

16545

JUL 22 2011

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-08)

Instructions for completing the EDS and the Contract process.



Received

JUL 25 2011

DOA Contracts

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: A70-0-106032	2. Date prepared: 4/27/2011
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3. CONTRACTS & LEASES

<input type="checkbox"/> Professional/Personal Services	<input type="checkbox"/> Contract for procured Services
<input checked="" type="checkbox"/> Grant	<input type="checkbox"/> Maintenance
<input type="checkbox"/> Lease	<input type="checkbox"/> License Agreement
<input type="checkbox"/> Attorney	<input checked="" type="checkbox"/> Amendment# 3
<input type="checkbox"/> MOU	<input type="checkbox"/> Renewal #
<input type="checkbox"/> QPA	<input type="checkbox"/> Other

FISCAL INFORMATION

4. Account Number: 61910-94000.571100	5. Account Name: ISDH DHHS Fund
6. Total amount this action: \$80,027.00	7. New contract total: \$309,801.00
8. Revenue generated this action: \$0.00	9. Revenue generated total contract: \$0.00
10. New total amount for each fiscal year:	
Year 2010	\$119,892.00
Year 2011	\$189,819.00
Year	\$
Year	\$

TIME PERIOD COVERED IN THIS EDS

11. From (month, day, year): 1/1/2010	12. To (month, day, year): 12/31/2011
13. Method of source selection:	
<input type="checkbox"/> Bid/Quotation	<input checked="" type="checkbox"/> Negotiated
<input type="checkbox"/> RFP#	<input type="checkbox"/> Special Procurement
<input type="checkbox"/> Other (specify)	

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 #3 will add additional funding of \$80,027 for use during calendar year 2011, to continue to provide directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the tuberculosis services available in Marion County.

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 <i>aw</i>	41. Date Approved 7-22-11	42. Budget agency approval <i>JB</i>	43. Date Approved 08-01-11
44. Attorney General's Office approval	45. Date Approved 8/4/11	46. Agency representative receiving from AG	47. Date Approved

AGENCY INFORMATION

14. Name of agency: Department of Health	15. Requisition Number: 0000010860
16. Address: 2 N. Meridian Street Indianapolis, IN 46204	

AGENCY CONTACT INFORMATION

17. Name: Sarah Burkholder	18. Telephone #: 317/233-7545
19. E-mail address: sburkholder@isdh.in.gov	

COURIER INFORMATION

20. Name: Joseph Olivadoti	21. Telephone #: 317-233-7573
22. E-mail address: jolivadoti@isdh.in.gov	

VENDOR INFORMATION

23. Vendor ID # 0000003310	
24. Name: HEALTH & HOSPITAL CORP OF MARION COUNTY	25. Telephone #: 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) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
29. Primary Vendor: M/WBE Minority: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Women: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	30. If yes, list the %: Minority: _____ % Women: _____ %
31. Sub Vendor: M/WBE Minority: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Women: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	32. If yes, list the %: Minority: _____ % Women: _____ %
33. Is there Renewal Language in the document? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	34. Is there a "Termination for Convenience" clause in the document? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

RECEIVED

AUG 02 2011

OAG-ADVISORY

44180-003

270

61910-571100-4003610140300
TB 198-4

**Amendment No. 3
EDS Number A70-0-106032**

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 **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, 2011**, in the amount of **\$229,774**.

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 **\$80,027** making the new total of the Grant Agreement **\$309,801**. The additional funds will be used to **continue providing directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the tuberculosis services available in Marion County**. See Attachment D-1, attached hereto, which replaces Attachment D, and Attachments E and F, attached hereto, and made a part hereof and incorporated herein by reference as a part of this Grant Agreement.

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 \$189,819 for the period of January 1, 2011 through December 31, 2011. Total remuneration under this Grant Agreement shall not exceed \$309,801.

Paragraph 41 - Employment Eligibility Verification is added to read:

The Grantee affirms under the penalties of perjury that he/she/it does not knowingly employ an unauthorized alien.

The Grantee affirms under the penalties of perjury that he/she/it has enrolled and is participating in the E-Verify program as defined in IC 22-5-1.7-3. The Grantee agrees to provide documentation to the State that he/she/it has enrolled and is participating in the E-Verify program. Additionally, the Grantee is not required to participate if the Contractor is self-employed and does not employ any employees.

The State may terminate for default if the Grantee fails to cure a breach of this provision no later than thirty (30) days after being notified 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	<u>189,819</u>
Total		\$309,801

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.

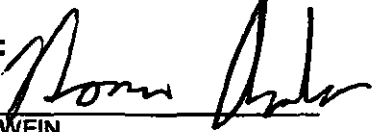
Non-Collusion and Acceptance

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.

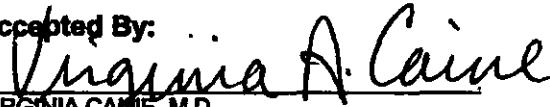
Accepted By:


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

DATE:

7/19/2011

Accepted By:


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

DATE:

7/19/11

Certification of Funds:


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

DATE:

7-22-11


Recommended and Approved By:


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

DATE:

7-22-11

Approved:


ROBERT D. WYNKOOP
COMMISSIONER
DEPARTMENT OF ADMINISTRATION
STATE OF INDIANA

DATE:

7/26/11

Approved:

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

DATE:

08-01-11

Approved as to Form and Legality:


GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE:

8-4-11

**Attachment D-1
A70-0-106032**

Marion County Public Health Department

PURPOSE OF GRANT AGREEMENT:

To provide directly observed therapy (DOT) services and directly observed preventive therapy (DOPT) for high-risk contacts, provide additional outbreak assistance, and partial funding for a nurse or TB consultant augmenting the TB services available in Marion County. This grant is from January 1, 2011 through December 31, 2011.

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 and outbreak assistance. 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.	\$98,035	Payment shall be due for hours worked and satisfactory completion of Marion County Public 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, especially with the homeless cases of TB and LTBI.	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 Public 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 Public Health Department Deliverables. Such payment shall be paid once monthly in arrears.
TB Consultant to assist with oversight of the homeless cases and assure that DOT, treatment, HIV, contact investigations and QA are done. 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.	\$30,000	Payment shall be due for hours worked and satisfactory completion of Marion County Public Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Each CHW will submit <i>The Tuberculosis Outreach Quarterly Report</i> (see Attachment F) to the MCPHD 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 10 th 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 Public 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 G).	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 Public 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 Public 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 <i>HIV Prevention Counseling</i> .	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 Public 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 Public Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Provide rent/housing for homeless cases of TB. 9 client months x \$625/ month	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.	\$5,625	Payment shall be paid one monthly upon in arrears with receipts of rent/housing paid.

Incentives and Enablers		\$1,753	
UV light maintenance Contract for homeless shelter		\$15,665	
Travel for DOT and to attend Regional TB Meetings		\$135	
Benefits		\$38,606	
Total		\$189,819	
Total Salary Costs			\$128,035
Fringe Benefits			\$ 38,606
Rent/Housing			\$5,625
Incentives/enablers			\$1,753
UV light contact			\$15,665
Travel			\$135
Total Grant Agreement			\$189,819

Salary: Three Community Outreach Workers for twelve months @\$84,716

- o P. Gray @ \$28,635
- o A. Cotterman @ \$27,446
- o K. Wilcox @ \$ 28,635
 - One community Outreach Worker for 6 months
- o E Murphy @ @ 13,319
 - One TB Consultant for 6 months
- o Vacant @ \$30,000

Fringe Benefits @ 30.2% of salaries = \$38,606

Travel:

Travel expenditures will be reimbursed by the State at the rate customarily paid by the Grantee or the current rate of \$.44/mile beginning 10/1/2009 being paid by the State of Indiana, whichever is the lesser.

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

OIR 1 2 3 4	DOT					DOPI					MILES Per Week
	TOTAL # OF PERSONS	DAILY	2X WEEK	3X WEEK	COMMENTS	TOTAL # OF PERSONS	DAILY	2X WEEK	3X WEEK	COMMENTS	
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