Request for Proposals

Minnesota Accountable Health Model
Accountable Communities for Health
Grant Program

September 2, 2014
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1. Overview

The Minnesota Department of Health (MDH) requests proposals for the Minnesota Accountable Health Model Accountable Communities for Health grant program. The grants are intended to support readiness to advance the Minnesota Accountable Health Model and expand active community participation with a broad range of stakeholders and providers in addressing local health needs. This grant opportunity will provide funding to Accountable Communities for Health (ACH), to advance the Minnesota Accountable Health Model through:

- Implementing and expanding necessary infrastructure to support ACH implementation.
- Developing a plan to meet ACH requirements.

The Minnesota Accountable Communities for Health will leverage the work of the Minnesota Accountable Health Model by integrating key community and broad provider partnerships and will support:

- Readiness and participation in the Minnesota Accountable Health Model\(^1\)
- Achievement of the triple aim of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.\(^2\)
- Up to $5.55 million is available to fund Accountable Communities for Health. Awards will include three early implementer ACH sole source proposals funded in September, 2014 at $370,000 per grantee for $1,110,000, and up to 12 new grants.
  - The three early implementer ACH Community Care Teams (Essentia Ely, Mayo Clinic, Olmsted County, and HCMC, Brooklyn Park) are already at work in Minnesota and successfully building models for integrated services between health care, public health, community partners, behavioral health, and social services. The lessons learned through the development of Community Care Teams and the on-going support of their efforts was used as the basis for the development of Accountable Communities for Health.

2. Available Funding and Estimated Awards

2014: Up to $4,440,000 is available for the following:

- Implementation of 24-month projects.
- Grants will be in place for two years starting January 1, 2015 – December 31, 2016.
- Up to $370,000 will be awarded per proposal for up to 12 Accountable Communities for Health.

*The Minnesota Department of Health and Minnesota Department of Human Services reserve the right to award fewer than 12 new ACH grants and to award more than $370,000 per grant.*

\(^1\) [http://www.mn.gov/sim/](http://www.mn.gov/sim/)
\(^2\) The Institute for Healthcare Improvement Triple Aim for Populations [http://www.ihi.org/explore/tripleaim/pages/default.aspx](http://www.ihi.org/explore/tripleaim/pages/default.aspx)
Funds May Be Used to Cover:

- Development of the ACH leadership team infrastructure such as recruitment activities of ACH members, facilitation of ACH meetings, and coordination of the ACH team and necessary operations resources.
- Implementation of community care coordination systems / teams including staffing and infrastructure.
- Support for community participation and community engagement.
- Planning for sustainability of the ACH.
- Participation in state and federal evaluation of the model.
- Participation in the ACH learning collaborative facilitated by the Minnesota Department of Health and Minnesota Department of Human Services.
- Project management activities of the ACH grant.

Review Methodology:

The State will evaluate proposals on a continuum of development including those ACH teams that are newly started and have begun implementation, those teams that are making steady progress, and those that are advanced. Collectively, the final selected proposals will represent a range of steady progress towards the goal of full implementation across the State in urban, suburban, and rural settings.

Matching Funds Requirement:

There are no requirements for matching funds. However, applicants will be asked to describe in-kind funding dollars and sources.

3. Grant Timeline

<table>
<thead>
<tr>
<th>RFP Activity</th>
<th>Date</th>
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<tbody>
<tr>
<td>RFP posted</td>
<td>Tuesday, September 2, 2014, 4:00 PM CST</td>
</tr>
<tr>
<td>Optional Informational Q &amp; A Webinar on RFP and Continuum of Accountability Matrix Call-in number: 1-888-742-5095 Code: 9334093774</td>
<td>Wednesday, September 10, 2014, 11:00 AM – 12:30 PM CST</td>
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<tr>
<td>Required non-binding Letter of Intent due to MDH (see letter template Form G)</td>
<td>Friday, September 26, 2014, 4:00 PM CST</td>
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<tr>
<td>Proposals due to MDH</td>
<td>Monday, October 20, 2014, 4:00 PM CST</td>
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<tr>
<td>Oral Presentations for selected applicants</td>
<td>Thursday and Friday, November 6 &amp; 7, 2014</td>
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<tr>
<td>Estimated Notice of Awards</td>
<td>Monday, November 24, 2014, 4:00 PM CST</td>
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<tr>
<td>Estimated grant start date</td>
<td>January 1, 2015</td>
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4. Background

The Minnesota Accountable Health Model:

The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the Center for Medicare & Medicaid Innovation\(^3\) and administered in partnership by the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH). The purpose of the Minnesota Accountable Health Model is to provide Minnesotans with better value in health care through integrated, accountable care using innovative payment and care delivery models that are responsive to local health needs. The funds will be used to help providers and communities work together to create healthier futures for Minnesotans, and drive health care reform in the State.

The vision of the Minnesota Accountable Health Model is:

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

The Minnesota Accountable Health Model will test whether increasing the percentage of Medicaid enrollees and other populations (i.e. commercial, Medicare) in accountable care payment arrangements will improve the health of communities and lower health care costs. To accomplish this, the state will expand the Integrated Health Partnerships (IHP) demonstration, formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services\(^4\).

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. The model will also encourage addressing the non-clinical (social determinants) determinants of health at a community level.

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\(^3\) [http://innovations.cms.gov](http://innovations.cms.gov)

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

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

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

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

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

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

The activities contained in this RFP are linked to Driver 4, the Minnesota Accountable Health Model Accountable Communities for Health Grant Program.

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. Tools have been developed to assess a broad range of organizations readiness to expand the “triple aim”. The Minnesota Accountable Health Model: Continuum of Accountability Matrix is designed to illustrate the basic capabilities, relationships, and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It will help the state identify criteria and priorities for investment, and to lay out developmental milestones that indicate organizations or partnerships are making progress towards the vision.

In addition, the Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool is an interactive tool that allows organizations to answer questions to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and their status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve these goals, and how we may be able to provide additional tools or resources. The tool allows a broad range of providers to assess their current status and progress in moving toward accountable care.

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6  [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)
The ACH applicant and each ACH partner will be required to submit a completed Minnesota Accountable Health Model: Continuum of Accountability Matrix assessment, as well as submitting a completed assessment for the collaborative ACH as a whole. (See instructions for applicants in using the matrix assessment tool in section 12 of the RFP.)

For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit State Innovation Model Grant.7

**Accountable Communities for Health, Foundational Reform Activities:**

The Minnesota Model includes a strong focus on integration of the traditional health care system across acute care, primary care, behavioral health, substance abuse, and long-term care as well as with other local, community-based public health, social service, and educational systems designed to address the social determinants that impact the health of Minnesotans. To achieve lasting improvements in population health will require these new partnerships and new ways of working together - a concerted effort between health sectors aligned in common goals.8

The development of Accountable Communities for Health (ACH) takes integration to the next level, affording Minnesota the opportunity to advance new and innovative relationships across multiple systems by engaging a broad range of providers, public health, and communities to plan for population health improvement activities and patient-centered coordinated care, with increasing financial accountability for outcomes.

Through this model, Minnesota is building on a foundation that is already in place through many of the health reform activities begun in 2008:

**Integrated Health Partnerships** In 2013, the Minnesota Department of Human Services (DHS) began a demonstration to test alternative and innovative health care delivery systems, including Accountable Care Organizations. The Integrated Health Partnerships (IHP) demonstration, formerly called the Health Care Delivery Systems (HCDS) demonstration, strives to deliver higher quality and lower costs through innovative approaches to care and payment.

**E-health** Minnesota has been a leader in e-health through the Minnesota e-Health Initiative. 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. In order to help providers achieve the 2015 interoperable EHR mandate, the initiative developed the Minnesota Model for Adopting Interoperable EHRs in 2008 to outline seven practical steps leading up to and including EHR interoperability.

7 [http://www.mn.gov/sim](http://www.mn.gov/sim)

**Health Care Homes** is a foundational model with new standards for primary care that focus on “whole person” redesign and patient/family centered coordinated care. Additionally, certified HCHs are required to have a strong quality improvement infrastructure and relationships in place with community organizations to which patients may be referred. Currently 49% of the state’s primary care clinics are certified HCHs.

As described in Section 1 Overview, three **Community Care Teams** (Essentia Ely, Mayo Clinic, Olmsted County, and HCMC Brooklyn Park) were funded through a competitive grant process in 2011 to learn how communities and a broad group of providers and public health could work together. The Community Care Teams (CCT) have developed new community partnerships that focus on prioritized community health needs, and have begun the hard work of integrating services to address gaps in care for complex patients through referral and transitions management and implementation of new practice guidelines.

The **Statewide Health Improvement Program** (SHIP) supports the implementation of evidence-based approaches to policy, system, and environmental changes in communities, worksites, schools, and health care settings that encourage healthy lifestyles such as healthy eating, active living, and living smoke-free, making the healthy choice the easy choice. The population-focused approach is designed to be sustainable and represents a marked departure from traditional, individually focused public health prevention programs.

**Community Transformation Grants** (CTG) work to expand SHIP efforts in tobacco-free living, active living, healthy eating, and quality clinical and other preventive services, all toward a goal of addressing health disparities, helping control health care spending, and creating a healthier future. CTG maximizes health impact through transformation of preventive care; targeting efforts to improve health equity and reduce health disparities; and expanding the evidence-base for policy, systems, and environmental changes.

**Statewide Quality Reporting and Measurement System** (SQRMS) serve as the foundation for clinic and hospital measurement reporting efforts and is aligned across payers. These standardized measures are a uniform approach to quality measurement across the state and serve as benchmarks for performance.

ACHs will build on past reform activities and engage community members and a broad range of providers in a process to establish priorities to build partnerships that will further integrate and coordinate care with Accountable Care Organizations (ACOs) within their communities.
5. **Grant Applicant**

ACH teams must choose an organization to serve as the grant recipient. To be eligible, the applicant organization must be located in the State of Minnesota. Proposals may be initiated by a tribe, a community or consumer organization, public health, health care provider, a health plan, a county, or other non-profit or for profit entity. Provider or community members of the ACH leadership team or community care coordination system / team may be located in bordering states where Minnesotans are provided services. The applicant organization for the ACH grant must meet the State’s fiscal requirements and other grant participation requirements, including the ability to collect and submit data and manage staffing, facilities, communication, and other grant operations.

6. **Goals and Outcomes**

The specific goals of this grant program are to test how health outcomes and costs are improved when ACOs adopt Accountable Communities for Health models that support integration of health care with non-medical services, compared to those that do not adopt these models. To successfully participate and achieve the goals and outcomes the ACH grantee must:

**Ensure infrastructure is in place to successfully implement the ACH:**

- A target population supported by community-based data defining the population and how it is a health priority for the ACH.
- Strategies and resources to advance health equity and reach underserved communities.
- Community engagement with a variety of community partners.
- Ability to participate in federal and state evaluation requirements.
- Commitment from community partners.
- Commitment from an Accountable Care Organization (ACO) or like entities engaged in a value-based payment arrangement with one or more payers.

**Implement required ACH grant deliverables:**

- Community-led leadership team that represents people who live in the community, members of the target population, and a broad range of providers representing the spectrum of settings necessary to provide coordinated care for the target population and the identified priority health issues.
- Community-based care coordination team system or model.
- Development and implementation of population based prevention goals.
- Development of sustainability plan.
- Plan for how the team will measure progress towards goals.
- Participation in the ACH Learning Collaborative and evaluation activities.
7. Essential Infrastructure

The following are required infrastructure elements that must be in place for a community to submit a successful ACH proposal.

Target Population:

The proposal must describe a target population to focus the team’s implementation efforts during the grant. The population could be defined by any of the following:

- Geographical such as a selected population of people living in a community area, city, group of communities or cities, a college/university, or a county or group of counties.
- High resource utilizers such as diabetics, persons with mental health conditions, or a specific population in a health care providers or a Medicaid or Medicare recipient.
- An underserved or marginalized group of people that lives in a community such as in a public housing high-rise, people living in poverty, or those populations with health disparities.
- Virtual population such as, all the people in a specific broader population who have specified clinical conditions, or disabilities.

The description of the target populations must be supported by community based data such as local public health or hospital assessment data, health systems utilization data, long-term care services and supports gaps analysis, community-collected data, program evaluation, or data from projects such as the Statewide Health Improvement Project known as SHIP (see Appendix B for resources). Intentional efforts must be made to reach marginalized or underserved communities, discuss the strategies to address these population needs, and identify community resources that will impact social determinants of health. ACHs will be asked to describe how community partners from the target population are engaged in the development of the ACH grant proposal and the ongoing work of the ACH.

Advancing Health Equity Strategies:

Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health. Advancing health equity through a health in all policies approach is foundational to achieving health equity. Policies should be examined and resources targeted where efforts will have the greatest impact on populations with the greatest need in the targeted population.

A specific goal to the ACH is to strengthen community relationships and partnerships to advance health equity. As the ACH considers its targeted population they must expand the range and depth of relationships to create avenues for meaningful participation of Minnesota’s diverse communities in ACH leadership team and oversight. The ACH applicant will describe those partnerships and strategies to incorporate health equity in development of the key deliverables of the ACH.

Community engagement efforts should be culturally appropriate and tailored to the specific needs of diverse cultural groups and identified targeted populations.
Community Engagement:

Community engagement is an essential component to changing the paradigm by engaging people who live in the community in developing local solutions. The proposal must describe ACH team’s ability to ensure mechanisms for communication, how to link diverse people and resources to the work of the ACH including leadership opportunities, and how to regularly communicate information and obtain feedback.

Partnering with the community is necessary to create change and improve health. The individuals and parties involved must identify opportunities for co-learning and feel that they each have something to contribute to the pursuit of improved health, while at the same time see something to gain\(^9\).

Although it is essential to begin by using existing resources, sustaining community engagement may involve using experts and resources to help a variety of stakeholders develop necessary capacities and infrastructure to support community engagement activities. ACH grant funds can be used to support to individual community member’s costs for participation or broader community engagement and community leadership activities.

Building lasting partnerships between communities with local public health, social/community services and health care providers will go a long way towards creating community engagement with accountability for population health outcomes and costs.

Community Partnerships:

ACHs are expected to engage people who live in the community and include a combination of partner organizations that cross the continuum of health, health care, community-based care and organizations addressing the social determinants of health; and people who reflect the target population. Community partners and partnerships must be described including how community members will partner on the ACH leadership team and within the ACH.

Every ACH must include people who live in the community and a broad range of provider organizations including health care providers and others that reflect the targeted population and the goals of the Minnesota Accountable Health Model such as:

- Local public health departments
- Long-term care services and supports (e.g., skilled nursing facilities, assisted living, home health, home and community based services)
- Behavioral health
- Social services (e.g. employment, housing)

Community partners may include but are not limited to:

- Accountable Care Organizations (ACO)
- Alternative medicine therapies
- Assisted living facilities
- Behavioral health providers
- Community based non-profit or for profit organizations
- Community mental health centers
- Community services organizations
- Community wellness programs
- Dental offices
- Emergency Medical Services (EMS)
- Employers
- Faith based organizations
- Federally Qualified Health Centers (FQHC)
- Food systems
- Health plans
- Home health organizations
- Hospitals
- Housing
- Law enforcement and correction agencies
- Local Public Health
- Long-term care services and supports providers
- Long-term care and post-acute care facilities
- People who live in the community
- People who represent the targeted population
- Pharmacies
- Primary care, community, rural health providers, and health care homes
- Schools and educational institutions
- Social services or social supports
- Transportation

Partner letters of support are required and must describe partner roles and commitment to participate in the leadership team and the overall ACH grant project.

Local Public Health (LPH) Requirements:

To create lasting improvements in the health of individuals, communities, and populations, state and national leaders in public health and health care delivery have advocated for better integration between public health and health care systems. The Institute of Medicine suggests that better relationships between primary care and public health will enhance the capacity of both sectors to carry out their missions and catalyze a collaborative movement toward improved
population health\textsuperscript{10}. LPH partners are well poised to provide valuable assessment information about community health issues and gaps and to bring partners together to meet the health needs of a community. The intent in outlining this requirement is to bring the expertise of LPH to the ACH while advancing the partnership between public health, health care, social services, behavioral health, ACO partners, and others.

Local public health (LPH) is a key member to achieving the goals of communities within an ACH. While LPH participation on the ACH leadership team is strongly desired, barriers to serving on the leadership team such as time and resource constraints may prevent that level of involvement. To ensure that the role of LPH has been considered in the ACH, LPH must submit a letter of support that describes their involvement in the ACH. Involvement could include participating in the leadership team, advising the ACH grant project, or no participation at that time. The State encourages public health partners that are unable to participate in the leadership team in the initial project planning to engage again at a later point in project implementation.

**Quality Infrastructure / Measurement:**

A culture of continuous improvement is a critical component of health system transformation, which includes creating standardized performance measurements and competencies. Understanding the ACHs quality improvement infrastructure and QI activities of partners is key to the ongoing work of the ACH. ACH medical services provider partners will likely participate in the Statewide Quality Reporting and Measurement System (SQRMS), a system through which results on a wide range of quality measures are publicly reported by hospitals and clinics throughout the state. Other providers and communities have other reporting requirements that support the culture of quality improvement. Applicants must describe their ability to use the data they currently have and new data they will need to collect to ensure they can monitor the results of their progress and the work to achieve the goals for the target population.

There will be no requirement for development of a formal individual ACH evaluation. ACHs will be required to participate in State and Federal evaluation, including collecting or submitting data as specified by the State or Federal evaluators to assess progress on various indicators, and to report on measures that the ACH defines to demonstrate progress.

**ACO Partnerships:**

The proposal must describe the ACHs relationship in working with Accountable Care Organization (ACO) partners. The Minnesota Accountable Health Model will further test and evaluate whether investments in Accountable Communities for Health will impact how health outcomes and costs improved when ACOs adopt Community Care Team and Accountable

Communities for Health models to support integration of health care with non-medical services, compared to those who do not adopt these models.

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. 11

- An “ACO partner” must be a provider participating in an ACO or similar accountable care payment arrangements that is based on performance on cost, quality and experience.
- The ACO needs to be an active partner in the ACH. This includes contributing to planning for sustainability, measurement and data sharing, and ongoing review and communication with the ACH.

An Accountable Community for Health must have at least one or more organizations participating in or planning to participate in an Accountable Care Organization (ACO) or similar accountable care payment model. 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.
- **ACO-like arrangements** 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) or total cost of care and similar risk-based arrangements with commercial populations or in Medicare Advantage Plans.

If no participating providers are currently participating in an ACO or ACO-like arrangement, describe the plan and timeline under which at least one collaborating partner will meet this requirement during the first year of the grant period. Failure to demonstrate progress on achieving this requirement during Year 1 of the grant will affect Year 2 grant funds.

8. Required Deliverables and Activities

ACH Leadership Team:

The leadership team structure of the ACH must include people who live in the community and are part of the target population, and a broad range of providers and community partners. The goal is to implement partnerships with decision making that reflects the membership of the ACH team. Partnership development will be measured throughout the grant cycle. The leadership team is responsible for identifying the health strategies and priorities for the ACH and must be in place at the time of the application and lead the development of the proposal, although membership in the leadership team can continue to grow and change after application/award. The leadership team will focus on local solutions for the chosen population with consideration of moving towards coordination of and/or integrating services between a broad range of providers.

The ACH team should consider their approach and activities to:

- Ensure that community members and those providers responsible for services to the identified target population are included in the leadership team’s decision-making processes.
- Facilitate understanding by the leadership team of health issues that impact the target population.
- Create alignment for shared responsibility to develop and implement innovative strategies, e.g. operationalizing care teams and patient-centered care, population health initiatives, and other requirements.

The grant will support continued implementation and facilitation of the ACH team, and coordination with local partners.

Community Based Care Coordination System / Team:

Many individuals, particularly those with multiple medical or behavioral health issues, face challenges getting the care they need. Patients with complex conditions often require health care, access to healthy food, physical safety, and supportive services (such as mental health or chemical dependency counseling, housing, home care, or rehabilitation services) from multiple entities; for these patients, it is easy to get lost in the cracks between systems, resulting in poor health outcomes and higher costs.

Barriers on the provider side prevent most health care providers from partnering effectively with available community organizations, either because of lack of understanding of available services or lack of resources to coordinate with services beyond health care. In many communities, there are gaps in community services, or community partners are unaware of other service agencies. While electronic health record adoption has advanced in Minnesota, many providers of supportive services such as behavioral health, long term supports and services and social services do not have electronic health records or the means to transmit patient data securely to other partners in the care continuum.
Community organizations, behavioral health, and long-term care have different funding streams and, operational structures, and often work in silos in the community. There is a lack of integrated case management or coordination in the community that leads to fragmented care and the risk of duplication of care coordination.

The ACH community based care coordination system or team provides direct service coordination for persons in the community. Staffing and administrative structures for ACH care coordination teams build on existing community resources and reflect the needs in targeted populations supported by the community assessment data. The community based care coordination system / team is supported financially initially through implementation of the ACH grant and methodology or other future shared savings approaches. The system / team develops transitions management for high need patients and families from health care delivery systems and coordinates referrals with a broad range of community providers and partners to address social determinants of health to ensure patient centered coordinated care with enhanced communication is in place.

ACHs should build on current resources already funded by community partners such as social services, local public health, home visiting, long-term care, behavioral health, and other community partners

**Population Based Prevention:**

Minnesota believes that communities must have the flexibility to focus on population based prevention health goals that best fit their needs. One challenge in development of the ACH population based prevention component is bridging community prevention needs, assessment data points, and provider concerns. Some key questions to assess this information are: Do providers and community members have a common definition of health? What local health issue has significant impact on cost and quality outcomes in the community? What local policies are barriers to optimal health? Is there general agreement among the team and community about the ACH priorities, goals, and outcomes?

A key long term goal through the ACH is to integrate community-specific public agencies such as, local public health departments, social services organizations or schools and others into ACHs to identify and work together towards population prevention based health goals. State initiatives such as SHIP and CTG and federal strategies through CMMI / CDC focus on population health including diabetes, tobacco cessation, hypertension, obesity, and adverse childhood experiences (ACEs). ACHs are to identify a population based prevention project that may include one of these four elements or align with their target population for the ACH.

Applicants should use data to support their rationale to focus on a particular population and related prevention goals. A strong source of data is the county or hospital community health assessment data that can be accessed through the local public health department. Population prevention health data may be gained through measurement of quality of life and social determinants of health. For example, the CDC utilizes the “healthy days” measurement to assess how a person’s health affects their broader life. Additional resources for teams to consider are Statewide Health Improvement Program (SHIP), Community Transformation Grant (CTG), Center for Medicare and
Medicaid Innovation (CMMI) resources, Community Action Programs for community needs assessment data, and long-term care services and supports gaps analysis data. See resources in Appendix B.

**Sustainability Plan:**

Throughout the grant, sustainability will be a goal. Activities and investments will be paired with policy and/or additional federal approvals as needed in order to increase likelihood that activities will continue beyond the funded period. Applicants will describe how they plan to move along the continuum of accountability based on the Minnesota Accountable Health Model: Continuum of Accountability Matrix, and consider key elements necessary for sustainability by successful continuation of community partnerships, funding mechanisms and long term measurement. Another area of consideration for sustainability planning is the resources that would be necessary to continue and improve community based care coordination efforts after the grant funding ends.

Grantees will receive training and technical assistance from the State and/or contracted vendors to support the development of an effective and sustainable ACH leadership team and community care coordination system/team. Topics might include identifying population health needs; building and maintaining the community partnerships needed for the ACH to be effective; developing effective governance structures; making use of available clinical/population health data for improvement efforts; establishing mechanisms for secure sharing of clinical data across settings; community engagement tools and strategies; quality improvement and transition management; and other topics identified through stakeholder engagement or community feedback. Selection of technical assistance topics will happen in close consultation with the ACH Advisory Subgroup and ACH teams, and will build on resources developed through other aspects of Minnesota’s Accountable Health Model.

Communicating success stories and identifying models and best practices that can be replicated and adapted to meet local needs throughout the State will also contribute to the sustainability of the Accountable Communities for Health (ACH).

**Measurement Plan:**

There will be no requirement that each ACH develop its own formal evaluation plan, however the applicant must describe selected measures and how the team will use those measures to indicate progress towards the ACH goals.

Throughout its work to test the Accountable Communities for Health model, the ACH will make use of process or outcome measures to assess the degree to which ACHs are moving towards ACH goals. ACH grantees will have flexibility in setting priorities for clinical/community partnerships and health improvement, within a range of options aligned with the overall goals of the ACH model around behavioral health and primary care integration, care for patients with multiple chronic conditions, and addressing the needs of patients/community members who need long-term care services and supports. ACHs will also be required to use standardized measures to assess their progress on deliverables.
To identify lessons learned and test the Accountable Communities for Health model, the State will, to the extent possible use existing data collection mechanisms and leverage current required quality measures and reporting requirements to maintain alignment with other drivers and reduce reporting burden.

To compile lessons learned from ACHs, the State will use existing information gathered through grantee reports, summary documents from stakeholder engagement activities, and program evaluation results. Grantees should be prepared to participate in additional data gathering requests such as in-depth interviews, survey tools, partnership surveys, and other evaluation activities.

**Learning Collaborative:**

The State will provide significant technical support and peer learning opportunities to new ACH teams to implement best practices through the ACH learning collaborative, as well as to support development of ACH leadership structures, community-clinical care partnerships, care coordination models / systems, and sustainability plans.

ACH grantees must actively participate in learning collaborative activities intended to facilitate peer exchange and share expertise from experts in the field. Activities over the course of the two-year project include at least four in-person learning collaborative meetings for a minimum of four ACH team members and regular webinars / conference calls.

**Health Reform History:**

The ACH application must include a description of previous health reform activities to indicate experience in implementing health reform work such as: ACOs/Integrated Health Partnerships (IHP), Emerging Professions, E-Health, Health Care Homes, Behavioral Health Integration, Statewide Health Improvement Project (SHIP), Community Transformation Grant (CTG), or other health reform efforts.

9. **Review Process**

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, 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, including geographic location, number of grantees, and a cross section of target populations.

Top scoring applicants will be required to provide an oral presentation on their proposal to representatives of the Minnesota Department of Health and Minnesota Department of Human Services. Oral presentations will provide an opportunity for leadership team members, including community partners, to present a brief (20-30 minute) overview of their proposal that
demonstrates how the impacted target population is involved in the ACH and to clarify questions about the proposal. Oral presentations will assist in final funding decisions.

Only complete applications that meet eligibility and application requirements and are received on or before October 20, 2014, will be reviewed. Reviewers will determine which applications best meet the criteria as outlined in the RFP and should be recommended for funding. We anticipate that grant award decisions will be made by November 26, 2014. Applicants will be notified by letter whether or not their grant proposal was funded. MDH reserves the right to negotiate changes to budgets submitted with the proposal.

Grant agreements will be entered into with those organizations that are awarded grant funds. The anticipated effective date of the agreement is January 1, 2015, or the date upon which all signatures are obtained. Grant agreements will end on December 31, 2016. No work on grant activities can begin until a fully executed grant agreement is in place.
## Grant Application and Program Summary

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grant Applicant</strong></td>
<td>To be eligible, the applicant organization must be located in the State of Minnesota. Proposals may be initiated by a, a tribe, a community or consumer organization, public health, health care provider, health plan, a county, or other non-profit or for profit entity. See section 5, page 8.</td>
</tr>
<tr>
<td><strong>Total Funds Available</strong></td>
<td>$4,440,000 for up to 12 ACHs in the two-year grant cycle.</td>
</tr>
<tr>
<td><strong>Maximum Grant Amount</strong></td>
<td>Up to 12 new grant awards at up to $370,000.</td>
</tr>
<tr>
<td><strong>Duration of Funding</strong></td>
<td>January 1, 2015 through December 31, 2016.</td>
</tr>
<tr>
<td><strong>Grant Purpose</strong></td>
<td>To test how health outcomes and costs improve when Accountable Care Organizations adopt Community Care Team and Accountable Communities for Health models to support integration of health care with non-medical services, compared to those who do not adopt these models.</td>
</tr>
<tr>
<td><strong>Letter of Intent</strong></td>
<td><strong>Required</strong>: Non-binding Letter of Intent to Respond required by September 26, 2014 using the template in Form G.</td>
</tr>
<tr>
<td></td>
<td>The letter is to include the following four elements: applicant organization; key partners; potential Accountable Care Organization (ACO) partner; and the planned target population.</td>
</tr>
<tr>
<td></td>
<td>Letters of Intent to Respond should be submitted via e-mail to: Chris Dobbe&lt;br&gt;Minnesota Department of Health&lt;br&gt;Health Care Homes / Care Integration Practice Transformation Unit&lt;br&gt;<a href="mailto:Chris.Dobbe@state.mn.us">Chris.Dobbe@state.mn.us</a></td>
</tr>
<tr>
<td><strong>Application Requirements</strong></td>
<td>• Applications must be written in 12-point font with one-inch margins with a maximum of 22 pages of narrative.&lt;br&gt;• Page limits are outlined in Section 11.&lt;br&gt;• All pages must be numbered consecutively.&lt;br&gt;• Applicants must submit ten (10) copies of the proposal and an electronic version of the proposal on a USB drive. Faxed or emailed applications will not be accepted.&lt;br&gt;• Applications must meet application deadline requirements; late applications will not be reviewed.&lt;br&gt;• Applications must be complete and signed where noted.&lt;br&gt;• Incomplete applications will not be considered for review.</td>
</tr>
<tr>
<td>Requirement</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
</tbody>
</table>
| Applicants must submit proposals in this order using forms provided in Word and Excel | 1. Application Face Sheet (Form A)  
2. Project summary, 1 page  
3. Essential infrastructure, 12 pages  
4. Project description and required deliverables, 6 pages  
   • Project work plan (Form B) (Document referenced in grant contract)  
5. Applicant capacity to implement the project, 3 pages  
6. Budget (Form C)  
7. Budget Narrative (Form D)  
8. Due diligence form (Form E)  
9. Continuum of Accountability Matrix Assessment Tally (Form F)  
10. Letters of Support Checklist (Form H)  
11. ACH Partners Table (Form I) |
| Submitting the Proposal | Applicants must submit ten (10) copies of the proposal and an electronic proposal on a USB drive.  
Proposals must be received by 4:00 p.m. on Monday October 20, 2014 |
| Application Deadline | 4:00 p.m. CST October 20, 2014 |
| Applications Sent | **Delivery Address:**  
Minnesota Department of Health  
Health Care Homes / SIM Unit  
85 East 7th Place, Suite 220  
Saint Paul, Minnesota 55101  

**Mailing Address:**  
Minnesota Department of Health  
Health Care Homes / SIM Unit  
P.O. Box 64882  
Saint Paul, Minnesota 55164-0882 |
| Contact Information | Questions about ACH grants and the proposal process should be directed to:  
Chris Dobbe  
Minnesota Department of Health  
Health Care Homes / Care Integration Practice Transformation Unit  
[Chris.Dobbe@state.mn.us](mailto:Chris.Dobbe@state.mn.us) |
11. Proposal Instructions

Required Elements:
Proposals for these grants must not exceed 22 pages of single-spaced 12-point type. The 22-page limit includes items A-D below, excluding Form B Work Plan.

A. Project Summary

Provide a brief summary of the project including desired outcomes, the areas/populations served, and partners. Describe what the project will accomplish (goals/outcomes/objectives) with respect to community Accountable Community for Health needs. Limit the project summary to one page.

B. Essential Infrastructure

Keep this section to 12 or fewer pages, addressing all of the elements below from Population through Health Reform History.

Target Population:
Include a description of the following target population activities.

- Target population to be served. Demographic data must be used and cited to support identification and description including when appropriate, charts or tables describing the target population. Include a geographic map of the service area if possible.
- Problem statement of unmet needs in the target population.
- Rationale for choosing the target population, supported by data such as the community health assessment or other population based data. Include citations for data.
- Why the ACH is suited to provide services to this population.
- How this project will meet the needs of the population.
- How the population being served was represented in the ACH planning process.
- General health status of targeted population. Relevant factors such as age, poverty, disparities, substance abuse, and other determinants of health should be included.
- How the target population overlaps with the attributed population for provider ACOs.
- Healthcare services infrastructure serving this target population, e.g., hospitals, primary care and specialty clinics, community health centers, health care homes and emergency medical services.
- Community services infrastructure serving this target population, e.g., public health, social services, long-term care and supports, and behavioral health.
- Workforce: describe the availability, distribution, and shortages within the health workforce, and/or experience with new emerging health professions that impacts the target population.

Advancing Health Equity:
The ACH adopts a policy approach to advance health equity that requires thinking about health equity in all aspects of the ACH work.
Include a description of the following:

- How the community views health equity.
- How health equity is being considered in all work of the ACH. See Appendix B Resources for MDH Advancing Health Equity report.
- Identified strategies and timeline to incorporate health equity in the development of key deliverables.
- New partnerships needed for this work or how the ACH will build on current community partnerships.

**Community Partnerships:**

- Describe how community partners are suited to address the target population and project goals.
- Include letters of support from the leadership team and other participants that specify commitment and contributions on the part of the partnering entity (see Form H Letters of Support Checklist).
  - Include letters of support from community partners engaging with the target population.
  - Include a letter of support from the participating Accountable Care Organization(s) outlining their active involvement with the ACH.
  - Include a letter from the applicant organization agreeing to serve as fiscal agent. The letter must state the organization’s willingness to accept and account for grant funds under this program.
  - Include a letter of support from local public health that describes their level of participation as outlined in Section 7.
  - If appropriate, describe why a letter of support from a key partner is not included in the application.
- Provide a table listing each community partner, (name of organization, representative, and role in the ACH). Use Form I.

**Community Engagement:**

Describe current or proposed community engagement efforts and the ongoing plan for community participation in the development and implementation of ACH work including, but not limited to:

- Community partners participation in development of the ACH grant proposal.
- Infrastructure in place for communication with target populations and broader community.
- Mechanisms to receive input by the broader community on ACH activities.
- Resources to address ongoing community engagement efforts.
- Funding for community engagement through stipends or subgrants.

**Quality Infrastructure / Measurement:**

Articulate the team’s ability to participate in federal and state evaluation requirements.

- ACH members experience with quality improvement methods and processes.
- Ability to collect and report data.
• Expertise of staff responsible for data collection including implementation of surveys, audits, and development of reports.
• Barriers to submission of measurement reports required in Section 14.
• Measures in place to demonstrate on a quarterly basis the applicant’s progress towards meeting the applicant’s goals to address the targeted population.

**Accountable Care Organization Partnerships:**

• Describe current or proposed ACO or ACO-like arrangements that ACH providers are involved in, including participation in the Integrated Health Partnerships (formerly known as Health Care Delivery System demonstrations), the Medicare Shared Savings Program, the Pioneer ACO program, or other payment arrangements with at least one payer involving shared risk/shared savings or total cost of care.
• If no ACH providers are currently participating in ACO or ACO-like arrangements, describe the plan and timeline under which at least one collaborating provider will meet this requirement before the end of year one of the grant. Failure to demonstrate progress on achieving this requirement during Year 1 of the grant will affect Year 2 grant funds.
• Include a letter of support from the participating Accountable Care Organization(s).

**Health Reform History:**

Briefly describe previous health reform experience for ACH partners such as: ACOs Integrated Health Partnerships (IHP) activity, implementation of Emerging Professions, adoption of E-Health, Health Care Homes certification, Behavioral Health Integration, and implementation of population prevention programs such as Statewide Health Improvement Project (SHIP), Community Transformation Grant (CTG), or other health reform efforts.

**B. Criteria for grant review:** The Essential Infrastructure section of the application will be reviewed and scored according to the following criteria (25 points):

- The applicant has clearly identified the target population.
- The rationale for choosing the target population is supported by data such as community health assessment or other population based data.
- The strategy for serving underserved or marginalized populations is clearly articulated.
- The applicant describes how health equity is integrated into the work of the ACH.
- The applicant clearly identifies how community partners are suited to address the identified population and goals as described.
- There are sufficient letters of support from community partners, some that reflect the target population.
- The applicant clearly describes the level of community engagement and plan for ongoing community engagement in the work of the ACH.
- The applicant clearly describes the team’s ability to participate in tests of change, and the federal and state evaluation requirements.
- The applicant outlines the team’s partnership with an ACO.
- There are sufficient letters of participation from ACO partner(s).
- The health reform history for ACH partners is described.
C. Work Plan and Deliverables

In a narrative of 6 or fewer pages, describe the plan to achieve all of the requirements in the proposal description section. As appropriate, identify meaningful support and collaborations with key partners and stakeholders (including patients/consumers) in planning, designing and implementing activities.

Use Form B Work Plan to outline the following for each grant year. (Form B is not included in the 6 page limit.)

- Key objectives to achieve outcomes and goals
- Activities and methods for accomplishing each objective
- How the ACH will track progress toward meeting objectives
- Major milestones for completing objectives and activities

Use the key deliverables in Form B to describe payment for corresponding deliverables in the SIM Budget Document. Form B Work Plan and the SIM budget document will be the work plan attachments in the grant contract and the documents used to monitor ongoing grant deliverables.

Leadership Team Structure:

- Describe the leadership structure, including logistics for operations, the scope of the leadership team’s oversight of project operations, how and how often decision-making and communications will occur, and all individual members of the leadership team and their affiliations.
- Explain how the leadership team has begun implementation and how members participated in development of the proposal.
- Define how the leadership structure includes members that reflect the targeted population, such as underserved / marginalized community members.
- Describe any future plans for expanding the leadership structure.

Community Care Coordination Model:

Describe how the Community care coordination model / system focuses on building a model of patient centered coordinated care with community providers / partners.

The ACH community based care coordination system or team provides direct service coordination for high resources / needs persons in the targeted population in the community. The application must describe the following components and outline a timeline for implementation:

- Describe how community based care coordination systems or teams build on current resources such as primary care, care coordination / health care homes, social services, public health, behavioral health, and non-profit community resources.
- Outline staffing and administrative structures for ACH and the implementation plan. Include in implementation planning communications methods, how data will be shared, transitions planning, systems for referrals with a broad range of community providers and partners to
address social determinants of health to ensure patient centered coordinated care with enhanced communication is in place.

• Estimate the number of persons you anticipate serving in the ACH community care coordination model and the timelines.
• Staffing / administrative structures should be outlined by the number of hours / FTEs in the Minnesota Accountable Health Model budget planning Form C.

Population Based Prevention:

Describe in what way the ACH defines population based prevention for the community and/or how it ties into goals for the target population or local projects such as the Statewide Health Improvement Program (SHIP), Community Transformation Grants (CTG), or CMMI focus area (see below), or other local public health initiative.

• ACH must describe a population based prevention plan in one of three above referenced areas, or can work on other population health issues related to their population by the end of year one. When possible the goal is to build on population based prevention work that has been started through other health reform projects or community wellness work.
• Describe process or outcomes measures that will be used to track progress for population based prevention.

Statewide Health Improvement Program (SHIP) community strategies are local prevention strategies that focus on decreasing obesity and reducing the number of people who use tobacco and are exposed to tobacco smoke.\(^{12}\)

The Center for Medicare and Medicaid Innovation (CMMI) and Centers for Disease Control and Prevention (CDC) have provided a list of population health metrics for SIM test states, with a focus on three areas: diabetes, tobacco cessation, and obesity. States must demonstrate activities or collaborations in those three areas, but can also go beyond those areas to work on other population health issues\(^{13}\).

Measurement Plan:

Describe how the team will measure and ensure progress towards the team’s goals including:

• Strategies and measures that will be used to evaluate performance for the target population and/or underserved populations during the grant period.
• How progress toward meeting grant-funded goals will be tracked, measured, and evaluated.
• Barriers to participating in collection of the required data elements. See Section 14 for reporting requirements.

\(^{12}\) [http://www.health.state.mn.us/ship/](http://www.health.state.mn.us/ship/)

Sustainability Plan:

Outline what needs to be in place for this effort to be sustained after grant funding ends. Develop a sustainability plan with emphasis on a new model that improves the triple aim goals by responding to the following:

- How the ACH intends to move along the continuum on the [Minnesota Accountable Health Model: Continuum of Accountability Matrix](#) during the period of the grant.
- Key strategies to engage and maintain community partners for ongoing capacity and long-term sustainability.
- How ACHs can sustain the culture shift as communities and providers work together with ACOs in partnership to achieve triple aim goals.
- Key elements necessary to success and sustainability for ACHs including
  - necessary sources of funding and
  - long term measurements.
- Potential barriers to long term sustainability.
- Resources needed to sustain the community care coordination model.

ACH Learning Collaborative:

Affirm that the team will participate in the learning collaborative and is committed to shared leaning. A minimum of four members of an ACH team will be required to participate in ACH leaning collaborative activities as well as ongoing webinars for shared leaning. Travel costs for attending two in-person meetings per year are to be reflected in the budget and budget narrative.
C. Affirm that the team will participate in the learning collaborative and is committed to shared learning. A minimum of four members of an ACH team will be required to participate in ACH learning collaborative activities as well as ongoing webinars for shared learning. Travel costs for attending two in-person meetings per year are to be reflected in the budget and budget narrative. **Criteria for grant review: Work Plan and Deliverables section of the application will be reviewed and scored according to how clearly, measurable, and realistically the proposed objectives for key elements were described** (35 points):

- The leadership structure is well developed and/or future plans for expanding the leadership structure are described.
- The leadership team has begun implementation and members participated in development of the proposal.
- Leadership structure includes members that reflect the target population, such as underserved / marginalized community members.
- Community care coordination model / system is focused on building a model of patient centered coordinated care with community providers / partners.
- Population based prevention is based on a shared definition of health for the community, and/or ties into the defined population’s goals or other local projects such as SHIP, CTG, or LPH.
- Measurement plan describes how the team will measure and ensure progress towards the team’s goals.
- Sustainability planning is innovative and looks to the future. Outlines what needs to be in place to be sustainable.
- Commitment to team participation in the learning collaborative and shared learning.

D. Applicant Capacity and Project Implementation

This section describes the applicant’s (grant recipient/ organization submitting the grant proposal) experience and capacity to implement the project. Keep this section to 3 or fewer pages, excluding CVs or resumes. This section must describe:

- Name(s), title(s), organization(s), and qualifications of the project lead or co-leads (add CV’s).
- Description of the source of any in-kind technical support for the project, internal and/or external.
- The proposed ACH team infrastructure, facilities, staffing, and other capacity to develop a community care coordination system / model.
- A brief history of the applicant organization(s) and any notable accomplishments relevant to the likelihood of success as an ACH.
- A brief description of experience of the applicant to manage a collaborative community or multidisciplinary project with diverse partners.
- Anticipated barriers and challenges in implementing this project and potential solutions.
D. Criteria for grant review: The Applicant Experience and Capacity to Manage the Grant section of the application will be reviewed and scored according to the following criteria (15 points):

- The description gives a clear picture of the history, structure, and capacity provided by the applicant agency.
- The applicant agency has a successful history of coordinating collaborative community or multidisciplinary team projects.
- The applicant is able to identify possible barriers to implementing the ACH as well as potential solutions.
- The applicant demonstrates the capacity (infrastructure, facilities, staffing) to support the logistics for the proposed ACH.
- The applicant agency has the capacity to manage communication and overall infrastructure for achieving goals.
- The applicant clearly describes the local oversight structure for project implementation.
- The applicant clearly defines the leadership role(s) / responsibilities for the ACH, qualifications of this person(s) and their scope of authority to lead the team (includes resumes of key staff).

E. Budget

**ACH Implementation Grants (up to $370,000 per grant)**

Include a budget for:

- Year one (January 1, 2015 – December 31, 2015)
- Year two (January 1, 2016 – December 31, 2016)

All duties must be performed in accordance with the Federal Department of Health and Human Services Grants Policy Statement which is available at [http://www.gsa.gov/portal/category/100000](http://www.gsa.gov/portal/category/100000)

**Eligible Expenses:**

Grant funds may be used to cover costs of personnel, consultants, subcontracts, supplies, grant related travel, stipends and other.

**Ineligible Expenses:**

Funds may not be used to pay for direct patient care services fees, purchase of computers, equipment, building alterations or renovations, construction, fund raising activities, political education or lobbying, or purchase of equipment.

**Indirect Costs:**

Indirect costs are not allowed in this proposal.
In-Kind:

An established minimum level of in-kind contribution is not a grant requirement. However, a description of in-kind that will be provided by ACH partners is required and will be considered in scoring the budget section.

Proposals are to include the amounts and sources of financial or in-kind resources that will be used. In-kind 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; or other project costs for which grant funding is not being requested.

Optional Additional Funds:

In the event that the State awards fewer than 12 ACHs through this RFP, additional funds may be available above the $370,000 limit. As a separate section in the Minnesota Accountable Health Model Contractor Budget Template and the Budget Narrative form, describe what additional expenditures that your ACH might anticipate to meet your ACH project goals if you were awarded additional ACH grant dollars, up to a maximum of $300,000. You must use the separate budget spreadsheet page and designated narrative section, and not combine optional budget items with the budget/narrative for the $370,000 grant budget. Include the expenditure and the estimated costs.

Budget Forms:

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:**

**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.

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

B. Fringe:

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

C. Consultant Costs.

Provide the name of contractors or organizations, the services to be provided, hourly rate, and projected costs.

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

D. Equipment:

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

E. Supplies:

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

If it is necessary to include expenditures in the “Other” category, include a detailed description of the proposed expenditures as they relate to the project. Add additional “Other” lines to the budget form as needed.
• **Support Expenses**: Telephone equipment and services, internet connection costs, teleconferences, videoconferences, meeting space rental, and equipment rental.

• **Meals**:
  o Consumer/Provider Board Participation, food is a covered expense for 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. See HHS GPS page II-33.
  o As part of a per diem or subsistence allowance provided in conjunction with allowable travel See HHS GPS Section II-42.

• **Stipends**: 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.

• **ACH Leadership Team Participation**: Allowable in accordance with applicable program proposal:
  o 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.
  o 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 for:*

- Leadership Structure
- Community Care Coordination Systems /Teams
- Population Based Prevention Plan
- Measurement Plan
- Sustainability Plan
- Learning Collaborative Participation
- Project management
- Other Applicable Infrastructure Elements
E. Criteria for grant review: The Budget section of the application will be reviewed and scored according to the following criteria (20 points):

- Are the Budget Form and Budget Justification Narrative complete?
- Do amounts on the Budget Form match what is in the Budget Justification Narrative?
- Is the information in the Budget Justification Narrative consistent with what is proposed in the work plan?
- Are the projected costs reasonable and sufficient to accomplish the proposed activity?
- Does the fiscal lead have the capacity to manage financial and other administrative functions?
- Does the budget include a description of in-kind dollars?

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

12. Continuum of Accountability Matrix Assessment

In preparation for ACH application, individual organizations/providers must complete the Continuum of Accountability Matrix Assessment Tool for their organization. In addition, ACH proposal partners must come together collectively and complete the Matrix Assessment Tool to reflect one single score for the ACH partnership.³⁴

After the assessments have been completed, use Form F to enter results.
- List individual organizations on Form F and enter results for each organization following instructions in the tally form.
- Enter the name of the ACH and collective results for the ACH in the final column.

Applicants must use Form F to communicate the results for the ACH RFP. A webinar will be scheduled for September 10, 2014 to review use of the Matrix tool and submission process.

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 not formally be part of an existing ACO, but are 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.

³⁴(https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)
The goal is for organizations and the ACH to complete a self-assessment of where they are currently at in the continuum of accountability.

13. Proposal Evaluation

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Infrastructure</td>
<td>30 points</td>
</tr>
<tr>
<td>Proposal Description / Required Deliverables / Work Plan</td>
<td>35 points</td>
</tr>
<tr>
<td>Applicant Capacity and Project Implementation</td>
<td>15 points</td>
</tr>
<tr>
<td>Budget</td>
<td>20 points</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 points</strong></td>
</tr>
</tbody>
</table>

14. Grant Participation Requirements

ACH grantees must submit quarterly reports and participate in regular conference calls and site visits, as well as participate in state and federal evaluation activities and in the ACH learning collaborative. Via a vendor, the State will develop a web-based communications system for ACHs and an ACH-specific communication plan to disseminate relevant information both to and from ACHs.

Funded applicants will be required to:

- Submit and share copies of all tools, resources, documents, and other guidance.
- Submit written narrative progress reports quarterly using a MDH template by April 10th, July 10th, October 10th, and January 10th.
- Submit expenditure reports and invoices for the grant period by April 10th, July 10th, October 10th, and January 10th.
- Submit the following required measurement data as specified by MDH in quarterly reports:
  - Number of ACH partners, number of referrals to and persons served by community care coordination system / team.
  - Number of ACO partners and estimated future ACO populations.
  - Level of ongoing ACH partnership development in ACH leadership team using a standardized tool.
  - Progress measures determined by the ACH applicant in the measurement plan.
  - Population health measures defined by the ACH applicant in the work plan.
- Submit additional measures in timeframe to be determined:
  - Measures of patient experience using a standardized tool.
  - New measures may also be developed to ensure the Model goals are achieved such as patient experience.
- Submit a year one and final report within 90 days of the due date (content template specified by MDH including lessons learned).
- Participate in MDH provided or identified trainings, meetings, and technical assistance, including participation in any state-funded activities.
• Collaborate with any other contractors, grantees, or partners associated with SIM grant and Minnesota Accountable Health Model as appropriate.
• Four team members must participate in the ACH learning collaborative and required learning collaborative activities.

**Contract requirements include:**

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

**15. Required Forms**

Below is a listing of forms required for submission of an Accountable Communities for Health 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 Face Sheet with Instructions
- Form B: Project Work Plan
- Form C: Budget, Minnesota Accountable Health Model Contractor Budget Template
- Form D: Budget Justification Narrative
- Form E: Due Diligence Review Form
- Form F: Continuum of Accountability Matrix Assessment Tally Tool with Instructions
- Form G: Letter of Intent to Respond Template
- Form H: Letters of Support Checklist
- Form I: ACH Partners Table
### Accountable Communities for Health

<table>
<thead>
<tr>
<th>Description</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Legal name and address of the applicant agency with which grant</td>
<td></td>
</tr>
<tr>
<td>agreement would be executed</td>
<td></td>
</tr>
<tr>
<td>2. Minnesota Tax I.D. Number</td>
<td>Federal Tax I.D. Number</td>
</tr>
<tr>
<td>3. Requested funding for the total grant period</td>
<td>$</td>
</tr>
<tr>
<td>4. Director of applicant agency</td>
<td></td>
</tr>
<tr>
<td>Name, Title and Address</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Telephone Number: ( )</td>
<td></td>
</tr>
<tr>
<td>FAX Number: ()</td>
<td></td>
</tr>
<tr>
<td>5. Fiscal management officer of applicant agency</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Name, Title and Address</td>
<td>Telephone Number: ( )</td>
</tr>
<tr>
<td>Telephone Number: ( )</td>
<td></td>
</tr>
<tr>
<td>FAX Number: ()</td>
<td></td>
</tr>
<tr>
<td>6. Operating agency (if different from number 1 above)</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Name, Title and Address</td>
<td>Telephone Number: ( )</td>
</tr>
<tr>
<td>Telephone Number: ( )</td>
<td></td>
</tr>
<tr>
<td>FAX Number: ()</td>
<td></td>
</tr>
<tr>
<td>7. Contact person for applicant agency (if different from number 4 above)</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Name, Title and Address</td>
<td>Telephone Number: ( )</td>
</tr>
<tr>
<td>Telephone Number: ( )</td>
<td></td>
</tr>
<tr>
<td>FAX Number: ()</td>
<td></td>
</tr>
<tr>
<td>8. Contact person for further information on grant application</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Name, Title Address</td>
<td>Telephone Number: ( )</td>
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<tr>
<td>Telephone Number: ( )</td>
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<tr>
<td>FAX Number: ()</td>
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<tr>
<td>9. Certification</td>
<td>I certify that the information</td>
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<tr>
<td></td>
<td>contained herein is true and</td>
</tr>
<tr>
<td></td>
<td>accurate to the best of my knowledge</td>
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<td></td>
<td>and that I submit this application</td>
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<td>on behalf of the applicant agency.</td>
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<tr>
<td></td>
<td>Signature of Authorized Agent for</td>
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<tr>
<td></td>
<td>Grant Agreement</td>
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<td></td>
<td>Title</td>
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<td></td>
<td>Date</td>
</tr>
</tbody>
</table>
Form A: Application Face Sheet Instructions

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

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

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

3. **Requested funding for the total grant period**
   Amount the applicant agency is requesting in grant funding for the grant period. The grant period will be from January 1, 2015 – December 31, 2016. The grantee must submit a budget for each year, starting with January 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. **Operating Agency**
   Complete only if other than the applicant agency listed in 1 above.

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

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

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

**Accountable Communities for Health**

**Applicant:**

**Instructions:** Enter objectives, activities, tracking methods, and milestones/timelines for grant years 1 and 2 on separate lines. Use the key objectives and deliverables in the work plan to crosswalk to Section 2 Deliverables of Budget Form C.

<table>
<thead>
<tr>
<th>Elements: Implementation Of:</th>
<th>OBJECTIVES</th>
<th>ACTIVITIES</th>
<th>TRACKING METHODS</th>
<th>MILESTONES/TIMELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example:</strong> Leadership team structure, year 1</td>
<td>Establish guidelines for leadership structure. Increase representation by target population.</td>
<td>Develop guidelines for leadership structure with the leadership team. Engage XYZ organization/individual.</td>
<td>Charter Meeting Minutes Approval process Leadership structure membership</td>
<td>Leadership structure in place by September 2015 At least one additional agency representing target population added by December 2015</td>
</tr>
<tr>
<td>Leadership Team Structure Year 1</td>
<td></td>
<td></td>
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<tr>
<td>Leadership Team Structure Year 2</td>
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<tr>
<td>Community Care Coordination Model Year 1</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Elements: Implementation Of:</td>
<td>OBJECTIVES</td>
<td>ACTIVITIES</td>
<td>TRACKING METHODS</td>
<td>MILESTONES/ TIMELINES</td>
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<tr>
<td>Community Care Coordination Model Year 2</td>
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<tr>
<td>Population Based Prevention Year 1</td>
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<td>Population Based Prevention Year 2</td>
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<td>Measurement Plan Year 1</td>
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<td>Measurement Plan Year 2</td>
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<td>Sustainability Plan Year 1</td>
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<td>Sustainability Plan Year 2</td>
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<tr>
<td>Elements: Implementation Of</td>
<td>OBJECTIVES</td>
<td>ACTIVITIES</td>
<td>TRACKING METHODS</td>
<td>MILESTONES/TIMELINES</td>
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<tr>
<td>Learning Collaborative Participation Year 1</td>
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<td>Learning Collaborative Participation Year 2</td>
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<td>Applicant Project Management Year 1</td>
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<td>Applicant Project Management Year 2</td>
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<tr>
<td>Other Applicable Infrastructure Elements Year 1</td>
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<tr>
<td>Other Applicable Infrastructure Elements Year 2</td>
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</tbody>
</table>
Applicant/ACH: 
Total Contract Period: January 1, 2015 - December 31, 2016

Budget Form Instructions for ACH 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 ACH 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 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
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<td>0</td>
<td>$</td>
</tr>
</tbody>
</table>

Total Salaries and Wages: $ 

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.

<table>
<thead>
<tr>
<th>Total Fringe:</th>
<th>$</th>
</tr>
</thead>
</table>
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>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name: 
Organization: 
Services: 
Total Consultant Costs: $ 

D. EQUIPMENT: Equipment costs are not allowed.

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

Total Equipment Costs: $ 

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

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

Total Supply Costs: $ 

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

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

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

Total Travel Costs: $ 

G. OTHER: If applicable, list items not included in previous budget categories below. Include a detailed description of the proposed expenditures in Form D Budget Justification Narrative. Consult budget instructions in Section 11E for examples of allowable costs in this category.

<table>
<thead>
<tr>
<th>Item</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Other Costs:</td>
<td>$</td>
</tr>
</tbody>
</table>

**GRAND PROJECT TOTAL**  

$ 

### Section Two

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

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Structure</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Community Care Coordination Systems/Teams</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Population-based Prevention Planning</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Measurement Plan</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Structure</td>
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</tr>
<tr>
<td>Community Care Coordination Systems/Teams</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Population-based Prevention Planning</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Measurement Plan</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>
### Deliverable: Sustainability Planning Goals

<table>
<thead>
<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tbody>
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**TOTAL**

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<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tbody>
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</table>

### Deliverable: Learning Collaborative Participation

<table>
<thead>
<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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**TOTAL**

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<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
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<tr>
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### Deliverable: Applicant Project Management

<table>
<thead>
<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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**TOTAL**

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<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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<tr>
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</table>

### Deliverable: Community Engagement

<table>
<thead>
<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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**TOTAL**

<table>
<thead>
<tr>
<th>Avg by Hour</th>
<th>Estimated Hrs</th>
<th>Billable Amt</th>
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</table>

**GRAND PROJECT TOTAL**

|            |               | $            |

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**In-kind support**

**In-kind**: Include amounts and sources of in-kind including financial resources that will be used by the ACH and for which grant funds are not being requested.

<table>
<thead>
<tr>
<th>In-kind Item</th>
<th>Amount</th>
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<tbody>
<tr>
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**TOTAL**

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</table>
Form D: Budget Justification Narrative

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

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

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

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

B. Fringe

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

C. Consultant Costs

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

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

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

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

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

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

---

**In-kind**

**Narrative Justification** (describe in-kind contributions that will be provided by ACH partners. 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):

---

**Optional Additional Funds Budget and Justification**

Expenses not covered in any of the previous budget categories. *(briefly describe in the budget justification what additional expenditures that your ACH might anticipate to meet your ACH project goals if you were awarded additional ACH grant dollars. Please include the expenditure and the estimated costs.)*

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<th>Item</th>
<th>Cost</th>
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**Total**
The applicant organization’s administrative staff (finance manager, accountant, or executive director) must complete the Due Diligence form.

Due Diligence Review Form

Instructions

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

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

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

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

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

## Organization Information

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<tbody>
<tr>
<td>1.</td>
<td>How long has your organization been doing business?</td>
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<td>2.</td>
<td>Does your organization have a current 501(c) 3 status from the IRS? Circle Yes or No.</td>
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<td>3.</td>
<td>How many employees does your organization have (both part time and full time)?</td>
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<td>4.</td>
<td>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.</td>
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<td>5.</td>
<td>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.</td>
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<tr>
<td>6.</td>
<td>Does your organization receive management or financial assistance from any other organizations? Circle Yes or No. If yes, provide details.</td>
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<tr>
<td>7.</td>
<td>What was your organization's total revenue in the most recent 12-month accounting period?</td>
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<tr>
<td>8.</td>
<td>How many different funding sources does the total revenue come from?</td>
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<tr>
<td>9.</td>
<td>Have you been a grantee of the Minnesota Department of Health within the last five years? Circle Yes or No. If yes, from which division(s)?</td>
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<tr>
<td>10.</td>
<td>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.</td>
</tr>
<tr>
<td>11.</td>
<td>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.</td>
</tr>
<tr>
<td>12.</td>
<td>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.</td>
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<tr>
<td>13.</td>
<td>Which of the following best describes your organization's accounting system? Circle one response.</td>
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<tr>
<td>14.</td>
<td>Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately? Circle one response.</td>
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<tr>
<td>15.</td>
<td>If your organization has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items? Circle one response.</td>
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<td>Question</td>
<td>Yes</td>
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<td>16. Are time studies conducted for employees who receive funding from multiple sources? Circle one response.</td>
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<td>17. Does the accounting system have a way to identify overspending of grant funds? Circle one response.</td>
<td>Yes</td>
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<tr>
<td>18. If grant funds are mixed with other funds, can the grant expenses be easily identified? Circle one response.</td>
<td>Yes</td>
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<td>19. Are the officials of the organization bonded? Circle one response.</td>
<td>Yes</td>
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<td>20. Did an independent certified public accountant (CPA) ever examine the organization's financial statements? Circle one response.</td>
<td>Yes</td>
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<td>21. Has any debt been incurred in the last six months? Circle Yes or No. If yes, what was the reason for the new debt? What is the funding source for paying back the new debt?</td>
<td>Yes</td>
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<td>22. What is the current amount of unrestricted funds compared to total revenues?</td>
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<td>23. Are there any current or pending lawsuits against the organization? Circle Yes or No.</td>
<td>Yes</td>
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<td>24. If yes, could there be an impact on the organization's financial position? Circle one response.</td>
<td>Yes</td>
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<tr>
<td>25. Has the organization lost any funding due to accountability issues, misuse, or fraud? Circle Yes or No. If yes, please describe the situation, including when it occurred and whether issues have been corrected.</td>
<td>Yes</td>
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</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: Minnesota Accountable Health Model: Continuum of Accountability Matrix Tally Sheet (sample only)

Individual organizations / providers must complete the Continuum of Accountability Matrix Assessment Tool for their organization. In addition, ACH proposal 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 F (see Example tab in Excel file):
1. Enter the name of each organization and the name of the ACH in the spaces below.
2. Place an x in the box that represents the score for each individual agency and the ACH overall.

Enter Organizations and ACH name below.

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<thead>
<tr>
<th>Organization 1:</th>
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<tr>
<td>Organization 2:</td>
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<td>Organization 3:</td>
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<td>Organization 4:</td>
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<td>Organization 5:</td>
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<td>Organization 6:</td>
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<td>ACH Name:</td>
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<tr>
<td>Level</td>
<td>Description</td>
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<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>
</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>
</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>
</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>
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### Payment Transformation Section

2. What types of alternatives to fee-for-service (FFS) payment arrangement(s) do you participate in?

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<th>Level</th>
<th>Description</th>
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<th>Org 2</th>
<th>Org 3</th>
<th>Org 4</th>
<th>Org 5</th>
<th>Org 6</th>
<th>ACH</th>
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<td>Pre- Level</td>
<td>We only receive payment for delivered services in the form of fee-for-service without any incentives.</td>
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<td>A</td>
<td>We have little or no readiness to manage global costs, but may be willing to assume fixed payment for some ancillary services. Examples include: Health care home or similar coordination fees, quality improvement/incentive payments.</td>
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<td>B</td>
<td>We are ready to manage global costs with upside risk. We participate in shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk (e.g. episode-based payments).</td>
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</table>
2. What types of alternatives to fee-for-service (FFS) payment arrangement(s) do you participate in? (Continued)

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<td>C</td>
<td>We are ready to manage global cost with upside and downside risk. We participate in shared savings and some arrangements moving toward risk sharing through Total Cost of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization.</td>
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<td>D</td>
<td>We are ready to accept global capitation payments. Community partners are sharing in accountability for cost, quality and population health are included in the financial model in some form.</td>
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Place on Letterhead:
*Deadline September 26, 2014, 4:00 pm CST*
Accountable Communities for Health

(date)

This is written notification of the intent to submit an application to the Minnesota Department of Health for funding under the Minnesota Accountable Health Model Accountable Communities for Health (ACH) grant program. We understand that the application deadline for our proposal is October 20, 2014 at 4:00 pm CST. Information on our ACH is provided below.

**Applicant organization name:**

**Contact person:**

**Contact person email:**

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

**Planned ACO partner:**

**Planned target population:**

**Signature:**

**Title:**

Please submit the letter as an email attachment to [Chris.dobbe@state.mn.us](mailto:Chris.dobbe@state.mn.us)

Or provide the letter via mail or courier to:

Minnesota Department of Health
Health Care Homes / SIM Unit

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

**Mailing Address (must arrive by the deadline to be accepted):**
P.O. Box 64882
Saint Paul, Minnesota 55164-0882
Form H: Letters of Support Checklist

Use this form to track the letters of support you are including in the Accountable Communities for Health proposal. Include letters of support from the leadership team and other participants that specify commitment and contributions on the part of the partnering entity.

☐ Organization that will be the fiscal agent. The letter must state the organization’s willingness to accept and account for grant funds under this program.

☐ Accountable Care Organization

☐ Local Public Health. The letter must describe their level of participation as outlined in section 7.

☐ Community partners that engage with the target population.

Describe below why a letter of support from a key partner is not included in the application.
Form I: ACH Partners Table

Use this form to list members of the ACH community partnership as it exists at the time you submit the proposal.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Title of Agency Representative</th>
<th>Role in ACH (fiscal agent, leadership, etc.)</th>
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Appendixes

Appendix A: Minnesota Accountable Health Model Glossary

Appendix B: Resources

Appendix C: MDH Sample Contract

Appendix D: Policy and regulatory levers for Accountable Health Communities
Appendix A: Minnesota Accountable Health Model Glossary

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

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

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


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

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

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


**Care Coordinator**
A care coordinator is a person who has primary responsibility to organize and coordinate care and services for clients/patients served in a variety of settings, e.g., health care homes, behavioral health clinics, acute care settings and so on.
Care Manager
A care manager is a person who has primary responsibility to organize and coordinate care based on a set of evidence-based, integrated clinical care activities that are tailored to the individual patient, and that ensure each patient has his or her own coordinated plan of care and services.

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

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

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

Community Engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (Fawcett et al., 1995)
Computerized Provider Order Entry (CPOE) is a computer application that allows a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.

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

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

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

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

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

Health Care Home

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

Source: Minnesota Department of Health Health Care Homes (aka Medical Homes) (www.health.state.mn.us/healthreform/homes/) accessed 09.10.13

Health Equity

Exists when every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.


Health Information Exchange (HIE)

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

Health Information Technology (HIT)

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

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

Integrated care

Integrated care covers a complex and comprehensive field and there are many different approaches to and definitions of the concept. One overarching definition (Grone, O. and Garcia-Barbero, M. 2002) is integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.
Interprofessional Team
Interprofessional Team, as defined in the Institute of Medicine’s (IOM) Report, *Health Professions Education: A Bridge to Quality*, (2003) an interdisciplinary (Interprofessional) team is “composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods.” (p. 54) Members of an Interprofessional team communicate and work together, as colleagues, to provide quality, individualized care for patients. [http://www.iom.edu/Reports/2003/health-professions-education-a-bridge-to-quality.aspx](http://www.iom.edu/Reports/2003/health-professions-education-a-bridge-to-quality.aspx)

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

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

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

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

Population Health

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


Provider

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

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

Public Health

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

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

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

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

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

1. Accountable Communities for Health: How to get started
   http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_188779

2. Adverse Childhood Experience (ACE) in Minnesota
   http://www.health.state.mn.us/divs/cfh/program/ace/index.cfm

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

4. Community Action Programs
   http://www.echominnesota.org/sites/default/files/resources/Minnesota Community Action Programs by County UPDATED.pdf

5. Long-term care services and supports gaps analysis

6. Minnesota Accountable Communities for Health Advisory Subgroup

7. Minnesota Accountable Health Model http://www.health.state.mn.us/healthreform/sim/

8. Minnesota Accountable Health Model: Continuum of Accountability Matrix

9. MN SIM website

10. SAMHSA-HRSA Center for Integrated Health Solutions:
    www.integration.samhsa.gov/integrated-care-models

11. SIM ACH Resources / Literature Review
Appendix C: MDH Sample Contract

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

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

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

Minnesota Department of Health
Grant Agreement

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

Recitals

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

   the State is empowered to enter into this grant agreement.

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

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

Grant Agreement

1. Term of Agreement

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

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

   1.3 Survival of Terms The following clauses survive the expiration or cancellation of this grant contract: 8. Liability; 9. State Audits; 10.1 Government Data Practices; 10.2 Data Disclosure; 12.
2. **Grantee's Duties** The Grantee, who is not a state employee, shall: *Attach additional pages if needed, using the following language,* "complete to the satisfaction of the State all of the duties set forth in Exhibit A, which is attached and incorporated into this agreement."

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

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

4. **Consideration and Payment**

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

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

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

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

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

*OR*

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

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

4.2 Terms of Payment

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

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

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

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

**Authorized Representatives**

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

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

7. Assignment, Amendments, Waiver, and Merger

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

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

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

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

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

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


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

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

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

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

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

   17.1 Contractor Debarment, Suspension and Responsibility Certification

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

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

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

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

   (c) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state of local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement or receiving stolen property; and
(d) Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this grant/contract are in violation of any of the certifications set forth above.

17.2 Audit Requirements to be Included in Grant Agreements with Subrecipients

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

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

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

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

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

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

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

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

The reporting requirements for audit reports shall be in accordance with the American Institute of Certified Public Accountants' (AICPA) audit guide, "Audits of State and Local Governmental Units," issued in 1986. The Federal Government has approved the use of the audit guide.
In addition to the audit report, the Grantee shall provide comments on the findings and recommendations in the report, including a plan for corrective action taken or planned and comments on the status of corrective action taken on prior findings. If corrective action is not necessary, a statement describing the reason it is not should accompany the audit report.

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

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

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

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

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

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

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

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

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

17.4 Lobbying

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

17.5 Equal Employment Opportunity

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

17.6 Cost Principles

The Grantee agrees to comply with the provisions 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 person(s) have executed the grant agreement on behalf of the Grantee as required by applicable articles, bylaws, resolutions, or ordinances.  
   By: ____________________________  
   (with delegated authority)  
   Title: ____________________________  
   Date: ____________________________  
   By: ____________________________  
   Title: ____________________________  
   Date: ____________________________  
   Distribution:  
   Agency – Original (fully executed) Grant Agreement  
   Grantee  
   State Authorized Representative

2. State Agency  
   Grant Agreement approval and certification that State funds have been encumbered as required by Minn. Stat. §§16A.15 and 16C.05.  
   By: ____________________________  
   Title: ____________________________  
   Date: ____________________________
##Minnesota Policy | Statutory Reference | Policy Description
--- | --- | ---
**Purchaser and payer**

| Integrated Health Partnerships  
Payment Reform/ACO contracting | **MN Stat. 256B.0755 Subdivisions 1 (b)(6) and 3 (b)** | Integrated Health Partnership, formally an HCDS to demonstrate how it will coordinate with other services affecting its patient’s health, quality of care, and cost of care including counties, other provider types, and purchasers. Encourages projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care. [https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/](https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/) |


| In-Reach Care Coordination | **MN Stat. 256B.0625 Subd. 56** | Provides a new service for Medicaid enrollees who have high emergency department utilization to receive community-based coordination and navigation services (e.g. health care access, housing, transportation) immediately preceding and as part of a hospital discharge. [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177610](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177610) |

**Promoter of wellness**

| Local Public Health Act | **MN Stat. Chapter 145A** | Developed an "integrated system of community health services under local administration and within a system of state guidelines and standards" (local public health); establishes SCHSAC; sets expectations for community needs assessment, community engagement and development of local health priorities. [http://www.health.state.mn.us/divs/opi/gov/lphact/](http://www.health.state.mn.us/divs/opi/gov/lphact/) |

<p>| Statewide Health Improvement Program (SHIP) | <strong>MN Stat. 145.986</strong> | Requires the commissioner of health to award competitive grants to community health boards and tribal governments to convene, coordinate, and implement |</p>
<table>
<thead>
<tr>
<th>Minnesota Policy</th>
<th>Statutory Reference</th>
<th>Policy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.</td>
<td></td>
<td><a href="http://www.health.state.mn.us/ship/">http://www.health.state.mn.us/ship/</a></td>
</tr>
<tr>
<td>Community Transformation Grant (CTG)</td>
<td><strong>Prevention and Public Health Fund of the Affordable Care Act, Pub. L. 111-148</strong></td>
<td>Requires support to community-level efforts to reduce chronic diseases such as heart disease, hypertension, cancer, stroke and diabetes.</td>
</tr>
</tbody>
</table>

**Provider**

| Hennepin County pilot “Hennepin Health” | **MN Stat. 256B.0756** | Authorized Hennepin to develop pilot programs to test alternative and innovative integrated care delivery networks. | [http://www.hennepin.us/residents/health-medical/hennepin-health](http://www.hennepin.us/residents/health-medical/hennepin-health) |
| Preferred Integrated Network (PIN) | **MN Stat. 245.4682 Subd. 3** | Authorized DHS to implement up to three projects to demonstrate the integration of physical and mental health services within MCOs and coordination of these services with county social services. | [http://www.dhs.state.mn.us/main/idcp?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139287](http://www.dhs.state.mn.us/main/idcp?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139287) |

**Regulator**

| Health Plan Collaboration Plans | **MN Stat. 62Q.075** | Requires health plans to submit "collaboration plans" to commissioner of health describing how they will work with local health departments to achieve public health goals. | [http://www.health.state.mn.us/divs/opi/pm/collaboration-plans/](http://www.health.state.mn.us/divs/opi/pm/collaboration-plans/) |

**Federal Administrator**

| IRS Rules for Community Needs Assessment | **Internal Revenue Service 26 CFR Parts 1 and 53 (Reg- 106499-12) RIN 1545-BL30** | Draft rules to implement ACA requirement that hospitals conduct community needs assessments; develop plans to address identified needs; and requires engagement of community members and consultation with a state, regional or local public health authority. | [http://www.mnhospitals.org/data-reporting/mandatory-reporting/community-health-needs-assessment](http://www.mnhospitals.org/data-reporting/mandatory-reporting/community-health-needs-assessment) |