16085 DEC 28 2010

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

Received
DEC 27 2010
IDOA Contracts

Instructions for completing the EDS and the Contract process.

1. Please read the guidelines on the back of this form.
2. Please type all information.
3. Check all boxes that apply.
4. For amendments / renewals, attach original contract.
5. Attach additional pages if necessary.

TG
GW/2-11-11

1. EDS Number:	2. Date prepared:
A70-1-106037	11/8/2010

3. CONTRACTS & LEASES

___ Professional/Personal Services	___ Contract for procured Services
X Grant	___ Maintenance
___ Lease	___ License Agreement
___ Attorney	X Amendment# 1
___ MOU	___ Renewal #
___ QPA	___ Other

FISCAL INFORMATION

4. Account Number:	5. Account Name:
61910-94000.573100	ISDH DHHS Fund
6. Total amount this action: $73,913.00	7. New contract total: $96,376.00
8. Revenue generated this action: $0.00	9. Revenue generated total contract: $0.00

10. New total amount for each fiscal year :

Year 2010	$22,463.00
Year 2011	$73,913.00
Year	$
Year	$

TIME PERIOD COVERED IN THIS EDS

11. From (month, day, year):	12. To (month, day, year):
10/1/2010	12/31/2011

13. Method of source selection:
___ Bid/Quotation ___ Emergency X Negotiated
___ RFP# ___ Other *(specify)* ___ Special Procurement

AGENCY INFORMATION

14. Name of agency:	15. Requisition Number:
Department of Health	0000013273

16. Address: 2 N. Meridian Street, Indianapolis, IN 46204

AGENCY CONTACT INFORMATION

17. Name:	18. Telephone #:
Sarah Burkholder	317/233-7545

19. E-mail address: sburkholder@isdh.in.gov

COURIER INFORMATION

20. Name:	21. Telephone #:
Joseph Olivadoti	317/233-7573

22. E-mail address: jolivadoti@isdh.in.gov

VENDOR INFORMATION

23 Vendor ID # 0000075348

24. Name:	25. Telephone #:
INDIANA PUBLIC HEALTH ASSN	317-221-2392

26. Address: PO BOX 1705, INDIANAPOLIS, IN 46206

27. E-mail address: jking@inpha.org

28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) X Yes ___ No

29. Primary Vendor: M/WBE	30. If yes, list the %:
Minority: ___ Yes X No	Minority: ___ %
Women: ___ Yes X No	Women: ___ %
31 Sub Vendor:M/WBE	32. If yes, list the %:
Minority: ___ Yes X No	Minority: ___ %
Women: ___ Yes X No	Women: ___ %
33. Is there Renewal Language in the document? X Yes ___ No	34. Is there a "Termination for Convenience" clause in the document? X Yes ___ No

35. Will the attached document involve data processing or telecommunications systems(s)? ___ Yes: IOT or Delegate has signed off on contract

36. Statutory Authority *(Cite applicable Indiana or Federal Codes)*:
410 IAC 1-2.3

37. Description of work and justification for spending money. *(Please give a brief description of the scope of work included in this agreement.)*
Amendment #1 will continue to provide one regional Tuberculosis Nurse Consultant for 2011, to oversee the local case management of patients, provide education on contact investigation to local health department staff, and physicians in northern Indiana (Districts 1, 2, and 3).

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DEC 29 2010
OAG-ADVISORY

38. Justification of vendor selection and determination of price reasonableness:
Tuberculosis funds from the Centers for Disease Control and Prevention are being awarded due to the growing complexity of TB case management and the need to provide additional surveillance and containment activities.

39. If this contract is submitted late, please explain why: *(Required if more than 30 days late.)*

40. Agency fiscal officer or representative approval	41. Date Approved	42. Budget agency approval	43. Date Approved
	12-28-10		12-28-10
44. Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved
	12/29/10		

51775-001

61910-573100-4003610140300
TB 388-3

Amendment No. 1
EDS Number A70-1-106037

This is an Amendment to the existing Tuberculosis Cooperative Grant Agreement entered into by and between the **Indiana State Department of Health** (hereinafter referred to as the "State") and **Indiana Public Health Association Inc.** (hereinafter referred to as the "Grantee") for the period from October 1, 2010 through December 31, 2010, in the amount of $22,463.

In consideration of the mutual undertakings and covenants hereinafter set forth, the parties agree as follows:

The amount of the Grant Agreement is being increased by $73,913 making the new total of the Grant Agreement $96,376. The additional funds will be used to continue providing one regional Tuberculosis Nurse Consultant to oversee the local case management of patients, provide education on contact investigation to local health department staff, and physicians in northern Indiana. See Attachments D, E, and F, attached hereto, and made a part hereof and incorporated herein by reference as a part of this Grant Agreement. The expiration date of this Grant Agreement is being extended to December 31, 2011.

The following paragraph replaces the previous Grant Agreement paragraph:

Paragraph 20A – **Additional Payment Terms** is amended to read:

The State disburses Grant funds on a cost reimbursement basis. Actual expenditures of authorized costs will be reimbursed monthly by the State upon receipt of duly executed Invoices from the Grantee. Invoices shall be due by the 20th day after the end of each month. Payments shall not exceed $22,463 for the period of October 1, 2010 through December 31, 2010, and $73,913 for the period of January 1, 2011 through December 31, 2011. Total remuneration under this Grant Agreement shall not exceed $96,376.

Paragraph 20B is amended to read:

All accounts will be closed sixty (60) days after the end of each Grant Agreement period as specified in Paragraph 20A. Any invoice submitted after sixty (60) days will not be reimbursed by the State.

Funding Summary

61910-573100-4003610140300	10/01/10 through 12/31/10	$22,463
61910-573100-4003610140300	01/01/11 through 12/31/11	73,913
Total		$96,376

All other matters previously agreed to and set forth in the original Grant Agreement and not affected by this Amendment shall remain in full force and effect.

Non-Collusion and Acceptance

The undersigned attests, subject to the penalties of perjury, that he/she is the Grantee, or that he/she is the properly authorized representative, agent, member or officer of the Grantee, that he/she has not, nor has any other member, employee, representative, agent or officer of the Grantee, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid any sum of money or other consideration for the execution of this Grant Agreement other than that which appears upon the face hereof.

The rest of this page has been left blank intentionally.

In Witness Whereof, the Grantee and the State of Indiana have, through duly authorized representatives, entered into this Grant Agreement Amendment. The parties having read and understanding the foregoing terms of the Grant Agreement Amendment do by their respective signatures dated below agree to the terms thereof.

Accepted By:

JERRY KING
EXECUTIVE DIRECTOR
INDIANA PUBLIC HEALTH ASSOCIATION INC

DATE: 11/30/2010

Certification of Funds:

ALLEN L. COLLIER
DIRECTOR OF FINANCE
DIVISION OF FINANCE
OPERATIONAL SERVICES COMMISSION
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 12-21-10

Recommended and Approved By:

MICHAEL R. KISTLER
CHIEF FINANCIAL OFFICER
OPERATIONAL SERVICES COMMISSION
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 12-22-10

Approved:

ROBERT D. WYNKOOP
COMMISSIONER
DEPARTMENT OF ADMINISTRATION
STATE OF INDIANA

DATE: 12/27/10

Approved:

for
ADAM M. HORST, DIRECTOR
STATE BUDGET AGENCY
STATE OF INDIANA

DATE: 12-28-2010

Approved as to Form and Legality:

GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE: 12/29/10

Attachment D
A70-1-106037
Indiana Public Health Association

PURPOSE OF GRANT AGREEMENT:

The purpose of this grant is to provide the following services to the TB/Refugee Health Division of the Indiana State Department of Health (ISDH).

A. Provide one (1) Regional TB Nurse Consultant to oversee the local case management of patients, provide education on contact investigation to local health department staff, and physicians in Northern Indiana. (Districts 1, 2, & 3)

SERVICE RECIPIENTS: Health Departments and Individuals in Northern Indiana.

GRANT ACTIVITIES

Required Activities	Measurable Criteria	Annual Salary
The Regional Nurse will oversee the county health department case management and contact investigation of TB suspects and cases; identify and bring to the attention of ISDH staff high-risk groups and other areas of concern. The Regional TB Nurses shall attend monthly staff meetings in Indianapolis, unless approval is given before the meeting. The Regional TB Nurses will be responsible to help plan and execute the TB Regional Meetings.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	$46,995
The Regional Nurse will submit a quarterly report of activities for the specified time period to the local supervisor and a copy to the State TB Program (see ATTACHMENT E). This report addresses key issues, highlights, site visits, prevention activities, TB strategies; educational programs presented and attended, and progress in achieving the stated objectives.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	
The Regional Nurse provided through this Grant Agreement shall function in accordance with the Statewide *Tuberculosis Program Objectives* and policies established by the Indiana State Department of Health (see ATTACHMENT F).	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	
The Regional Nurse must complete or show proof of having completed an approved course of Tuberculin Skin Test administration, reading and interpretation and a revalidation each third year.		
The Regional Nurse must complete or show proof of having completed a course in HIV Prevention Counseling.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	

Required Activities	Measurable Criteria	Annual Salary
The Regional Nurses must participate in at least one TB and one HIV training session throughout the year. The Regional Nurse may select the specific course and submit the attendance or completion certificate with the *Tuberculosis Regional Quarterly Report* to the State TB Program.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	
Regional Nurse may attend at least one out-of –state training approved by the TB Program Director		
Total Salary Costs		**$46,995**
Fringe Benefits		**$11,749**
Travel (.40/mile)		**$7,000**
Communication Charges		**$1,000**
Supplies		**$450**
Administrative Fees (10% x 67,194)		**6,719**
Total Grant		**$73,913**

- **Salary:** One Regional Nurse for 12 months ($24.10/hr x 1950 hours) @$46,995
- **Fringe Benefits: $11,749**

- **Travel: $7,000**

In-State:

Travel expenditures will be reimbursed by the State at the rate customarily paid by the Grantee or the current rate being paid by the State of Indiana, whichever is the lesser.

1,800 miles x 0.40/mile = $6,000

Out-of-State:

Reimbursement for out-of-state travel, registration fees, air travel, ground transportation, and hotel will follow State travel regulations. All out-of-state travel using Grant funds must have prior written authorization from the State. Authorization for out-of-state travel must be requested in writing at least eight weeks prior to expected travel date. Up to $1,000 for Regional Nurse to attend ISDH approved training.

- **Supplies: $450**

- **Communication Charges: $1,000**

- **Invoices:**

All invoices must be accompanied by written documentation of actual expenditures for all claimed items. The Grantee will be paid monthly for hours worked and the deliverables defined and referenced above. Such payment shall be made in arrears upon receipt and approval of invoice.

- Day to day work supervision to be provided by the TB/Refugee Health Division.

ATTACHMENT E
A70-1-106037

Tuberculosis Regional Nurse Quarterly Report

2011

This report is to be completed by each Regional TB Nurse Consultant funded by the TB Program. All narrative and statistical sections must be completed. Successful submission of this report satisfies the terms of the contract for reporting.

All reports are due to ISDH by the 10th of the following months:

1st Quarter: 01/01/11 thru 03/31/11	**Due: April 10, 2011**
2nd Quarter: 04/01/11 thru 06/30/11	**Due: July 10, 2011**
3rd Quarter: 07/01/11 thru 09/30/11	**Due: October 10, 2011**
4th Quarter: 10/01/11 thru 12/31/11	**Due: January 10, 2012**

GRANTEE: _____

QUARTER: _____ **DATE SUBMITTED:** _____

SUBMITTED BY: _____

ISDH Use Only	
Date Received:	**Reviewed by:**

Quarterly Reports may be faxed to 317-233-7747 or mailed to:

TB/Refugee Health Division
Indiana State Department of Health
Tuberculosis Control Program
2 North Meridian Street, 6-D
Indianapolis, IN 46204

2010 County	Month			Month			Month		
	Number of Site Visits/calls*	Number of New Case/Suspects	Number of Trainings Given**	Number of Site Visits/calls*	Number of New Case/Suspects	Number of Trainings Given**	Number of Site Visits/calls*	Number of New Case/Suspects	Number of Trainings Given**
Total									

*Record number of site visits/record number of phone calls to the county ** Should be explained in the narrative

Mileage	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Total

REQUIRED TRAINING		OTHER TRAINING	
Meeting	**Date Attended**	**Meeting**	**Date Attended**
Monthly Regional TB Nurse Consultant Meetings	__/___/___ ___/___/___ ___/___/____		
Regional Meeting			
Basic TST Course/Revalidation			
HIV Counseling and Testing Course/Meeting			
TB Symposium/Other			

Summary of collaborative efforts, professional visits, other activities: _____

Barriers encountered or resolved, progress toward goals, other comments: _____

Attachment F
A70-1-106037
TB Program Objectives

For State and Local Health Departments

1) By 12/31/2011, 90.2% of TB patients from 2009 for whom therapy of one year or less is indicated will have completed therapy within twelve (12) months.

2) By 12/31/2011, contacts will be identified for at least 98% of all sputum AFB smear-positive TB cases.

3) By 12/31/2011, ensure that at least 75% of contacts to sputum AFB smear-positive TB cases will be evaluated for TB infection and disease.

4) By 12/31/2011, at least 70% of infected contacts from 2010 will be started on treatment for latent TB infection

5) By 8/15/2011, at least 70% of infected contacts from cohort year 2009, which were started on treatment for latent TB infection, will complete therapy.

6) By 12/31/2011 ensure that 53.5 % of TB cases with a positive sputum culture have documented conversion to a negative culture within 60 days of starting treatment.

7) By 12/31/2011 ensure that 91.8 % of TB cases 12 years and older with a pleural or respiratory site of disease have a documented sputum culture report.

8) By 12/31/2011, ensure that drug-susceptibility testing is performed on 97% of TB patients with initial positive cultures.

9) By 12/31/2011, HIV status will be known for at least 67% of all adult TB patients.

10) Continue to reduce the incidence of TB in foreign-born persons each year to meet the target of 18.7 cases / 100,000 by 2011.

11) Continue to reduce the incidence of TB in U.S.-born African-Americans each year to meet the target of 3.6cases / 100,000 by 2011.

12) Continue to reduce the incidence of TB for children younger than 5 years of age each year to meet the target of 1.5 cases / 100,000 by 2011.