

Request for Proposals



City of Minneapolis
Health Department

Request for Proposals for
**Clinics to Implement Process and Care Improvements
for Hypertension and Pre-diabetes Management**

RFP 2015-67 Issued August 28, 2015

Proposals Due: October 7, 2015 by 4 p.m.

August 26, 2015

To Minneapolis Primary Care Clinics and Clinic Systems:

Attached is a Request for Proposals (RFP) to implement process and care improvements in the management of hypertension and pre-diabetes for adult and priority adult populations in Minneapolis. If your agency meets the requirements, please consider submitting a proposal. The RFP contains more detail about the program and the application process.

Proposals are due no later than 4 p.m. on October 7, 2015. A pre-proposal conference call will be held on September 9, 2015 at 9:00 a.m.

Thank you for your consideration.

Sincerely,



Gretchen Musicant
Commissioner of Health

Attachments

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For reasonable accommodations or alternative formats please contact the Minneapolis Health Department at 612-673-2301 or health@minneapolismn.gov. People who are deaf or hard of hearing can use a relay service to call 311 at 612-673-3000. TTY users call 612-673-2157 or 612-673-2626.
Para asistencia 612-673-2700 - Rau kev pab 612-673-2800 - Hadio aad Caawimaad u baahantahay 612-673-3500.

I. INVITATION:

Cardiovascular disease is the leading cause of death and is responsible for a majority of healthcare visits in the US. Although tremendous progress has been made in reducing cardiovascular morbidity and mortality, the absolute burden of cardiovascular disease has not declined, and costs are still rising.

The burden of cardiovascular disease and diabetes can be reduced through the implementation of the Chronic Care Model in health care systems. The Chronic Care Model is organized around elements that have been shown to improve outcomes. The elements of the Chronic Care Model include decision support, clinical information systems, self-management education, and delivery system design.

The Minneapolis Health Department's Healthy Living Initiative is requesting proposals from clinics or organizations with more than one clinic to implement process and care improvement programs for patients with hypertension (undiagnosed and diagnosed) and pre-diabetes. These services are a component of our federally funded Community Wellness Grant from the Minnesota Department of Health. This grant builds on current work to prevent and better manage obesity, diabetes, heart disease and stroke and the reduction of health disparities through:

- Using electronic health records and health information technology to identify patients with undiagnosed hypertension or pre-diabetes;
- Expanding and monitoring system-wide, provider-focused quality measures;
- Engaging non-physician healthcare professionals in hypertension management and increasing the use of self-measured blood pressure monitoring;
- Linking clinical and community resources to support heart disease, stroke and type 2 diabetes prevention by engaging community health workers;
- Integrating community pharmacists into hypertension treatment and management through bi-directional referrals to and from primary care clinics.

The overall funding available under this grant is \$605,000. The maximum award per organization will be \$50,000/year, and a total maximum of \$100,000 for the 24-month project period (November 1, 2015 – October 31, 2017). A health system may apply to conduct the required activities in more than one clinic, however, each participating clinic must be in Minneapolis and meet the eligibility criteria. There is potential for a third year of reduced funding dependent on funding available to the Minneapolis Health Department (MHD) and the performance of the selected organizations. MHD expects to fund 6 -7 organizations (i.e., clinics or health systems).

The MHD will support the selected clinics with ongoing technical assistance, practice facilitation, quality improvement coaching, and training opportunities. In addition, MHD will work to increase awareness of and accessibility of community resources for healthy living. The Minnesota Department of Health has contracted with Stratis Health, the University Of Minnesota College Of Pharmacy, Wellshare International Health Care Homes, and the Minnesota Community Health Worker Alliance to provide technical assistance on data collection, modification of electronic health records, engagement, use of community pharmacists and community health workers.

The purpose and goal of this RFP is to fund clinics or clinic systems to implement process improvement programs that identify patients with undiagnosed hypertension and pre-diabetes and improve the care provided to all patients with hypertension and pre-diabetes. It is the goal of this program for clinics to be able to collect quality measure and outcomes data to track and monitor quality improvement efforts, to develop registries for hypertensive and pre-diabetic patients to monitor care, to develop/enhance team-based care by incorporating non-physician team members to support patient education and patient self-management strategies for hypertension and pre-diabetes and to implement clinic decision support systems for the treatment of hypertension.

To be eligible for grant funding clinics must:

- Be located in and provide primary care services to Minneapolis adults;
- Serve a patient population that includes 50% or more of adults from populations experiencing health disparities (specific racial and ethnic groups, low-income groups, etc.).

The Project is described in more detail in the "Scope of Services" (Attachment A), contained within this RFP.

II. PRE-PROPOSAL CONFERENCE CALL:

A pre-proposal telephone conference call will be held on Wednesday, September 9, 2015 at 9:00 a.m. for potential applicants. Please dial in at: 1-877-685-5350 and enter passcode: 6126733557. While participation on the conference call is not required, it is encouraged for all organizations considering responding to this RFP, because it will be the only opportunity to ask questions directly to staff. Following the conference call a summary of questions and answers from the call will be posted by September 11 on the City's RFP website: <http://www.minneapolismn.gov/finance/procurement/rfp>.

Potential applicants may submit additional questions in writing at any time through email at health@minneapolismn.gov, subject line: Clinics RFP, with the final due date no later than 4 p.m. on September 25. Responses to the questions will be posted at least weekly on Tuesdays, with the final posting on September 29, 2015 at the City's RFP website at: <http://www.minneapolismn.gov/finance/procurement/rfp>

III. PROPOSAL DUE DATE and LOCATION:

The responder should submit an **original and six (6) copies** of the proposal to the City of Minneapolis Procurement Office, labeled:

City of Minneapolis - Procurement
Request for Proposals for: Hypertension and Pre-diabetes Services/Health Department
330 2nd Avenue South, Suite 552
Minneapolis, MN 55401

Proposals are due by **4:00 P.M. October 7, 2015**

NOTE: Late Proposals may not be accepted.

IV. PROPOSAL FORMAT:

Proposals must include a Proposal Cover Sheet (Attachment A-1), the documents outlined on the cover sheet and a narrative that provides all of the information requested below. Please see Section V – “EVALUATION OF PROPOSALS” to understand the criteria that will be used to evaluate proposals.

Please limit the narrative to seven (7) single-spaced pages with a 12 point font and one inch margins. The cover sheet, work plan, budget, and budget justification do not count towards the page limit.

NARRATIVE

A. ORGANIZATIONAL STRUCTURES, CAPACITIES AND APPROACHES TO IMPROVE CARE AND PRIORITY POPULATION HEALTH

1. Provide an organizational overview (organization type, mission, services and number of people served annually)
2. Provide a demographic profile of patients. Who are your adults and priority adult populations?
3. Describe your clinic’s experiences and approaches in implementing quality improvement processes if applicable specific to hypertension, including patient self-monitoring, and diabetes/pre-diabetes.
 - o If applicable, describe your model of team-based care including the roles of your team care members, the engagement of community health workers and/or pharmacists and your interest in utilizing a model of team-based care.
 - o Describe your organization’s staffing for these quality improvement efforts. Who leads the improvement effort (champion)?
 - o Indicate if you currently maintain a registry of patients with hypertension.
4. Describe clinics electronic health record system and how it is used in quality improvement efforts.
 - o Describe your clinic’s capacity to collect requested data and monitor performance and any data related IT needs.
5. Describe your clinic/organization’s current use of community health workers and how they are integrated or might be integrated into the patient’s care team. If applicable, describe the services they provide and how you fund their positions.
6. Describe your clinic/organization’s current use of pharmacists and how they are or might be integrated into the patient’s care team. Indicate if you currently have pharmacists on staff or contract with community pharmacists.

B. IMPACT OF IMPROVEMENT EFFORTS

1. If applicable, describe the results, challenges, and lessons learned from your hypertension and diabetes/pre diabetes quality improvement processes.

2. Describe the most anticipated organizational or care improvements that may be achieved through this funding and describe whether these improvement activities will build on existing improvements.
3. If you are applying as an organization with more than one clinic site, how will your organization assure that each participating clinic fully implements the program? Please describe how you will influence and monitor clinic improvements and patient outcomes in individual participating clinics
4. Describe how you will reach out to priority populations and the number of people and the percentage of priority population you might serve.

C. PROJECT OVERVIEW

- Provide an overview of your proposed project and goals.
- Describe the most anticipated organizational or care improvements that may be achieved through this funding and describe whether these improvement activities will build on existing improvements.
- Identify your champion, who will lead this effort and what is this person’s credential? What percent time will the champion work on this project? What authority does s/he have to pursue the proposed changes?
- Describe your commitment to participate in activities supporting the grant goals i.e. developing a team-based care model that includes pharmacists, community pharmacists, dietician, health educators/coaches, CHWs and/or others; refining team roles and functions that support the coordination or care, in particular referrals and follow-up to evidence based patient programs; re-designing work flows to incorporate new or enhanced clinical protocols e.g. blood pressure self-monitoring.
- If you are applying as an organization with more than one clinic site, how will your organization assure that each participating clinic fully implements the program? Please describe how you will influence and monitor clinic improvements and patient outcomes in individual participating clinics.
- If you currently are working on other similar projects, how will you link and leverage resources? How will the proposed work complement similar projects in your organization/clinic? How will you integrate similar efforts?

REQUIRED ATTACHMENTS

A-1 Proposal Cover Sheet (See Attachment A-1): including list of required administrative documents for submission.

A-2 Work plan (See Attachment A-2): Using a table format describe how your organization will implement the project including, 1 to 3 SMART objectives for each required element, the responsible parties, project activities, a timeframe for each activity, and the proposed outcomes. The table can be expanded into multiple pages.

A-3 Budget and Budget Justification (See Attachment A-3)

V. EVALUATION OF PROPOSALS:

An evaluation panel made up of representatives of the health department’s Healthy Living team, and the Minnesota Department of Health will review proposals. Evaluations will be based on the required criteria listed in Section IV “Proposal Format” .

Organizational capacity - Leadership, experience, current services and proven track record serving priority populations and successfully implementing quality improvement initiatives with priority populations, commitment to implement improvement efforts, IT capacity
Impact - Percent of patients populations experiencing disparities; anticipated number of patients impacted through proposed activities; anticipated impact on these patients
Approach - All of the required elements are included in the proposal; the proposed strategies are realistic and achievable and enhance clinics’ current activities; proposed activities are likely to improve clinical outcomes; willingness to be innovative
Budget and Budget Justification - Reasonableness and cost efficiency of the budget.

VI. SCHEDULE:

The following is a listing of key proposal and project milestones:

Milestone	Date
RFP release	8/28/2015
Pre-proposal conference call	9/9/2015, 9:00 a.m.
Submit questions about RFP by	10/07/2015
Answers to questions will be posted	On Tuesdays through 9/29/2015
Proposals due by 4:00 p.m.	10/7/2015
Applicants notified of funding decision	Week of 10/12/2015
Contract negotiations with selected applicants	Week of 10/19/2015
Estimated start date	11/23/2015
Estimated end date	10/31/2017

VII. CONTRACT:

The contracting parties will be the City of Minneapolis and the organizations selected to provide the services as described herein. The selected proposals, along with the RFP and any modifications will be incorporated into a formal agreement after negotiations.

VIII. REJECTION OF PROPOSAL: The City reserves the right to reject any proposals or any Providers on the basis of the proposal submitted.

IX. ADDENDUM TO THE RFP: If any addendum is issued for this RFP, it will be posted on the City of Minneapolis web site at: <http://minneapolismn.gov/inance/procurement/rfp>. The City reserves the right to cancel or amend the RFP at any time.

ATTACHMENT A SCOPE OF SERVICES

It is the intent of this document to outline a general description of the project, the extent of services required, and the relationship of the Project to other work, and the agencies or other parties that will interact with the Provider.

Background

The CDC states that nearly one in three adults (67 million) has high blood pressure. Of those, about half (36 million) have uncontrolled high blood pressure. In 2012, 26 percent of adult Minnesotans reported being told that they have high blood pressure.¹ According to the 2015 Minnesota Healthcare Quality Report, only 76 percent of patients with high blood pressure seen in clinics had their blood pressure under control. High blood pressure increases the risk for heart attack, chronic heart failure and stroke which are one of the leading causes of death in Minnesota.

In 2013, 7.4% of Minnesota adults (about 310,000) had been diagnosed with diabetes (type 1 or 2), and the percentage of MN adults with diagnosed diabetes has nearly doubled since 1994. (Minnesota Department of Health Diabetes Fact Sheet, 2014). Pre-diabetes occurs when blood sugar (glucose) levels are higher than normal, but not high enough to be considered diabetes. Approximately 37% or 1 in 3 American adults have Pre-diabetes, translating to approximately 1.5 million adult Minnesotans and as many as 115,000 adults in Minneapolis.

National data show 9 in 10 adults with Pre-diabetes don't know they have it. The latest survey of Minneapolis adults (2010 SHAPE survey) showed only 4% reported having Pre-diabetes, suggesting many Minneapolis adults with Pre-diabetes don't know they have it. (Geiss et al. 2010 Am. J. Prev. Med 38(4):403-409.)

In April 2015, the Minneapolis Health Department was one of four Minnesota communities awarded Centers for Disease Control and Prevention (CDC) funding through the Minnesota Department of Health. Two focus areas of this grant are to increase the identification of and improve the treatment of hypertension and pre-diabetes in clinic settings and to improve community-clinical linkages.

Funding

The overall funding available under this grant is \$605,000. The maximum award per organization will be \$50,000/year, and a total maximum of \$100,000 for a 24-month project period (November 1, 2015 – October 31, 2017). A health system may apply to conduct the required activities in more than one clinic; however, each participating clinic must be in Minneapolis and meet the eligibility criteria. The Minneapolis Health Department expects to fund 6-7 organizations (i.e., clinics or health systems).

Limited funding for a third year (2018) may also be available, dependent on funding available to the Minneapolis Health Department and the performance of the selected organizations.

¹*Behavioral Risk Factor Surveillance System Survey Data*, from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

Allowable uses of funds include staff time to plan and implement process improvement programs, data analysis, EHR modifications, staff time devoted to quality improvement, consultants, attending meetings with MHD/ MDH staff, staff training and other similar uses. Funds can also be used to pay or contract for community health workers, pharmacists, or similar positions.

Funds may not be used to conduct lobbying or advocacy activities, purchase food, pay for the provision of clinical care, purchase home blood pressure monitoring machines, or other patient incentives.

Goals and Programmatic Requirements

The overall goal of the program is for clinics to implement a comprehensive process improvement program to identify and improve outcomes for patients with hypertension, pre-diabetes, and diabetes. Proposals should focus on innovative strategies for patient self-management and community-clinical linkages. These could include increasing community-based organization's involvement or community outreach and leveraging community health improvement efforts.

Attachment B, Logic Model, outlines an approach to reaching project goals.

The required elements of the Proposal include:

1. Collect and provide baseline and outcome data
 - Team participation in monthly educational and skill –based webinars and/or conference calls in monthly meetings to develop and implement clinic specific action plans, workflow and systems related to strategies
2. Develop and maintain hypertension (year1) and pre-diabetes (year2)registries
3. Implement evidence-based guidelines for hypertension treatment
4. Provide team-based care that includes:
 - Referral and follow-up with clinic care team
 - Patient education and self-management strategies for hypertension and pre-diabetes
 - Blood pressure self-management
 - Incorporate non-physician team members (pharmacists and community health workers) into the project.

The required elements are described in more detail below.

Clinics or organizations (with more than one participating clinic) are encouraged to implement these activities over the course of the project period using a phased-in approach as appropriate. Baseline and project data collection activities must begin during year 1. Clinics can propose to begin with a hypertension registry in year 1 and add the pre-diabetes registry in year 2 or they can develop the registries simultaneously.

Clinics, including multi-clinic organizations, will participate in regular webinars and conferences organized by Minnesota Department of Health and Stratis Health to receive education and skill-building assistance on implementing evidence–based guidelines on hypertension control and pre-diabetes.

1. Baseline data collection

The clinics will submit baseline data on all measures described in Figure 1.

Figure 1: Clinical Quality Measures

#	Measure	Description
1	Controlling High Blood Pressure (NQF 0018)	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
2	Presence of a Hypertension Self-Management Plan	Percentage of patients with high blood pressure who have documentation of a self-management plan within the past 12 months.
3	Undiagnosed Hypertension	Percentage of adult patients whose most recent blood pressure is elevated and do not have a hypertension diagnosis.
4	Body Mass Index (BMI) Screening and Follow-Up (NQF 0421)	Percentage of adult patients with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.
5	Tobacco Use: Screening & Cessation Intervention (NQF 0028)	Percentage of adult patients who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.
6	Prediabetes: Screening and Diagnosis	Percentage of adult patients screened for diabetes with a lab value in the pre-diabetic range [HbA1c (5.7-6.4); Fasting Plasma Glucose (100-125)] Who have a documented pre-diabetes diagnosis?
7	Referrals to Lifestyle-change programs	Number of persons with high blood pressure who are referred to an evidence-based lifestyle change program.

Clinics will submit annually required baseline data as an aggregated number of adult patients served annually, a de-identified patient level data set of all adult patients including the data elements for the healthy lifestyle/risk reduction to MDH. MDH will analyze the data and send clinics a data report. Potential data measures are mean systolic and diastolic blood pressure, control of blood pressure, and proportion of patients with documented follow up. MDH will work collaboratively to develop a data collection tool.

2. Develop Hypertension and Pre-diabetes Registries

A successful registry helps to determine gaps in care that requires practice redesign, monitors if patients are on track to achieve their therapeutic goals, supports tracking of follow – up visits and referrals, and provides a feed-back loop for self-monitoring patients to reduce their risks for developing heart disease, stroke, or diabetes.

In year 1, clinics will develop and implement a process that identifies and registers patients with undiagnosed hypertension; provides a feed-back loop for self-measured blood pressure monitoring; assists with clinical decision processes, and tracks referral and follow-up visits. In year 2, clinics will develop a registry of patients with pre-diabetes and referral and tracking of referrals to lifestyle change programs and follow-up. Clinics will decide the patient inclusion criteria for the registries.

3. Incorporate evidence-based guidelines for treatment

Clinics will make hypertension control a priority and ensure that the most recent clinical guidelines (JNC 8) have been adopted, approved by clinic leadership, and integrated into clinic operations. Standardized treatment protocols and other evidence-based interventions (i.e. pre-visit planning strategies, in-between appointment checks, equipment calibration, and patient education) are essential tools to improve patient care. As part of this requirement, clinics will evaluate compliance with these processes and provide regular feedback to the healthcare team.

4. Team-based Care

Clinics will need to assure that team-based care processes (i.e. medication management, patient follow-up and adherence, blood pressure self-monitoring and self-management support tools and resources, structured follow up mechanism) are used to improve hypertensive patient care and that staff members are trained to perform at their highest level.

Team-based care interventions typically include activities to:

- Facilitate communication and coordination of care support among various team members
- Enhance use of evidence-based guidelines by team members
- Establish regular, structured follow-up mechanisms to monitor patients' progress and schedule additional visits as needed
- Actively engage patients in their own care by providing them with education about hypertension medication, adherence support (for medication and other treatments), and tools and resources for self-management (including health behavior change

Engaged non-physician care team members (i.e. community health worker/patient navigator, pharmacist, nutritionist, physical therapist) provide enhanced hypertension care by performing tasks such as providing patient information and follow ups, medication management therapy, blood pressure monitoring, community outreach to promote health literacy, health care navigation and nutrition and physical activity counseling.

With this funding, clinics will develop systems and policies to establish and/or improve:

a) Medical clinic follow-up

The clinics will develop an organized system of regular follow-up and review of patients with hypertension and will establish a follow-up visit protocol for patients with hypertension to increase adherence to treatment.

b) Provide patient education and self-management training

Clinics will develop a process to ensure that patient education and self-management are delivered in culturally and linguistically appropriate ways through patient educators, health coaches, or

Community health workers with linkages to community resources and, when appropriate, to the Diabetes Prevention Program.

c) Self-measured blood pressure monitoring

Home blood pressure self-monitoring plus clinical support successfully reduce morbidity and mortality due to high blood pressure. Self-monitoring of blood pressure is defined as the regular use of a personal blood pressure measurement device that is used by the patient outside a clinical setting to measure blood pressure at different points in times.

Clinics will provide blood pressure self-monitoring education (i.e. taking the blood pressure, record the readings, transmit the reading and following up with provider recommendations) by a designated trained team member for patients with high blood pressure as determined by the provider. A system will be put in place to allow patients to record their readings and assure correct transmission to the provider's office and to receive feedback on reported information. Please note that although patient self-monitoring of blood pressure is a grant requirement, grant funds cannot be used to purchase blood pressure monitors.

d) Community-Clinical Linkages -Engagement with Community Health Workers

Integrating community health workers into multidisciplinary health teams has emerged as an effective strategy for improving the control of hypertension and the prevention of type 2 diabetes. Core roles of CHWs could be:

- Bridging cultural differences between communities and healthcare providers
- Providing culturally appropriate health education and information
- Ensuring that people get access to care they need
- Administering health screening tests (blood pressure)
- Creating linkages to community resources
- Supporting patient self-management plans and individualized goal setting.

Clinics are encouraged to employ or contract for a community health worker (certified or uncertified). One potential contracting agency is Wellshare International. The community health workers need to be integrated into the care team to promote linkages between health systems and community resources, to provide self-management education on hypertension and pre-diabetes and to increase referrals and follow-up to evidence-based lifestyle change programs.

e) Community-Clinical Linkages -Engagement with Pharmacist

New collaborative care models identify pharmacists as important contributors to the healthcare team, and enhanced training equips pharmacists with necessary skills to provide a variety of preventive and wellness services, including:

- Medication therapy management (MTM),
- Screening for diabetes and cardiovascular disease,
- Health education for health risks and conditions such as hypertension, smoking cessation and weight management.

Clinics will incorporate a pharmacist (community pharmacist or pharmacy resident) to provide medication management therapy and medication education to increase patients' medication adherence.

Technical Assistance for Clinics

1. **The Minneapolis Health Department (MHD)** will assist clinics with practice facilitation/quality improvement coaching to help build organizational capacity for continuous improvement.
2. **Stratis Health** will work with clinics on quality improvement, change management, data collection and analysis for quality and performance measurement modifications to electronic health records (EHR) and practice facilitation. Specifically, Stratis Health will
 - Meet on site with clinic teams to provide direct technical assistance
 - Assist clinics in conducting an HIT assessment for each clinic that includes race, ethnicity, language (REL) documentation and provide EHR technical assistance such as creating patient lists to identify persons with undiagnosed high blood pressure or pre-diabetes
 - Help develop a feedback loops for self-measured blood pressure monitoring
 - Help with clinical decision support
 - Assist with tracking of referrals and follow-up
 - Work with the Minnesota Department of Health on a data collection plan for each clinic
3. **The Minnesota Department of Health (MDH)** will host and coordinate monthly webinars or conference calls for clinic teams and grantees to provide education and assist with skill building on implementing evidence-based guidelines on hypertension control and pre-diabetes.
4. **The University of Minnesota - College of Pharmacy** will provide support to clinics around engagement and use of community pharmacists. The College can help clinics identify a pharmacist or work with a pharmacy resident (if no on-staff pharmacist is available) to provide medication management therapy services to patients to increase medication adherence.
5. **The Minnesota Community Health Worker Alliance** will assist clinics with the engagement of community health workers.
6. **MDH Health Care Homes** will provide guidance for project alignment for certification or recertification.

The technical assistance will be provided at no charge to clinics. It is not necessary to include these costs in the budget.

Pre-application Considerations

Please review carefully the attached General Conditions for Requests for Proposals (Attachment C), and particularly the insurance requirements. Failure to maintain required insurance coverage may result in contract termination. Additional information may be required from agencies awarded funding, including but not limited to:

- DUNS number
- Agency organizational chart
- Agencies approved to receive funding in excess of \$50,000 per year (including all City contracts) must complete the City's Affirmative Action plan process prior to executing a contract.

Resources

Hypertension and Pre-diabetes Registry

<http://www.measureuppressure.com/HCPProf/Find/Toolkit/Plank6.pdf>

<http://www.nyc.gov/html/doh/downloads/pdf/chi/chi30-2.pdf>

Patient Education and Self-management Training

http://millionhearts.hhs.gov/Docs/MH_Protocol_Implementation.pdf

<http://millionhearts.hhs.gov/resources/protocols.html>

http://millionhearts.hhs.gov/Docs/MH_SMBP_Clinicians.pdf

<http://www.thecommunityguide.org/cvd/SETteambasedcare.pdf>

<http://www.thecommunityguide.org/cvd/cvd-AJPM-recs-team-based-care.pdf>

https://www.icsi.org/_asset/4qjdnr/HealthyLifestyles.pdf

Blood pressure self-monitoring

http://millionhearts.hhs.gov/Docs/MH_SMBP.pdf

<https://www.heart360.org/default.aspx>

Incorporate evidence-based guidelines for hypertension treatment

<http://www.clinicaladvisor.com/features/how-to-implement-hombpmonitoring/article/206808/>

<http://www.measureuppressure.com/HCPProf/toolkit.pdf>

<http://www.astho.org/Prevention/NY-Develops-Clinical-Pathway/>

<http://millionhearts.hhs.gov/Docs/Hypertension-Protocol.pdf>

Medical Clinic Follow-up

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3191684/>

http://millionhearts.hhs.gov/Docs/MH_SMBP_Clinicians.pdf

Medication Adherence

http://www.acpm.org/?page=MedAdherTT_ClinRef

http://millionhearts.hhs.gov/Docs/BP_Toolkit/TipSheet_HCP_MedAdherence.pdf

Community Health Workers and Pharmacists

<http://www.cdc.gov/dhdsp/pubs/chw-toolkit.htm>

http://www.cdc.gov/dhdsp/programs/spha/docs/1305_ta_guide_chws.pdf

http://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf

<http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1501TheExpandingRoleOfPharmacists.pdf>

Definitions

NQF 0018 - Controlling High Blood Pressure

Measure Description: The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator Statement:

The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Denominator Statement:

Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Exclusions:

Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

Exclude all patients with a diagnosis of pregnancy during the measurement year.

Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

NQF 0421 -BMI Screening and Follow-up

Measure Description: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or within the previous six months.

- Normal Parameters: Age 65 years and older BMI > or = 23 and < 30
- Age 18 – 64 years BMI > or = 18.5 and < 25

Numerator Statement:

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters

Denominator Statement:

All patients aged 18 years and older

Exclusions:

A patient is identified as a Denominator Exclusions (B) and excluded from the Total Denominator Population (TDP) in the Performance Denominator (PD) calculation if one or more of the following reason (s) exist:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)

- Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

Community-clinical linkages are connections between community and clinical sectors to improve population health. This definition allows for flexibility for community-clinical linkage interventions to be applied to all public health areas and focus on the unique contribution that each sector brings to improving population health.

Community Health Workers (CHWs) are members of a community who have been shown to serve as a liaison between diverse ethnic, cultural, low-income or geographic communities and health care service providers. CHWs may also be referred to as promotor(a) de salud or health promoter, community care coordinator, community health information specialist, lay health advisor, community health advocate/educator or community outreach worker.

Community Pharmacists are pharmacists who are working in community settings (e.g., a chain or independent retail pharmacy) rather than in health care systems.

Priority Populations

- Priority Populations are those population subgroups with uncontrolled high blood pressure or at risk for type-2 diabetes who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, or low income.)
- Asian American
- Black or African American
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- American Indian and Alaska Native

(CDC - Office of Minority Health)

ATTACHMENT A-1
Process and Care Improvements for Hypertension and Pre-diabetes Management
PROPOSAL COVERSHEET

Name of Applicant Agency		
Agency Telephone Number		
Agency Address		
Agency Website		
Contact Person Name and Title		
E-mail Address		
Phone Number		
Sites (Names and Addresses) where the project will be implemented		
Number and percent of patients diagnosed with controlled and uncontrolled hypertension within each clinic (estimates are okay)	Controlled	
	Uncontrolled	
Number and percent of patients with pre-diabetes (if available, estimate is okay). If applying as a network of clinics, please answer by clinic.		
Total Dollar Amount Requesting	\$	

Checklist of attached documents:

Proposal (original + six copies)

_____ Application narrative (maximum 7 pages)

_____ A-2 Work plan Form is required

_____ A-3 Budget and Budget justification. Form is suggested, not required.

Administrative Documents (only one set required)

_____ Most recent audit and management letter (or financial statements for past three years)

_____ IRS determination letter for 501(c) (3) not-for-profit agencies

ATTACHMENT A-2
Process and Care Improvements for Hypertension and Pre-diabetes Management
Project Work plan

SMART Objectives (1 to 3 for each element)	Responsible Party(is)	Activities/Strategies	Timeline	Deliverable (Year 1 and 2)
Data collection (baseline and ongoing)				
HTN and Pre-diabetes Registries				
Evidence -Based Treatment Guidelines				
Team based Care (Clinical Follow-Up, Patient Education / Self-Management, Self-Monitored Blood Pressure)				
Community- Clinical Linkages (Engagement of a CHW and Pharmacist)				

Definition -SMART Objective
S - specific, significant, stretching
M - measurable, meaningful, motivational
A - agreed upon, attainable, achievable, acceptable, action-oriented
R - realistic, relevant, reasonable, rewarding, results-oriented
T - time-based, time-bound, timely, tangible, trackable

ATTACHMENT A-3

Process and Care Improvements for Hypertension and Pre-diabetes Management Budget

Revenues	Year 1 Amount	Year 2 Amount	Total
Proposed funding (this request)			
In-kind (not required)			
Fee-for-service (if applicable)			
Other			
TOTAL	\$	\$	\$

Expense Item	Year 1 Amount	Year 2 Amount	Total
Personnel			
Contractual			
E.H.R. Modifications			
Supplies & Materials			
Training			

Overhead (</= 10%)			
TOTAL	\$	\$	\$

Budget Justification

Please provide detailed justification for each line item.

PERSONNEL (SALARY/WAGES)

For all individuals funded by the grant identify title, FTE, and their role on the project and their qualifications for this role. Justify the time allocated to the project for each individual (e.g., explain why a full-time position is needed, or a quarter-time position is adequate, to accomplish the assigned responsibilities).

FRINGE BENEFITS

For the amount provided in the table, indicate whether the calculation was based on an across-the-board fringe benefits rate used by your agency (e.g., 25% of salary), or whether it was computed based on actual fringe costs for each individual. Identify what benefits are included (e.g., health insurance, dental insurance, life or disability insurance, FICA, pension, etc.)

OTHER EXPENSES (Modify subheads to match subheads used in budget table.)

Mileage - Describe the purpose for the travel; provide the numbers of miles and mileage rate used.

Supplies - Describe the supplies and their applicability to the project.

Printing - Estimate costs for printing or photocopying and explain how the amount was derived.

Postage/courier - *If mailing costs are expected to be more than a minimal amount, provide an explanation for the amount requested.*

Space costs - *If agency space will be charged to the grant, explain how the percentage of overall space allocated to the project was determined. If new space will be rented for the project, identify the location and monthly charge.*

Other (specify) - *add an explanation for any other categories identified in the budget table.*

CONTRACTUAL COSTS

Identify any subcontractors that will be used for the project. Identify how they were or will be selected, and their qualifications and experience relative to the proposed project. If you use consultants, specify the hourly rate and the numbers of hours allocated.

ADMINISTRATIVE COSTS

Specify the rate used (not to exceed 10% of the total direct costs) and indicate what agency costs are covered by the rate.

ATTACHMENT B
Process and Care Improvements for Hypertension and Pre-diabetes Management
Logic Model - A Strategic Planning Tool

STRATEGIES	SHORT-TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Health systems interventions to improve quality of healthcare delivery to populations with HTN and pre-diabetes	Reduce morbidity and mortality risk for hypertensive and diabetic patients		
Collect and Report Data			
<i>Collect baseline Adult Healthy Lifestyle/Risk Reduction Measure Set and National Quality Measures for MDH</i> <ul style="list-style-type: none"> Monitor and assess modifiable risk factors for pre-diabetics Submit Adult Healthy Lifestyle/Risk Reduction Measure sets, NQF0018, NQF00421 and a pre-diabetic measure (TBD) Participation of designated members in monthly webinars and conferences <i>Ongoing data collection and reporting</i> <ul style="list-style-type: none"> Submit data as determined to MDH Work collaboratively with MDH and Stratis MDH and clinics will work collaboratively to develop a data collection tool 	Assessment of modification and updating needs of electronic health records Data collection	Improved quality of care and delivery of care monitoring	
Implement standardized treatment protocols and evidence based interventions	Increased usage of evidence based protocols and improvements in patient care		Improvements in patient outcomes
<i>Develop patient registries for hypertension and pre-diabetes (years 2-3)</i> <ul style="list-style-type: none"> Identify target population Set up parameters for registry Set up registry Register patients, populate and maintain Provide team members access to registry <i>Incorporate evidence-based guidelines for treatment</i> <ul style="list-style-type: none"> Implement /update clinical decision support system for the treatment and management of hypertension (JNC8) Ensure compliance with hypertension treatment guidelines by staff <i>Team-based Care</i> <p>A. Medical Clinic Follow-up</p> <ul style="list-style-type: none"> Facilitate communication and coordination of care support among team members Establish clinic follow up visit protocols/systems for patient and team members Establish protocol/system to monitor care plan that was created with the patient 	Identification of registry criteria and parameters Assessment of compliance and adherence to clinical support systems Assessment of the quality of care, delivery	Increased monitoring of patients with undiagnosed and uncontrolled high blood pressure and improvement in patient management Increased compliance	↓ patients with uncontrolled hypertension and Pre-diabetes

STRATEGIES	SHORT-TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
<p>and identifies patient-led goals</p> <ul style="list-style-type: none"> Establish protocols to actively engage patient in the care decision making process and provide education and linkages to resources Evaluate compliance and provide regular feed back to health care team <p>B. Patient education and life style change management</p> <ul style="list-style-type: none"> Protocol for patient centered care plan for patients with hypertension and/or pre-diabetes Culturally and linguistically appropriate patient education on self-management Patient referrals to community resources for lifestyle change classes <p>C. Blood pressure self-monitoring</p> <ul style="list-style-type: none"> Protocol for blood pressure education and self-monitoring System/protocol for follow-up and reporting Monitoring improvement indicators for patients with uncontrolled hypertension 	<p>of care , team training needs, team expectations</p>	<p>and adherence to team based care protocols</p> <p>Increased numbers of education sessions offered and patients enrolled in life style modification classes</p> <p>Increased rates of patients self-monitoring BP</p>	<p>↑ Smoking cessation</p> <p>↓ BMI</p> <p>↓ patients with uncontrolled hypertension</p>
<p>Community -Clinical linkages with CHW and Pharmacist</p>		<p>Increased patient education and self-management</p>	<p>Improved patient outcomes</p>
<ul style="list-style-type: none"> Hire/contract/engage through CHW provider organizations with CHW for internal and external patient education strategies Assure engagement of CHW with internal and/or external pharmacist Pharmacists provide medication therapy management and education CHW's provide assistance to pharmacists and health care team Develop protocol for CHW's outreach engagements Develop protocol for collaborative engagements with pharmacist (if applicable) 	<p>Assessment of outreach needs and opportunities</p>	<p>Increased rates of referrals to community resources</p> <p>Increased patient education opportunities</p> <p>Established medication adherence plan</p>	<p>↓ patients with uncontrolled hypertension</p> <p>↑ Medication adherence</p>

ATTACHMENT C

General Conditions for Request For Proposals (RFP)

(Revised: May, 2015)

The General Conditions are terms and conditions that the City expects all of its Consultants to meet. The Consultant agrees to be bound by these requirements unless otherwise noted in the Proposal. The Consultant may suggest alternative language to any section at the time it submits its response to this RFP. Some negotiation is possible to accommodate the Consultant's suggestions.

1. City's Rights

The City reserves the right to reject any or all proposals or parts of proposals, to accept part or all of proposals on the basis of considerations other than lowest cost, and to create a project of lesser or greater expense and reimbursement than described in the Request for Proposal, or the respondent's reply based on the component prices submitted.

2. Equal Opportunity Statement

The Consultant agrees to comply with applicable provisions of applicable federal, state and city regulations, statutes and ordinances pertaining to the civil rights and non-discrimination in the application for and employment of applicants, employees, subcontractors and suppliers of the Consultant. Among the federal, state and city statutes and ordinances to which the Consultant shall be subject under the terms of this Contract include, without limitation, Minnesota Statutes, section 181.59 and Chapter 363A, Minneapolis Code of Ordinances Chapter 139, 42 U.S.C Section 2000e, et. seq. (Title VII of the Civil Rights Act of 1964), 29 U.S.C Sections 621-624 (the Age Discrimination in Employment Act), 42 U.S.C Sections 12101-12213 (the Americans with Disability Act or ADA), 29 U.S.C Section 206(d) (the Equal Pay Act), 8 U.S.C Section 1324 (the Immigration Reform and Control Act of 1986) and all regulations and policies promulgated to enforce these laws. The Consultant shall have submitted and had an "affirmative action plan" approved by the City prior to entering into a Contract.

3. Insurance

Insurance secured by the Consultant shall be issued by insurance companies acceptable to the City and admitted in Minnesota. The insurance specified may be in a policy or policies of insurance, primary or excess. Such insurance shall be in force on the date of execution of the Contract and shall remain continuously in force for the duration of the Contract.

Acceptance of the insurance by the City shall not relieve, limit or decrease the liability of the Consultant. Any policy deductibles or retention shall be the responsibility of the Consultant. The Consultant shall control any special or unusual hazards and be responsible for any damages that result from those hazards. The City does not represent that the insurance requirements are sufficient to protect the Consultant's interest or provide adequate coverage. Evidence of coverage is to be provided on a current ACORD Form. A thirty (30) day written notice is

required if the policy is canceled, not renewed or materially changed. The Consultant shall require any of its subcontractors, if sub-contracting is allowable under this Contract, to comply with these provisions, or the Consultant will assume full liability of the subcontractors.

The Consultant and its subcontractors shall secure and maintain the following insurance:

- a) **Workers Compensation** insurance that meets the statutory obligations with Coverage B-Employers Liability limits of at least \$100,000 each accident, \$500,000 disease - policy limit and \$100,000 disease each employee.
- b) **Commercial General Liability** insurance with limits of at least \$2,000,000 general aggregate, \$2,000,000 products - completed operations \$2,000,000 personal and advertising injury, \$100,000 each occurrence fire damage and \$10,000 medical expense any one person. The policy shall be on an "occurrence" basis, shall include contractual liability coverage and the City shall be named an additional insured. The amount of coverage will be automatically increased if the project amount is expected to exceed \$2,000,000 or involves potentially high risk activity.
- c) **Commercial Automobile Liability** insurance covering all owned, non-owned and hired automobiles with limits of at least \$1,000,000 per accident.
- d) **Professional Liability** Insurance or Errors & Omissions Insurance providing coverage for 1) the claims that arise from the errors or omissions of the Consultant or its subcontractors and 2) the negligence or failure to render a professional service by the Consultant or its subcontractors. The insurance policy should provide coverage in the amount of \$2,000,000 each claim and \$2,000,000 annual aggregate. The insurance policy must provide the protection stated for two years after completion of the work.

4. **Hold Harmless**

The Consultant will defend, indemnify and hold harmless the City and its officers and employees from all liabilities, claims, damages, costs, judgments, lawsuits and expenses, including court costs and reasonable attorney's fees regardless of the Consultant's insurance coverage, arising directly from any negligent act or omission of the Consultant, its employees, agents, by any sub-contractor or sub-consultant, and by any employees of the sub-contractors and sub-consultants of the Consultant, in the performance of work and delivery of services provided by or through this Contract or by reason of the failure of the Consultant to perform, in any respect, any of its obligations under this Contract.

The City will defend, indemnify and hold harmless the Consultant and its employees from all liabilities, claims, damages, costs, judgments, lawsuits and expenses including court costs and reasonable attorney's fees arising directly from the negligent acts and omissions of the City by reason of the failure of the City to perform its obligations under this Contract. The provisions of the Minnesota Statutes, Chapter 466 shall apply to any tort claims brought against the City as a result of this Contract.

Except as provided in section # 13, neither party will be responsible for or be required to defend any consequential, indirect or punitive damage claims brought against the other party.

5. Subcontracting

The Consultant shall provide written notice to the City and obtain the City's authorization to sub-contract any work or services to be provided to the City pursuant to this Contract. As required by Minnesota Statutes, Section 471.425, the Consultant shall pay all subcontractors for subcontractor's undisputed, completed work, within ten (10) days after the Consultant has received payment from the City.

6. Assignment or Transfer of Interest

The Consultant shall not assign any interest in the Contract, and shall not transfer any interest in the same either by assignment or novation without the prior written approval of the City. The Consultant shall not subcontract any services under this Contract without prior written approval of the City Department Contract Manager designated herein.

7. General Compliance

The Consultant agrees to comply with all applicable Federal, State and local laws and regulations governing funds provided under the Contract.

8. Performance Monitoring

The City will monitor the performance of the Consultant against goals and performance standards required herein. Substandard performance as determined by the City will constitute non-compliance with this Contract. If action to correct such substandard performance is not taken by the Consultant within a reasonable period of time to cure such substantial performance after being notified by the City, Contract termination procedures will be initiated. All work submitted by Consultant shall be subject to the approval and acceptance by the City Department Contract Manager designated herein. The City Department Contract Manager designated herein shall review each portion of the work when certified as complete and submitted by the Consultant and shall inform the Consultant of any apparent deficiencies, defects, or incomplete work, at any stage of the project.

9. Prior Uncured Defaults

Pursuant to Section 18.115 of the City's Code of Ordinances, the City may not contract with persons or entities that have defaulted under a previous contract or agreement with the City and have failed to cure the default.

10. Independent Consultant

Nothing contained in this Contract is intended to, or shall be construed in any manner, as creating or establishing the relationship of employer/employee between the parties. The Consultant shall at all times remain an independent Consultant with respect to the work and/or services to be performed under this Contract. Any and all employees of Consultant or other persons engaged in the performance of any work or services required by Consultant under this

Contract shall be considered employees or subcontractors of the Consultant only and not of the City; and any and all claims that might arise, including Worker's Compensation claims under the Worker's Compensation Act of the State of Minnesota or any other state, on behalf of said employees or other persons while so engaged in any of the work or services to be rendered or provided herein, shall be the sole obligation and responsibility of the Consultant.

11. Accounting Standards

The Consultant agrees to maintain the necessary source documentation and enforce sufficient internal controls as dictated by generally accepted accounting practices (GAAP) to properly account for expenses incurred under this Contract.

12. Retention of Records

The Consultant shall retain all records pertinent to expenditures incurred under this Contract in a legible form for a period of six years commencing after the later of contract close-out or resolution of all audit findings. Records for non-expendable property acquired with funds under this Contract shall be retained for six years after final disposition of such property.

13. Data Practices

The Consultant agrees to comply with the Minnesota Government Data Practices Act (Minnesota Statutes, Chapter 13) and all other applicable state and federal laws relating to data privacy or confidentiality. The Consultant and any of the Consultant's sub-consultants or sub-contractors retained to provide services under this Contract shall comply with the Act and be subject to penalties for non-compliance as though they were a "governmental entity." The Consultant must immediately report to the City any requests from third parties for information relating to this Contract. The City agrees to promptly respond to inquiries from the Consultant concerning data requests. The Consultant agrees to hold the City, its officers, and employees harmless from any claims resulting from the Consultant's unlawful disclosure or use of data protected under state and federal laws.

All Proposals shall be treated as non-public information until the Proposals are opened for review by the City. At that time, the names of the responders become public data. All other data is private or non-public until the City has completed negotiating the Contract with the selected Consultant(s). At that time, the proposals and their contents become public data under the provisions of the Minnesota Government Data Practices Act, Minnesota Statutes, Chapter 13 and as such are open for public review.

14. Inspection of Records

Pursuant to Minnesota Statutes, Section 16C.05, all Consultant records with respect to any matters covered by this Contract shall be made available to the City and the State of Minnesota, Office of the State Auditor, or their designees upon notice, at any time during normal business hours, as often as the City deems necessary, to audit, examine, and make excerpts or transcripts of all relevant data.

15. Living Wage Ordinance

The Consultant may be required to comply with the “[Minneapolis Living Wage and Responsible Public Spending Ordinance](http://www.minneapolismn.gov/www/groups/public/@finance/documents/webcontent/convert_255695.pdf)” (http://www.minneapolismn.gov/www/groups/public/@finance/documents/webcontent/convert_255695.pdf), Chapter 38 of the City’s Code of Ordinances (the “Ordinance”). Unless otherwise exempt from the ordinance as provided in Section 38.40 (c), any City contract for services valued at \$100,000 or more or any City financial assistance or subsidy valued at \$100,000 or more will be subject to the Ordinance’s requirement that the Consultant and its subcontractors pay their employees a “living wage” as defined and provided for in the Ordinance.

16. Applicable Law

The laws of the State of Minnesota shall govern all interpretations of this Contract, and the appropriate venue and jurisdiction for any litigation which may arise hereunder will be in those courts located within the County of Hennepin, State of Minnesota, regardless of the place of business, residence or incorporation of the Consultant.

17. Conflict and Priority

In the event that a conflict is found between provisions in this Contract, the Consultant's Proposal or the City's Request for Proposals, the provisions in the following rank order shall take precedence: 1) Contract; 2) Proposal; and last 3) Request for Proposals (only for Contracts awarded using RFP).

18. Travel

If travel by the Consultant is allowable and approved for this Contract, then Consultant travel expenses shall be reimbursed in accordance with the City’s [Consultant Travel Reimbursement Conditions](http://www.minneapolismn.gov/www/groups/public/@finance/documents/webcontent/wcms1p-096175.pdf) (<http://www.minneapolismn.gov/www/groups/public/@finance/documents/webcontent/wcms1p-096175.pdf>).

19. Billboard Advertising

City Code of Ordinance 544.120, prohibits the use of City and City-derived funds to pay for billboard advertising as a part of a City project or undertaking.

20. Conflict of Interest/Code of Ethics

Pursuant to Section 15.250 of the City’s Code of Ordinances, both the City and the Consultant are required to comply with the City’s Code of Ethics. Chapter 15 of the Code of Ordinances requires City officials and the Consultant to avoid any situation that may give rise to a “conflict of interest.” A “conflict of interest” will arise if Consultant represents any other party or other client whose interests are adverse to the interests of the City.

As it applies to the Consultant, the City's Code of Ethics will also apply to the Consultant in its role as an "interested person" since Consultant has a direct financial interest in this Agreement. The City's Code of Ethics prevents "interested persons" from giving certain gifts to employees and elected officials.

21. Termination, Default and Remedies

The City may cancel this Contract for any reason without cause upon thirty (30) days' written notice. Both the City and the Consultant may terminate this Contract upon sixty (60) days' written notice if either party fails to fulfill its obligations under the Contract in a proper and timely manner, or otherwise violates the terms of this Contract. The non-defaulting party shall have the right to terminate this Contract, if the default has not been cured after ten (10) days' written notice or such other reasonable time period to cure the default has been provided. If termination shall be without cause, the City shall pay Consultant all compensation earned to the date of termination. If the termination shall be for breach of this Contract by Consultant, the City shall pay Consultant all compensation earned prior to the date of termination minus any damages and costs incurred by the City as a result of the breach. If the Contract is canceled or terminated, all finished or unfinished documents, data, studies, surveys, maps, models, photographs, reports or other materials prepared by the Consultant under this Contract shall, at the option of the City, become the property of the City, and the Consultant shall be entitled to receive just and equitable compensation for any satisfactory work completed on such documents or materials prior to the termination.

Notwithstanding the above, the Consultant shall not be relieved of liability to the City for damages sustained by the City as a result of any breach of this Contract by the Consultant. The City may, in such event, withhold payments due to the Consultant for the purpose of set-off until such time as the exact amount of damages due to the City is determined. The rights or remedies provided for herein shall not limit the City, in case of any default by the Consultant, from asserting any other right or remedy allowed by law, equity, or by statute. The Consultant has not waived any rights or defenses in seeking any amounts withheld by the City or any damages due the Consultant.

22. Ownership of Materials

All finished or unfinished documents, data, studies, surveys, maps, models, photographs, reports or other materials resulting from this Contract shall become the property of the City upon the City's payment for and final approval of the final report or upon payment and request by the City at any time before then. The City at its own risk, may use, extend, or enlarge any document produced under this Contract without the consent, permission of, or further compensation to the Consultant.

23. Intellectual Property

All Work produced by the Consultant under this Contract is classified as "work for hire" and upon payment by the City to the Consultant will be the exclusive property of the City and will be surrendered to the City immediately upon completion, expiration, or cancellation of this

Contract. “Work” covered includes all reports, notes, studies, photographs, designs, drawings, specifications, materials, tapes or other media and any databases established to store or retain the Work. The Consultant may retain a copy of the work for its files in order to engage in future consultation with the City and to satisfy professional records retention standards. The Consultant represents and warrants that the Work does not and will not infringe upon any intellectual property rights of other persons or entities.

Each party acknowledges and agrees that each party is the sole and exclusive owner of all right, title, and interest in and to its services, products, software, source and object code, specifications, designs, techniques, concepts, improvements, discoveries and inventions including all intellectual property rights thereto, including without limitations any modifications, improvements, or derivative works thereof, created prior to, or independently, during the terms of this Contract. This contract does not affect the ownership of each party’s pre-existing, intellectual property. Each party further acknowledges that it acquires no rights under this Contract to the other party’s pre-existing intellectual property, other than any limited right explicitly granted in this Contract.

24. Equal Benefits Ordinance

Minneapolis Code of Ordinances, Section 18.200, relating to equal benefits for domestic partners, applies to each Consultant and subcontractor with 21 or more employees that enters into a “contract”, as defined by the ordinance that exceeds \$100,000. The categories to which the ordinance applies are personal services; the sale or purchase of supplies, materials, equipment or the rental thereof; and the construction, alteration, repair or maintenance of personal property. The categories to which the ordinance does not apply include real property and development contracts.

Please be aware that if a “contract”, as defined by the ordinance, initially does not exceed \$100,000, but is later modified so the Contract does exceed \$100,000, the ordinance will then apply to the Contract. A complete text of the ordinance is available at:

http://www.minneapolismn.gov/www/groups/public/@finance/documents/webcontent/convert_261694.pdf

It is the Consultant’s and subcontractor’s responsibility to review and understand the requirements and applicability of this ordinance.

25. City Ownership and Use of Data

The City has adopted an Open Data Policy (“Policy”). The City owns all Data Sets as part of its compliance with this Policy. Data Sets means statistical or factual information: (a) contained in structural data sets; and (b) regularly created or maintained by or on behalf of the City or a City department which supports or contributes to the delivery of services, programs, and functions. The City shall not only retain ownership of all City Data Sets, but also all information or data created through the City’s use of the software and /or software applications licensed by the Consultant (or any subcontractor of sub-consultant of the Consultant) to the City.

The City shall also retain the right to publish all data, information and Data Sets independently of this Contract with the Consultant and any of Consultant's subcontractors or sub-consultants involved in providing the Services, using whatever means the City deems appropriate.

The City shall have the right to access all data, regardless of which party created the content and for whatever purpose it was created. The Consultant shall provide bulk extracts that meet the public release criteria for use in and within an open data solution. The Consultant shall permit and allow free access to City information and Data Sets by using a method that is automatic and repeatable. The Data Sets shall permit classification at the field level in order to exclude certain data.

26. Small & Underutilized Business Program (SUBP) Requirements

There are no SUBP goals on this RFP. However, if there are subcontracting opportunities later identified, Consultant shall inform the Contract Manager to obtain authorization as stated under #5 of the Terms and Conditions. Consultant shall take action to afford MBEs and WBEs full and fair opportunities to compete on this contract and resulting subcontracts. To locate certified MBEs and WBEs under the Minnesota Uniform Certification Program (MnUCP), please visit <http://mnucp.metc.state.mn.us/> or contact contractcompliance@minneapolismn.gov.