Request for Proposals for Qualified Vendor to Provide Community Health Needs and Assets Assessment Services

Publication Date: July 15, 2021

IMPORTANT DATES

Thursday, July 15, 2021	RFP Released
Friday, July 30, 2021	Last day to submit RFP questions (by 5:00pm CT)
Friday, August 13, 2021	Proposals due by 5:00pm CT
Friday, August 20, 2021	Applicants notified of decision
September 1, 2021	Agreement begins

Minnesota Community Care
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www.mncare.org

For more information, contact:

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PART 1: RFP OVERVIEW

1.1 General Information

Minnesota Community Care is a federally qualified health center (FQHC) as funded by the Bureau of Primary Health Care (BPHC), Health Services and Resources Administration (HRSA).

- **Announcement Title:** Request for Proposals for Qualified Vendor to Provide Community Health Needs and Asset Assessment Services
- **Application Deadline:** Friday, August 13, 2021 by 5:00pm Central Time
- RFP available at: www.mncare.org > About Us > News & Events

1.2 General Information

Minnesota Community Care (mncare.org) is seeking Proposals from qualified Responders to provide Community Health Needs and Asset Assessment (CHNAA) services. The term of any resulting Agreement is anticipated to be from September, 2021 to August, 2022 (12 months), contingent on satisfactory vendor performance and funding availability.

Proposals must be submitted by 5:00pm Central Time on **Friday, August 13, 2021**. This RFP does not obligate Minnesota Community Care to enter into an Agreement, and Minnesota Community Care reserves the right to cancel this solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by the Responder.

1.3 Eligible Applicants

Eligible applicants include any vendor with demonstrable experience and skill in providing services, as described.

Priority will be given to vendors who are:

- Led by[1] Black, indigenous, people of color (BIPOC) and serving BIPOC communities; and
- Aligned with Minnesota Community Care's mission, values, and equity statement (refer to Part 2).

Collaboration among individuals, organizations, or entities is welcome, but not required. A single application should be submitted on behalf of all partners in the collaboration. Applicants who wish to work together but have not formed a legal partnership must designate one organization as a fiscal agent.[2]

[1] "*Led by*" defined as more than 50% of the Board, leadership, and staff identify as BIPOC.

[2] A **fiscal agent** is an organization that assumes full legal and contractual responsibility for the fiscal management and award conditions of the Professional Services Agreement and has authority to sign the agreement. A fiscal agent is often a different entity from the operating organization (which performs the work). In a multi-entity collaboration, one entity must be designated as the fiscal agent.

PART 2: ORGANIZATIONAL OVERVIEW

2.1 Our Mission and Values

Our Mission Statement: Strengthening the well-being of our community through health care for all.

Our Values: At Minnesota Community Care, we…

- Put the patient first. We partner with and care for our patients by seeking to understand the world through their eyes and empowering all employees to put our patients first.
- Champion equity. We value diversity, equity and inclusion through our advocacy, workplace practices, policies, and efforts towards equitable access to health-related services.
- Uplift people. Through a culture of respect, collaboration, and creativity we empower the best in each other. We uplift each other, our patients, and community members. We value all people, honoring each individual's dignity, unique strengths, and challenges with a mutual respect for all.

2.2 Our Equity Statement

At Minnesota Community Care, we partner to impact systemic barriers to health access. Guided by this commitment:

> We believe that healthcare is a fundamental human right, and aspire to the elimination of health inequities so communities can flourish.
>
> We actively champion the equitable distribution of resources and opportunities in our organization and our communities.
>
> We see diversity, the differences among us, as an asset to be appreciated, uplifted, and celebrated.
>
> We value the lived experiences of our diverse communities that craft the spirit of our inclusive organization.
>
> We affirm that in order to succeed we must honor the diverse voices and stories of those we serve and those that serve.
>
> We strive to align our policies, practices, and resources so that all people have authentic opportunities to thrive.
>
> We cultivate an environment in which all people feel safe to bring their full selves.

Our dedication to diversity, equity and inclusion deepens our community relevance, value, and effectiveness, and underlies our mission *to strengthen the well-being of our community through health care for all*.

2.3 Our History

Since 1969, Minnesota Community Care has been a safety-net health care provider for historically marginalized and underserved communities. Our mission "to strengthen the well-being of our

community through health care for all" is inspired by a living history rooted in the push for health equity and the fight for the fundamental human right of access to health care for all. To impact health disparities, we focus on the incredibly complex and substantial barriers our communities face to leading health lives; we serve people throughout their lives and across generations; and we make our communities stronger in the process.

Minnesota Community Care first incorporated in 1972 as West Side Health Center. Co-located within Neighborhood House, we served 1,900 patients that year. Today, we are the largest federally qualified health center (FQHC) in Minnesota. With an annual operating budget of $30+ million, 400 employees, and over 100,000 square feet of service delivery space, we provide primary, specialty, behavioral/mental health, and oral health care, and enabling/supportive services to over 37,000 unduplicated individuals through 140,000 patient encounters annually in our service area (UDS, 2018). Our patients predominantly identify as people of color (87%), low-wealth (65% patients </= 100% FPL), and un/under-insured (39% patients uninsured, 48% patients publicly insured) (UDS, 2018). As a community health center, our service delivery sites are located within the communities we serve: in addition to two ambulatory care clinics (La Clinica, East Side Clinic) and a freestanding dental clinic (West Side Dental), we operate 10 school-based clinics, 3 co-located Health Care for the Homeless sites, and a co-located Public Housing Primary Care clinic (McDonough Homes Clinic).

Over our 50-year history, we have adapted and expanded our programs and services in response to the community's need for accessible and affordable health care: we initiated our Health Care for the Homeless program in 1987, launched our HouseCalls homeless prevention program in partnership with Ramsey County in 1992, opened a Public Housing Primary Care clinic in partnership with the St. Paul Public Housing Agency in 1993, started delivering Ryan White-funded HIV primary care services in 2000, opened onsite 340B pharmacies in 2002 (La Clinica) and 2008 (East Side Clinic), and acquired Health Start school-based clinics in 2003. Notably, Minnesota Community Care's network of 10 school-based clinics operating in 2019 grew out of the singular Maternal and Infant Cares Clinic co-located in St. Paul Mechanic Arts High School; opened by Ramsey Hospital in 1972, this clinic was the genesis of school-based health in Minnesota. Over the years, our response to community need has also included establishing dental services (1978), opening an expanded dental clinic (West Side Dental Clinic, 2001), and extending dental services to the East Side (2013) and Downtown (2018) neighborhoods in St. Paul.

Our historical reputation is as a fighter for the health of those less fortunate; building on this legacy we are proactively transitioning into a catalyst for "health for all" across Minnesota.

2.4 Our Service Area

Minnesota Community Care is one of three community health centers operating on the east side of the Mississippi River in the Twin Cities seven-county metropolitan area. Our service area (see Appendix A) incorporates all of Ramsey County, and portions of Dakota and Washington Counties. The defined service area has a population of 473,512 (2017).

With the addition of new service delivery sites in 2021, Minnesota Community Care's reach is expanding into the band of rural counties immediately south of the Twin Cities metropolitan area, namely Goodhue, Rice, and Scott counties.

PART 3: SCOPE OF WORK

We are seeking proposals for the delivery of Community Health Needs and Asset Assessment (CHNAA) services for an engagement not to exceed 12 months. Competitive applicants will align their professional services with the Key Community Recommendations listed in Appendix B.

3.1 Tasks and Deliverables

Applicants shall recommend a Scope of Work, including tasks, tollgates (milestones), and deliverables, based on its unique experience and expertise. At a minimum, however, deliverables shall include:

- Qualitative and quantitative assessment of strengths (assets) and unmet health needs of service area residents; and
- Targeted assessment of key populations in service area, namely: people experiencing homelessness, public housing residents, and school-aged youth (11-22 years).

3.2 Key Information

All applicants are requested to provide information on the following in their Proposal:

- Describe your research philosophy. How do you respect the autonomy and voice of those (i.e. individuals, communities) you research?
- Describe proposed methodology, strategies/tactics, and tools. In description, include recommended sample size(s) for any quantitative and/or qualitative data collection.
- How do you define equity? How does this definition get applied through your research philosophy and proposed methodology?

PART 4: RFP PROCESS

4.1 Application Deadline

All applications must be received by Minnesota Community Care no later than 5:00 p.m. Central Time on Friday, August 13, 2021.

Late applications will not be accepted. It is the applicant's sole responsibility to allow sufficient time to address all potential delays caused by any reason whatsoever. Minnesota Community Care will not be responsible for delays caused by computer or technology problems.

4.2 Submission Instructions

Applicants are **strongly encouraged** to submit applications via email to ckaigama@mncare.org with the subject line CHNAA Vendor Application – [insert applicant name].

Applicants who are unable to submit via email may submit their application via mail. If submitting by mail, please submit a single printed copy bound with a paper clip (do not staple). Applications submitted by mail should be sent to:

Minnesota Community Care
Attention: Paige A. Bowen
380 E. Lafayette Frontage Road, Suite 200
St. Paul, MN 55107

All mailed applications must be received by the deadline.

By submitting an application, each applicant warrants that the information provided is true, correct, and reliable for purposes of evaluation for potential Agreement. The submission of inaccurate or misleading information may be grounds for disqualification. All costs incurred in responding to this RFP will be borne by the applicant.

4.3 Responders' Questions

All questions regarding this RFP must be submitted in writing by 5:00pm Central Time on Friday, July 30, 2021. Please address all questions to: pbowen@mncare.org.

Answers to all questions received by the deadline will be answered and posted at mncare.org (see About Us > News & Events) no later than Friday, August 6, 2021.

4.4 Application Format

All applications must include:

1. Organizational capacity statement
2. Scope of work
3. 12-month work plan, including major milestones and metrics of success
4. CVs/Biographical Sketches of Project Staff
5. Project pricing (time, materials, and professional fees)
6. References and/or samples (minimum 3) of comparable work completed

Incomplete applications will not be considered or evaluated.

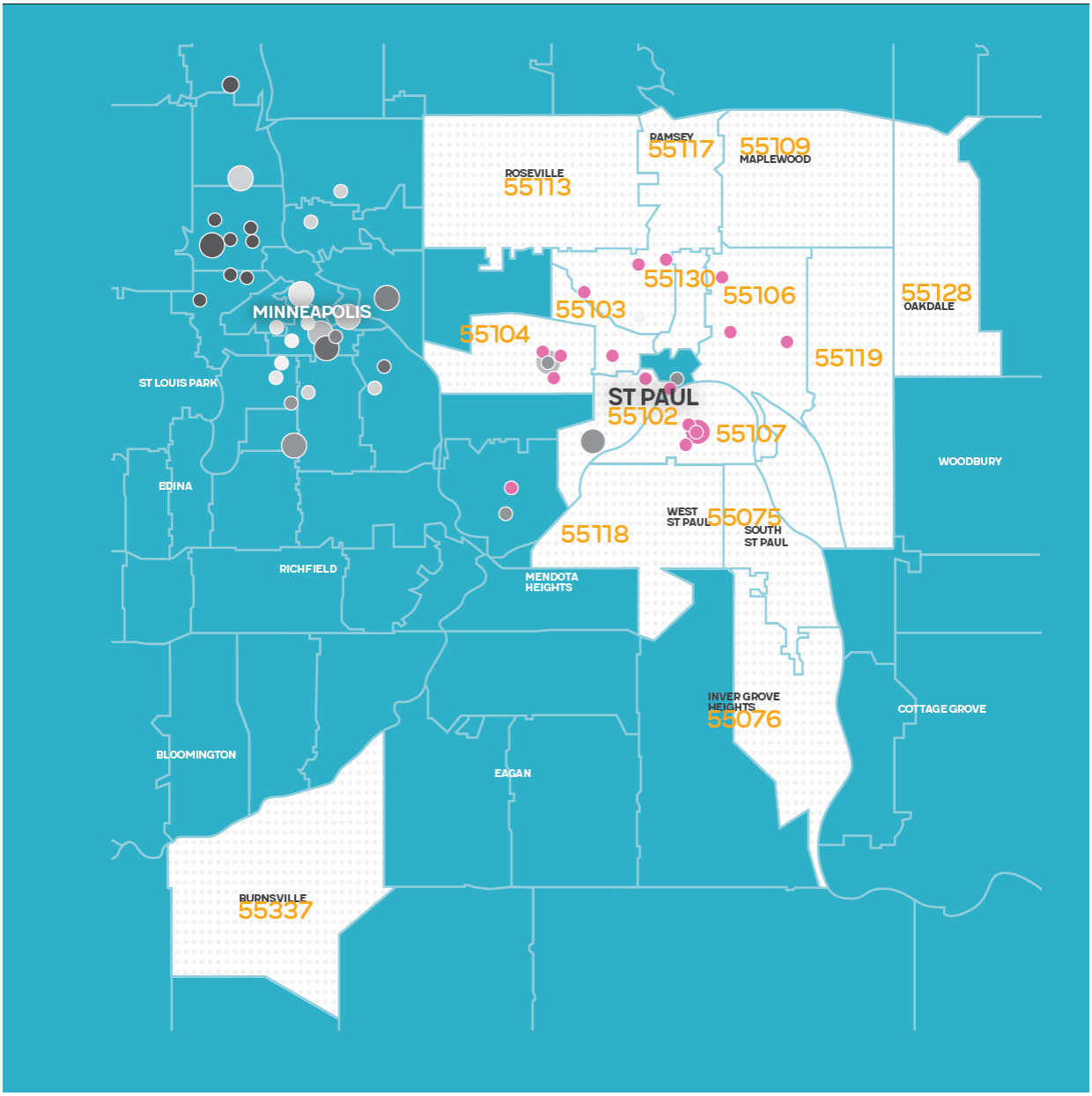
Applicants are welcome to use their preferred proposal formatting and software. The preferred file format is PDF; if you choose to submit in a different format, please confirm compatibility prior to submission (contact: pbowen@mncare.org).

4.5 Review and Selection Process

The successful Applicant will be selected through a competitive process. The Review Committee shall be Minnesota Community Care's Health Equity Design Partner and its Vice Presidents of Advancement; Population Health and Quality; and Equity, People, and Culture. The Review Committee will evaluate all eligible and complete applications received by the deadline. This review will include an initial screening for fit; short-listed vendors may be invited to interview, as deemed necessary by the Review Committee.

The Review Committee will develop a standardized scoring system to determine the extent to which the application meets the selection criteria. Cost, performance, and priority applicant status will be considered in these selection criteria. After scoring applications and conducting interviews (as applicable), the Review Committee will participate in a review meeting to collaboratively discuss applications. Reviewers will be able to modify their individual scores based on team discussions at this meeting. After this meeting, the Review Committee will make its final decision on all applications, and communicate as such to applicants by email by Friday, August 20, 2021.

APPENDIX A: SERVICE AREA MAP[3]



[3] UDS Mapper, 2019

APPENDIX B: KEY COMMUNITY RECOMMENDATIONS [4]

Minnesota Community Care should:

1. Honor the strength of and authentically partner with community-led organizations to confront health inequities and influence social determinants of health that impact the wellbeing of communities.
2. Go to where the community is, with staff who represent that community, to engage with communities about whole-body health promotion and education.
3. Engage with partners to hold the State accountable for its role in reinforcing and perpetuating structural racism and other forms of institutional discrimination, and to advocate for public policy that deconstructs racism, discrimination, and trauma.
4. Promote equitable access for marginalized communities to pursue careers in health care delivery and leadership.
5. Develop an equity plan that holds leadership accountable for measurable transformation.
6. (Re)design its physical spaces to be trauma-informed, culturally welcoming, inclusive environments to accommodate people from all communities.
7. Expand its applied definition of culturally-responsive care to include service delivery from a provider/patient shared understanding of health and wellness.
8. Provide ongoing, comprehensive training on bias and historical trauma that leads to an organizational culture shift.
9. Invest in building a workforce, contractor/vendor pool, and leadership team(s) that authentically represent the communities served.
10. Uplift its existing model for Community-Based Participatory Action Research to inform its models for quality, population health, and operations.
11. Actively seek to understand how individuals, families, and communities are impacted by social and structural determinants of health, and create respectful spaces for patients to share concerns and receive support.
12. Center health equity as an integral component of accountability to its Community Board and the communities it serves.
13. Apply a continuous timeline to its needs and assets assessments process.
14. Engage communities in designing community health improvement and/or action plans in response to findings from its needs and assets assessments.
15. Adopt policies and procedures that address structural racism, historical trauma, and social and structural determinants of health, and be accountable to its community-led Board of Directors to act upon such.
16. Design operational and clinical processes that respect each patient's time, lived experience, and social and structural determinants of health.
17. Identify and understand the barriers to access unique to each community served.
18. Provide patients with affordable, accessible healthcare, and connect eligible patients to insurance and public benefits.
19. Assure that no existing or future funding restricts access to care for any subset of the community.
20. Proactively reflect on where vulnerable communities live and/or spend time to identify new sites for service delivery, programming, and outreach.
21. Provide patient- and family-centered care that values a patient's personal and cultural definition of health and wellbeing, and a family's contribution to individual health.

[4] Minnesota Community Care, 2019 Community Health Needs and Assets Assessment

22. Develop operational policies and procedures that honor individual and familial cultural values, and that create safe spaces for patients to make decisions that promote health for themselves and their families.
23. Make data-informed operational and clinical decisions so that its care models are effective in reducing health disparities.
24. Understand the impact of integrated health care services, where people can receive support for multiple concerns in one place, and provide a “one-stop shop” for health, that includes physical, mental and dental health care, in order to improve overall patient and community health.