16198

JAN 05 2010

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

Received

JAN 07 2011

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.

1. EDS Number:	2. Date prepared:
A70-0-106031	12/16/2010

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: 61910-94000.583110	5. Account Name: ISDH DHHS Fund
6. Total amount this action: $26,419.00	7.New contract total: $79,562.00
8. Revenue generated this action: $0.00	9.Revenue generated total contract: $0.00

10.New total amount for each fiscal year :

Year 2010 $53,143.00

Year 2011 $26,419.00

Year ____ $ ____

Year ____ $ ____

TIME PERIOD COVERED IN THIS EDS

11. From (month, day, year):	12. To (month, day, year):
1/1/2010	6/30/2011

13. Method of source selection:

X Negotiated ___ Bid/Quotation ___ Emergency ___ Special Procurement

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

AGENCY INFORMATION

14. Name of agency:	15. Requisition Number:
Department of Health	0000010861

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 # 0000075244

24. Name:	25. Telephone #:
LAKE COUNTY	219-755-3842

26. Address: LAKE COUNTY HEALTH DEPARTMENT, 2293 N MAIN ST, CROWN POINT, IN 46307-1896

27. E-mail address: doffinx@lakecountyin.org

28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) ___ Yes X 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 this agreement for six months, ending 06/30/2011, to provide directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the TB services available in Lake County including Hammond and East Chicago.

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

TB 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. The vendor is located in the area being served.

RECEIVED

JAN 12 2011

OAG-ADVISORY

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
	1-6-11		01-11-2011
44.Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved
	1-14-11		

44150-001

61910-583110-4003610140300
TB 144-4

Amendment No. 1
EDS Number A70-0-106031

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 **Lake County Health Department** (hereinafter referred to as the "Grantee") for the period from January 1, 2010 through December 31, 2010, in the amount of $53,143.

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 $26,419 making the new total of the Grant Agreement $79,562. 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 Lake County including Hammond and East Chicago. 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 June 30, 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 $53,143 for the period of January 1, 2010 through December 31, 2010, and $26,419 for the period of January 1, 2011 through June 30, 2011. Total remuneration under this Grant Agreement shall not exceed $79,562.

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

61910-583110-4003610140300	01/01/10 through 12/31/10	$53,143
61910-583110-4003610140300	01/01/11 through 06/30/11	26,419
Total		$79,562

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:

SUSAN BEST, D.O.
HEALTH COMMISSIONER
LAKE COUNTY HEALTH DEPARTMENT

DATE:

Attested By:

PEGGY HOLINGA KATONA
AUDITOR
LAKE COUNTY

DATE: 12-28-10

Certification of Funds:

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

DATE: 1-6-11

Recommended and Approved By:

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

DATE: 1-4-11

Approved:

ROBERT D. WYNKOOP
COMMISSIONER
DEPARTMENT OF ADMINISTRATION
STATE OF INDIANA

DATE: 1-10-11

Approved:

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

DATE: 01-11-2011

Approved as to Form and Legality:

for
GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE: 1-14-11

Attachment D
A70-0-106031
Lake County Health Department

1. **PURPOSE OF THE GRANT:**

   To provide regional directly observed therapy (DOT) services and directly observed preventive therapy (DOPT) for high-risk contacts, augmenting the TB services available in Lake County for a period of six months.

2. **SERVICE RECIPIENTS:**

   Individuals residing in Lake County

3. **CONSIDERATION FOR DELIVERABLES AND SCHEDULE OF PAYMENT**

REQUIRED ACTIVITIES	MEASURABLE CRITERIA	ANNUAL RATE FY 2011	SCHEDULE OF PAYMENT
One Outreach Worker (ORW) will be responsible for delivering and observing the ingestion of medications, observing, and collecting sputum samples, assisting with contact investigation, educating clients, and transporting clients as needed to medical appointments related to TB care. TB Outreach Workers may assist local health department TB case management activities.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	$14,615	Payment shall be due for hours worked and satisfactory completion of Lake County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
The ORW interacts with and performs 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. Actively collaborates with local health department, physicians, hospitals, and laboratories.	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 Lake County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Programs and seminars attended by the ORW will have a TB/HIV element. HIV counseling and testing will be made available to all clients followed through this project.	Services to be provided in accordance with the Tuberculosis Control Program		Payment shall be due for hours worked and satisfactory completion of Lake County Health Department

	Objectives and Protocols.		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.		Payment shall be due for hours worked and satisfactory completion of Lake County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
The Outreach Worker will submit *The Tuberculosis Outreach Quarterly Report* (See ATTACHMENT E) to 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 each quarter. April 11, 2011 June 30, 2011		Payment shall be due for hours worked and satisfactory completion of Lake 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 the Statewide *Tuberculosis Program Objective* 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.		Payment shall be due for hours worked and satisfactory completion of Lake County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
There will be a TB Symposium during the Grant Agreement Period. Attendance is required.	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 Lake County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
The Outreach Worker 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.		Payment shall be due for hours worked and satisfactory completion of Lake County Health Department Deliverables. Such payment shall be paid

			once monthly in arrears.
The Outreach Worker 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.		Payment shall be due for hours worked and satisfactory completion of Lake County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Total Salary Costs		**$14,615**	
Fringe		**10,055**	
Travel ($0.40/mile)		**$1,320**	
Supplies		**$429**	
Total Grant Agreement		**$26,419**	

- **Salary:** J. Glover for six months @$14,615

ASSOCIATED DELIVERABLES

- Fringe: $10,055
  - Retirement $1,462
  - FICA $1,118
  - Insurance $7,475
- Travel @ $0.40/mile $1,320
- Supplies: $429 which will include office equipment as needed.

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.

- **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.

Attachment E
A70-0-106031

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: June 30, 2011**

GRANTEE: Lake 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
A70-0-106031
TB Program Objectives

For State and Local Health Departments

1) By 6/30/2011, 90% of TB patients from the previous year cohort, for whom therapy of one year or less indicated, will complete therapy within twelve (12) months.

2) By 6/30/2011, contacts will be identified for at least 90% of all sputum AFB smear-positive TB cases.

3) By 6/30/2011, ensure that at least 95% of contacts to sputum AFB smear-positive TB cases will be evaluated for TB infection and disease.

4) By 6/30/2011, at least 75% of infected contacts from the first six months of cohort year 2009, which were started on treatment for latent TB infection will complete therapy.

5) By 6/30/2011, reporting data for new TB cases will be at least 90% complete.

6) By 6/30/2011, ensure that drug-susceptibility testing is performed on all TB patients with initial positive cultures.

7) By 6/30/2011, HIV status will be known for at least 75% of all adult TB patients.

8) By 6/30/2011, increase the number of foreign-born persons entering the U.S. on Class A or B TB medical waivers who complete an evaluation, initiate, and complete treatment.

9) By 6/30/2011, reduce the incidence of TB in U.S.-born African-Americans.

10) By 6/30/2011, and annually thereafter, completion of therapy quality indicators (QI) will be measured for the state and each local health jurisdiction with one (1) or more cases of TB, and shared with each department.

Completion of therapy quality indicators include:

- Proportion of verified cases (Class III) who complete an American Thoracic Society-approved treatment regimen within twelve (12) months.
- Proportion of verified cases (Class III) who initiate therapy with Isoniazid (INH), Rifampin (RIF), Pyrazinamide (PZA), and Ethambutol (EMB).
- Proportion of verified cases (Class III) with documented sputum culture conversion to negative, and
- Proportion of verified cases on directly observed therapy (DOT).