16118

DEC 2? 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

2/11-11

LB

1. EDS Number:	2. Date prepared:
A70-0-106032	11/17/2010

3. CONTRACTS & LEASES

- ___ Professional/Personal Services
- X Grant
- ___ Lease
- ___ Attorney
- ___ MOU
- ___ QPA _____
- ___ Contract for procured Services
- ___ Maintenance
- ___ License Agreement
- X Amendment# 2
- ___ Renewal # _____
- ___ Other _____

FISCAL INFORMATION

4. Account Number:	5. Account Name:
61910-94000.571100	ISDH DHHS Fund
6. Total amount this action: $109,792.00	7.New contract total: $229,774.00
8. Revenue generated this action: $0.00	9.Revenue generated total contract: $0.00

10.New total amount for each fiscal year :

Year 2010 $119,982.00

Year 2011 $109,792.00

Year ____ $ ____

Year ____ $ ____

TIME PERIOD COVERED IN THIS EDS

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

13. Method of source selection:

___ Bid/Quotation ___ Emergency X Negotiated ___ Special Procurement

___ RFP# ____ ___ Other *(specify)* _____

AGENCY INFORMATION

14. Name of agency:	15. Requisition Number:
Department of Health	0000010860

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 # 0000003310

24. Name:	25. Telephone #:
HEALTH & HOSPITAL CORP OF MARION COUNTY	317-221-2110

26. Address: HEALTH & HOSPITAL CORP OF MARION COUNTY, 3838 N RURAL ST, INDIANAPOLIS, IN 46205

27. E-mail address: mgutwein@hhcorp.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 #2 will continue for one calendar year, to provide directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the tuberculosis services available in Marion County.

RECEIVED
DEC 29 2010
OAG-ADVISORY

38. Justification of vendor selection and determination of price reasonableness:

TB funds from the Centers for Disease Control and Prevention are being awarded to the growing complexity of TB case management and the need to provide additional surveillance and containment activities. The vendor is centrally located in the city being served.

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
	12-22-10		12-28-10
44.Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved
CAB	1-5-11		

44180-002

330

61910-571100-4003610140300
TB 198-4

Amendment No. 2
EDS Number A70-0-106032

This is an Amendment to the existing Tuberculosis Cooperative Grant Grant Agreement entered into by and between the **Indiana State Department of Health** (hereinafter referred to as the "State") and **The Health and Hospital Corporation of Marion County d.b.a. Marion County Health Department** (hereinafter referred to as the "Grantee") for the period from January 1, 2010 through December 31, 2010, in the amount of $119,982.

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 $109,792 making the new total of the Grant Agreement $229,774. The additional funds will be used to continue providing directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the TB services available in Marion County. 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 $119,982 for the period of January 1, 2010 through December 31, 2010, and $109,792 for the period of January 1, 2011 through December 31, 2011. Total remuneration under this Grant Agreement shall not exceed $229,774.

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

61910-571100-4003610140300	01/01/10 through 12/31/10	$119,982
61910-571100-4003610140300	01/01/11 through 12/31/11	109,792
Total		$229,774

145611

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:

MATTHEW GUTWEIN
PRESIDENT/EXECUTIVE DIRECTOR
THE HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY
D.B.A. MARION COUNTY HEALTH DEPARTMENT

DATE: 12-16-10

Accepted By:

VIRGINIA CAINE, M.D.
HEALTH OFFICER
MARION COUNTY HEALTH DEPARTMENT

DATE: 12/14/10

Certification of Funds:

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

DATE: 12-22-10

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:

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

DATE: 12-28-10

Approved as to Form and Legality:

GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE: 1-5-11

Attachment D
A70-0-106032
Marion County Health Department

PURPOSE OF GRANT AGREEMENT:

To provide directly observed therapy (DOT) services and directly observed preventive therapy (DOPT) for high-risk contacts, augmenting the TB services available in Marion County.

SERVICE RECIPIENTS:

Individuals living in Marion County.

CONSIDERATION FOR DELIVERABLES AND SCHEDULE OF PAYMENT:

REQUIRED ACTIVITIES	MEASURABLE CRITERIA	ANNUAL RATE FY 2011	SCHEDULE OF PAYMENT
Three Community Health Workers (CHWs) will be responsible for delivering and observing the ingestion of medications, observing, and collecting sputum samples, assisting with contact investigation, educating clients, and arranging for transport as needed to medical appointments related to TB care. TB Community Health Workers may assist local health department TB case management activities.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.	$84,716	Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
The CHWs interact with and perform Directly Observed Therapy/Directly Observed Preventive Therapy (DOT/DOPT) with TB patients to promote adherence to medical regimens, thus assuring continuity and completion of therapy.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.

Programs and seminars attended by the CHWs will have a TB/HIV element. HIV counseling and testing will be offered to clients followed through this project.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Activities shall supplement, not supplant the local TB activities necessary for case management, control and prevention of TB in the designated area.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Each CHW will submit *The Tuberculosis Outreach Quarterly Report* (See ATTACHMENT E) to the MCHD TB Program Coordinator and the local supervisor who will sign and address any barriers or problems encountered. A copy of the Report should be sent to the State TB Control Program.	All reports are due by the 10th of the month following the end of each quarter. April 10, 2011 July 10, 2011 October 10, 2011 January 10, 2012		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
The TB outreach services provided through this Grant Agreement shall be in accordance with Tuberculosis Program Objectives 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 as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.

There will be one Outreach Worker meeting for the CHWs and one Regional meeting during the Grant Agreement Period. Attendance is required.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
TB Control Program will participate in quarterly cohort reviews (when requested) via teleconference or in-person	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols		Payment shall be due for hours worked and satisfactory completion of Allen County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Each CHW must complete, or show proof of having completed, an approved course in *HIV Prevention Counseling.*	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Each CHW should be available on an as-needed basis to assist in outbreak situations in other geographical areas of the State.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Total Salary Costs		**$84,716**	
Fringe Benefits		**$ 25,076**	
Total Grant Agreement		**$109,792**	

- **Salary:** Three Community Outreach Workers for twelve months @$84,716
    - **P.** Gray @ $28,635
    - **A.** Cotterman @ $27,446
    - **K.** Wilcox @ $ 28,635

    - Fringe Benefits @ 29.6% of salaries = $25,076

- **Invoices:**
  All invoices must be submitted on a monthly basis and 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.

ATTACHMENT E
A70-0-106032

Tuberculosis Outreach Quarterly Report

2011

This report is to be completed by each TB Outreach Worker funded by the ISDH TB Program, then reviewed and signed by their supervisor. 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: Marion County Health Department

QUARTER:_____ DATE SUBMITTED: _____

SUBMITTED BY: _____

I have reviewed, discussed, and addressed issues/concerns identified in this report with the Outreach Worker.

SUPERVISOR'S SIGNATURE: _____

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
2 North Meridian Street, 6-A
Indianapolis, IN 46204

QTR	DOT					DOPT					MILES
1 2 3 4	TOTAL # OF PERSONS	DAILY	2X WEEK	3X WEEK	COMMENTS	TOTAL # OF PERSONS	DAILY	2X WEEK	3X WEEK	COMMENTS	Per Week
WEEK 1											
WEEK 2											
WEEK 3											
WEEK 4											
WEEK 5											
WEEK 6											
WEEK 7											
WEEK 8											
WEEK 9											
WEEK 10											
WEEK 11											
WEEK 12											
WEEK 13											
TOTALS											

REQUIRED TRAINING		OTHER TRAINING	
Meeting	**Date Attended**	**Meeting**	**Date Attended**
Outreach Workers Meeting			
Regional Meeting			
Basic TST Course/Recert			
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
A70-0-106032
Marion County Program Objectives for 2011

Completion of Therapy
By 12/31/2011, 90.2% of TB patients from 2010 for whom therapy of one year or less is indicated will have completed therapy within twelve (12) months.

Known HIV Status
By 12/31/2011, HIV status (negative or positive result from test performed within one year of TB diagnosis) will be known for at least 80% of all TB patients.

Recommended Initial Therapy
By 12/31/2011, 88% of patients will be started on the recommended initial 4-drug regimen when suspected of having TB disease.

Sputum Culture Reported
By 12/31/2011, 90% of TB cases 12 years and older with a pleural or respiratory site of disease have a documented sputum culture report.

Contact Investigation
90% of preliminary (first round) contact investigation reports (for AFB sputum smear positive TB cases) will be submitted to ISDH within 3 months of the case report date.

By 6/30/2011, develop a written plan for timely submission of the Summary of Tuberculosis Contact Investigation Report to Indiana State Department of Health. The written plan should include the following three stages of submission:

- 3 weeks after the index case has been reported to the ISDH, (after the first round of tuberculin skin test (TST) or Interferon-gamma release assay (IGRA)
- 12 weeks after the index case has been reported (after the second round of TST or IGRA)
- 12 months after the index case has been reported (include the ISDH Contact Investigation Report with the Summary of Tuberculosis Contact Investigation Report when faxing to the ISDH)
- List all contacts on worksheets