health IT Glossary (http://www.hhs.gov/healthit/glossary.html) accessed 09.10.13

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

Health
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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 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 Exchange (HIE)
Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient’s vital medical information electronically—improving the speed, quality, safety and cost of patient care. [http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie](http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie)

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.

Interoperability
The ability of two or more information systems or components to exchange information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed. Source: [Office of the National Coordinator for HIT Glossary](http://www.healthit.gov/policy-researchers-implementers/glossary), accessed 09.10.13

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

Long-Term 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 to 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.

LTPAC Settings (e.g., Skilled Nursing Facility (SNF), Home Health, Inpatient Rehab, Long Term Acute Care Hospital, Hospice). This category of providers serves some of the nation's most vulnerable individuals and uses a significant portion of the Medicare and Medicaid budgets. Patients served by these providers experience frequent transitions in care and episodes of care coordination with eligible hospitals and professionals. Some of these providers may need interoperable EHR technology to support new care delivery and payment models in the Affordable Care Act and in private sector initiatives.
(Excerpted from: [Office of the National Coordinator for Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0 Appendix G: HIT Glossary](http://www.healthit.gov/policy-researchers-implementers/interoperability)

Long-Term Services & Supports (LTSS)
Assistance with activities of daily living and instrumental activities of daily living provided to older people and adults with disabilities that cannot perform these activities on their own due to a physical, cognitive, or chronic health conditions. LTSS may provide care, case management and service coordination to people who live in their own home, a residential setting, a nursing facility, or other institutional setting. LTSS also include supports provided to family members and other unpaid caregivers. LTSS may be provided in institutional and community settings. [http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf](http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf)
(Excerpted from: [Office of the National Coordinator for Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0 Appendix G: HIT Glossary](http://www.healthit.gov/policy-researchers-implementers/interoperability)

Minnesota e-Health Initiative
The Minnesota e-Health Initiative is a public-private collaborative whose Vision is to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health. Source: Minnesota Department of Health, [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) accessed 09.11.13

Minnesota Accountable Health Model - SIM Minnesota
2015 e-Health Grant Program
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April 6, 2015
Minnesota Model for EHR Adoption
In 2008, the Minnesota e-Health Initiative developed the Minnesota Model for Adopting Interoperable EHRs that is applied to all aspects of the Initiative’s work and policy development. The model has seven steps which are grouped into three major categories:

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


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

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


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

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

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

Social Determinants of Health
Complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.

Social Services
The system of programs, benefits and services made available by public, non-profit or private agencies that help people meet those social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services, for the purposes of SIM, include but are not limited to organizations that provide housing, transportation, or nutritional services to individuals or families. Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models, accessed 09.27.13

Summary of Care Record
A summary of care record may include the following elements:

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

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 09.10.2
Appendix B: Criteria for Scoring Grant Proposals

Community Collaborative Description (15 points)

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

Needs Assessment (15 points)

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

Project Description (10 points)

- Does the applicant clearly identify their target population and why the collaborative is suited to provide services to that target population? If applicable, does the applicant clearly identify how this project meets the needs of the community in rural and/or underserved areas or populations?
- Does the applicant provide a clear description of how this project (goals/objectives) will meet the e-health needs of the community – including coordination of health and health care services?
- Does the applicant provide a clear description of the how this project may improve community health outcomes?
Work Plan and Evaluation Plan (25 points)

- Does the applicant provide clear measures and outcomes for each proposed objective?
- Does the applicant provide clear objectives and time frame for each proposed component?
- Are the proposed methods for each objective for each component clearly described, measurable, and realistic?
- Is the use case clearly identified and described?
- Is the proposed communication plan adequate for the proposed activities/strategies for each objective?
- To what extent does the proposed evaluation plan effectively measure the project’s progress toward meeting their objectives?
- Does the applicant include evidence that the project is part of the collaborative long term strategic plan?
- Does the applicant include documentation that development planning activities have been completed including due diligence, workflow analysis, clinician and consumer involvement (if applicable), etc.?
- Is the applicant’s plan for implementation, staff training, maintenance and technical support reasonable?
- Is the formal process for governance clearly described?

Project Team (10 points)

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

Budget (20 points)

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

Evidence of Commitment and Support (5 points)

- Does the proposal include Letters of Commitment from all collaborating organizations?
- Do the letters of commitment must also declare current participation in an accountable care organization (ACO) or similar health care model that includes a financial reward and/or risk sharing among participants?
Appendix C: Use Case Format Templates

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

Use Case Format 1:

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

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

3. **Standards**
   Describe HIT standards that support data reporting/exchange.

Use Case Format 2:

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

1.1.1.1 Office of National Coordinator for Health IT (ONC)

Standards and Interoperability (S&I) Framework

Public Health Reporting Initiative

User Story Template

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

User Story Narrative

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

1.1.2 Goal

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

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

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

1.1.4 Data

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

1.1.5 Standards

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

1.1.6 Other Information

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

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

1.3 Story Submitter Contact Information

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

Attachment 1: User Story: Actors and Workflow Template

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name of Your User Story</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actors:</td>
<td>Business Actors (people): List participants in data reporting/exchange Technical Actors (information systems): List information systems involved in data reporting/exchange</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Flow of Events</th>
<th>Data Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe activities of Business Actors in reporting or data exchanges:</td>
<td>List types of documents/forms/datasets by event:</td>
</tr>
</tbody>
</table>

1. Patient visits Provider. Provider enters visit data into EHR.
2. Provider orders Test
3. etc.

1. Patient, provider demographics, Medical Summary
2. Consent or Consent Refusal, Test order
3. etc

<table>
<thead>
<tr>
<th>Pre-Conditions:</th>
<th>Sender - List Technical Actor(s), i.e., system(s) that creates/sends reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Conditions:</td>
<td>Receiver - List Technical Actor(s), i.e., system(s) that receives reports</td>
</tr>
<tr>
<td>Preferred Timing:</td>
<td>Identify the desired frequency of reporting/data exchange</td>
</tr>
</tbody>
</table>
Appendix D: Sample MDH Grant Agreement

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

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

Minnesota Department of Health

Grant Agreement

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

Recitals

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

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

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

Grant Agreement

1. Term of Agreement

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

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

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

3. **Time** The Grantee must comply with all the time requirements described in this grant agreement. In the performance of this grant agreement, time is of the essence, and failure to meet a deadline may be a basis for a determination by the State's Authorized Representative that the Grantee has not complied with the terms of the grant.

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

4. **Consideration and Payment**

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

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

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

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

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

OR

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

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

4.2 Terms of Payment

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

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

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

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

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.


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

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

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

11. Ownership of Equipment

If this grant agreement disburses any federal funds, select option #1 and delete option #2. If this grant agreement disburses only state funds, select option #2 and delete option #1.

Option #1

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

Option #2:

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

12. Ownership of Materials and Intellectual Property Rights

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

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

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

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

14. Publicity and Endorsement

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

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

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

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

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

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

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

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

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

17.1 Contractor Debarment, Suspension and Responsibility Certification

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

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

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

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

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

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

17.2 Audit Requirements to be Included in Grant Agreements with Subrecipients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17.3 Drug-Free Workplace

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

17.4 Lobbying

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

17.5 Equal Employment Opportunity

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

17.6 Cost Principles

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

17.7 Rights to Inventions – Experimental, Developmental or Research Work

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

17.8 Clean Air Act

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: _______________________________

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