DEPARTMENT OF STATE HEALTH SERVICES

This contract, number 2013-041110 (Contract), is entered into by and between the Department of State Health Services (DSHS or the Department), an agency of the State of Texas, and COLLIN COUNTY HEALTH CARE SERVICES (Contractor), a Government Entity, (collectively, the Parties).

1. **Purpose of the Contract.** DSHS agrees to purchase, and Contractor agrees to provide, services or goods to the eligible populations as described in the Program Attachments.

2. **Total Amount of the Contract and Payment Method(s).** The total amount of this Contract is $1,482,201.00, and the payment method(s) shall be as specified in the Program Attachments.

3. **Funding Obligation.** This Contract is contingent upon the continued availability of funding. If funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or health and human services agencies, amendment to the Appropriations Act, health and human services agency consolidation, or any other disruptions of current appropriated funding for this Contract, DSHS may restrict, reduce, or terminate funding under this Contract.

4. **Term of the Contract.** This Contract begins on 09/01/2012 and ends on 08/31/2013. DSHS has the option, in its sole discretion, to renew the Contract as provided in each Program Attachment. DSHS is not responsible for payment under this Contract before both parties have signed the Contract or before the start date of the Contract, whichever is later.

5. **Authority.** DSHS enters into this Contract under the authority of Health and Safety Code, Chapter 1001.

6. **Documents Forming Contract.** The Contract consists of the following:

   a. Core Contract (this document)
   b. Program Attachments:

      2013-041110-001 Tuberculosis Prevention and Control - State
      2013-041110-002 Tuberculosis Prevention and Control - Federal
      2013-041110-003 CPS - CITIES READINESS INITIATIVE
      2013-041110-004 IMMUNIZATION BRANCH - LOCALS
      2013-041110-005 Public Health Emergency Preparedness (PHEP)
      2013-041110-006 RLSS/LOCAL PUBLIC HEALTH SYSTEM-PnP

   c. General Provisions (Sub-recipient)
   d. Solicitation Document(s) (N/A), and

e. Contractor's response(s) to the Solicitation Document(s) (N/A).
f. Exhibits

Any changes made to the Contract, whether by edit or attachment, do not form part of the Contract unless expressly agreed to in writing by DSHS and Contractor and incorporated herein.

7. **Conflicting Terms.** In the event of conflicting terms among the documents forming this Contract, the order of control is first the Core Contract, then the Program Attachment(s), then the General Provisions, then the Solicitation Document, if any, and then Contractor's response to the Solicitation Document, if any.

8. **Payee.** The Parties agree that the following payee is entitled to receive payment for services rendered by Contractor or goods received under this Contract:

Name: COLLIN COUNTY
Address: 2300 BLOOMDALE RD #3100
MCKINNEY, TX 75071-8517
Vendor Identification Number: 17560008736026

9. **Entire Agreement.** The Parties acknowledge that this Contract is the entire agreement of the Parties and that there are no agreements or understandings, written or oral, between them with respect to the subject matter of this Contract, other than as set forth in this Contract.

By signing below, the Parties acknowledge that they have read the Contract and agree to its terms, and that the persons whose signatures appear below have the requisite authority to execute this Contract on behalf of the named party.

DEPARTMENT OF STATE HEALTH SERVICES

By: _____
Signature of Authorized Official

8-27-12
Date

Lucina Suarez, Ph.D.

Acting Assistant Commissioner for
Prevention and Preparedness Services

1100 WEST 49TH STREET
AUSTIN, TEXAS 78756

512.776.7111

Lucina.suarez@dshs.state.tx.us

COLLIN COUNTY HEALTH CARE SERVICES

By: _____
Signature

8/14/12
Date

Keith Self, President
Printed Name and Title

2300 Bloomdale Road
Suite 4192
Address

McKinney, TX 75071
City, State, Zip

(972) 548-4631
Telephone Number

E-mail Address for Official Correspondence

CONTRACT NO.2013-041110
PROGRAM ATTACHMENT NO.001
PURCHASE ORDER NO.0000385406

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: Tuberculosis Prevention and Control - State

TERM:09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

A. PROVISION OF SERVICES:

Throughout the Contractor's defined service area of Collin, Contractor shall develop and provide basic services and associated activities for tuberculosis (TB) prevention and control, and expanded outreach services to individuals of identified special populations who have TB and/or who are at high risk of developing TB.

Contractor shall provide these services in compliance with the following:

- DSHS' most current version of the Standards of Performance for the Prevention and Control of Tuberculosis, available at http://www.dshs.state.tx.us/IDCU/disease/tb/publications/SOP-2008-final.doc;
- DSHS Standards for Public Health Clinic Services, Revised August 31, 2004 available at http:// www.dshs.state.tx.us/qmb/dshsstndrds4clinicservs.pdf;
- DSHS' TB Policy and Procedures Manual, available at http://www.dshs.state.tx.us/idcu/disease/tb/publications/;
- American Thoracic Society (ATS) and Centers for Disease Control and Prevention (CDC) joint statements on diagnosis, treatment and control of TB available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm;
- Diagnostic Standards and Classification of Tuberculosis in Adults and Children, (American Journal of Respiratory and Critical Care Medicine, Vol. 161, pp. 1376-1395, 2000) at http://ajrccm.atsjournals.org/cgi/content/full/161/4/1376;
- Treatment of Tuberculosis, (ATS/CDC/IDSA), 2003 available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm;
- Targeted Tuberculin Testing and Treatment of Latent TB Infection (LTBI), Morbidity and Mortality Weekly Report, Vol. 49, No. RR-6, 2000 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm;
- Updated: Adverse Event Data and Revised American Thoracic Society/CDC Recommendations Against the Use of Rifampin and Pyrazinamide for Treatment of Latent Tuberculosis Infection – United States, 2003, MMWR 52 (No. 31) at

http://www.eclipsconsult.com/eclips/article/Pulmonary%20Disease/S8756-3452(08)70243-3;

- Controlling Tuberculosis in the United States, MMWR, Vol. 54, No. RR-12, 2005 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm;
- Guidelines for the Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children at http://www.cdc.gov/mmwr/pdf/rr/rr58e0826.pdf;
- Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents at http://www.cdc.gov/mmwr/pdf/rr/rr58e324.pdf; and
- Updated Guidelines on Managing Drug Interactions in the Treatment of HIV-Related Tuberculosis at http://www.cdc.gov/tb/publications/guidelines/TB_HIV_Drugs/default.htm.

Contractor shall comply with all applicable federal and state regulations and statues, including, but not limited to, the following:

- Texas Tuberculosis Code, Health and Safety Code, Chapter 13, subchapter B;
- Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81;
- Screening and Treatment for Tuberculosis in Jails and Other Correctional Facilities, Health and Safety Code, Chapter 89;
- Texas Administrative Code TAC, Title 25, Part 1, Chapter 97, Subchapter A, Control of Communicable Diseases; and
- Texas Administrative Code TAC, Title 25, Part 1, Chapter 97, Subchapter H, Tuberculosis Screening for Jails and Other Correctional Facilities.

All references to TB cases or suspected TB cases refer to active TB disease unless otherwise stated. All references to latent TB infection (LTBI) refer to the condition where infection has occurred but there has not been progression to active TB disease.

Contractor shall monitor and manage its usage of anti-tuberculosis medications and testing supplies furnished by DSHS in accordance with first-expiring-first-out (FEFO) principles of inventory control to minimize waste for those products with expiration dates. On a monthly basis, the Contractor shall perform a count of its inventory of anti-tuberculosis medications and tuberculosis testing supplies furnished by DSHS and reconcile the quantities by product and lot number found by this direct count with the quantities by product and lot number listed in the electronic inventory management system furnished by DSHS. All these tasks shall be performed by the Contractor using the designated database and the designated procedures

Contractor shall perform all activities under this Program Attachment in accordance with Contractor's final, approved work plan (attached as Exhibit A), and detailed budget as approved by DSHS. Contractor must receive written approval from DSHS before varying from applicable policies, procedures, protocols, and the final approved

work plan, and must update its implementation documentation within forty-eight (48) hours of making approved changes so that staff's working on activities under this contract are made aware of the change(s).

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS Program will monitor Contractor's expenditures on a quarterly basis. If expenditures are below those projected in Contractor's total Program Attachment amount, Contractor's budget may be subject to a decrease for the remainder of the Program Attachment term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

REPORTING:

Due to the inherent time to complete treatment for tuberculosis disease and latent tuberculosis infection in relation to the period of the Program Attachment, required reporting under this Program Attachment will show results for work performed under previous Program Attachments.

Contractor shall provide a complete and accurate annual narrative report, in the format provided by DSHS, demonstrating compliance with the requirements of this Program Attachment. The report shall include, but is not limited to, a detailed analysis of performance related to the performance measures listed below. The narrative report shall be sent to the Department of State Health Services, Tuberculosis Services Branch, Mail Code 1873, 4110 Guadalupe, PO Box 149347, Austin, Texas 78714-9347 via regular mail, or by fax to (512)371-4675, or e-mail to TBContractReporting@dshs.state.tx.us.

Contractor shall maintain the documentation used to calculate performance measures as required by the General Provisions Article VIII "Records Retention" and by the Texas Administrative Code Title 22, Part 9 Chapter 165, §165.1 regarding the retention of medical records.

Report periods and due dates are as follows:

PERIOD COVERED	DUE DATE
January – December 2012	February 15, 2013

Contractor shall send all initial reports of confirmed and suspected TB cases to DSHS within seven (7) working days of identification or notification.

Updates to initial DSHS Report of Cases and Patient Services Form (TB-400) (e.g., diagnosis, medication changes, x-rays, and bacteriology) and case closures shall be sent within thirty (30) calendar days from when a change in information in a required

reporting field occurs to DSHS at 4110 Guadalupe, Mail Code 1873, PO Box 149347, Austin, Texas 78714-9347.

Contractor shall send an initial report of contacts on all Class 3 TB cases and smear-positive Class 5 TB suspects within thirty (30) days of identification using DSHS Report of Contacts Form (TB-340 and TB-341).

New follow-up information (not included in the initial report) related to the evaluation and treatment of contacts shall be sent to DSHS on the TB-340 and TB-341 at intervals of ninety (90) days, 120 days, and two (2) years after the day Contractor became aware of the TB case.

Electronic reporting to DSHS for Class 3 TB cases, smear positive Class 5 TB suspects, and their contacts may become available during the term of this Program Attachment. Contractor may avail itself of this option if it adheres to all the electronic reporting requirements (including system requirements) provided at that time.

Contractor will determine and report annually the number of persons which receive at least one (1) TB service including but not limited to tuberculin skin tests, chest radiographs, health care worker services, or treatment with one or more anti-tuberculosis medications.

Contractor shall evaluate and monitor Class B immigrants and when needed place them on appropriate prophylaxis for successful completion of treatment. Immigrant notifications shall be obtained through the Electronic Disease Notification (EDN) system. The TB Follow-up Worksheet in EDN shall be completed for all immigrants whose notification was obtained through EDN.

Contractor shall evaluate refugees and other at-risk clients referred by the Refugee Health Program for further clinical evaluation and when needed place those refugees on appropriate prophylaxis and monitor them for successful completion of treatment. The TB Worksheet in EDN shall be completed on refugees and other at-risk clients who are reported through EDN.

SECTION II. PERFORMANCE MEASURES:

The following performance measures will be used to assess, in part, Contractor's effectiveness in providing the services described in this Contract, without waiving the enforceability of any of the other terms of the Contract or any other method of determining compliance:

1. Cases, and suspected cases, of TB under treatment by Contractor shall be placed on timely and appropriate Directly Observed Therapy (DOT). If data indicates a compliance rate for this Performance Measure of less than 90%,

4

then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

2. Newly diagnosed TB cases that are eligible* to complete treatment within 12 months shall complete therapy within 365 days or less;

   **Exclude TB cases 1) diagnosed at death, 2) who die during therapy, 3) who are resistant to Rifampin, 4) who have meningeal disease, and/or 5) who are younger than 15 years with either miliary disease or a positive blood culture for TB.*
   If data indicates a compliance rate for this Performance Measure of less than 85%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

3. TB cases with initial cultures positive for Mycobacterium tuberculosis complex shall be tested for drug susceptibility and have those results documented in their medical record. If data indicates a compliance rate for this Performance Measure of less than 97.4%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

4. Newly-reported cases of TB with Acid-fast Bacillis (AFB) positive sputum culture results will have documented conversion to sputum culture-negative within 60 days of initiation of treatment. If data indicates a compliance rate for this Performance Measure of less than 45%, then DSHS may (at its sole discretion) require additional measures be taken by contractor to improve the percentage, on a timeline set by DSHS;

5. Newly-reported TB cases shall have an HIV test performed (unless they are known HIV- positive, or if the patient refuses) and shall have positive or negative HIV test results reported to DSHS according to the reporting schedule provided in Section 1, B herein. If fewer than 80% of newly reported TB cases have a result of an HIV test reported, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

6. Newly-reported suspected cases of TB disease shall be started in timely manner on the recommended initial 4-drug regimen. If fewer than 93.2% of newly-reported TB cases are started on an initial 4-drug regimen in accordance with this requirement, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

7. Newly-reported TB patients with a positive AFB sputum-smear result shall have at least three contacts identified as part of the contact investigation that must be pursued for each case. If data indicates a compliance rate for this

Performance Measure of less than 90%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

8. Newly-identified contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive TB case shall be evaluated for TB infection and disease. If data indicates a compliance rate for this Performance Measure of less than 81.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

9. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case and that are newly diagnosed with latent TB infection (LTBI) shall be started on timely and appropriate treatment. If data indicates a compliance rate for this Performance Measure of less than 65%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

10. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case that are newly diagnosed with LTBI and that were started on treatment shall complete treatment for LTBI as described in Targeted Tuberculin Testing and Treatment of Latent TB Infection (LTBI), Morbidity and Mortality Weekly Report, Vol. 49, No. RR-6, 2000, and according to the timelines given therein. If data indicates a compliance rate for this Performance Measure of less than 45%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

11. Newly-reported TB patients that are older than 12-years-old and that have a pleural or respiratory site of disease shall have sputum AFB-culture results reported to DSHS according to the timelines for reporting initial and updated results given herein. If data indicates a compliance rate for this Performance Measure of less than 89.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS; and

12. All reporting to DSHS shall be completed as described in Section I, B-Reporting and submitted by the deadlines given.

If the Contractor fails to meet any of the performance measures, the Contractor shall furnish in the narrative report, due February 15, 2013, a written explanation including a plan (with schedule) to meet those measures. This requirement does not excuse any violation of this Contract, nor does it limit DSHS as to any options available under the contract regarding breach.

SECTION III. SOLICITATION DOCUMENT:

Exempt Governmental Entity

SECTION IV. RENEWALS:

None

SECTION V. PAYMENT METHOD:

Cost Reimbursement

Funding is further detailed in the attached Categorical Budget and if applicable, Equipment List.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) and acceptable supporting documentation for reimbursement of the required services/deliverables. The B-13 can be found at the following link http://www.dshs.state.tx.us/grants/forms/b13form.doc. Vouchers and supporting documentation should be mailed or submitted by fax or electronic mail to the addresses/number below.

Department of State Health Services
Claims Processing Unit, MC 1940
1100 West 49th Street
PO BOX 149347
Austin, Texas 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13) to the Claims Processing Unit is (512) 776-7442. The email address is invoices@dshs.state.tx.us.

SECTION VII. BUDGET:

SOURCE OF FUNDS: *STATE*

DUNS #074873449

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, **Article III. Funding, Section 3.06 Nonsupplanting**, is revised to include the following:

Funding from this Contract shall not be used to supplant (i.e., used in place of funds dedicated, appropriated or expended for activities funded through this Contract) state or local funds, but Contractor shall use such funds to increase state or local funds currently available for a particular activity. Contractor shall maintain local funding at a sufficient rate to support the local program. If the total cost of the project is greater than DSHS' share set out in SECTION VII. BUDGET, Contractor shall supply funds for the remaining costs in order to accomplish the objectives set forth in this Contract.

All revenues directly generated by this Contract or earned as a result of this Contract during the term of this Contract are considered program income; including income generated through Medicaid billings for TB related clinic services. Contractor may use the program income to further the scope of work detailed in this Contract, and must keep documentation to demonstrate such to DSHS's satisfaction. This program income may not be used to take the place of existing local, state, or federal program funds.

General Provisions, **Article XIII. General Terms, Section 13.15 Amendment**, is amended to include the following:

Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least ninety (90) days prior to the end of the term of this Program Attachment.

2013-041110-001

Categorical Budget:

PERSONNEL	$136,975.00
FRINGE BENEFITS	$42,462.00
TRAVEL	$242.00
EQUIPMENT	$0.00
SUPPLIES	$0.00
CONTRACTUAL	$2,400.00
OTHER	$99.00
TOTAL DIRECT CHARGES	$182,178.00
INDIRECT CHARGES	$0.00
TOTAL	$182,178.00
DSHS SHARE	$182,178.00
CONTRACTOR SHARE	$966.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $182,178.00

Financial status reports are due: 12/31/2012, 03/29/2013, 06/28/2013, 10/30/2013

COLLIN COUNTY HEALTH CARE SERVICES
DSHS Contract Number: 2013-041110-001
DSHS Program ID: TB/PC-STATE
EXHIBIT A

WORK PLAN

QUESTION 1—Proposed services. The proposed services aimed at the prevention and control of Tuberculosis (TB) provided by Collin County Health Care Services (CCHCS) through its TB Elimination Program include: performing TB skin testing or IGRA (when indicated) and chest x-ray services for the public as well as contacts to TB cases, providing TB-related medical care and Directly Observed Therapy (DOT) for active TB cases, providing Latent Tuberculosis Infection (LTBI) treatment and Directly Observed Preventive (DOPT) therapy to patients at risk of developing TB disease, providing TB screening for immigrants, performing contact investigations in compliance with the Texas Department of State Health Services (DSHS) standards, cooperating with other TB prevention partners in TB elimination activities, and imparting key information/education regarding the management of TB patients to medical and professional personnel in the community.

Service area, Population to be Served. The area served by the CCHCS TB Elimination Program is Collin County, Texas. Collin County, located in North Texas, is part of the Dallas/Fort Worth Metroplex. The geographical area of Collin County covers 847.56 square miles[1] and is comprised of metropolitan centers, suburban communities, and rural landscapes. The population of Collin County has increased to an estimated 842,364 residents in 2010[2]. McKinney, the county seat, was identified as the nation's fastest growing city between April 1, 2000 and July 1, 2008 when its population more than doubled to 121,211 residents[3]. Collin County's rise in numbers has been relatively diverse from an ethnicity standpoint in comparison with other counties and the state as a whole. With these factors in mind, it is of growing concern that the TB case rate for Collin County has steadily increased from 2.9 to 4.7 cases per 100,000 persons in recent years[4].

POPULATION PERCENTAGE BY ETHNICITY, 2010[5]					PERCENT CHANGE IN POPULATION BY ETHNICITY 2000-2010[5]			
County	White, %	Black, %	Hispanic, %	Other, %	White, %	Black, %	Hispanic, %	Other, %
Collin	71.3	5.7	14.0	9.0	58.5	94.8	133.5	101.5
Dallas	31.7	20.3	41.9	6.1	-22.7	8.8	54.1	44.0
Denton	71.1	7.1	16.0	5.8	50.7	90.5	115.1	94.9
Tarrant	49.1	13.4	30.4	7.1	-1.4	30.3	94.5	100.8
Texas	45.1	11.5	38.8	4.6	3.3	20.8	47.7	69.0

Individuals served from counties outside stated service area. In order to serve community-based, TB-related health care needs, CCHCS partners with Collin County Detention Facility, as well as North Texas Job Corps Center (both located in McKinney). Furthermore, CCHCS has partnered with PrimaCare for TB DOT services in unusual situations. Serving individuals outside of Collin County is a challenge that requires diligent attention since the spread of TB can cross geographical boundaries as a result of patients moving and contact exposures. For new reports of suspect TB patients reported to CCHCS where the patient resides in another county, both the Epidemiology staff and the TB Program Manager forward lab results and critical information to the DSHS Region 2/3 office and/or the health department where the patient resides in order to expedite the follow up needed for that patient. For a small number of cases, the TB patient's workplace is located in Collin County, even though they reside in another county. Consequently, if the provision of DOT and/or TB services to the out of county TB patient has the potential to enhance compliance, the Collin County Health Authority and CCHCS Administrator will approve extending TB services to the

[1] U.S. Census Bureau, State and County QuickFacts, Collin County, available from http://quickfacts.census.gov/qfd/states/48/4805.html; Internet; accessed 5/5/10.

[2] Texas Department of State Health Services, Texas Health Data—Population, available from http://soupfin.tdh.state.tx.us/pop2000a.htm, Internet; accessed 5/5/10.

[3] U.S. Census Bureau Press Release 7/1/09, available from http://www.census.gov/Press-Release/www/releases/archives/population/013960.html; Internet; accessed 5/5/10.

[4] Texas Department of State Health Services, IDCU Tuberculosis Statistics, M.TB Complex Surveillance Data (2005-2009), Cases and rates by county, available from; Internet; http://www.dshs.state.tx.us/idcu/disease/tb/statistics/ ; accessed 19 May 2011.

[5] Texas Department of State Health Services, Texas Health Data—Population, available from http://soupfin.tdh.state.tx.us/pop2000a.htm, Internet; accessed 5/5/10.

13

out-of-county patient on a case-by-case basis.

QUESTION 2—Service Delivery System, Workforce. Collin County Health Care Services (CCHCS) is a local health department whose mission is to protect and promote the health of the people of Collin County. CCHCS provides the following services to the community: childhood and adult immunizations, epidemiology (disease surveillance), Tuberculosis clinic services, STD/HIV clinic services, WIC program services, state Indigent Program services, and primary care services through a partnership with independent clinics. **The CCHCS organizational chart is attached in the previous section**. The TB prevention services and control measures in place for the Collin County area are provided by the CCHCS Tuberculosis Elimination Program. Services are provided via: patient office visits; home DOT visits; contact investigations; verbal, written, and electronic communication to and from patients, health care providers, hospitals, state TB consultants, and other contacts. Although regular CCHCS business hours are Monday-Friday (8-11 a.m., 1-4 p.m.), the TB Clinic attends patients Monday-Friday (7 a.m.-5 p.m.), with nursing staff accommodating patient visits as needed.

The program staff workforce currently includes 9 Full Time Employees (1 TB Nurse Program Manager, 3 Registered Nurse Case Managers, 1 Outreach Worker, 2 Contact Investigator/Case Registrars, 1 Clinic Support Tech, and 1 Contact Investigator) as shown on the organizational chart (Form E-Organization, Resources & Capacity). The CCHCS Medical Director/Collin County Health Authority (MD/CCHA) spends roughly 60% of her work hours providing diagnosis, treatment, and follow up to TB patients during clinic hours and she is assisted by the nursing staff. The MD/CCHA also makes home visits to special needs or non-adherent TB patients as needed. The outreach worker is responsible for DOT visits, and other staff members perform DOT as a back up in addition to their regularly assigned tasks. There are also two Case Registrars who provide reporting, data entry, and data analysis tasks. To illustrate the challenges facing the TB Elimination Program staff, for calendar year 2010, the team members were responsible for a caseload of 37 TB suspects/cases and a total of 1,870 TB clinic office visits and 4,661 DOT home visits were performed.

Training plays an important role for program staff. It enables them to maintain a reliable working knowledge of TB case management and to keep abreast of important changes in laws/policies dictating patient treatment. Initial training is intensive for new employees—40 hours of job-related instruction during the first 6 weeks of employment and successful completion of the CDC's Core Curriculum on Tuberculosis (Revision 2011) and the CDC's TB 101 for Health Care Workers. Training is ongoing throughout the year for all program staff members via courses from CDC (Heartland National TB Center), DSHS, and other health care partners. These trainings include conferences, webinars, online courses, and peer training with other local health department TB program staff. In addition, the TB Elimination Program Manager performs an annual observation of each employee's skills to address any problems related to the performance of TB clinic duties. TB staff members meet together for case review sessions on a regular basis to discuss obstacles to treatment for current patients, updates on treatment status, challenges with contact investigation, and other patient issues that arise.

Policies. The primary set of policies outlining the duties, processes, and functions of the TB Elimination Program is contained in the *Collin County Health Care Services Policy and Procedure Manual—Tuberculosis Clinic*. State-mandated changes occur and are implemented throughout the year within 14 days of being notified of the change. The policy and procedures manual is reviewed, edited, and updated annually with the signed acknowledgment of all CCHCS staff members.

Support Resources. The CCHCS TB Elimination Program has a wide range of support resources. The most accessible support comes from CCHCS staff members assigned to other clinics/areas. For example, the CCHCS Administrator, MD/CCHA, CCHCS Coordinator, and Chief Epidemiologist perform QA, analyze data, perform case audits, and administrative tasks (managing grant funds, documentation of grant deliverables) for the TB Elimination Program. The CCHCS TB Elimination Program receives limited contract funding from the State of Texas and uses local funding to pay for the majority of its employee salaries and fringe benefits, travel, equipment, supplies, and other TB Elimination Program costs.

The CCHCS Coordinator has managed the TB grant funds from both state and federal agencies since 2008. Other CCHCS employees may provide various levels of support which can include, but is not limited to: data entry, compiling correspondence to patients and other agencies, and communicating with hospital and medical staff regarding labs or patient care. Furthermore, other Collin County departments, such as GIS/Rural Addressing and the Information Technology Department, have provided assistance by mapping out de-identified TB data for analysis and presentation to policy makers to help them understand the scope of TB in Collin County. The CCHCS TB Elimination Program also receives and appreciates the research and expertise offered by the Heartland TB consultants when difficult and/or unique challenges arise in the treatment and infection control of TB patients. In situations where an infectious TB patient becomes non-adherent, the MD/CCHA receives support from the Collin County Sherriff's Office and other local police jurisdictions when law enforcement officers escort her to the patient's home while she is performing her duties as the CCHA. Should a patient's actions require legal intervention or a legal consultation would benefit the CCHCS TB team, the CCHCS TB Elimination Program receives legal support from both the Collin County District Attorney's office and Collin County's contracted legal counsel.

QUESTION 3—Number of persons receiving services. The CCHCS TB Elimination Program Manager compiles monthly reports detailing the program services performed in the community. Reports can include the number of

current patients based on their TB classification who are receiving medication and/or have been identified by CCHCS (i.e. active TB disease, LTBI, etc...), the number of diagnostic tests performed (i.e. TST's performed, IGRA's performed, chest radiograph), healthcare worker services (i.e. office visits, DOT visits, etc...) and other community interactions (i.e. jail data, large contact investigations, etc...) The monthly report is provided to the TB staff, the Chief Epidemiologist, the MD/CCHA, and the CCHCS Administrator. Documentation on services provided is also reported in mid-year and year-end grant reports.

QUESTION 4—How data is collected and tabulated. The CCHCS TB Elimination Program maintains current and historical records of all the services performed for its patients. Both hard copy patient files and electronic records are used to track services rendered. All patient services, treatment, lab reports, radiologic reports, progress notes, DSHS forms, Electronic Disease Notification (EDN) forms, Report of Verified Case of Tuberculosis forms, and relevant information are contained in the patient's chart for the duration of their treatment period. The patient's physical chart is retained indefinitely. The Case Registrar transfers specific patient and service information (i.e. information on cases, TB suspects, contacts to active TB cases, and LTBI's, skin test, sputum test results, chest x-ray results and other case information) from the TB400A and/or TB400B forms into Texas Wide Integration Client Encounter System (TWICES) according to current DSHS requirements. The TB Registrar also transfers the information provided on the CCHCS Cohort Review Presentation form to the centralized TB database (MS Excel). The CCHCS Cohort Review Presentation form is filled out quarterly by the Nurse Case Managers to capture essential patient data and information related to grant performance measures for each case/suspect. The database also contains information for patients who are LTBI's and non-LTBI's. The Case Registrar updates the information on the MS Excel database as new chart information becomes available. Additionally, assigned CCHCS TB Elimination Program staff members receive, process, and submit information related to immigrant and refugee patients according to DSHS and CDC standards. Every month, data from EDN processing is documented for future reporting at the quarterly cohort review meeting.

How community surveillance is conducted. Community surveillance is conducted throughout Collin County through a partnership with North Texas Job Corps, the Samaritan Inn, and the Collin County Detention Facility (Adult and Juvenile). North Texas Job Corps performs TB skin testing on all campus admissions. The TB Program Elimination staff coordinates treatment of all identified cases of LTBI. Should a Job Corps patient leave the Job Corps program prior to completion of LTBI treatment, the TB Elimination Program staff members oversee the transfer of the case to the appropriate health department to ensure the continuity of the patient's treatment. The Samaritan Inn, Collin County's only homeless shelter, also provides TB skin tests to their residents. Moreover, day care providers require their employees to undergo a skin test at the time of hiring and at yearly intervals. Other health care employers, such as area hospitals, have TB skin testing as a part of pre-employment screening and refer positive skin tests to the CCHCS TB Elimination program for evaluation by the MD/CCHA, treatment, and work clearance.

While CCHCS Elimination Program staff members continually respond to passive laboratory surveillance, they are working towards initiating active laboratory surveillance. On a daily basis, a nurse logs into the DSHS public health laboratory for sputum test results. The results are organized by provider, and the nurses can seek the test of a client based on the date of testing and name of the patient. DSHS calls this system PHLIMS – Public Health Laboratory Information Management System. DSHS limits access to records and data relevant to a specified facility's patients and laboratory specimens. At this time, CCHCS is in the preliminary stages of implementing an electronic medical records project and working through possible solutions to incorporate electronic laboratory reporting and enhanced surveillance. Furthermore, the contact investigation process allows for the team to identify unreported cases of TB.

Cases from outside of CCHCS are referred to the Collin County TB Elimination Program as a result of a continual effort to encourage health care providers in the community to follow the guidelines for notifiable conditions. In the past, CCHCS has provided school nurses and physicians with a handbook on clinic services which included information on reporting infectious disease and basic information about TB. The Epidemiology and TB team members interact with hospitals, health care providers, schools, day care centers, patients, and others on a daily basis, and instruct individuals on reporting timeframes and how to report TB to CCHCS. Additionally, the Chief Epidemiologists and the Health Authorities in the North Texas Area communicate/meet on a monthly basis to discuss public health issues, including TB. The MD/CCHA and CCHCS Administrator meet with the Collin-Fannin County Medical Society Meetings on an ongoing basis. Dr Marshall, the Health Director and Medical Director, of the Collin County (CC) TB Elimination Program, continues to be highly visible in the county's TB activities and facilitates physician referrals to the program. CCHCS is well known for its TB services and has a good relationship with area hospitals and their Infection Control Preventionists. Cases are frequently referred to the program from county providers.

Outbreaks and how they are managed. An outbreak of TB in Collin County would be defined as more than one case of active TB in a household or other identifiable cohort, with contact known to spread TB (i.e. a workplace with shared transportation.) An outbreak would be handled by providing initial and follow up skin testing of all contacts to the active TB case. Contacts would receive a thorough assessment and treatment for LTBI as indicated by current practice standards. The active TB case would be referenced as the index case to the contacts on both the DSHS forms in the patient file and in the MS Excel database.

The CCHCS TB Elimination Program has successfully treated and managed several TB outbreaks as defined above. For example, a TB outbreak occurred within an extended family that lived in crowded conditions in a trailer home in rural Collin County. The index TB case is the patriarch of the family and the contact investigation revealed that there were 6 other family members living in the home, including: his wife; his married daughter, son-in-law and their infant son, a young adult daughter; and a daughter still in high school. The infant grandson living in the shared home was admitted to Children's hospital and treated for active TB. The remaining five family members living in the home were treated for LTBI. Aside from the family members living in the same household, the index TB case has an adult son who lives in a separate residence with his wife, 6 year old son, 4 year old son and 1 year old daughter. The contact investigation performed by the CCHCS TB Elimination Program staff revealed that there were additional close contacts that needed to be assessed and possibly treated. Even though he lived in a separate residence, staff members discovered that the 6 year old grandson spent a great deal of time after school at his grandfather's home. Due to the 6 yr old grandson's symptoms, he was admitted to Children's Hospital where he received a complete medical evaluation and subsequently began a four-drug therapy regimen. Also, because the 6 year attended a public elementary school, an extensive contact investigation was carried out at the school where 154 skin tests were administered, 8 LTBI cases were identified and treated (2 children, 6 adults). Next, the two other siblings to the 6 yr old grandson, a 4 yr old grandson and a 1 year old granddaughter, were also admitted to Children's Hospital for evaluation. Of note, the 1 year old granddaughter's gastric aspirates tested positive for MTB. To summarize, from the initial index case of active TB, 4 active pediatric TB cases and 14 LTBI cases were evaluated and treated by the CCHCS TB Elimination Program staff.

QUESTION 5—DATA QUALITY--Data is collected and tabulated on existing TB cases in addition to the new cases of suspect/confirmed TB and LTBI cases that are identified. Referrals may come from physicians, hospitals, or other local health departments. Lab reports and/or notifiable disease reports may be sent by health care providers, DSHS, school officials, detention facilities, and other community contacts either to the Epidemiology staff or the TB Program Elimination staff directly. Contact investigations also have a high probability of producing potential new cases.

As a new TB case or LTBI is identified, a dedicated hard-copy patient file is created to maintain all information for the patient, from initial report to case closing. Specific data from the DSHS reporting forms, toxicity checks, and DOT outreach visits are currently recorded in the hand-written patient file documents for data collection and analysis. To better gauge the overall performance of the CCHCS TB Elimination Program, the Nurse Case Managers fill out the CCHCS Cohort Review Presentation Form each quarter on each case/suspect assigned to them. The boxes/questions on the form directly relate to the data entry fields in the MS Excel database for TB cases. Some of the data entry categories/fields include: demographics, cases status, RVCT#, radiological findings, drug susceptibilities, drug regimen, total # of contacts identified, # of contacts appropriate for evaluation, # of contacts evaluated, total # of LTBI, # LTBI started treatment, # LTBI discontinued treatment, and specific questions related to grant performance measures. The Case Registrar enters the data into TWICES and the MS Excel database for TB cases as a part of their job function.

The CCHCS Chief Epidemiologist, as supervisor over the Epidemiology and TB Elimination Program staff, oversees the TB Elimination Program Manager, who is responsible for managing the staff members who perform data collection. The TB Elimination Program Manager works closely with the Case Registrar to the make sure that patient data is transferred to both TWICES and the centralized TB database (MS Excel) promptly and accurately. To encourage the timeliness and accuracy of data collection, the TB Team Calendar was established to outline each TB team member's responsibilities and deadlines. The TB Nurse Case Managers and Contact Investigators meet each quarter with the CCHCS Chief Epidemiologist to review a minimum number of open and closed case/suspect charts and LTBI charts using the most current DSHS chart review/audit tools. Each quarter, the CCHCS Chief Epidemiologist provides the team with a written summary of findings that is discussed at the quarterly meeting. The TB Elimination Program staff is then able to understand any errors/problems with accuracy, reporting, contact investigations, etc... and address them as a group.

Another component of our data quality efforts at CCHCS TB Elimination Program is the use of the TB genotyping of cases for better contact investigations. The Chief Epidemiologist and the Health Authority have been working with the experts at the CDC and DSHS to understand how the program works and tracing cases back to clusters and sub-clusters with the objective of improving our case investigations, determining possible transmission areas, and understanding how our population is interconnected.

Written Plan. In 2011, CCHCS began using a strategic/written plan tailored to the time and staffing resources available to the CCHCS TB Elimination Program. The purpose of the strategic/written plan is to provide structure for the processes that need to occur throughout the year (i.e. case reviews, cohort reviews, data capturing, grant reporting, chart QA reviews, etc..). The strategic/written plan also outlines the team goals for the coming year. As such, the strategic/written plan includes the following sections: introduction, background, organizational chart, mission statement, SWOT analysis (Strength, Weaknesses, Opportunities, Threats), goals and action plan, and evaluation/assessment. The goals and action plan section contains program objectives as well as the TB Team Calendar which is a realistic schedule outlining the tasks related to the cohort review process for the calendar year. The quarterly cohort review meetings allow team members an opportunity to identify and document obstacles, areas for improvement, and successful outcomes during the previous quarter. It is also a means to provide feedback from

chart reviews (QA), to review the current status of performance measures and give all team members insight on the program's performance on a quarterly basis. Using the strategic/written plan has increased awareness of TB performance measures, CDC and DSHS standards for all team members.

The two primary mechanisms used by the CCHCS TB Elimination Program to assess quality of our TB clinical data are the chart QA audits and the cohort review process. As part of the chart QA audit process, each nurse case manager has a minimum of 1 Open and 1 Closed active TB case/suspect chart reviewed each quarter. The Chief Epidemiologist conducts the chart audit with the most current DSHS case/suspect chart QA review tool, and compiles the findings for each case individually as well as in a summary format for all cases reviewed in the quarter. The assigned contact investigator also attends the chart review so that the contact investigation process is examined. Besides the case/suspect chart QA audits, the Chief Epidemiologist also meets with each Nurse Case Manager and reviews 1 Open and 1 Closed LTBI chart for accuracy and completeness. The Chief Epidemiologist uses the most current DSHS LTBI chart QA review tool to review each chart individually and uses the LTBI chart QA summary tool to provide an overview of all the LTBI charts audited. In this manner, a minimum of 3 Open and 3 Closed case/suspect charts are reviewed and 3 Open and 3 Closed LTBI charts are reviewed each quarter. In the span of a calendar year, 12 Open case/suspect charts, 12 Closed case/suspect charts, 12 Open LTBI charts, and 12 Closed LTBI charts are reviewed..

QUESTION 6—Coordination with providers in service area and other community programs. The CCHCS TB Elimination Program staff members work closely with various types of health and human services providers. In some instances, a patient's case may be initially reported to CCHCS, but the patient actually resides outside of Collin County and the staff members coordinate with the local health department where the patient resides to transfer the case. Coordination is especially important for persons who may begin treatment for LTBI at North Texas Job Corps, but leave the program later on and return to their previous out-of-county residence. In such cases, information is shared by fax and telephone with the appropriate personnel at the receiving health department in an effort to prevent disruption in treatment. Also, the collaboration between CCHCS and the Infection Control Practitioners working at area hospitals serves as a vital link in keeping up to date with potential cases and obstacles to patient treatment that may arise. These professionals provide early warning and documentation of potential TB cases. Staff members and the MD/CCHA act quickly to make contact with patients while they are still in the hospital, deliver the Health Authority Order, and expedite the patient education and contact investigation process. When a case investigation yields contacts who reside outside of Collin County, CCHCS TB Elimination Program staff members coordinate services such as skin testing and chest x-rays with their counterparts in the patient's county of residence to ensure continuity of assessment, case management, and treatment. Another example of coordination is a TB case where staff members worked hand-in-hand with a Department of Family and Protective Services (DFPS) caseworker because children in the household were placed in foster care. The MD/CCHA has also worked directly with private physicians directly when the active TB patient resided in a nursing home. In another situation, the MD/CCHA coordinated efforts with a Federal Probation officer when the TB patient was under the constraints of probation.

Avoidance of duplication of services. Regarding duplication of service in our service area, it is important to note that infectious disease, pulmonary, primary care, and other specialists refer all suspect and/or confirmed TB patients to Collin County Health Care Services (CCHCS) TB Clinic. Although a TB/LTBI patient may receive an initial skin test or chest x-ray at another location, the CCHCS TB Elimination Program is the final destination for treatment, follow up care, and contact investigation for all county TB/LTBI patients.

Plans for TB educational opportunities to area providers and community programs. One of the main goals of the CCHCS TB Elimination Program team for the 2012 calendar year is to expand and enhance the educational opportunities made available to area providers. While the CCHCS TB Elimination team typically provides education to smaller groups through presentations, website, fax, and email updates, the team recognizes that providing educational opportunities is an area that can be improved. To that end, for calendar year 2012, the team members have brainstormed and put into place various means of providing relevant information to area providers and they include: developing a standarized TB outreach packet, creating monthly community education goals, discussing and assigning tasks related to outreach for the current month at case review meetings, partnering with other CCHCS clinics to include TB information when they go to outreach events, and making follow-up visits in person to area hospitals and/or physician's offices to provide education and reinforce appropriate infection control, reporting, and treatment practices. For 2012, the CCHCS TB Elimination Program team is also working diligently to host a small conference that will offer area health care providers the opportunity to learn more about TB and the services provided by the local health department

QUESTION 7—Culturally diverse populations. CCHCS offices are fully compliant with ADA regulations and we have successfully provided long term TB service to paraplegic patients. CCHCS is located centrally within Collin County in McKinney and the clinic is within blocks of three major thoroughfares (Highway 75, Highway 380, and Highway 5). Parking, including spaces specifically designated for the disabled, is easily accessible. Patients are seen weekdays from 7 a.m. to 5 p.m. Program staff members make extra efforts to accommodate patients who need DOT either before or after normal business hours. CCHCS has an agreement with one of its existing partners, PrimaCare, to allow TB patients to have their DOT performed at a PrimaCare location. With locations throughout Collin County in McKinney, Frisco, Plano, and Richardson and extended hours (8am-9pm weekdays, 8am-5pm

17

weekends), we continue to use this option to improve DOT compliance and reduce/eliminate possible disruption to the TB patient's employment.

Assisting patients with TB and LTBI requires the delivery system to have the ability to provide services to culturally diverse populations. The CCHCS TB Elimination Program offers full range of service in Spanish, including consents, educational material, phone service, and clinical management. Also, we have several Spanish-speaking staff members, including contact investigators, a case registrar, and a support tech. For patients who require assistance in languages other than English or Spanish, the CCHCS TB Elimination Program staff access available educational materials via the internet in a language the patient is better able to understand. For office visits, or verbal communication, the program staff uses the telephone translation service, Language Line, so that the patient has a real-time translation of any instructions or information being dispensed to them. Subsequently, the CCHCS TB Elimination team has incorporated discussion on how to assist patients from a variety of cultural backgrounds as part of their quarterly cohort review sessions.

QUESTION 8—Strategy for Management of TB cases and suspects. The CCHCS TB Elimination Program has a full-time DOT outreach worker dedicated to the delivery and management of DOT and other staff members provide back-up DOT coverage as needed. In the beginning of process of working with the patient, the patient's home environment is assessed. Once DOT arrangements are made, a DOT outreach worker uses a county vehicle to deliver DOT directly to the patient at the patient's home or worksite, all the while carefully observing and monitoring the patient for toxicity and other health problems which may be due to treatment and/or underlying health conditions. Each DOT outreach worker has a county-issued cellular phone in order to be able to immediately and directly contact the TB Elimination Program Manager and/or the MD/CCHA in the event of an adverse reaction to medication or questions regarding medication administration. When these challenges arise, the CCHCS Administrator, MD/CCHA and Chief Epidemiologist work closely with the TB Elimination Program staff to assist where needed.

Incentives and enablers are used to ensure the well-being of TB cases and suspects. Food drives are employed to assist TB patients and in the past year, CCHCS has established a patient care fund that is supported by donations generated by a silent auction and employee 'jean day' contributions. The patient care fund is used to assist paitents with transportation, fuel, and other care-related costs. All staff monitor whether patients need to be connected with a food bank or some other local resource. The program manager maintains close contact with the local homeless shelter to assure a high visibility with this community.

QUESTION 9—Process for review of cases under management. A Nurse Case Manager receives and reviews the initial disease report which typically includes patient demographics, diagnostic results, and treatment information. A patient file is created to hold all of TB-related information necessary for case management. Next, the Nurse Case Manager follows up with the referring provider/hospital/agency and establishes a discharge care plan or plan of action to transfer the patient's TB care to the CCHCS TB Elimination Program. Then, the assessment and planning phase begins by establishing contact with patient either at home or at the facility in which they currently reside. The staff member verifies the patient's medical history and conducts a review of symptoms.

As part of the patient's (and their family's) introduction to the TB program, the Nurse Case Manager tactfully provides them with information to help them understand the process of managing and treating TB. During that interchange, the staff member can ascertain any TB treatment adherence issues that need to be addressed. Next, the contact investigation begins as close contacts, friends and family are assessed for exposure timeframes. A plan is established to ensure access to care and to encourage adherence to medical care and guidance. During the initial office visit to the CCHCS TB Clinic or during the patient's hospital stay, the patient begins the patient-physician relationship by meeting with the MD/CCHA who will be providing and monitoring care. From that point on, the case is reviewed continually throughout the treatment period. The patient's case is reviewed by the MD/CCHA throughout the patient's treatment, with special focus on detecting problems with adherence, adverse effects to medication, lab results indicating toxicity, changes in health such as pregnancy or diagnosis of other health conditions. The patient is examined by the MD/CCHA at least once a month, but may be seen more frequently if needed. Other considerations such as work/school absences, psychosocial issues, correspondence to U.S. Immigration representatives, correspondence to and from CDC officials, and any other necessary documentation, are kept in the patient's file. In addition, case review by the entire team occurs on a routine basis to assess the patients' status and needs. The TB contact investigation review team (Health Authority, Chief Epidemiologist, Contact Investigator, Program Manager, and others as appropriate) assess the conditions under which the case interacted with those in the community and decide whether the contact investigation needs to be expanded. Once patient completes the required therapy or the case is transferred because of change in residence, the case is closed according to state mandates.

QUESTION 10—Strategy for Implementation of Cohort Analysis of Cases Quarterly. The CCHCS TB Elimination Team has incorporated the CDC and DSHS guidelines for the cohort quarterly review process and created a customized strategic plan to use the available staffing and time resources. According to the CDC's guidelines, all patient cases should be reviewed approximately 6–9 months after the initial case reporting to analyze TB treatment and contact investigation results. The review would follow a cycle which would repeat throughout the year. For the CCHCS TB Elimination Program, the cohort review process includes a quarterly review of a minimum number of both open and closed case/suspect charts. All cases that are open and closed but not completed will have a CCHCS Cohort Review Presentation Form filled out each quarter by the Nurse Case Manager assigned to the case. Once

the case has been closed and completed, the Nurse Case Manager fills out a final cohort review form. All cohort review forms are submitted to the Case Registrar to check for accuracy, data entry, and analysis. The Case Registrar is responsible for providing a quarterly report that includes the status on all performance measures based on case information provided on the CCHCS Cohort Review Presentation Forms. The closed cases are presented by the Nurse Case Managers for the previous quarter during the quarterly cohort review. Two staff members are assigned to document the lessons learned, cases reviewed, and program changes needed for the group. To round out the cohort review meetings, other staff members provide information such as case review documentation, chart QA summaries, community education documentation, pharmacy inventory documentation, EDN data, performance measure reports, and staff training documentation.

Cohort Review Timeline and Schedule beginning January 2012

2011 4TH Quarter	2012 1ST Quarter	2012 2nd Quarter	2012 3rd Quarter	2012 4th Quarter
TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database
Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics
Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary
Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary
Ongoing case management, case review meetings	Ongoing case management, case review meetings	Ongoing case management, case review meetings	Ongoing case management, case review meetings	Ongoing case management, case review meetings
Follow up on suggestions from cohort review	Follow up on suggestions from cohort review	Follow up on suggestions from cohort review	Follow up on suggestions from cohort review	Follow up on suggestions from cohort review
1/5/2012—Quarterly Cohort Review Meeting	**3/22/2012—Quarterly Cohort Review Meeting**	**6/7/2012—Quarterly Cohort Review Meeting**	**10/4/2012—Quarterly Cohort Review Meeting**	**1/4/2013—Quarterly Cohort Review Meeting**
Cohort Review Session to discuss CLOSED cases from previous quarter	**Cohort Review Session to discuss CLOSED cases from previous quarter**	**PM-Cohort Review Session to discuss CLOSED case from previous quarter**	**PM-Cohort Review Session to discuss CLOSED cases from previous quarter**	**PM—Cohort Review Session to discuss CLOSED cases from previous quarter**
Treatment completion rate and performance measure reporting presented for cases and contacts to cases for 2011 calendar year end report due 3/1/2012	Treatment completion rate and performance measure reporting presented for cases and contacts to cases from 2012 calendar year start through 1st quarter	Treatment completion rate and performance measure reporting presented for cases and contacts to cases from calendar year start through 2nd quarter for mid year report due 7/1/2012	Treatment completion rate and performance measure reporting presented for cases and contacts to cases from calendar year start through 3rd quarter	Treatment completion rate and performance measure reporting presented for cases and contacts to cases for 2012 calendar year end report
Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session
Strategic plan presented for new calendar year (2012)				Strategic plan presented for new calendar year (2013)

QUESTION 11— **Strategy for Management of Contacts and Positive Reactors.** Since June 2010, a formal nurse case management process was put into place that has resulted in a greater measure of quality control and personal accountability of TB cases. The implementation of case management has allowed for the Nurse Case Manager to focus on a certain number of patients. In this manner, the Nurse Case Manager is able to maintain a continuous relationship with the patient, have regular interactions with the patient and their family, and obtain the patient's cooperation and trust. This groundwork helps the Nurse Case Manager more quickly arrange for evaluation of family members or other household members who may need directly observed preventive therapy. DOPT is provided by

19

the CCHCS TB Elimination Program for the following contacts to active TB: contacts less than 5 years of age, contacts who are infected with HIV or are substantially immune-compromised. The CCHCS TB Elimination Program is also willing to offer DOPT to contacts to active TB who may end treatment prematurely because of social or other obstacles such as substance abuse, unstable housing, chronic mental illness, or lack of employment.

QUESTION 12— Contact Investigations. The CCHCS TB Elimination Program staff members are committed to quickly identifying contacts to active TB as well as positive reactors. Whenever a case is reported, staff members immediately begin the process of conducting the contact investigations to expedite the discovery of additional active TB cases as well as identifying any LTBI patients who need evaluation and treatment. From the initial contact with the patient through to the end of treatment, staff members make sure that the patient has provided a clear and accurate picture of all contacts that may be at risk of infection. The Contact Investigator's role is to interview the patient, identify contacts, prioritize the contacts according to the most current CDC and DSHS guidelines, calculate the infection rate for the contact investigation, recommend expanding the contact investigation as needed, schedule contacts for TB screening, document TB screening results, document the treatment progress of the LTBI's, and report information regarding the contacts and their treatment progress to DSHS.

As part of their team goals in 2011, four members of the team received a comprehensive in-house training on contact investigations led by the team's primary contact investigator. A detailed contact investigation manual was developed as well as a PowerPoint presentation, two case studies, and a variety of references. The trainees practiced filling out the appropriate contact investigation forms based on the case studies and their comprehension was measured through a skills test with one of the case studies. By training additional staff members, the contact investigation case load has been been divided amongst the contact investigators in a similar fashion to the nurse case management division of caseload. These cross-training efforts have resulted in an increased accountability of the contact investigations, better monitoring of the progress of the contact investigations, including ensuring that a minimum of three contacts are identified for every case, that contact investigation deadlines are consistently met, delays in interviewing patients are avoided, and the percentage of infected contacts who complete therapy continues to meet performance measure goals.

To help encourage patients to continue treatment, the CCHCS TB Elimination staff has taken the initiative to provide practical assistance to those emaciated TB patients who are unable to afford nutritious food. The staff members accept canned food donated by the community as well as personally donate fresh meat, produce, and/or protein sources for distribution to the patients. Additionally, the employees of CCHCS have held a silent auction of donated items to raise funds to assist patients who may need help with transportation costs, food, or other needs. This kind of personal attention can give patients an added incentive to continue and complete their treatment.

QUESTION 13—Infection control procedures. Universal precautions are observed in all areas of care for the patient whether the patient visits the clinic or the DOT outreach worker meets the patient at their home/workplace. Some standard practices include: hand washing, blood borne precautions, and respiratory precautions. CCHCS has also adopted the Infection Control Manual for Ambulatory Care Clinics—2009 Fourth Edition that was distributed by DSHS for use in all CCHCS clinics and for staff members, patients, and visitors.

For patients seen at the CCHCS TB Clinic, respiratory control measures consist of both environmental control of exam rooms and personal respiratory protection. Environmental control of CCHCS exam rooms is managed by the use of four designated rooms equipped with HEPA systems. The HEPA system provides 100% recirculation of the negative air flow that is produced in the rooms. The room is closed a minimum of one hour after a patient with infectious TB leaves the room. The system is inspected once per month by the Collin County Facilities Management department.

To enhance the personal protection of all CCHCS staff, every staff member receives a skin test as part of their pre-employment as well as on a yearly basis. TB Elimination Program personnel are skin tested every six months. All TB Clinic staff and any other CCHCS employee who might have contact with active cases (front desk personnel, interpreters, etc.) are fit tested for N95 masks and instructed in their proper use. Routine re-fitting is carried out annually. CCHCS employees use N95 masks when they are in face-to-face contact with a suspect or known infectious case and when they perform procedures such as sputum collection or induction. TB suspects/cases that are considered contagious are provided with surgical masks to use while in the clinic.

QUESTION 14—Targeted TB Screening Programs for High-Risk Populations. The CCHCS TB Elimination Program staff understands the need to conduct targeted TB screening programs for high risk populations. Outreach services have been provided to the Samaritan Inn, Collin County's only homeless shelter, and CCHCS staff have participated in local health fairs, visiting community group settings (churches), visiting business groups, and other opportunities to increase the public awareness of services offered by CCHCS. CCHCS has also partnered with the local jail medical staff to provide TB-related education to physicians and nurses.

QUESTION 15—Provision of Professional Education and Training Programs. Education and training of the CCHCS TB Elimination Program staff is an ongoing process. As their priority after being hired, new clinical employees are required to successfully complete the CDC's Core Curriculum on Tuberculosis (Revision 2011) and the CDC's TB 101 for Health Care Workers. New TB Outreach Workers and staff members who provide back-up DOT are required to have 40 hours of office instruction and 40 hours of field work instruction. Successful understanding of instruction is documented by a pre-test and post-test process, as well as use of a preceptor in the field. The TB Elimination Program Manager also oversees the comprehensive initial training needed for new Nurse

10

Case Managers, Contact Investigators, and/or Case Registrars. Targeted TB in-service trainings are held throughout the year in the form of online webinars offered by DSHS, Heartland TB Centers, and/or DSHS. To supplement daily work experience, clinical personnel are scheduled to attend professional conferences as available. DSHS provides TB training as well. Furthermore, The CCHCS TB Elimination Program has developed its own Outreach Worker Training Manual as well as a Contact Investigation Training Manual to provide detailed instructions on outreach worker and contact investigator tasks. Furthermore, on a yearly basis, the TB Elimination Program Manager observes the clinical skills and patient services performed by each team member and provides feedback and additional training as needed. Lastly, the CCHCS TB Elimination Program team successfully conducted a three-day training session in June 2011 to train four of its staff members to help with contact investigation duties.

QUESTION 16—Evaluation of immigrants and refugees. Immigrants, who enter the county with a designation of Class A, Class B-1, or Class B-2, are seen in the CCHCS TB Clinic, evaluated by the MD/CCHA, and provided treatment as indicated. Electronic Disease Notification (EDN) are processed and reported on as required by DSHS.

STRATEGY TO DOCUMENT THE EVALUATION OF CLASSED-IMMIGRANTS AND REFUGEES

Class A-1 Immigrants: Active Disease, Current Treatment	A TB400A and TB400B will be submitted to DSHS which documents current treatment and follow
Class B-1 Immigrants: Pulmonary, No Treatment; Completed Treatment; and Extrapulmonary	A TB400A and TB400B will be submitted that either rules out TB disease, thus a closure code of TB will be submitted, or; a TB 400A and B with the new change in ATS classification will be submi This will be done after the following is begun: 1. Review TST status. If documentation is not available, a TST or IGRA will be administered. T or IGRA results will be evaluated as per ATS/CDC guidelines. 2. A current chest x-ray is taken and compared with the film from overseas. 3. Past TB treatment history is reviewed; History and physical exam performed by MD/CCHA. 4. Collection of sputum for testing on three consecutive days. One collection will be observed b clinic staff. 5. Medication is prescribed as appropriate per ATS/CDC guidelines by MD/CCHA. 6. Follow up as appropriate per ATS/CDC guidelines
Class B-2 Immigrants: LTBI Evaluation	A TB400A and TB400B will be submitted that either rules out TB disease, thus a closure code of TB will be submitted, or a TB 400A and B with the new change in ATS classification will be submitted. This will be done after the following occurs: 1. Review TST status. If documentation is not available, a TST or IGRA will be administered. T or IGRA results will be evaluated per ATS/CDC guidelines. 2. A current chest x-ray is taken and compared with the film from overseas. 3. Past TB treatment history is reviewed; History and physical exam performed by MD/CCHA. 4. Collection of sputum for testing on three consecutive days if deemed necessary by provider. 5. Medication is prescribed as appropriate per ATS/CDC guidelines by MD/CCHA. 6. Follow up as appropriate per ATS/CDC guidelines.
Class B-3 Immigrants: Contact Evaluation	Immigrants who enter the county with a designation of Class B-3 must be seen in the TB Clinic followed as a contact. A form TB 340 will be submitted with information regarding the Contact Investigation and any treatment given.

CONTRACT NO. 2013-041110
PROGRAM ATTACHMENT NO. 002
PURCHASE ORDER NO. 0000385335

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: Tuberculosis Prevention and Control - Federal

TERM: 09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

Throughout the Contractor's defined service area of Collin, the Contractor shall develop and provide: (1) basic services and associated activities for tuberculosis (TB) prevention and control; and (2) expanded outreach services to individuals of identified special populations who have TB and/or who are at high risk of developing TB.

Contractor shall provide the services outlined above in compliance with the following:

- DSHS Standards of Performance for the Prevention and Control of Tuberculosis, available at http://www.dshs.state.tx.us/IDCU/disease/tb/publications/SOP-2008-final.doc;
- DSHS Standards for Public Health Clinic Services, available at http://www.dshs.state.tx.us/qmb/dshsstndrds4clinicservs.pdf;
- DSHS TB Policy and Procedures Manual, available at http://www.dshs.state.tx.us/idcu/disease/tb/publications/;
- American Thoracic Society (ATS) and Centers for Disease Control and Prevention (CDC) joint statements on diagnosis, treatment and control of TB available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm;
- Diagnostic Standards and Classification of Tuberculosis in Adults and Children, (American Journal of Respiratory and Critical Care Medicine, Vol. 161, pp. 1376-1395, 2000) http://ajrccm.atsjournals.org/cgi/reprint/161/4/1376;
- Treatment of Tuberculosis, (ATS/CDC/IDSA), 2003 available at http://www.cdc.gov/tb/pubs/mmwr/Maj_guide/default.htm;
- Targeted Tuberculin Testing and Treatment of Latent TB Infection (LTBI), Morbidity and Mortality Weekly Report, Vol. 49, No. RR-6, 2000, available at http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf;
- Updated: Adverse Event Data and Revised American Thoracic Society/CDC Recommendations Against the Use of Rifampin and Pyrazinamide for Treatment of Latent Tuberculosis Infection – United States, 2003, MMWR 52 (No. 31) http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5231a4.htm;

- Controlling Tuberculosis in the United States, MMWR, Vol. 54, No. RR-12, 2005 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm;
- Guidelines for the Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children at http://www.cdc.gov/mmwr/pdf/rr/rr58e0826.pdf;
- Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents at http://www.cdc.gov/mmwr/pdf/rr/rr58e324.pdf; and
- Updated Guidelines on Managing Drug Interactions in the Treatment of HIV-Related Tuberculosis at http://www.cdc.gov/tb/publications/guidelines/TB_HIV_Drugs/default.htm.

Contractor shall comply with all applicable federal and state regulations and statutes, including, but not limited to, the following:

- Texas Tuberculosis Code, Health and Safety Code, Chapter 13, Subchapter B;
- Communicable Disease Prevention and Control Act, Texas Health and Safety Code, Chapter 81;
- Screening and Treatment for Tuberculosis in Jails and Other Correctional Facilities, Health and Safety Code, Chapter 89;
- Texas Administrative Code TAC, Title 25, Part 1, Chapter 97, Subchapter A, Control of Communicable Diseases; and
- Texas Administrative Code TAC, Title 25, Part 1, Chapter 97, Subchapter H, Tuberculosis Screening for Jails and Other Correctional Facilities.

Contractor shall perform all activities under this Renewal Program Attachment in accordance with Contractor's final, approved work plan (attached as Exhibit A), and detailed budget as approved by DSHS. Contractor must receive written approval from DSHS before varying from applicable policies, procedures, protocols, and the final approved work plan, and must update its implementation documentation within forty-eight (48) hours of making approved changes so that staff working on activities under this contract knows of the change(s).

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS will monitor Contractor's expenditures on a quarterly basis. If expenditures are below what is projected in Contractor's total Renewal Program Attachment amount, Contractor's budget may be subject to a decrease for the remainder of the Contract term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

Because of the inherent time to complete treatment for tuberculosis disease and latent tuberculosis infection in relation to the period of this Renewal Program Attachment, required reporting under this Renewal Program Attachment will show results for work performed under previous Renewal Program Attachments.

Contractor shall provide a complete and accurate annual narrative report, in the format provided by DSHS, demonstrating compliance with the requirements of this Renewal Program Attachment. That report shall include, but is not limited to, a detailed analysis of performance related to the performance measures listed below. A progress report of activities in January through May 2013 shall also be submitted in a format provided by DSHS. These reports shall be

27

sent to the Department of State Health Services, Tuberculosis Services Branch, Mail Code 1873, PO Box 149347, Austin, Texas 78714-9347 via regular mail, or by fax to (512) 371-4675, and sent by e-mail to TBContractReporting@dshs.state.tx.us. Contractor shall maintain the documentation used to calculate performance measures as required by the General Provisions Article VIII "Records Retention" and by the Texas Administrative Code Title 22, Part 9 Chapter 165, §165.1 regarding the retention of medical records.

Report periods and due dates are as follows:

PERIOD COVERED	DUE DATE
January 2012 – December 2012	February 15, 2013
January 2013 – May 2013	July 15, 2013

Contractor shall send all initial reports of confirmed and suspected TB cases to DSHS within seven (7) working days of identification or notification. Any updates to initial DSHS Report of Cases and Patient Services Forms (TB-400) (e.g., diagnosis, medication changes, x-rays, and bacteriology) and case closures shall be sent within thirty (30) days of when a change in information in a required reporting field occurs to DSHS at PO Box 149347, Mail Code 1873, Austin, Texas 78714-9347.

Contractor shall send an initial report to DSHS of contacts on all Class 3 TB cases and smear-positive Class 5 TB suspects within thirty (30) days of identification using DSHS' Report of Contacts Form (TB-340 and TB-341). Any new follow-up information (not included in the initial report) related to the evaluation and treatment of contacts shall be sent to DSHS on the TB-340 and TB-341 at intervals of ninety (90) days, 120 days, and two (2) years after the day the Contractor became aware of the TB case.

Electronic reporting to DSHS for Class 3 TB cases, smear positive Class 5 TB suspects, and their contacts may become available during the term of this Renewal Program Attachment. Once notified of this option by DSHS, Contractor may avail itself of this option if it adheres to all the electronic reporting requirements (including system requirements) provided at that time.

Contractor will determine and report annually the number of persons which receive at least one (1) TB service, including but not limited to: tuberculin skin tests, chest radiographs, health care worker services, or treatment with one or more anti-tuberculosis medications.

Contractor shall monitor and manage its usage of anti-tuberculosis medications and testing supplies furnished by DSHS in accordance with first-expiring-first-out (FEFO) principles of inventory control to minimize waste for those products with expiration dates. On a monthly basis, the Contractor shall perform a count of its inventory of anti-tuberculosis medications and tuberculosis testing supplies furnished by DSHS and reconcile the quantities by product and lot number found by the direct count with the quantities by product and lot number listed in the electronic inventory management system furnished by DSHS. All these tasks shall be performed by the Contractor using the designated database and the designated procedures.

2A

Contractor shall evaluate and monitor Class B immigrants and when needed place them on appropriate prophylaxis for successful completion of treatment. Immigrant notifications shall be obtained through the Electronic Disease Notification (EDN) system. The TB Follow-up Worksheet in EDN shall be completed for all immigrants whose notification was obtained through EDN.

Contractor shall evaluate refugees and other at-risk clients referred by the Refugee Health Program for further clinical evaluation and when needed place those refugees on appropriate prophylaxis and monitor them for successful completion of treatment. The TB Worksheet in EDN shall be completed on refugees and other at-risk clients who are reported through EDN.

SECTION II. PERFORMANCE MEASURES:

The following performance measures will be used to assess, in part, Contractor's effectiveness in providing the services described in this Renewal Program Attachment, without waiving the enforceability of any of the other terms of the contract or any other method of determining compliance:

1. Cases, and suspected cases, of TB under treatment by Contractor shall be placed on timely and appropriate Direct Observed Therapy (DOT). If data indicates a compliance rate for this Performance Measure of less than 90%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

2. Newly diagnosed TB cases that are eligible* to complete treatment within 12 months shall complete therapy within 365 days or less;
   **Exclude TB cases 1) diagnosed at death, 2) who die during therapy, 3) who are resistant to Rifampin, 4) who have meningeal disease, and/or 5) who are younger than 15 years with either miliary disease or a positive blood culture for TB.*
   If data indicates a compliance rate for this Performance Measure of less than 85%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

3. TB cases with initial cultures positive for Mycobacterium tuberculosis complex shall be tested for drug susceptibility and have those results documented in their medical record. If data indicates a compliance rate for this Performance Measure of less than 97.4%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

4. Newly-reported cases of TB with Acid-fast Bacillis (AFB) positive sputum culture results will have documented conversion to sputum culture-negative within 60 days of initiation of treatment. If data indicates a compliance rate for this Performance Measure of less than 45% then DSHS may (at its sole discretion) require additional measures be taken by contractor to improve the percentage, on a timeline set by DSHS;

5. Newly-reported TB cases shall have an HIV test performed (unless they are known HIV-positive, or if the patient refuses) and shall have positive or negative HIV test results reported to DSHS according to the schedule provided herein. If fewer than 80% of newly reported TB cases have a result of an HIV test reported, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

6. Newly-reported suspected cases of TB disease shall be started in timely manner on the recommended initial 4-drug regimen. If fewer than 93.2% of newly-reported TB cases are started on an initial 4-drug regimen in accordance with this requirement, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

7. Newly-reported TB patients with a positive AFB sputum-smear result shall have at least three contacts identified as part of the contact investigation that must be pursued for each case. If data indicates a compliance rate for this Performance Measure of less than 90%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

8. Newly-identified contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive TB case shall be evaluated for TB infection and disease. If data indicates a compliance rate for this Performance Measure of less than 81.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

9. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case and that are newly diagnosed with latent TB infection (LTBI) shall be started on timely and appropriate treatment. If data indicates a compliance rate for this Performance Measure of less than 65%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

10. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case that are newly diagnosed with LTBI and that were started on treatment shall complete treatment for LTBI as described in Targeted Tuberculin Testing and Treatment of Latent TB Infection (LTBI), Morbidity and Mortality Weekly Report, Vol. 49, No. RR-6, 2000, and according to the timelines given therein. If data indicates a compliance rate for this Performance Measure of less than 45%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

11. Newly-reported TB patients that are older than 12-years-old and that have a pleural or respiratory site of disease shall have sputum AFB-culture results reported to DSHS according to the timelines for reporting initial and updated results given herein. If data

indicates a compliance rate for this Performance Measure of less than 89.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS; and

12. All reporting to DSHS shall be completed as described herein under Section I above and submitted by the deadlines given.

If the Contractor fails to meet any of the performance measures, the Contractor shall furnish in the narrative report, due February 15, 2013, a written explanation including a plan (with schedule) to meet those measures. This requirement does not excuse any violation of this Contract, nor does it limit DSHS as to any options available under the contract regarding breach.

SECTION III. SOLICITATION DOCUMENT:

Exempt - Governmental Entity

SECTION IV. RENEWALS:

DSHS may renew the Program Attachment for up to one (1) additional one-year term, at DSHS's sole discretion.

SECTION V. PAYMENT METHOD:

Cost Reimbursement

Funding is further detailed in the attached Categorical Budget and if applicable, Equipment List.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) and acceptable supporting documentation for reimbursement of the required services/deliverables. Vouchers and supporting documentation should be mailed or submitted by fax or electronic mail to the addresses/number below.

Claims Processing Unit, MC1940
Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13) to the Claims Processing Unit is (512) 776-7442. The email address is invoices@dshs.state.tx.us.

27

SECTION VII. BUDGET

SOURCE OF FUNDS:

CFDA Funding #93.116

DUNS #074873449

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, **Article III. FUNDING, Section 3.06, Nonsupplanting**, is revised to include the following:

Funding from this Renewal Program Attachment shall not be used to supplant (i.e., used in place of funds dedicated, appropriated or expended for activities funded through this Renewal Program Attachment) state or local funds, but Contractor shall use such funds to increase state or local funds currently available for a particular activity. Contractor shall maintain local funding at a sufficient rate to support the local program. If the total cost of the project is greater than DSHS' set funding, Contractor shall supply funds for the remaining costs in order to accomplish the objectives set forth in this Program Attachment.

All revenues directly generated by this Renewal Program Attachment or earned as a result of this Renewal Program Attachment during the term of this Renewal Program Attachment are considered program income, including income generated through Medicaid billings for TB related clinic services. Contractor shall use this program income to further the scope of work detailed in this Renewal Program Attachment, and must keep documentation to demonstrate such to DSHS's satisfaction. This program income may not be used to take the place of existing local, state, or federal program funds.

General Provisions, ARTICLE IV. **PAYMENT METHODS AND RESTRICTIONS,** Section 4.02 **Billing Submission**, is amended to include the following:

Contractor shall submit requests for reimbursement or payment, or revisions to previous reimbursement request(s), no later than January 30, 2013 for costs incurred between the services dates of September 1, 2012 and December 31, 2012

General Provisions, ARTICLE IV. **PAYMENT METHODS AND RESTRICTIONS,** Section 4.05 **Financial Status Reports**, is amended to include the following:

Contactor shall submit FSRs to Accounts Payable by the last business day of the month following the end of each term reported. The FSR period will be reported as follows: Quarter One shall include September 1, 2012 through December 31, 2012. Quarter two shall include January 1, 2013 through March 31, 2013. Quarter three shall include April 1, 2013 through June 30, 2013. Quarter four shall include July 1, 2013 through August 31, 2013. Contractor shall submit the final FSR no later than sixty (60) calendar days following the end

of the applicable term.

General Provisions, **Article XIII. General Terms**, **Section 13.15 Amendment**, is amended to include the following:

Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least ninety (90) days prior to the end of the term of this Program Attachment.

2013-041110-002

Categorical Budget:

PERSONNEL	$73,778.00
FRINGE BENEFITS	$22,871.00
TRAVEL	$1,781.00
EQUIPMENT	$0.00
SUPPLIES	$4,099.00
CONTRACTUAL	$33,460.00
OTHER	$0.00
TOTAL DIRECT CHARGES	$135,989.00
INDIRECT CHARGES	$0.00
TOTAL	$135,989.00
DSHS SHARE	$135,989.00
CONTRACTOR SHARE	$0.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $135,989.00

Financial status reports are due: 01/31/2013, 04/30/2013, 07/31/2013, 10/30/2013

DSHS CONTRACT: 2013-041110-002
COLLIN COUNTY HEALTH CARE SERVICES
TB/PC-FEDERAL
EXHIBIT A WORK PLAN

QUESTION 1—Proposed services. The proposed services aimed at the prevention and control of Tuberculosis (TB) provided by Collin County Health Care Services (CCHCS) through its TB Elimination Program include: performing TB skin testing or IGRA (when indicated) and chest x-ray services for the public as well as contacts to TB cases, providing TB-related medical care and Directly Observed Therapy (DOT) for active TB cases, providing Latent Tuberculosis Infection (LTBI) treatment and Directly Observed Preventive (DOPT) therapy to patients at risk of developing TB disease, providing TB screening for immigrants, performing contact investigations in compliance with the Texas Department of State Health Services (DSHS) standards, cooperating with other TB prevention partners in TB elimination activities, and imparting key information/education regarding the management of TB patients to medical and professional personnel in the community.

Service area, Population to be Served. The area served by the CCHCS TB Elimination Program is Collin County, Texas. Collin County, located in North Texas, is part of the Dallas/Fort Worth Metroplex. The geographical area of Collin County covers 847.56 square miles[1] and is comprised of metropolitan centers, suburban communities, and rural landscapes. The population of Collin County has increased to an estimated 842,364 residents in 2010[2]. McKinney, the county seat, was identified as the nation's fastest growing city between April 1, 2000 and July 1, 2008 when its population more than doubled to 121,211 residents[3]. Collin County's rise in numbers has been relatively diverse from an ethnicity standpoint in comparison with other counties and the state as a whole. With these factors in mind, it is of growing concern that the TB case rate for Collin County has steadily increased from 2.9 to 4.7 cases per 100,000 persons in recent years[4].

POPULATION PERCENTAGE BY ETHNICITY, 2010[5]					PERCENT CHANGE IN POPULATION BY ETHNICITY 2000-2010[5]			
County	White, %	Black, %	Hispanic, %	Other, %	White, %	Black, %	Hispanic, %	Other, %
Collin	71.3	5.7	14.0	9.0	58.5	94.8	133.5	101.5
Dallas	31.7	20.3	41.9	6.1	-22.7	8.8	54.1	44.0
Denton	71.1	7.1	16.0	5.8	50.7	90.5	115.1	94.9
Tarrant	49.1	13.4	30.4	7.1	-1.4	30.3	94.5	100.8
Texas	45.1	11.5	38.8	4.6	3.3	20.8	47.7	69.0

Individuals served from counties outside stated service area. In order to serve community-based, TB-related health care needs, CCHCS partners with Collin County Detention Facility, as well as North Texas Job Corps Center (both located in McKinney). Furthermore, CCHCS has partnered with PrimaCare for TB DOT services in unusual situations. Serving individuals outside of Collin County is a challenge that requires diligent attention since the spread of TB can cross geographical boundaries as a result of patients moving and contact exposures. For new reports of suspect TB patients reported to CCHCS where the patient resides in another county, both the Epidemiology staff and the TB Program Manager forward lab results and critical information to the DSHS Region 2/3 office and/or the health department where the patient resides in order to expedite the follow up needed for that patient. For a small number of cases, the TB patient's workplace is located in Collin County, even though they reside in another county. Consequently, if the provision of DOT and/or TB services to the out of county TB patient has the potential to enhance compliance, the Collin County Health Authority and CCHCS Administrator will approve extending TB services to the

[1] U.S. Census Bureau, State and County QuickFacts, Collin County, available from http://quickfacts.census.gov/qfd/states/48/4805.html; Internet; accessed 5/5/10.

[2] Texas Department of State Health Services, Texas Health Data—Population, available from http://soupfin.tdh.state.tx.us/pop2000a.htm, Internet; accessed 5/5/10.

[3] U.S. Census Bureau Press Release 7/1/09, available from http://www.census.gov/Press-Release/www/releases/archives/population/013960.html; Internet; accessed 5/5/10.

[4] Texas Department of State Health Services, IDCU Tuberculosis Statistics, M.TB Complex Surveillance Data (2005-2009), Cases and rates by county, available from; Internet; http://www.dshs.state.tx.us/idcu/disease/tb/statistics/ ; accessed 19 May 2011.

[5] Texas Department of State Health Services, Texas Health Data—Population, available from http://soupfin.tdh.state.tx.us/pop2000a.htm, Internet; accessed 5/5/10.

(i.e. active TB disease, LTBI, etc...), the number of diagnostic tests performed (i.e. TST's performed, IGRA's performed, chest radiograph), healthcare worker services (i.e. office visits, DOT visits, etc...) and other community interactions (i.e. jail data, large contact investigations, etc...) The monthly report is provided to the TB staff, the Chief Epidemiologist, the MD/CCHA, and the CCHCS Administrator. Documentation on services provided is also reported in mid-year and year-end grant reports.

QUESTION 4—How data is collected and tabulated. The CCHCS TB Elimination Program maintains current and historical records of all the services performed for its patients. Both hard copy patient files and electronic records are used to track services rendered. All patient services, treatment, lab reports, radiologic reports, progress notes, DSHS forms, Electronic Disease Notification (EDN) forms, Report of Verified Case of Tuberculosis forms, and relevant information are contained in the patient's chart for the duration of their treatment period. The patient's physical chart is retained indefinitely. The Case Registrar transfers specific patient and service information (i.e. information on cases, TB suspects, contacts to active TB cases, and LTBI's, skin test, sputum test results, chest x-ray results and other case information) from the TB400A and/or TB400B forms into Texas Wide Integration Client Encounter System (TWICES) according to current DSHS requirements. The TB Registrar also transfers the information provided on the CCHCS Cohort Review Presentation form to the centralized TB database (MS Excel). The CCHCS Cohort Review Presentation form is filled out quarterly by the Nurse Case Managers to capture essential patient data and information related to grant performance measures for each case/suspect. The database also contains information for patients who are LTBI's and non-LTBI's. The Case Registrar updates the information on the MS Excel database as new chart information becomes available. Additionally, assigned CCHCS TB Elimination Program staff members receive, process, and submit information related to immigrant and refugee patients according to DSHS and CDC standards. Every month, data from EDN processing is documented for future reporting at the quarterly cohort review meeting.

How community surveillance is conducted. Community surveillance is conducted throughout Collin County through a partnership with North Texas Job Corps, the Samaritan Inn, and the Collin County Detention Facility (Adult and Juvenile). North Texas Job Corps performs TB skin testing on all campus admissions. The TB Program Elimination staff coordinates treatment of all identified cases of LTBI. Should a Job Corps patient leave the Job Corps program prior to completion of LTBI treatment, the TB Elimination Program staff members oversee the transfer of the case to the appropriate health department to ensure the continuity of the patient's treatment. The Samaritan Inn, Collin County's only homeless shelter, also provides TB skin tests to their residents. Moreover, day care providers require their employees to undergo a skin test at the time of hiring and at yearly intervals. Other health care employers, such as area hospitals, have TB skin testing as a part of pre-employment screening and refer positive skin tests to the CCHCS TB Elimination program for evaluation by the MD/CCHA, treatment, and work clearance.

While CCHCS Elimination Program staff members continually respond to passive laboratory surveillance, they are working towards initiating active laboratory surveillance. On a daily basis, a nurse logs into the DSHS public health laboratory for sputum test results. The results are organized by provider, and the nurses can seek the test of a client based on the date of testing and name of the patient. DSHS calls this system PHLIMS – Public Health Laboratory Information Management System. DSHS limits access to records and data relevant to a specified facility's patients and laboratory specimens. At this time, CCHCS is in the preliminary stages of implementing an electronic medical records project and working through possible solutions to incorporate electronic laboratory reporting and enhanced surveillance. Furthermore, the contact investigation process allows for the team to identify unreported cases of TB.

Cases from outside of CCHCS are referred to the Collin County TB Elimination Program as a result of a continual effort to encourage health care providers in the community to follow the guidelines for notifiable conditions. In the past, CCHCS has provided school nurses and physicians with a handbook on clinic services which included information on reporting infectious disease and basic information about TB. The Epidemiology and TB team members interact with hospitals, health care providers, schools, day care centers, patients, and others on a daily basis, and instruct individuals on reporting timeframes and how to report TB to CCHCS. Additionally, the Chief Epidemiologists and the Health Authorities in the North Texas Area communicate/meet on a monthly basis to discuss public health issues, including TB. The MD/CCHA and CCHCS Administrator meet with the Collin-Fannin County Medical Society Meetings on an ongoing basis. Dr Marshall, the Health Director and Medical Director, of the Collin County (CC) TB Elimination Program, continues to be highly visible in the county's TB activities and facilitates physician referrals to the program. CCHCS is well known for its TB services and has a good relationship with area hospitals and their Infection Control Preventionists. Cases are frequently referred to the program from county providers.

Outbreaks and how they are managed. An outbreak of TB in Collin County would be defined as more than one case of active TB in a household or other identifiable cohort, with contact known to spread TB (i.e. a workplace with shared transportation.) An outbreak would be handled by providing initial and follow up skin testing of all contacts to the active TB case. Contacts would receive a thorough assessment and treatment for LTBI as indicated by current practice standards. The active TB case would be referenced as the index case to the contacts on both the DSHS forms in the patient file and in the MS Excel database.

The CCHCS TB Elimination Program has successfully treated and managed several TB outbreaks as defined above. For example, a TB outbreak occurred within an extended family that lived in crowded conditions in a trailer home in

The two primary mechanisms used by the CCHCS TB Elimination Program to assess quality of our TB clinical data are the chart QA audits and the cohort review process. As part of the chart QA audit process, each nurse case manager has a minimum of 1 Open and 1 Closed active TB case/suspect chart reviewed each quarter. The Chief Epidemiologist conducts the chart audit with the most current DSHS case/suspect chart QA review tool, and compiles the findings for each case individually as well as in a summary format for all cases reviewed in the quarter. The assigned contact investigator also attends the chart review so that the contact investigation process is examined. Besides the case/suspect chart QA audits, the Chief Epidemiologist also meets with each Nurse Case Manager and reviews 1 Open and 1 Closed LTBI chart for accuracy and completeness. The Chief Epidemiologist uses the most current DSHS LTBI chart QA review tool to review each chart individually and uses the LTBI chart QA summary tool to provide an overview of all the LTBI charts audited. In this manner, a minimum of 3 Open and 3 Closed case/suspect charts are reviewed and 3 Open and 3 Closed LTBI charts are reviewed each quarter. In the span of a calendar year, 12 Open case/suspect charts, 12 Closed case/suspect charts, 12 Open LTBI charts, and 12 Closed LTBI charts are reviewed..

QUESTION 6—Coordination with providers in service area and other community programs. The CCHCS TB Elimination Program staff members work closely with various types of health and human services providers. In some instances, a patient's case may be initially reported to CCHCS, but the patient actually resides outside of Collin County and the staff members coordinate with the local health department where the patient resides to transfer the case. Coordination is especially important for persons who may begin treatment for LTBI at North Texas Job Corps, but leave the program later on and return to their previous out-of-county residence. In such cases, information is shared by fax and telephone with the appropriate personnel at the receiving health department in an effort to prevent disruption in treatment. Also, the collaboration between CCHCS and the Infection Control Practitioners working at area hospitals serves as a vital link in keeping up to date with potential cases and obstacles to patient treatment that may arise. These professionals provide early warning and documentation of potential TB cases. Staff members and the MD/CCHA act quickly to make contact with patients while they are still in the hospital, deliver the Health Authority Order, and expedite the patient education and contact investigation process. When a case investigation yields contacts who reside outside of Collin County, CCHCS TB Elimination Program staff members coordinate services such as skin testing and chest x-rays with their counterparts in the patient's county of residence to ensure continuity of assessment, case management, and treatment. Another example of coordination is a TB case where staff members worked hand-in-hand with a Department of Family and Protective Services (DFPS) caseworker because children in the household were placed in foster care. The MD/CCHA has also worked directly with private physicians directly when the active TB patient resided in a nursing home. In another situation, the MD/CCHA coordinated efforts with a Federal Probation officer when the TB patient was under the constraints of probation.

Avoidance of duplication of services. Regarding duplication of service in our service area, it is important to note that infectious disease, pulmonary, primary care, and other specialists refer all suspect and/or confirmed TB patients to Collin County Health Care Services (CCHCS) TB Clinic. Although a TB/LTBI patient may receive an initial skin test or chest x-ray at another location, the CCHCS TB Elimination Program is the final destination for treatment, follow up care, and contact investigation for all county TB/LTBI patients.

Plans for TB educational opportunities to area providers and community programs. One of the main goals of the CCHCS TB Elimination Program team for the 2012 calendar year is to expand and enhance the educational opportunities made available to area providers. While the CCHCS TB Elimination team typically provides education to smaller groups through presentations, website, fax, and email updates, the team recognizes that providing educational opportunities is an area that can be improved. To that end, for calendar year 2012, the team members have brainstormed and put into place various means of providing relevant information to area providers and they include: developing a standarized TB outreach packet, creating monthly community education goals, discussing and assigning tasks related to outreach for the current month at case review meetings, partnering with other CCHCS clinics to include TB information when they go to outreach events, and making follow-up visits in person to area hospitals and/or physician's offices to provide education and reinforce appropriate infection control, reporting, and treatment practices. For 2012, the CCHCS TB Elimination Program team is also working diligently to host a small conference that will offer area health care providers the opportunity to learn more about TB and the services provided by the local health department

QUESTION 7—Culturally diverse populations. CCHCS offices are fully compliant with ADA regulations and we have successfully provided long term TB service to paraplegic patients. CCHCS is located centrally within Collin County in McKinney and the clinic is within blocks of three major thoroughfares (Highway 75, Highway 380, and Highway 5). Parking, including spaces specifically designated for the disabled, is easily accessible. Patients are seen weekdays from 7 a.m. to 5 p.m. Program staff members make extra efforts to accommodate patients who need DOT either before or after normal business hours. CCHCS has an agreement with one of its existing partners, PrimaCare, to allow TB patients to have their DOT performed at a PrimaCare location. With locations throughout Collin County in McKinney, Frisco, Plano, and Richardson and extended hours (8am-9pm weekdays, 8am-5pm weekends), we continue to use this option to improve DOT compliance and reduce/eliminate possible disruption to the TB patient's employment.

Assisting patients with TB and LTBI requires the delivery system to have the ability to provide services to culturally diverse populations. The CCHCS TB Elimination Program offers full range of service in Spanish, including consents,

assigned to document the lessons learned, cases reviewed, and program changes needed for the group. To round out the cohort review meetings, other staff members provide information such as case review documentation, chart QA summaries, community education documentation, pharmacy inventory documentation, EDN data, performance measure reports, and staff training documentation.

Cohort Review Timeline and Schedule beginning January 2012

2011 4TH Quarter	2012 1ST Quarter	2012 2nd Quarter	2012 3rd Quarter	2012 4th Quarter
TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database	TB cases counted, cohort review forms filled out, data from forms entered into TB database
Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics	Treatment started, ongoing, or completed based on case specifics
Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary	Contact investigation initiated, ongoing or completed as necessary
Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary	Infected contacts begin, continue or end LTBI treatment as necessary
Ongoing case management, case review meetings	Ongoing case management, case review meetings	Ongoing case management, case review meetings	Ongoing case management, case review meetings	Ongoing case management, case review meetings
Follow up on suggestions from cohort review	Follow up on suggestions from cohort review	Follow up on suggestions from cohort review	Follow up on suggestions from cohort review	Follow up on suggestions from cohort review
1/5/2012—Quarterly Cohort Review Meeting	**3/22/2012—Quarterly Cohort Review Meeting**	**6/7/2012—Quarterly Cohort Review Meeting**	**10/4/2012—Quarterly Cohort Review Meeting**	**1/4/2013—Quarterly Cohort Review Meeting**
Cohort Review Session to discuss CLOSED cases from previous quarter	**Cohort Review Session to discuss CLOSED cases from previous quarter**	**PM-Cohort Review Session to discuss CLOSED case from previous quarter**	**PM-Cohort Review Session to discuss CLOSED cases from previous quarter**	**PM—Cohort Review Session to discuss CLOSED cases from previous quarter**
Treatment completion rate and performance measure reporting presented for cases and contacts to cases for 2011 calendar year end report due 3/1/2012	Treatment completion rate and performance measure reporting presented for cases and contacts to cases from 2012 calendar year start through 1st quarter	Treatment completion rate and performance measure reporting presented for cases and contacts to cases from calendar year start through 2nd quarter for mid year report due 7/1/2012	Treatment completion rate and performance measure reporting presented for cases and contacts to cases from calendar year start through 3rd quarter	Treatment completion rate and performance measure reporting presented for cases and contacts to cases for 2012 calendar year end report
Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session	Document obstacles, lessons learned, and successes discussed during cohort review session
Strategic plan presented for new calendar year (2012)				Strategic plan presented for new calendar year (2013)

QUESTION 11— Strategy for Management of Contacts and Positive Reactors. Since June 2010, a formal nurse case management process was put into place that has resulted in a greater measure of quality control and personal accountability of TB cases. The implementation of case management has allowed for the Nurse Case Manager to focus on a certain number of patients. In this manner, the Nurse Case Manager is able to maintain a continuous relationship with the patient, have regular interactions with the patient and their family, and obtain the patient's cooperation and trust. This groundwork helps the Nurse Case Manager more quickly arrange for evaluation of family members or other household members who may need directly observed preventive therapy. DOPT is provided by the CCHCS TB Elimination Program for the following contacts to active TB: contacts less than 5 years of age, contacts who are infected with HIV or are substantially immune-compromised. The CCHCS TB Elimination Program is also willing to offer DOPT to contacts to active TB who may end treatment prematurely because of social or other obstacles such as substance abuse, unstable housing, chronic mental illness, or lack of employment.

QUESTION 12— Contact Investigations. The CCHCS TB Elimination Program staff members are committed to quickly identifying contacts to active TB as well as positive reactors. Whenever a case is reported, staff members

additional training as needed. Lastly, the CCHCS TB Elimination Program team successfully conducted a three-day training session in June 2011 to train four of its staff members to help with contact investigation duties.

QUESTION 16—Evaluation of immigrants and refugees. Immigrants, who enter the county with a designation of Class A, Class B-1, or Class B-2, are seen in the CCHCS TB Clinic, evaluated by the MD/CCHA, and provided treatment as indicated. Electronic Disease Notification (EDN) are processed and reported on as required by DSHS.

STRATEGY TO DOCUMENT THE EVALUATION OF CLASSED-IMMIGRANTS AND REFUGEES

Class A-1 Immigrants: Active Disease, Current Treatment	A TB400A and TB400B will be submitted to DSHS which documents current treatment and follow-
Class B-1 Immigrants: Pulmonary, No Treatment; Completed Treatment; and Extrapulmonary	A TB400A and TB400B will be submitted that either rules out TB disease, thus a closure code of n TB will be submitted, or; a TB 400A and B with the new change in ATS classification will be submitt This will be done after the following is begun: 1. Review TST status. If documentation is not available, a TST or IGRA will be administered. TS or IGRA results will be evaluated as per ATS/CDC guidelines. 2. A current chest x-ray is taken and compared with the film from overseas. 3. Past TB treatment history is reviewed; History and physical exam performed by MD/CCHA. 4. Collection of sputum for testing on three consecutive days. One collection will be observed by clinic staff. 5. Medication is prescribed as appropriate per ATS/CDC guidelines by MD/CCHA. 6. Follow up as appropriate per ATS/CDC guidelines
Class B-2 Immigrants: LTBI Evaluation	A TB400A and TB400B will be submitted that either rules out TB disease, thus a closure code of n TB will be submitted, or a TB 400A and B with the new change in ATS classification will be submitted. This will be done after the following occurs: 1. Review TST status. If documentation is not available, a TST or IGRA will be administered. TS or IGRA results will be evaluated per ATS/CDC guidelines. 2. A current chest x-ray is taken and compared with the film from overseas. 3. Past TB treatment history is reviewed; History and physical exam performed by MD/CCHA. 4. Collection of sputum for testing on three consecutive days if deemed necessary by provider. 5. Medication is prescribed as appropriate per ATS/CDC guidelines by MD/CCHA. 6. Follow up as appropriate per ATS/CDC guidelines.
Class B-3 Immigrants: Contact Evaluation	Immigrants who enter the county with a designation of Class B-3 must be seen in the TB Clinic ar followed as a contact. A form TB 340 will be submitted with information regarding the Contact Investigation and any treatment given.

CONTRACT NO. 2013-041110
PROGRAM ATTACHMENT NO. 003
PURCHASE ORDER NO. 0000385781

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: CPS - CITIES READINESS INITIATIVE

TERM: 09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

Contractor shall perform activities in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP12-1201) from the Centers for Disease Control and Prevention (CDC). To comply with the Public Health Emergency Preparedness (PHEP) cooperative agreement's capabilities-based approach, Cities Readiness Initiative (CRI) requirements support the Medical Countermeasure Dispensing and Medical Materiel Management and Distribution capabilities. The Cities Readiness Initiative supports medical countermeasure distribution and dispensing (MCMDD) for all-hazards events including the ability of jurisdictions to develop capabilities to respond to large-scale biological attacks with anthrax as the primary threat consideration and to broaden activities to improve all-hazards planning capabilities.

The Centers for Disease Control and Prevention (CDC) developed an MCMDD composite score to serve as a collective indicator of MCMDD preparedness and operational capability within local jurisdictions, CRI Metropolitan Statistical Areas (MSAs), and states. Preparedness across these levels will be subsequently defined as a composite measure derived from results of Technical Assistance Reviews (TARs), drill submissions, full-scale exercises, and compliance with programmatic standards. 2012 to 2013 is the second year of the five-year MCMDD composite score framework which was introduced in the budget period from 2011 to 2012.

Contractor shall develop plans and infrastructure so the targeted Metropolitan Statistical Area (MSA) is prepared to provide medical countermeasures to the identified population within 48 hours after the federal decision to do so during a large-scale public health emergency. To accomplish this, the Contractor shall:

A. Meet the requirements of Capability 8: Medical Countermeasure Dispensing and the associated functions, tasks, and resource elements for this capability; and
B. Enhance the jurisdiction's capability to establish a network of Points of Dispensing (PODs) operated by volunteers or paid staff trained on current POD Standards
C. Meet the requirements of Capability 3: Emergency Operations Coordination and associated functions, tasks, and resource elements for this capability and
D. Enhance the jurisdiction's capability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight,

organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

Contractor shall coordinate planning and program implementation activities to ensure that state and local health departments, hospitals, other health care entities, health care providers, state and local public safety agencies, and emergency management agencies are able to mount a collective medical countermeasure response featuring seamless interaction of event-specific planning and operational components in the following areas of medical countermeasure core planning functions (based on the TAR requirements):

1. Development of a Plan With Strategic National Stockpile Elements
2. Management of Strategic National Stockpile / Command and Control
3. Requesting Medical Countermeasures Assets
4. Tactical Communications Plan
5. Public Information and Communication
6. Security
7. Regional/Local Distribution Site (if applicable)
8. Inventory Management
9. Distribution (if applicable)
10. Dispensing Medical Countermeasures
11. Coordination with Hospitals and Alternate Care Facilities
12. Training and Exercising

Contractor shall comply with all applicable federal and state laws, rules and regulations including, but not limited to, the following:

A. Public Law 107-117, Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States, Act. 2002;
B. Public Law 107-188, Public Health Security and Bioterrorism Preparedness and Response Act of 2002;
C. Public Law 109-417, Pandemic and All-Hazards Preparedness Act of 2006; and
D. Chapter 81, Texas Health and Safety Code.

Contractor shall comply with all applicable regulations, standards and guidelines in effect on the beginning date of this program Attachment.

The following documents are incorporated by reference and made a part of this Program Attachment:

A. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Public Health Emergency Preparedness Cooperative Agreement, Funding Opportunity Number CDC-RFA-TP12-1201
B. Public Health Emergency Preparedness Workplan for the Cities Readiness Initiative, which is hereby attached as Exhibit A
C. Texas Strategic National Stockpile Program Manual http://www.snstexas.info;

D. Texas Public Health and Medical Emergency Management 5-Year Strategic Plan
E. Tactical Guide, Companion Document to the Texas Public Health and Medical Emergency Management 5-Year Strategic Plan 2012 to 2016
F. Homeland Security Exercise and Evaluation Plan (HSEEP) Documents: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx;
G. Community Preparedness Section Exercise Team Web Site: http://www.dshs.state.tx.us/comprep/exercise/.
H. *Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011* at: http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf

Funds awarded herewith must be matched by costs or third party contributions that are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for cost sharing or matching. The non-federal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated, including plant, equipment, or services. The costs that the contractor incurs in fulfilling its matching or cost-sharing requirement are subject to the same requirements, including the cost principles, that are applicable to the use of Federal funds, including prior approval requirements and other rules for allowable costs as described in 45 CFR 74.23 and 45 CFR 92.24.

Contractor is required to provide matching funds for this Program Attachment not less than 10% of total costs. Refer to the DSHS Contractor's Financial Procedures Manual, Chapter 9 at http://www.dshs.state.tx.us/contracts/cfpm.shtm for additional guidance on match requirements, including descriptions of acceptable match resources. Documentation of match, including methods and sources, must be included in Contractor's contract budget and Contractor must follow procedures for generally accepted accounting practices and meet audit requirements.

Contractor shall coordinate activities and response plans within the jurisdiction with the state, regional and other local jurisdictions, among local agencies and with hospitals and major health care entities, jurisdictional Metropolitan Medical Response Systems, and Councils of Government.

Contractor shall cooperate with DSHS to coordinate all planning, training, and exercises performed under this Contract with the State of Texas, Texas Division of Emergency Management of the State of Texas, or other points-of-contact at the discretion of the division, to ensure consistency and coordination of requirements at the local level and eliminate duplication of effort between the various domestic preparedness funding sources in the state.

Contractor shall inform DSHS in writing if it shall not continue performance under this Program Attachment within thirty (30) days of receipt of an amended standard(s) or guideline(s). DSHS may terminate this Program Attachment immediately or within a reasonable period of time as determined by DSHS.

Contractor shall develop, implement, and maintain a timekeeping system for accurately documenting staff time and salary expenditures for all staff funded through this Program Attachment, including partial Full Time Equivalents (FTEs) and temporary staff.

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS will monitor Contractor's expenditures on a quarterly basis. If expenditures are below that projected in Contractor's total Contract amount, Contractor's budget may be subject to a decrease for the remainder of the Contract term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

SECTION II. PERFORMANCE MEASURES:

Contractor shall provide sufficient documentation of planning, training, and exercising per the functions and tasks of Capability 8, Medical Countermeasure Dispensing found in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011* to meet the requirements of the evidence-based benchmark, demonstrated capability to receive, stage, store, distribute, and dispense materiel during a public health emergency. This benchmark includes a composite performance indicator of preparedness from the Division of Strategic National Stockpile (DSNS) in CDC's Office of Public Health Preparedness and Response. This indicator can be found on the DSNS extranet at
http://emergency.cdc.gov/stockpile/extranet

Contractor shall perform activities for Medical Countermeasure Dispensing, Capability 8, Function 4, Tasks 1 through 7 noted in the attached Exhibit A.

Contractor shall comply with the following activities for the CDC-defined performance measure related to Medical Countermeasure Dispensing, Capability 8:

Prepare for and participate in Technical Assistance Reviews

Perform and submit metrics on three (3) Division of Strategic National Stockpile (DSNS) operational drills and After Action Reviews / Improvements Plans to the exercise team no later than April 1, 2013

Demonstrate compliance with current programmatic medical countermeasure guidance through submission of point of dispensing (POD) standards data

Conduct all exercises and training in accordance with Homeland Security Exercise Evaluation Program (HSEEP) guidance

Perform one full-scale dispensing exercise that includes all pertinent jurisdictional leadership and emergency support function leads, planning and operational staff, and all applicable personnel in the MSA within the 2011 to 2016 performance period

Contractor shall provide sufficient documentation of planning, training, and exercising per the functions and tasks of Capability 3, Emergency Operations Coordination and associated functions, tasks, and resource elements for this capability.

Contractor shall provide reports as requested by DSHS to satisfy information-sharing requirements set forth in Texas Government Code, Sections 421 .071 and 421.072 (b) and (c).

Contractor shall provide services in the following counties: Collin

SECTION III. SOLICITATION DOCUMENT:

Exempt – Governmental Entity

SECTION IV. RENEWALS:

DSHS may renew the Program Attachment for up to three (3) additional one-year terms, at DSHS's sole discretion.

SECTION V. PAYMENT METHOD:

Cost Reimbursement.

Funding is further detailed in the attached Categorical Budget and, if applicable, Equipment List

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment by submitting the State of Texas Purchase Voucher (Form B-13) on a monthly basis and acceptable supporting documentation for reimbursement of the required services/deliverables. Additionally, the Contractor shall submit the Match/Reimbursement Certification (Form B-13A) and the Financial Status Report (FSR-269A) on a quarterly basis. Vouchers and supporting documentation shall be mailed or submitted by fax or electronic mail to the addresses/number below.

Claims Processing Unit, MC1940
Texas Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13), Match/Reimbursement Certification Form (B-13A), and Financial Status Report to the Claims Processing Unit is (512) 458-7442. The email address is invoices@dshs.state.tx.us.

SECTION VII. BUDGET:

SOURCE OF FUNDS:

CFDA# 93.069

DO

DUNS NUMBER: 074873449

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, **Compliance and Reporting** Article I, **Reporting** Section 1.03, is revised to include the following:

> Contractor shall provide DSHS with monthly supporting documents/reports in the format provided by DSHS, any financial reports, and any other reports that DSHS determines necessary to accomplish the objectives and monitor compliance of this Program Attachment.
>
> Contractor shall submit copies of all documentation addressing the activities specified in Exhibit A to DSHS by a date to be determined by DSHS during Budget Period 1 via the Texas SNS SharePoint web link: http://www.snstexas.info.
>
> If Contractor is legally prohibited from providing such reports, contractor shall immediately notify DSHS.

General Provisions, **Payment Methods and Restrictions** Article IV, **Billing Submission** Section 4.02, is amended to include the following:

> Contractor shall submit requests for reimbursement or payment, or revisions to previous reimbursement request(s), no later than July 30, 2013 for costs incurred between the services dates of September 1, 2012 and June 30, 2013.

General Provisions, **Payment Methods and Restrictions** Article IV, **Financial Status Reports (FSRs)** Section 4.05, is amended to include the following:

> Contractor shall submit FSRs to Accounts Payable by the last business day of the month following the end of each term reported. The FSR period will be reported as follows: Quarter One shall include September 1, 2012 through November 30, 2012. Quarter two shall include December 1, 2012 through February 28, 2013. Quarter three shall include March 1, 2013 through June 30, 2013. Quarter four shall include July 1, 2013 through August 31, 2013. Contractor shall submit the final FSR no later than sixty (60) calendar days following the end of the applicable term.

General Provisions, **Terms and Conditions of Payment** Article V, is revised to include:

> DSHS will monitor Contractor's billing activity and expenditure reporting on a quarterly basis. Based on these reviews, DSHS may reallocate funding between contracts to maximize use of available funding.

General Provisions, **Allowable Costs and Audit Requirements** Article VI, **Allowable Costs** Section 6.01, is amended to include the following:

For the purposes of this Program Attachment, funds may not be used for fund raising activities, lobbying, research, construction, major renovations, clinical care, purchase vehicles of any kind, reimbursement of pre-award costs, funding an award to another party or provider who is ineligible, or backfilling costs for staff.

General Provisions, **Access and Inspection** Article IX, **Access** Section 9.01 is hereby revised to include the following:

In addition to the site visits authorized by this Article of the General Provisions, Contractor shall allow DSHS to conduct on-site quality assurance reviews of Contractor. Contractor shall comply with all DSHS documentation requests and on-site visits. Contractor shall make available for review all documents related to the Statement of Work and Exhibit A, the CRI Work Plan, upon request by the DSHS Program staff.

General Provisions, **General Business Operations of Contractor** Article XII, Section 12.20 **Equipment (Including Controlled Assets)**, is revised as follows:

Contractor is required to initiate the purchase of equipment approved no later than August 31, 2013 as documented by issue of a purchase order or written order confirmation from the vendor on or before August 31 2013. In addition, all equipment must be received no later than 60 calendar days following the end of the Program Attachment term.

General Provisions, **General Terms** Article XIII, **Amendment** Section 13.15, is amended to include the following:

Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least 90 days prior to the end of the term of this Program Attachment.

Categorical Budget:

PERSONNEL	$67,857.00
FRINGE BENEFITS	$9,228.00
TRAVEL	$12,151.00
EQUIPMENT	$0.00
SUPPLIES	$27,815.00
CONTRACTUAL	$0.00
OTHER	$61,498.00
TOTAL DIRECT CHARGES	$178,549.00
INDIRECT CHARGES	$0.00
TOTAL	$178,549.00
DSHS SHARE	$160,818.00
CONTRACTOR SHARE	$17,731.00
OTHER MATCH	$17,731.00

Total reimbursements will not exceed $160,818.00

Financial status reports are due: 12/31/2012, 03/29/2013, 07/30/2013, 10/30/2013

EXHIBIT A

PUBLIC HEALTH EMERGENCY PREPAREDNESS WORKPLAN

FOR

CITIES READINESS INITIATIVE
(PPCPS/CRI)

Funding Opportunity Number CDC-RFA-TP12-1201

CDC Capability 8: Medical Countermeasure Dispensing

Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and / or recommendations.

Demonstrated capability to receive, stage, store, distribute, and dispense materiel during a public health emergency
Evidence-based Benchmark 2 (page 223 of the Funding Opportunity Announcement 3-2-12)

As part of their responses to public health emergencies, public health departments must be able to provide countermeasures to 100% of their identified populations within 48 hrs. after the decision to do so.

MEASURE: Medical Countermeasure Dispensing (MCMD) Composite Score

The medical countermeasure distribution and dispensing (MCMDD) composite score serves as a relatively accurate indicator of preparedness and operational capability. States must meet a minimum overall MCMDD composite benchmark of 52 for Budget Period 1 (2012 to 2013). The overall state composite score will include contributions from CRI local planning jurisdictions' preparedness assessments and data submissions. The score will be derived from the following parameters:

a. Completion of the Local Technical Assistance Review (LTAR) within each planning/local jurisdiction within each CRI during Budget Period 1

b. Submission of accurate, verified metrics through After Action Reviews and Improvement Plans of three (3) SNS drills (not the same drill performed three (3) times)

c. Compliance with established medical countermeasure distribution and dispensing standards, target measures, and metrics as described in CDC's MCMDD Composite Guide

d. Participation in at least one 1 full-scale dispensing exercise within the five-year performance period that tests and validates medical countermeasures dispensing operations

e. Results and documentation of medical countermeasure dispensing full-scale exercise(s) must be developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards and can be performed during any one of five PHEP

budget periods between 2011 and 2016.

f. Each CRI Metropolitan Statistical Area (MSA) dispensing exercise include pertinent jurisdictional leadership and emergency support function leads, planning and/or operational staff in the exercise planning process and must incorporate participation from all CRI MSA jurisdictional partners in some form based on current capability assessments and needs.

Functions	Activities (assess the ability to perform the following tasks)
1) Identify and initiate medical countermeasure dispensing strategies Notify and coordinate with partners to identify roles and responsibilities consistent with the identified agent or exposure and within a time frame appropriate to the incident	1) Prior to an incident, and if applicable during an incident, engage subject matter experts (e.g. epidemiology, laboratory, radiological, chemical, and biological) including federal partners to determine what medical countermeasures are best-suited and available for the incidents most likely to occur based on a jurisdictional risk assessment. 2) Engage private sector, local, state, regional, and federal partners as appropriate to the incident, to identify and fill required roles prior to an incident, and if applicable during an incident.
2) Receive medical countermeasures Identify dispensing sites and / or intermediary distribution sites and prepare these modalities to receive medical countermeasures in a time frame applicable to the agent or the exposure.	1) Assess the extent to which current jurisdictional medical countermeasures can meet incident needs. 2) Request additional medical countermeasures from private, jurisdictional, and / or federal partners using established procedures, according to incident needs. 3) Identify and notify any intermediary distribution sites based on the needs of the incident.

3) Activate dispensing modalities Ensure resources (e.g. human, technical, and space) are activated to initiate dispensing modalities that support a response requiring the use of medical countermeasures for prophylaxis and / or treatment.	1) Activate dispensing strategies, dispensing sites, dispensing modalities, and other approaches, as necessary, to achieve dispensing goals commensurate with the targeted population. 2) Activate staff that will support the dispensing modality in numbers necessary to achieve dispensing goals commensurate with the targeted population. 3) If indicated by the incident, implement mechanisms for providing medical countermeasures for public health responders, critical infrastructure personnel, and their families, if applicable. 4) Initiate site specific security measures for dispensing locations, if applicable. 5) Inform public of dispensing operations including locations, time period of availability, and method of delivery.
4) Dispense medical countermeasures to identified population Provide medical countermeasures to individuals in the target population, in accordance with public health guidelines and/or recommendations for the suspected or identified agent or exposure.	1) Maintain dispensing site inventory management system to track quantity and type of medical countermeasures present at the dispensing site. 2) Screen and triage individuals to determine which medical countermeasure is appropriate to dispense to individuals if more than one type or subset of medical countermeasure is being provided at the site.

This function is associated with the CDC-defined performance measure: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC's Office of Public Health Preparedness and Response. Note: State jurisdictions are expected to ensure attainment of Tasks 1 through 7 by their local communities. (page 77, *Public Health Preparedness Capabilities: National Standards for State and Local Planning*)	3) Distribute pre-printed drug/vaccine information sheets that include instructions on how to report adverse events. 4) Monitor dispensing site throughput and adjust staffing and supplies as needed in order to achieve dispensing goals commensurate with the targeted population. 5) Document doses of medical countermeasures dispensed, including but not limited to: product name and lot number, date of dispensing, and location of dispensing (e.g., address and zip code). 6) Report aggregate inventory and dispensing information to jurisdictional authorities at least weekly during an incident, but potentially more frequently based on incident needs. 7) Determine the disposition of unused medical countermeasures within the jurisdictional health system according to jurisdictional policies.
5) Report adverse events Report adverse event notifications (e.g., negative medical countermeasure side effects) received from an individual, healthcare provider, or other source.	1) Activate mechanism(s) for individuals and healthcare providers to notify health departments about adverse events. 2) Report adverse event data to jurisdictional and federal entities according to jurisdictional protocols.

6) Drills and Exercises Submit drill supporting documentation by April 1st, 2013	Conduct a minimum of three different POD drills (not the same drill performed three times) during each budget period using the CDC and Texas guidance within each planning/local jurisdiction within each CRI metropolitan statistical area (MSA). The three required drills may be chosen from any of the eight available drills as indicated on the DSNS Extranet website. These drills may include any three of the following: staff call down, site activation, facility set-up, pick-list generation, dispensing, resource allocation game, decision-making tool, and/or modeling of throughput. Pick-list generation should not be used in jurisdictions that do not perform the distribution function. Complete and submit drill reporting requirement data and / or metrics required by the Centers for Disease Control and Prevention (CDC) for these drills to the DSHS Central Office through the Exercise Team of the Preparedness and Coordination Branch of the Community Preparedness Section. Participate in at least one full scale exercise within the five-year PHEP performance period that tests, validates, and demonstrates medical countermeasures dispensing plans. Each CRI MSA dispensing exercise must include pertinent jurisdictional leadership and emergency support function leads, planning and operational staff, and all applicable personnel. Engage other emergency response agencies and/or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure dispensing exercise objectives.

7) Technical Assistance Review (TAR)	Submit the resulting exercise data, after action report(s) and improvement plan(s) to DSHS Exercise Team. Participate in an annual CDC/DSHS technical assistance review and submit required documentation according to a coordinated schedule and the guidance outlined in the Texas SNS Program Manual.
8) Meeting Participation	Participate in the Texas SNS meetings

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight,

organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

Functions	Activities (assess the ability to perform the following tasks)
1) Conduct preliminary assessment to determine need for public activation	1) At the time of an incident and as applicable during an incident, work with jurisdictional officials (e.g. emergency management coordinators, elected or appointed leadership officials, and epidemiology, laboratory, surveillance, medical, and chemical, biological, and radiological subject matter experts to analyze data, assess emergency conditions, and determine the activation levels necessary 2) Determine whether public health has the lead role, a supporting role, or no role. 3) Define incident command and emergency management structure for the public health event or incident according to using the Federal Emergency Management Agency (FEMA) typing structure
2) Activate public health emergency operations	1) Prior to an event or incident, identify incident commander and emergency management functions for which public health is responsible 2) Identify a pool of staff who have the skills necessary to fulfill required incident command and emergency management roles deemed necessary for a response. The pool should include public health subject matter experts, Incident Commander, Section Chiefs, Command Staff, and support positions (e.g. information technology specialists)

	3) Identify staff to serve in the required incident command and emergency management roles for multiple operational periods to ensure continuous staffing during activation 4) Identify primary and alternate physical locations or a virtual structure (owned by public health or have access to through a memorandum of understanding or other written agreements) that will serve as the public health emergency operations center 5) Notify designated incident command staff of the public health response 6) Assemble designated staff at the appropriate emergency operations centers (i.e. public health emergency operations center or jurisdictional emergency operations center)
3) Develop incident response strategy	1) Produce or contribute to an Incident Command or Unified Command approved Incident Action Plan prior to the start of the second operational period 2) Disseminate the Incident Action Plan to public health response staff 3) Revise and brief staff on the Incident Action Plan at least at the start of each new operational period
4) Manage and sustain the public health response	1) Coordinate public health and medical emergency operations for the public health response)e.g. phone calls, meetings, and conference calls) 2) Track and account for all public health resources during the public health response 3) Maintain situational awareness using information gathered from medical, public health, and other health

	stakeholders (e.g. fusion centers) 4) Conduct shift change briefings between outgoing and incoming public health staff to communicate priorities, status of tasks, and safety guidance
5) Demobilize and evaluate public health emergency operations	1) Return resources to a condition of "normal state of operations" 2) Conduct final incident closeout of public health operations 3) Produce After Action Report for public health operations to identify improvement areas and promising practices 4) Implement Improvement Plan items 5) Track the implementation progress of Improvement Plans items assigned to public health through a corrective actions system

CONTRACT NO. 2013-041110
PROGRAM ATTACHMENT NO. 004
PURCHASE ORDER NO. 0000384984

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: IMMUNIZATION BRANCH - LOCALS

TERM: 09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

Contractor shall implement and operate an immunization program for children, adolescents, and adults, with special emphasis on accelerating interventions to improve the immunization coverage of children two (2) years of age or younger (0 to 35 months of age). Contractor shall incorporate traditional and non-traditional systematic approaches designed to eliminate barriers, expand immunization capacity, and establish uniform operating policies, as described herein.

Contractor shall be enrolled as a provider in the Texas Vaccines for Children Program (TVFC) by the effective date of this Renewal Program Attachment, and must adhere to the TVFC Operations Manual and associated TVFC policy guidelines provided by DSHS (located at http://www.dshs.state.tx.us/immunize/tvfc/tvfc_manual.shtm).

Contractor shall comply with written policies and procedures provided by DSHS in managing vaccines supplied through the TVFC program, including guidelines for proper storage and handling of vaccines and for safeguarding vaccine in the event of natural disaster. Contractor shall comply with all requirements laid out in the final, approved Work Plan (Exhibit A).

- Contractor will continue to use the current vaccine management system as described in the TVFC Operations Manual until directed by DSHS to transition to a new "provider choice" system. Contractor shall, as directed by DSHS, implement provider choice in contractor's clinic(s) by the schedule provided by DSHS.
- Contractor shall notify providers of changes to vaccine managements reporting, and present updates and training to providers, as requested by DSHS. This would include any transition to a "provider choice" system.
- Contractor shall plan and implement community-based activities to accomplish the required tasks as specified in the final, approved work plan (Exhibit A).

Contractor shall report all reportable conditions as specified in 25 Texas Administrative Code (TAC) Part I §§97.1-97.6 and §§97.101-97.102, and as otherwise required by law.

Contractor shall report all vaccine adverse event occurrences in accordance with the 1986 National Childhood Vaccine Injury Act (NCVIA) 42 U.S.C. § 300aa-25 (located at http://vaers.hhs.gov/default.htm).

5A

Contractor shall inform and educate the public about vaccines and vaccine-preventable diseases, as described in the *DSHS Immunization Contractors Guide for Local Health Departments.*

Contractor shall work to promote a health care workforce within the Local Health Department's service area (including Contractor's staff) that is knowledgeable about vaccines, vaccine safety, vaccine-preventable diseases, and delivery of immunization services.

Contractor shall not deny vaccinations to recipients because they do not reside within Contractor's jurisdiction or because of an inability to pay an administration fee.

Contractor shall comply with all applicable federal and state regulations and statutes, including but not limited to:

- Human Resources Code §42.043, VTCA;
- Education Code §§38.001-38.002, VTCA;
- Health and Safety Code §§12.032, 81.023 and 161.001-161.009, VTCA;
- 25 TAC Chapter 97;
- 25 TAC, Chapter 96;
- 25 TAC, Chapter 100;
- 42 USC §§247b and 300 aa-25; and
- Omnibus Budget Reconciliation Act of 1993, 26 USC §4980B.

Contractor shall comply with current applicable state and federal standards, policies and guidelines, including but not limited to DSHS's Standards for Public Health Clinic Services, revised August 31, 2004 (located at http://www.dshs.state.tx.us/qmb/default.shtm#public).

Contractor shall be responsible for conducting outreach regarding vaccinations for children (19 through 35 months of age in the Contractor's jurisdiction) included on the list distributed to Contractor by DSHS. Lists are distributed at the start of each tri-annual reporting period (September 1, 2012, January 1, 2013, and May 1, 2013).

Contractor must receive written approval from DSHS before varying from applicable policies, procedures, protocols, and/or work plans, and must update and disseminate its implementation documentation to its staff involved in activities under this contract within forty-eight (48) hours of making approved changes.

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS will monitor Contractor's expenditures on a quarterly basis. If expenditures are below what is projected in Contractor's total Renewal Program Attachment amount, Contractor's budget may be subject to a decrease for the remainder of the Contract term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

SECTION II. PERFORMANCE MEASURES:

The following performance measure(s) will be used, in part, to assess Contractor's effectiveness in providing the services described in this Renewal Program Attachment, without waiving the enforceability of any of the terms of the Contract:

- LHDs shall investigate and document, in accordance with *DSHS Texas Vaccine-Preventable Disease Surveillance Guidelines* (located at http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/resources/vpd_guide.pdf) and *NBS Data Entry Guidelines*, at least 90% of suspected reportable vaccine-preventable disease cases within thirty (30) days of notification.

- LHDs shall complete 100% of the follow-up activities, designated by DSHS, for TVFC provider quality assurance site visits assigned by DSHS.

- LHDs shall contact and provide case management to 100% of the number of hepatitis B surface antigen-positive pregnant women identified.

- LHDs shall contact 100% or 400 per FTE (whichever is fewer) families of children who are not up-to-date on their immunizations according to the ImmTrac-generated list provided to the LHD by DSHS at the beginning of each reporting period.

- LHDs shall review 100% of monthly biological reports, vaccine order forms (when applicable), and temperature logs for accuracy to ensure the vaccine supply is within established maximum stock levels.

- LHDs shall complete 100% of child-care facility and Head Start center assessments, in accordance with the *Immunization Population Assessment Manual,* as assigned by DSHS.

- LHDs shall complete 100% of public and private school assessments, retrospective surveys, and validation surveys, in accordance with the *Immunization Population Assessment Manual,* as assigned by DSHS.

- LHDs shall implement provider choice as directed by DSHS according to the schedule provided by DSHS.

Contractor shall utilize the AFIX (Assessment, Feedback, Incentives, and eXchange) methodology, found in the *Immunization Quality Assurance Tool Resource Manual,* (located at http://www.dshs.state.tx.us/immunize/docs/QA_site_visit.pdf) to conduct quality assurance site-visits for all sub-contracted entities and non-local health department Women, Infant and Children (WIC) clinics. Assessment shall be done using the DSHS Immunization Quality Assurance Site Visit tool provided by DSHS and the Comprehensive Clinic Assessment Software Application (Co-CASA), as specified by the DSHS Program. Contractor shall submit assessment results to the designated DSHS Regional Immunization Program manager within two (2) weeks after completion.

Contractor is required to complete and submit tri-annual reports, utilizing a format provided by the DSHS Program:

Report Type	Reporting Period	Report Due Date
Programmatic	9/1/2012 – 12/31/2012	1/30/2013
Programmatic	1/1/2013– 4/30/2013	5/30/2013
Programmatic	5/1/2013 – 8/31/2013	9/30/2013

Tri-annual reports should be submitted electronically to dshsimmunizationcontracts@dshs.state.tx.us according to the time frames stated above.

SECTION III. SOLICITATION DOCUMENT:

Exempt – Governmental Entity

SECTION IV. RENEWALS:

There are no renewals.

SECTION V. PAYMENT METHOD:

Cost Reimbursement
Funding is further detailed in the attached Categorical Budget and, if applicable, Equipment List.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) and acceptable supporting documentation for reimbursement of the required services/deliverables. The Form B-13 can be found at the following link http://www.dshs.state.tx.us/grants/forms/b13form.doc. Vouchers and supporting documentation should be mailed or submitted by fax or electronic mail to the addresses/number below.

Department of State Health Services
Claims Processing Unit MC 1940
1100 West 49th Street
P. O. Box 149347
Austin, Texas 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13) to the Claims Processing Unit is (512) 458-7442. The email address is invoices@dshs.state.tx.us.

SECTION VII. BUDGET:

SOURCE OF FUNDS: CFDA #93.268 and STATE

DUNS NUMBER: 074873449

SECTION VIII. SPECIAL PROVISIONS:

General Provision, **Funding** Article, Use of Funds Section, is revised to include:

- Funds shall not be used for purchase of vaccines, inpatient care, construction of facilities, or debt retirement.

- Travel expenses shall be reimbursed according to Contractor's written travel policy, as submitted and approved with Contractor's FY2011 Application for Immunization Funds. If no written travel policy was submitted, or if the submitted policy is not approved by DSHS, travel expenses shall be reimbursed according to current state travel regulations located at http://www.window.state.tx.us/comptrol/texastra.html.

For immunization activities performed under this Renewal Program Attachment, General Provisions, **General Business Operations of Contractor** Article, **Overtime Compensation** Section, is replaced with the following paragraphs:

- Contractor is authorized to pay employees who are not exempt under the Fair Labor Standards Act (FLSA), 29 USC, Chapter 8, §201 et seq., for overtime or compensatory time at the rate of time and one-half per FLSA.

- Contractor is authorized to pay employees who are exempt under FLSA on a straight time basis for work performed on a holiday or for regular compensatory time hours when the taking of regular compensatory time off would be disruptive to normal business operations.

- Authorization for payment under this provision is limited to work directly related to immunization activities and shall be in accordance with the amount budgeted in this contract Attachment. Contractor shall document proper authorization or approval for any work performed by exempt or non-exempt employees in excess of forty (40) hours per work week.

- All revenues directly generated by this Renewal Program Attachment or earned as a result of this Renewal Program Attachment during the term of this Renewal Program Attachment are considered program income; including income generated through Medicaid billings for immunization related clinic services. The Contractor shall use this program income to further the scope of work detailed in this Renewal Program Attachment, and must keep documentation to demonstrate such to DSHS's satisfaction. This program income may not be used to take the place of existing local, state, or federal program funds.

General Provisions, **Article XIII. General Terms**, **Section 13.15 Amendment**, is amended to include the following:

> Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least ninety (90) days prior to the end of the term of this Program Attachment.

2013-041110-004

Categorical Budget:

PERSONNEL	$242,998.00
FRINGE BENEFITS	$91,367.00
TRAVEL	$1,267.00
EQUIPMENT	$0.00
SUPPLIES	$1,400.00
CONTRACTUAL	$13,850.00
OTHER	$3,180.00
TOTAL DIRECT CHARGES	$354,062.00
INDIRECT CHARGES	$0.00
TOTAL	$354,062.00
DSHS SHARE	$354,062.00
CONTRACTOR SHARE	$45,312.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $354,062.00

Financial status reports are due: 12/31/2012, 03/29/2013, 06/28/2013, 10/30/2013

IMM/LOCALS
DSHS Contract Number: 2013-041110
COLLIN COUNTY HEALTH CARE SERVICES
EXHIBIT A

Contractors are required to perform all activities of the annual Work Plan in compliance with all documents referenced in this Work Plan.

1. PROGRAM PLANNING AND EVALUATION

General Requirement 1A: Implement a comprehensive immunization program. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 1A:

- Adhere to *Standards for Child and Adolescent Immunization Practices* and *Standards for Adult Immunization Practices* found at: http://www.cdc.gov/vaccines/pubs/pinkbook/index.html
- Maintain current policies in compliance with the *DSHS Immunization Contractors Guide for Local Health Departments* and have them available to Contractor's staff.
- Maintain staffing levels to meet required activities of the contract.
- Lapse no more than 5% of total funded amount of the contract.
- Submit required tri-annual reports by January 30, May 30, and September 30 of each contract term.

2. VACCINE MANAGEMENT

(http://www.dshs.state.tx.us/immunize/tvfc/tvfc_manual.shtm)

General Requirement 2A: Ensure that expired, wasted, and unaccounted-for vaccines do not exceed 5% in Contractor's clinics. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *TVFC Operations Manual.*

Activity 2A:

- Maintain storage and handling polices and procedures according to the *TVFC Operations Manual.*
- Ensure that appropriate Vaccine Management plan is in place at each clinic location and that it includes an updated *Emergency Contingency Plan.*

General Requirement 2B: Assist all other TVFC providers in local jurisdiction with maintaining appropriate vaccine stock levels. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *TVFC Operations Manual.*

Activities 2B:

- Evaluate maximum vaccine stock levels twice a year in **all** TVFC provider clinics under Contractor's jurisdiction and assess providers' inventories when visiting clinics. This activity will become part of the Electronic Vaccine Inventory (EVI)

61

system and local health departments will be advised if any assistance on this activity is needed.

- Review 100% of all vaccine orders, monthly biological reports, and monthly temperature logs for accuracy and to ensure that the vaccine supply requested is within established guidelines. Review may be done from a paper report or on the EVI system.
- If vaccine is available locally, conduct transfers and/or deliveries to support the TVFC providers requesting assistance.
- Educate and assist all TVFC providers with TVFC Provider Choice, as directed by DSHS
  - To avoid the appearance of impropriety, the LHD must not involve pharmaceutical manufacturer representative in provider choice trainings; or, the LHD must not take any other actions which appear to have a connection between activities sponsored under this contract and any other activities the LHD wishes to conduct on its own which would involve pharmaceutical manufacturer representatives giving presentations to providers.
- Offer provider updates, training and information as changes to vaccine management occurs.

3. REGISTRIES

(http://www.dshs.state.tx.us/immunize/providers.shtm and http://www.dshs.state.tx.us/immunize/immtrac/default.shtm)

General Requirement 3A: Effectively utilize ImmTrac (the DSHS on-line immunization registry) in Contractor's clinics. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 3A:

- Search for the client's immunization history at every client encounter.
- Review the client's record for vaccines due and overdue according to the CDC Recommended Schedules at http://www.cdc.gov/vaccines/recs/schedules/default.htm.
- Report to ImmTrac all immunizations administered to children (younger than 18 years) and consented adults in Contractor's clinics, either directly into ImmTrac online or through TWICES.
- Update demographic information as needed.
- Follow recommended guidelines for obtaining and submitting ImmTrac consent forms according to the instructions found at http://www.dshs.state.tx.us/immunize/docs/consent_guidelines.pdf.
- Implement changes to the consent process as directed by DSHS.
- Offer updated *Immunization History Report* to the client or client's parent or guardian at every client encounter.
- At every client encounter, compare all immunization histories (ImmTrac, TWICES, validated patient-held records, clinic medical record) and enter into ImmTrac or TWICES any historical immunizations not in ImmTrac.

General Requirement 3B: Work in good faith, and as described herein, to increase the number of children less than six years of age who participate in ImmTrac. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

62

Activity 3B:

- Verbally, and with DSHS produced literature, inform parents presenting at Contractor's clinics about ImmTrac and the benefits of inclusion in ImmTrac.

General Requirement 3C: Work in good faith, and as specified herein, to ensure ImmTrac-registered private providers use ImmTrac effectively as defined in the *DSHS Immunization Contractors Guide for Local Health Departments*. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 3C:

- Provide orientation to all ImmTrac providers at least once a year and maintain documentation of all technical assistance provided (e.g. telephone logs).
- Explain and demonstrate the effective use of ImmTrac according to the instructions located in the *DSHS Immunization Contractors Guide for Local Health Departments*.
- Explain guidelines for obtaining and submitting the ImmTrac Consent Form (ImmTrac Consent Form (C-7) consent forms according to the instructions found at instructions found at:
  http://www.dshs.state.tx.us/immunize/immtrac/default.shtm
- Conduct follow-up with registered ImmTrac providers who are inactive or not using ImmTrac effectively.

General Requirement 3D: Ensure that ImmTrac data, entered by Contractor's staff, is complete, current, and accurate. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 3D:

- Train Contractor's staff on ImmTrac data entry and quality standards.
- Update all demographic information, including address and telephone number, at every client encounter.

4. PROVIDER QUALITY ASSURANCE
(http://www.dshs.state.tx.us/immunize/tvfc/tvfc_manual.shtm)

General Requirement 4: Complete site visit follow-up assigned by DSHS Austin or Health Service Region staff within prescribed timeframes outlined in the *TVFC Operations Manual...* Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 4:

- Conduct site visit follow-up and submit results following the process described and within deadlines established in the *TVFC Operations Manual.*
- Conduct site visits in 100% of subcontracted entities as listed in the Inter-Local Application and non-Local Health Department WIC immunization clinics, if applicable.

63

5. PERINATAL HEPATITIS B PREVENTION

(*http://www.dshs.state.tx.us/idcu/disease/hepatitis/hepatitis_b/perinatal/manual/*)

General Requirement 5A: Ensure all pregnant women are screened for hepatitis B surface antigen (HBsAg) and that all HBsAg-positive pregnant women are reported to DSHS. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Perinatal Hepatitis B Prevention Manual.*

Activity 5A:

- Develop a surveillance system that includes prenatal care providers, obstetrical care providers, family practitioners, and labor and delivery facilities to assure all HBsAg-positive pregnant women are reported to DSHS within one week of diagnosis.
- Educate prenatal care providers routinely to screen pregnant women for HBsAg status during each pregnancy, implement procedures for documenting HBsAg screening results in prenatal care records and forward original laboratory results to the delivery facility.
- Educate delivery hospitals to verify prenatal HBsAg test results of pregnant women on admission for delivery and test for HBsAg at delivery.

General Requirement 5B: Ensure that all infants born to HBsAg-positive women and women whose HBsAg status is unknown will receive the first dose of the hepatitis B vaccine and hepatitis B immune globulin (HBIG) within 12 hours of birth. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Perinatal Hepatitis B Prevention Manual.*

Activity 5B:

- Assure all labor and delivery facilities develop standing orders and policies to administer the first dose of the hepatitis B vaccine and HBIG to at risk infants within 12 hours of birth
- Identify labor and delivery facilities that do not have standing orders and/or policies and educate providers to establish standing orders and policies to administer to at-risk infants the first dose of the hepatitis B vaccine and HBIG within 12 hours of birth
- Determine the number of newborns that do not receive the first dose of the hepatitis B vaccine and/or the hepatitis B immune globulin and work with those facilities to ensure all at-risk infants receive the hepatitis B vaccine series and hepatitis B immune globulin within 12 hours of birth
- Report to DSHS all infants born to HBsAg (+) women within fifteen (15) calendar days of the event.

General Requirement 5C: Ensure that 100% of the number of identified infants born to HBsAg-positive women will complete the hepatitis B vaccine series and post-vaccination serology (PVS) testing or staff will document appropriately if lost to follow-up. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Perinatal Hepatitis B Prevention Manual.*

64

Activity 5C:

- Administer or obtain from the provider or IMMTRAC the complete hepatitis B vaccine series. Infants shall complete the hepatitis B vaccine series by 6 – 8 months of age if the infant receives a single antigen or Pediarix vaccine and by 15 months of age if the infant receives the Comvax series.
- Perform PVS testing or obtain from the provider or IMMTRAC PVS testing results to determine immunity against hepatitis B. Post vaccine serology testing shall be done by 9 – 15 months of age if the infant received a single antigen or Pediarix vaccine and by 18 months of age if the infant received the Comvax vaccine series.

General Requirement 5D: All reported HBsAg (+) mothers shall be interviewed and names and locating information of household contacts and sexual partners elicited for serologic testing. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Perinatal Hepatitis B Prevention Manual.*

Activity 5D:

- Household contacts and sexual partners shall be identified for each reported HBsAg(+) mother
- Each identified contact and sexual partner shall be serologically tested to determine susceptibility status

General Requirement 5E: 80% of all susceptible household and sexual contacts to HBsAg-positive women will complete the hepatitis B vaccine series and post vaccine serology testing or staff will document appropriately if lost to follow-up. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Perinatal Hepatitis B Prevention Manual.*

Activity 5E:

- Administer the hepatitis B vaccine series according to the Recommended Adult Immunization Schedule to susceptible household contacts and sexual partner or obtains vaccination data from the provider.
- Administer post vaccine serology testing 1 – 2 months after the last dose of the vaccine series to determine status or obtain PVS results from the provider.

6. EDUCATION, INFORMATION, TRAINING, AND COLLABORATIONS (http://www.dshs.state.tx.us/immunize/providers.shtm)

General Requirement 6A: Conduct educational, promotional, and outreach activities for the general public to enhance immunization awareness, including distribution of DSHS-provided materials. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 6A:

- Contractor will provide vaccine and immunization education to target audiences and to the general public on the benefits of vaccination, the risk of vaccine-preventable diseases, staying on the ACIP Recommended Immunization Schedule(s) and the

65

importance of not missing any vaccines.

- Inform and educate parents of infants, children, adolescents, adults (men and women), grandparents, seniors, and healthcare providers and the general public about vaccines for all age groups and vaccine-preventable diseases. Information should include the importance and benefits of being fully vaccinated vaccine recommendations, and the location of community vaccination clinics.
- Conduct at least one monthly immunization education activity targeting one of the target groups.
- Document the activity with the number & type of participants, and evaluate activity by obtaining feedback from participants.
- Use national immunization observances as opportunities to conduct specific education and promotional activities to give emphasis to the importance and benefits of vaccines: National Infant Immunization Week (NIIW), National Immunization Month (NIM), National Adult Immunization Week (NAIW), and National Influenza Week (NIW).
- Develop and implement a written communications and customer service plan to assure customers receive consistent, correct immunization information and services in a courteous and friendly manner on a timely basis.
- Participate in special initiatives as directed by DSHS, such as the Dairy Queen Coupon project, the Hallmark Card Governor's Program, and others.
- Participate in statewide media campaigns by distributing DSHS-developed and produced public service announcements and materials to local television and radio stations, newspapers, parent publications, university newspapers, high school newspapers, and neighborhood newspapers.
- Promote www.ImmunizeTexas.com, the Immunization Branch's website, *The Upshot*, electronic newsletter, and the Vaccine Advisory, vaccine newsletter to providers in the Contractor's jurisdiction.
- Promote and distribute immunization literature for the public to TVFC providers and Contractor's clinics.
- Provide information to clients, families, and the general public on the purpose of ImmTrac, the benefits of ImmTrac participation, and the importance of maintaining a complete immunization history in ImmTrac.
- Inform the general public about the Texas Vaccines for Children (TVFC) program and the qualifications to participate in it.
- Distribute TVFC information and educational materials at venues where parents of TVFC-eligible children might frequent.
- Inform and highly recommend to the medical community and local providers within the Contractor's' jurisdiction on the annual CDC *Epidemiology and Prevention of Vaccine-Preventable Disease (EPI-VAC)* training.

General Requirement 6B: Educate, inform, and train the medical community and local providers within Contractor's jurisdiction on Immunization activities listed below: Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 6B:

- Provide training on TVFC requirements and updates (as described in the *TVFC Operations Manual*) to TVFC providers annually at a minimum.
- Ensure that the TVFC providers have the most up-to-date, DSHS-produced immunization information in their offices.

- Provide training, information, and technical assistance to promote the effective use of ImmTrac by private providers (which includes education regarding the benefits of ImmTrac participation).
- Educate private providers about the ImmTrac enrollment process and the statutory requirement to report immunizations.
- As directed by DSHS identify first responders and their immediate family in the community and inform them of the opportunity to be included in ImmTrac.
- Conduct educational training for hospital and health care providers within the Contractor's jurisdiction, to increase mandatory screening and reporting of HBsAg-positive women.
- Provide training on the prevention of Perinatal Hepatitis B to providers within the Contractor's jurisdiction.
- Educate physicians, laboratories, hospitals, schools, child-care staff, and other health providers on VPD reporting requirements.
- Educate and update providers on the most current Advisory Committee on Immunization Practices (ACIP) recommendations for all age groups, as well as on applicable regulatory vaccination requirements.
- Provide training relating to *Standards for Child and Adolescent Immunization Practices*, and *Standards for Adult Immunization Practices* (http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/appdx-full-a.pdf).
- Inform all private providers on the federal requirement that the most current Vaccine Information Statements (VIS) must be distributed to patients (http://www.cdc.gov/vaccines/pubs/vis/default.htm).
- Promote a health care workforce that is knowledgeable about vaccines, vaccine recommendations, vaccine safety, vaccine-preventable diseases, and the delivery of immunization services.
- Educate healthcare workers on the need to get themselves vaccinated.
- Provide information to community health care employers (hospitals, clinics, doctor's offices, long-term care facilities) about the importance of vaccination of health care workers.
- Educate private providers to send NIS surveys to the Contractor for research prior to returning the survey to CDC, if applicable.
- Coordinate educational and other activities with local WIC programs to assure that children participating in WIC are screened and referred to their "medical home" for vaccination using a documented immunization history in accordance with the *Standards for Child and Adolescent Immunization Practices* (http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/appdx-full-a.pdf).

- Offer educational opportunities to all WIC programs in the service area, including information about on-line and satellite-broadcast continuing education opportunities from the Centers for Disease Control and Prevention (CDC) Continuing Education web site (http://www.cdc.gov/vaccines/ed/default.htm).

General Requirement 6C: Conduct outreach to targeted groups for the promotion of best practices and special activities related to immunizations. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

61

Activities 6C:

- Conduct outreach (including, but not limited to, the specific outreach described in the *DSHS Immunization Contractors Guide for Local Health Departments*) to families of children 19 to 35 months of age who are not up to date on their immunizations according to ImmTrac; locate additional immunization histories; and enter history data into ImmTrac.
- Collaborate with prenatal health care providers, birth registrars, hospital staff, pediatricians, and other entities to educate parents, expectant parents, and providers about ImmTrac and the benefits of participation. Includes the dissemination of DSHS educational materials as appropriate.
- Identify and contact families of children for whom ImmTrac consent has been granted but who do not have complete immunization records in ImmTrac.

General Requirement 6D: Conduct recruitment to increase the number of ImmTrac providers, TVFC providers, and Perinatal Hepatitis B providers. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 6D:

- Conduct recruitment activities as defined in the *TVFC Operations Manual* with providers on the DSHS-supplied provider recruitment list.
- Target adolescent health care providers for recruitment and emphasize adolescent vaccine requirements and recommendations.
- Recruit new private provider sites for ImmTrac.
- Participate with DSHS regional staff in recruitment of hospitals and providers conducting surveillance and reporting of Perinatal Hepatitis B.

General Requirement 6E: Establish collaborative efforts with appropriate community entities regarding promoting immunizations and the reduction of vaccine-preventable diseases. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 6E:

- Identify providers, hospitals, schools, child care facilities, social service agencies, and community groups involved in promoting immunizations and reducing vaccine-preventable diseases.
- List and maintain contact information of group members and collaborations and identify the best practices they are promoting.
- Maintain written agreements and updates of group members and collaborations. Document communications, group meetings and planning of activities that promote the Best Practices identified in contract agreement. Documents are to be accessible during site visits.
- Report new group members on the tri-annual report.

7. EPIDEMIOLOGY AND SURVEILLANCE

(http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/resources/vpd_guide.pdf)

General Requirement 7: Investigate and document at least 90% of reportable suspected vaccine-preventable disease cases within thirty (30) days of notification in accordance with *DSHS Texas Vaccine-Preventable Disease Surveillance Guidelines* (*http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/resources/vpd_guide.pdf*) and National Electronic Disease Surveillance System (*NEDSS*)). Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 7:

- Adhere to the *DSHS Vaccine-Preventable Disease (VPD) Surveillance Guidelines, NEDSS Data Entry Guidelines*, and *Epi Case Criteria Guide* (*https://txnedss.dshs.state.tx.us:8009/PHINDox/UserResources/EpiCaseGuide.pdf*) in conducting this General Requirement and the associated activities.
- Complete all data entry into NEDSS Base System (NBS) following the *NBS Data Entry Guidelines.* (*https://txnedss.dshs.state.tx.us:8009/PHINDox/UserResources/Data_Entry_Guidelines_2007.pdf*).
- Verify and enter complete vaccination history in NBS on all VPD investigations with case status of confirmed or probable. Complete vaccination history should be assessed through ImmTrac, provider offices, school records, or patient records.
- Routinely review and follow up on all VPD laboratory reports received, including electronic lab reports (ELRs) sent from DSHS through NBS and Health Alert Network (HAN).
- Report on steps taken by Contractor to ensure the completeness of VPD reporting within Contractor's jurisdiction on triannual reports.
- All new VPD surveillance staff will attend Introduction to NBS training and complete the certification process in order to gain access to the NBS system.

8. POPULATION ASSESSMENT

(*Immunization Population Assessment Manual* available on line at http://www.dshs.state.tx.us/immunize/docs/school/2010-2011_PopulationAssessmentManual.pdf (Reference Stock No. 11-12550, Revised 09/10)

General Requirement/Activity 8A: When assigned by DSHS, complete 100% of child-care facility and Head Start center assessments and child care audits. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Population Assessment Manual.*

General Requirement/Activity 8B: When assigned by DSHS, complete 100% of public and private school assessments, retrospective surveys, and validation surveys. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments* and *Population Assessment Manual.*

69

9. SERVICE DELIVERY

General Requirement 9: Provide immunization services and ACIP-recommended vaccines in Contractor's clinics to children, adolescents and adults to maximize vaccine coverage levels within Contractor's jurisdiction. Activities under this requirement shall be conducted in accordance with the *DSHS Immunization Contractors Guide for Local Health Departments.*

Activities 9:

- Ensure that all ACIP-recommended vaccines are routinely available to eligible TVFC patients and that Adult Safety New vaccines are available to eligible adult patients.
- Recommend the simultaneous administration of all needed vaccines for the patient.
- Follow only medically supportable contraindications to vaccination.
- Verbally educate patients and parents/guardians about the benefits and risks of vaccination, and distribute DSHS educational materials as applicable as part of this conversation.
- Discuss, and attempt to schedule, the next immunization visit at each client encounter.
- Explain the benefits of a "medical home" and assist the parent/guardian in obtaining or identifying the child's medical home.
- Use a Reminder/Recall system (manual, TWICES, ImmTrac, or other system).
- Establish "standing orders" for vaccination in Contractor's clinics, consistent with legal requirements for standing order (including, but not limited to, those found in the Texas Medical Practice Act).
- Implement an employee immunization policy according to CDC recommendations in Contractor's clinics.

MD

DOCUMENT NO. 2013-041110
PROGRAM ATTACHMENT NO. 005
PURCHASE ORDER NO. 0000385924

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: Public Health Emergency Preparedness (PHEP)

TERM::09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

Contractor shall perform activities in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP12-1201) from the Centers for Disease Control and Prevention (CDC). CDC's new five-year Public Health Emergency Preparedness (PHEP) – Hospital Preparedness Program (HPP) Cooperative Agreement seeks to align PHEP and HPP programs by advancing public health and healthcare preparedness.

Contractor shall address the following CDC PHEP Capabilities by prioritizing the order of the fifteen (15) public health preparedness capabilities in which the Contractor intends to invest based upon:

A. A jurisdictional risk assessment;
B. An assessment of current capabilities and gaps; and
C. CDC's recommended tiered strategy for capabilities as listed below.

Tier 1 Capabilities

Capability 12:	Public Health Laboratory Testing
Capability 13:	Public Health Surveillance and Epidemiological Investigations
Capability 1:	Community Preparedness
Capability 8:	Medical Countermeasure Dispensing
Capability 9:	Medical Material Management and Distribution
Capability 14:	Responder Safety and Health
Capability 3:	Emergency Operations Coordination
Capability 4:	Emergency Public Information and Warning
Capability 6:	Information Sharing

Tier 2 Capabilities

Capability 11:	Non-Pharmaceutical Intervention
Capability 10:	Medical Surge
Capability 15:	Volunteer Management

Capability 2: Community Recovery
Capability 5: Fatality Management
Capability 7: Mass Care

Capability 1 – Community Preparedness:

Definition: Community Preparedness is the ability of communities to prepare for, withstand, and recover – in both the short and long terms – from public health incidents.

Capability 2 – Community Recovery:

Definition: Community Recovery is the ability to collaborate with community partners, e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible.

Capability 3 – Emergency Operations Center Coordination:

Definition: Emergency Operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices with the National Incident Management System.

Capability 4 – Emergency Public Information and Warning:

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Capability 5 – Fatality Management:

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death, and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

Capability 6 – Information Sharing:

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health

92

alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for and in response to events or incidents of public health significance.

Capability 7 – Mass Care:

Definition: Mass Care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that local health needs will continue to be met as the incident evolves.

Capability 8 – Medical Countermeasure Dispensing:

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Capability 9 – Medical Material Management and Distribution:

Definition: Medical material management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport distribute, and track medical material (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical material, as necessary, after an incident.

Capability 10 – Medical Surge:

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Capability 11 – Non-Pharmaceutical Interventions:

Definition: Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following: isolation and quarantine; restrictions on movement and travel advisory/warnings; social distancing; external decontamination; hygiene; and precautionary behaviors.

Capability 12 – Public Health Laboratory Testing:

Definition: Public health laboratory testing is the ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil). This

capability supports routine surveillance, including pre-event, incident and post-exposure activities.

Capability 13 – Public Health Surveillance and Epidemiological Investigations:

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

Capability 14 – Responder Safety and Health:

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

Capability 15 – Volunteer Management:

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

DSHS encourages partnership and collaboration within, between, and among jurisdictions in the State of Texas related to preparedness activities. Partnership opportunities may include, but are not limited to, planning activities, exercises, training, and responding to incidents, events, or emergencies.

Contractor shall comply with all applicable federal and state laws, rules, and regulations including, but not limited to, the following:

- Public Law 107-188, Public Health Security and Bioterrorism Preparedness and Response Act of 2002;
- Public Law 109-417, Pandemic and All Hazards Preparedness Act of 2006; and
- Chapter 81, Texas Health and Safety Code.

Contractor shall comply with all applicable regulations, standards and guidelines in effect on the beginning date of this Program Attachment. This is an inter-local agreement under Chapter 791 of the Government Code.

Through this Program Attachment DSHS and Contractor are furnishing a service related to homeland security and under the authority of Texas Government Code § 421.062, neither agency is responsible for any civil liability that may arise from furnishing any service under this Program Attachment.

The following documents and resources are incorporated by reference and made a part of this Program Attachment:

- Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Public Health Emergency Preparedness Cooperative Agreement, Funding Opportunity Number: CDC-RFA-TP12-1201;
- *Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011:* http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf;
- Presidential Policy Directive 8/PPD-8, March 30, 2011: http://www.hlswatch.com/wp-content/uploads/2011/04/PPD-8-Preparedness.pdf;
- Budget Period 1 Public Health Emergency Preparedness Work Plan for Local Health Departments, attached as Exhibit A;
- Contractor's FY13 Applicant Information and Budget Detail for FY13 base cooperative agreement;
- Texas Public Health and Medical Emergency Management 5-Year Strategic Plan;
- Tactical Guide, Companion Document to the Texas Public Health and Medical Emergency Management 5-Year Strategic Plan 2012 to 2016;
- Homeland Security Exercise and Evaluation Plan (HSEEP) Documents: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx;
- Ready or Not? Have a Plan; Surviving Disaster: How Texans Prepare (videos): http://www.texasprepares.org/survivingdisaster.htm; and
- Preparedness Program Guidance(s) as provided by DSHS and CDC.

Funds awarded herewith must be matched by costs or third party contributions that are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for cost sharing or matching. The non-federal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated, including plant, equipment, or services. The costs that the Contractor incurs in fulfilling the matching or cost-sharing requirement are subject to the same requirements, including the cost principles, that are applicable to the use of Federal funds, including prior approval requirements and other rules for allowable costs as described in 45 CFR 74.23 and 45 CFR 92.24.

The Contractor is required to provide matching funds for this Program Attachment not less than 10% of total costs. Refer to the DSHS Contractor's Financial Procedures Manual, Chapter 9 (http://www.dshs.state.tx.us/contracts/cfpm.shtm) for additional guidance on match requirements, including descriptions of acceptable match resources. Documentation of match, including methods and sources, must be included in the Contractor's contract budget, and Contractor must follow procedures for generally accepted accounting practices as well as meet audit requirements.

Contractor shall coordinate activities and response plans within the jurisdiction, with state, regional, other local jurisdictions, and tribal entities (where appropriate), with local agencies, with hospitals and major health care entities, jurisdictional Metropolitan Medical Response Systems, and Councils of Government.

If Contractor agrees to perform public health preparedness services for another county in exchange for all or a portion of the other county's funding allocation, Contractor shall submit to DSHS a signed Memorandum of Agreement (MOA) between Contractor and the other county. The MOA shall outline services, timelines, deliverables and the amount of funds agreed upon by both parties.

Contractor shall notify DSHS in advance of Contractor's plans to participate in or conduct local exercises, in a format specified by DSHS. Contractor shall participate in statewide exercises planned by DSHS as needed to assess the capacity of Contractor to respond to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Contractor shall prepare and submit to DSHS After-Action Reports (AARs), documenting and correcting any identified gaps or weaknesses in preparedness plans identified during exercises in a format specified by DSHS and in compliance with Homeland Security Exercise and Evaluation Plan (HSEEP) standards.

Contractor shall cooperate with DSHS to coordinate all planning, training and exercises performed under this Program Attachment with the Texas Division of Emergency Management (TDEM) or other points of contact at the discretion of the division, to ensure consistency and coordination of requirements at the local level and eliminate duplication of effort between the various domestic preparedness funding sources in the state.

Contractor shall participate in the Texas Disease Reporting Program described in Chapter 81, Texas Health and Safety Code by:

A. Educating, training and providing technical assistance to local providers and hospitals on Texas reportable disease requirements;
B. Monitoring participation by local providers and hospitals in appropriately reporting notifiable conditions;
C. Conducting disease surveillance and reporting notifiable conditions to the appropriate DSHS regional office;
D. Coordinating with DSHS regional Epidemiology Response Team members to build an effective statewide system for rapid detection of unusual outbreaks of illness through notifiable disease and syndromic or other enhanced surveillance; and
E. Reporting immediately all illnesses resulting from bioterrorism, chemical emergencies, radiological emergencies, or other unusual events and data aberrations as compared to background surveillance data to the jurisdiction's respective DSHS Health Service Region (HSR) regional office or to DSHS.

Contractor shall coordinate all risk communication activities with the DSHS Communications Unit by using DSHS's core messages posted on DSHS's website, and submitting copies of draft risk communication materials to DSHS for coordination prior to dissemination.

In the event of a public health emergency involving a portion of the state, Contractor shall mobilize and dispatch staff or equipment purchased with funds from the previous PHEP

cooperative agreement and that are not performing critical duties in the jurisdiction served to the affected area of the state upon receipt of a written request from DSHS.

Contractor shall inform DSHS in writing if Contractor shall not continue performance under this Program Attachment within thirty (30) days of receipt of an amended standard(s) or guideline(s). DSHS may terminate the Program Attachment immediately or within a reasonable period of time as determined by DSHS.

Contractor shall develop, implement, and maintain a timekeeping system for accurately documenting staff time and salary expenditures for all staff funded through this Program Attachment, including partial FTEs and temporary staff.

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS will monitor Contractor's expenditures on a quarterly basis. If expenditures are below that projected in Contractor's total Contract amount, Contractor's budget may be subject to a decrease for the remainder of the Contract term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

SECTION II. PERFORMANCE MEASURES:

Contractor must complete performance measures and benchmarks as outlined in the attached Exhibit A, Public Health Emergency Preparedness Work Plan for Local Health Departments, and as noted below:

A. Demonstrated adherence to PHEP reporting deadlines;
B. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency; and
C. Submission of Pandemic Influenza Operations Plans.

Failure to meet these performance measures may result in withholding a portion of the fiscal year 2013 PHEP base award.

Contractor shall document the following Evidence-based Benchmarks and Pandemic Influenza Plans:

A. <u>Demonstrated adherence to PHEP reporting deadlines.</u>
   1. A PHEP Budget Period 1 mid-year progress report shall be submitted to DSHS within an established timeframe designated by DSHS pending release of the report template from CDC. This report will include a status update on Pandemic and All-Hazards Preparedness Act (PAHPA) benchmarks, an update on current preparedness status, and self-identified gaps based on the public health preparedness capabilities as they related to overall jurisdictional needs; and interim financial reports.
   2. Annual PHEP Budget Period 1 progress report shall be submitted to DSHS within an established timeframe designated by DSHS pending release of the report template from CDC. The report will include an update on work plan

activities, budget expenditure reports, PAHPA benchmarks, CDC-defined performance measurement activities and data, and preparedness accomplishments, success stories, and program impact statements.

B. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency.

1. As part of their responses to public health emergencies, Contractor must be able to provide countermeasures to 100% of their identified population within 48 hours after the decision to do so. To achieve this standard, Contractor must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.

Using the framework and tools already established to assess capabilities to receive, distribute and dispense medical countermeasures, CDC has developed a composite measure to more fully represent preparedness and response activities.

The medical countermeasure distribution and dispensing (MCMDD) composite score will serve as a collective indicator of preparedness and operational capability within local/planning jurisdictions, Cities Readiness Initiative (CRI) areas, states, directly funded cities, territories, and freely associated states. Local, city, state, and territorial preparedness will be subsequently defined as a composite measure derived from results of the Technical Assistance Reviews (TARs), drill submissions, full-scale exercise, and compliance with programmatic standards.

Using the individual composite scores to represent local jurisdiction preparedness, CDC will compute an overall MCMDD composite score for Texas. During the progression of the 2011-2016, 2012-2017 PHEP cooperative agreement cycles, jurisdictions will be required to perform activities and submit documentation for a series of composite requirements to meet the advancing MCMDD composite benchmark. With the exception of the annual TAR and drill submission requirements, jurisdictions will have substantial flexibility in determining the order in which they perform or demonstrate capability to meet the composite measure. Local jurisdictions must submit all required supporting documentation by April 1, 2013. Supplemental information regarding this benchmark is found in Exhibit A.

C. Submission of Pandemic Influenza Operations Plans.

Submit Pandemic Influenza Operations Plans annually as required by Section 319C-1 of the PHS Act, as amended by PAHPA. DSHS will share further information upon release of such from ASPR and CDC in a separate guidance document.

The email address for submitting mid- and end-of-year reports, plus any additional programmatic reports is PHEP@dshs.state.tx.us

Contractor shall provide services in the following county(ies)/area: Collin

SECTION III. SOLICITATION DOCUMENT:

Exempt - Governmental Entity

SECTION IV. RENEWALS:

DSHS may renew the Program Attachment for up to three (3) additional one-year terms at DSHS's sole discretion.

SECTION V. PAYMENT METHOD:

Cost Reimbursement.

Funding is further detailed in the attached Categorical Budget and, if applicable, Equipment List.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) on a monthly basis and acceptable supporting documentation for reimbursement of the required services/deliverables. Additionally, the Contractor shall submit the Match/Reimbursement Certification (Form B-13A) and the Financial Status Report (FSR-269A) on a quarterly basis. Vouchers and supporting documentation should be mailed or submitted by fax or electronic mail to the addresses/number below.

Claims Processing Unit, MC1940
Texas Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13), Match/Reimbursement Certification Form (Form B-13A), and Financial Status Report to the Claims Processing Unit is (512) 458-7442. The email address is invoices@dshs.state.tx.us.

SECTION VII. BUDGET:

SOURCE OF FUNDS: *CFDA* # 93.069

DUNS NUMBER: 074873449

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, **Compliance and Reporting** Article I, is revised to include:

Contractor shall submit programmatic reports as directed by DSHS in a format specified by DSHS. Contractor shall provide DSHS other reports, including financial reports, and any other reports that DSHS determines necessary to accomplish the objectives of this contract and to monitor compliance. If Contractor is legally prohibited from providing such reports, Contractor shall immediately notify DSHS in writing.

Contractor shall provide reports as requested by DSHS to satisfy information-sharing Requirements set forth in Texas Government Code, Sections 421.071 and 421.072 (b) and (c).

The email address for submitting mid-year reports, annual reports, and any additional programmatic reports is PHEP@dshs.state.tx.us

General Provisions, **Payment Methods and Restrictions** Article IV, **Billing Submission** Section 4.02, is amended to include the following:

Contractor shall submit requests for reimbursement or payment, or revisions to previous reimbursement request(s), no later than July 30, 2013 for costs incurred between the services dates of September 1, 2012 and June 30, 2013.

General Provisions, **Payment Methods and Restrictions** Article IV **Financial Status Reports (FSRs)** Section 4.05, is amended to include the following**:**

Contractor shall submit FSRs to Accounts Payable by the last business day of the month following the end of each term reported. The FSR period will be reported as follows: Quarter One shall include September 1, 2012 through November 30, 2012. Quarter two shall include December 1, 2012 through February 28, 2013. Quarter three shall include March 1, 2013 through June 30, 2013. Quarter four shall include July 1, 2013 through August 31, 2013. Contractor shall submit the final FSR no later than sixty (60) calendar days following the end of the applicable term.

General Provisions, **Terms and Conditions of Payment** Article IV, is revised to include:

DSHS will monitor Contractor's billing activity and expenditure reporting on a quarterly basis. Based on these reviews, DSHS may reallocate funding between contracts to maximize use of available funding.

General Provisions, **Allowable Costs and Audit Requirements** ArticleVI, is amended to include the following:

For the purposes of this Program Attachment, funds may not be used for: fundraising activities, lobbying, research; construction, major renovations, reimbursement of pre-award costs; clinical care; the purchase of vehicles of any kind, funding an award to another party or provider who is ineligible, or backfilling costs for staff new construction, or the purchase of incentive items.

General Provisions, **General Terms** Article VIII, **Amendment** Section 13.15, is amended to include the following:

> Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least 90 days prior to the end of the term of this Program Attachment.

General Provisions**, General Business Operations of Contractor** Article XII**, Equipment Purchases (Including Controlled Assets), Section 12.20,** is revised as follows**:**

> Contractor is required to initiate the purchase of approved equipment no later than August 31, 2013 as documented by issue of a purchase order or written order confirmation from the vendor on or before August 31, 2013. In addition, all equipment must be received no later than 60 calendar days following the end of the Program Attachment term.

Categorical Budget:

PERSONNEL	$379,909.00
FRINGE BENEFITS	$119,495.00
TRAVEL	$14,818.00
EQUIPMENT	$0.00
SUPPLIES	$40,845.00
CONTRACTUAL	$0.00
OTHER	$135,644.00
TOTAL DIRECT CHARGES	$690,711.00
INDIRECT CHARGES	$0.00
TOTAL	$690,711.00
DSHS SHARE	$627,515.00
CONTRACTOR SHARE	$63,196.00
OTHER MATCH	$63,196.00

Total reimbursements will not exceed $627,515.00

Financial status reports are due: 12/31/2012, 03/29/2013, 07/30/2013, 10/30/2013

EXHIBIT A

Public Health Emergency Preparedness Work Plan

For

Local Health Departments

PPCPS/HAZARDS

Funding Opportunity Number CDC-RFA-TP12-1201

47

Introduction

DSHS developed this work plan in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP12-1201) from the Centers for Disease Control and Prevention (CDC). The funding opportunity announcement addresses alignment of the Public Health Emergency Preparedness (PHEP) Program and the Hospital Preparedness Program (HPP) through a five-year project period from 2012 to 2017,as noted in Section I. Statement of Work of the Program Attachment.

DSHS also developed this work plan in the spirit of flexibility and continuous quality improvement providing local health departments the ability to accomplish the intent of the PHEP HPP Cooperative Agreement with as much latitude as possible while adhering to the guidance of the funding opportunity announcement.

The work plan consists of the following sections that describe the activities and deliverables for PHEP 2011 to 2012, Budget Period 11 (August 1, 2011 to July 31, 2012):

I. Public Health Preparedness Capabilities
II. Annual Requirements
III. CDC-Defined Performance Measures
IV. Evidence-based Benchmarks and Pandemic Influenza Plans (PAHPA Benchmarks)

I. Public Health Preparedness Capabilities

Public health departments continue to face multiple challenges, including an ever-evolving list of public health threats. The Centers for Disease Control and Prevention (CDC) developed fifteen (15) capabilities to assist health departments with assessing preparedness capacity as well as developing strategic plans. The CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* is a published document found at the following link:
http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf.

The activities associated with this work plan link directly to the standardized capabilities briefly outlined in Section I. Statement of Work of the Program Attachment and found in full detail in the PDF document referenced above.

During this project period, Texas Department of State Health Services (DSHS) with consultation from the CDC intends to foster closer alignment between the PHEP Program and Hospital Preparedness Program. Grant alignment is a long-term initiative that will continue to evolve throughout the project period as PHEP and HPP seek additional opportunities to improve administrative and programmatic collaboration. DSHS recognizes that the capabilities required to fulfill HPP and PHEP programmatic goals differ but that increased collaboration will serve to strengthen both programs.

gk

In 2011, CDC released a Public Health Capabilities Planning Model that describes a high-level planning process public health departments may wish to follow as they address the 15 public health capabilities. The planning model allows local health departments to use the public health preparedness capabilities to a) determine preparedness priorities, b) plan appropriate preparedness activities, and c) demonstrate and evaluate achievement of capabilities through exercises, planned events, and real incidents. Contractors are encouraged to use routine activities and real incidents to demonstrate and evaluate the public health preparedness capabilities.

DSHS with consultation from the CDC strongly recommends that local health departments utilize a prioritization strategy to determine their work and the resulting investments regarding the 15 public health preparedness capabilities across the five-year project period based upon:

1) Jurisdictional risk assessments (reference the capability standards document for details on the Community Preparedness Capability 1 and requirements for risk assessments);

2) Current capabilities assessments and gap analyses identified using CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* as well as a self-assessment process utilizing CDC's Capabilities Planning Guide (CPG); and

3) CDC's recommended tiered strategy for capabilities outlined below

Tier 1 Public Health Preparedness Capabilities:

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Community Preparedness
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Responder Safety and Health
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Information Sharing

Tier 2 Public Health Preparedness Capabilities:

- Non-Pharmaceutical Intervention
- Medical Surge*
- Volunteer Management*
- Community Recovery
- Fatality Management*
- Mass Care

*PHEP funding should support the development of these Tier 2 capabilities in coordination with HPP activities.

Activity 1 for Section I, PHEP Capabilities: Continue to Conduct Jurisdictional Risk Assessments

Local health department personnel, DSHS health service regional staff, and DSHS central office staff developed the Texas Public Health Risk Assessment Tool (TPHRAT) during budget period 2011 to 2012 for use by local health departments in Texas to conduct jurisdictional risk assessments. The tool incorporates a capability-based approach and includes the identification of potential hazards, vulnerabilities, and risks within communities that relate to the public health, medical, and mental/behavioral health systems inclusive of at-risk individuals (See Public Health Preparedness Capability 1 of the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* document.)

Jurisdictional risk assessments should be developed in coordination with hospital preparedness partners, emergency management, and other community partners. The Threat Hazard Identification Risk Assessment (THIRA) from the Department of Homeland Security is a reference document for conducting jurisdictional risk assessments. The document is located at the following link:

http://www.dhs.gov/xlibrary/assets/rma-strategic-national-risk-assessment-ppd8.pdf

Deliverable 1 for Activity 1 for Section I, PHEP Capabilities

Status reports on the risk assessments using a template provided by DSHS must be submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC.

Deliverable 2 for Activity 1 for Section 1, PHEP Capabilities

Local jurisdictional risk assessments using the TPHRAT or data from the TPHRAT sufficient to meet the requirement from CDC for a state-level, awardee jurisdictional risk assessment must be submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC.

Activity 2 for Section 1, PHEP Capabilities: Continue to Perform Capability Assessments

CDC developed the Capabilities Planning Guide as a tool for local health departments to utilize in performing capabilities assessments. The document is located at the following link:

http://www.dshs.state.tx.us/commprep/phep/PHEP_CPG.aspx

46

Data analyses from the files associated with the link will result in a report from CDC intended to assist local health departments in prioritizing levels of action to address functions within capabilities. The levels of actions are:

1. no action necessary (no recommendation)
2. sustain
3. address as low priority
4. address as medium priority
5. address as high priority
6. address as very high priority

Deliverable 1 for Activity 2 for Section 1, PHEP Capabilities

Capabilities Planning Guide files must be submitted to submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC. Capabilities Planning Guide files must be submitted to DSHS via the following email address: phep@dshs.state.tx.us

Activity 3 for Section 1, PHEP Capabilities: Utilize CDC's Recommended Tiered Strategy as a Planning Component for the Health Department's Capability Prioritization

CDC's tiered strategy emphasizes Tier 1 capabilities because these capabilities provide the foundation for public health emergency preparedness. PHEP recipients should build priority resource elements in Tier I capabilities prior to comprehensive or significant investment in Tier 2 public health emergency preparedness capabilities.

Deliverable 1 for Activity 3 for Section 1, PHEP Capabilities (dependent on possible CDC request during the budget period)

Status reports on utilizing the tiered strategy using a template provided by DSHS must be submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC should CDC require reporting of such utilization.

II. Annual Requirements

Contractors are required to submit plans, status reports, and program and financial data, outlining progress in addressing annual requirements including evidence-based benchmarks and objective standards and performance data. Reports will also include information on outcomes of annual preparedness exercises regarding strengths, weaknesses and associated corrective actions, accomplishments highlighting the impact and value of the PHEP program in local jurisdictions; and descriptions of incidents requiring activations of emergency operations centers. Reports must describe the preparedness activities that were conducted with PHEP funds, the purposes for which PHEP funds were spent and the recipients of the funds; describe the extent to which the Contractor has met stated goals and objectives. To assist Contractors, DSHS will provide

a template consistent with information required by CDC to meet the following annual planning/reporting requirements for 2012 to 2013. .

1) HPP and PHEP Program Alignment
Contractors must demonstrate progress in coordinating public health and healthcare preparedness program activities and leveraging funding to support those activities as well as tracking accomplishments highlighting the impact of the HPP and PHEP programs in contractors' jurisdictions.

2) Administrative Preparedness Strategies (Capability 1. Community Preparedness): Contractors must describe administrative processes and approaches to receive and use emergency funds to mitigate and respond to emergency situations in a timely manner and actions to overcome challenges and barriers. Capability 1: Community Preparedness.

3) Exercise Planning and Implementation
Contractors must revise current multi-year exercise plans or develop a new plan for conducting exercises to test public health and healthcare preparedness capabilities. As part of this process, contractors must conduct one joint, full-scale exercise within the five-year project period. Joint exercises should meet multiple program requirements including PHEP, HPP, and Strategic National Stockpile requirements to minimize the burden on exercise planners and participants. Exercise plans must demonstrate coordination with relevant entities and include methods to leverage resources to the maximum extent possible. Exercise plans must be submitted to DSHS annually. Plans must include exercise schedules and describe exercise goals and objectives, identified capabilities to be tested, inclusion of at-risk individuals, participating partner organizations, and previously identified improvement plan items from real incidents or previous exercises. The multi-year plan must be updated annually.

4) Healthcare Coalition Planning
Contractors must contribute to successful coordinated preparedness. To do so, a plan must be developed to coordinate preparedness efforts among healthcare, public health, and behavioral health at the healthcare coalition level. This plan must include the strategy used by public health, healthcare, and mental health partners to encourage coordinated preparedness with preparedness partners at the jurisdictional level. The plan must also include a strategy to achieve mutual understandings among emergency response disciplines regarding respective roles in public health emergency preparedness and response. Plans must be submitted by to DSHS on a template provided by DSHS and within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC.

5)Volunteer Recruitment and Management (Capability 15, Volunteer Management): Contractor shall document efforts for volunteer recruitment and

management such as development of a Medical Reserve Corps or community equivalent and use of the Texas Disaster Volunteer Registry.

6) Coordination among cross-cutting public health preparedness programs
PHEP program components as a whole should complement and be coordinated with other public health and healthcare programs as applicable. For example, some functions within the Public Health Laboratory, Public Health Surveillance and Epidemiological Investigation and Information Sharing capabilities may mutually support activities as described in CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. Contractors should work with immunization programs and partners on syndromic surveillance and other activities to assure preparedness for vaccine-preventable diseases, influenza pandemics, and other events requiring a response.

7) Stakeholder Engagement (Capability 1, Community Preparedness Function 2 and Capability 2, Community Recovery, Function 1): Contractors shall identify the appropriate jurisdictional partner to address the emergency preparedness, response, and recovery needs of the older adults regarding public health, medical and mental health behavioral needs and address processes and accomplishments to meet these needs.

8) Public Comment Solicitation on Emergency Preparedness Plans (Capability 1, Community Preparedness, Function 2): Contractor shall describe processes for solicitation of public comment on emergency preparedness plans and their implementation such as the establishment of an advisory committee or similar mechanism to ensure ongoing public comment on emergency preparedness and response plans.

9) National Incident Management System (NIMS) (Capability 3, Emergency Operations Centers, Function 1):
Contractors should have plans, processes, and training in place to meet NIMS compliance requirements.

10) Public Health, Mental/Behavioral Health, and Medical Needs of At-risk Individuals (Capability 1, Community Preparedness; Capability 2, Community Recovery; Capability 4, Emergency Public Information and Warning; Capability 7, Mass Care; Capability 10, Medical Surge; and Capability 13, Public Health Surveillance and Epidemiological Investigation).

Describe plans to address the public health, mental/behavioral health, and medical needs of at-risk individuals in the event of a public health emergency. The definition of at-risk individuals is available at:
http://www.phe.gov/Preparedness/planning/abc/Documents/at-risk-individuals.pdf

11) Situational Awareness

Contactors will provide DSHS with situational awareness data generated through interoperable networks of electronic data systems. (Capability 6, Information Sharing)

12) Fiscal and Programmatic Systems Contractors will have in place fiscal and programmatic systems to document accountability and improvement.

13) One Annual Preparedness Exercise

Contractors will conduct at least one (1) preparedness exercise annually according to the Contractor's exercise plan and developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards. Contractor will submit to DSHS an exercise notification as soon as possible prior to the exercise and a final After Action Review/Improvement Plan within 60 days of the exercise.

The exercise can include a tabletop exercise, a drill, a functional exercise, or a full-scale exercise to test preparedness and response capabilities. Following such exercises, Contractors will report identified strengths, weaknesses, and corrective actions taken to address material weaknesses. CDC encourages PHEP recipients to exercise all preparedness capabilities; however, annual drills conducted to meet CDC's medical countermeasures dispensing and distribution (MCMDD) composite score can satisfy this requirement.

Activities for Section II, Annual Requirements

Local health departments have the flexibility to determine jurisdiction-specific activities for annual requirements.

Deliverables for Section II, Annual Requirements 1 and 2 and 4 through 12

Progress reports, program data, plans, and financial data from local health departments are deliverables for annual requirements 1 through 12. DSHS will provide templates for reports that are consistent with information requests from CDC in order to meet reporting requirements within a timeframe necessary to complete consolidation of statewide reporting to CDC.

Deliverable 1 for Section II, Annual Requirement 3
(Exercise Planning and Implementation)

Contractors must revise a current exercise plan or develop a new one and submit the plan to DSHS during Budget Period1 by a date to be determined following input from local health departments.

Deliverable 1 for Section II, Annual Requirement 13
(One Annual Preparedness Exercise)

QD

Submit an exercise notification to DSHS as soon as possible during the planning process for the exercise.

Deliverable 2 for Section II, Annual Requirement 13
(One Annual Preparedness Exercise)

Submit an HSEEP-compliant After Action Review/Improvement Plan to DSHS within 60 days of the exercise.

III. CDC-Defined Performance Measures

Performance measures are key tools to determine program effectiveness and may focus on any level of public health service delivery including local health departments, public health laboratories, healthcare coalitions, and healthcare organizations. DSHS with consultation from the CDC has determined the benefit of Contractors reporting on these capability-based performance measures. While Contractors will not have to report on all performance measures every year, Contractors will be required to collect and report select performance measure data for Budget Period 1 (2012 to 2013) on the following public health preparedness capabilities:

Community Preparedness, Capability 1
Emergency Operations Coordination, Capability 3
Emergency Public Information and Warning, Capability 4
Fatality Management, Capability 5
Information Sharing, Capability 6
Medical Countermeasures Dispensing, Capability 8
Medical Material Management and Distribution, Capability 9
Public Health Surveillance and Epidemiological Investigation, Capability 13
Volunteer Management, Capability 15

To reduce reporting burden, CDC may provide the option for states to report data for select performance measures from a sample of counties within each state (as opposed to reporting data from all counties or all local health departments). Further detail on performance measures and reporting requirements for 2012-2013 will be provided to DSHS by the CDC in the future, and DSHS will share this information with Contractors.

The list and requirements for reporting mid-year and annual or other performance measures may change as performance measures are developed, refined, and released by CDC.

Capability	Performance Measure
Community Preparedness	Median number of community sectors in which local health departments (LHDs) identified key organizations to participate in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts

	Median number of community sectors that LHDs engaged in using hazards, and vulnerabilities assessment (HVA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services
	Proportion of key organizations that LHDs engaged in a significant public health emergency preparedness activity
	Median number of community sectors that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services
Emergency Operations Coordination (EOC)	**Time for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for immediate duty**
	Production of the approved Incident Action Plan (IAP) before the start of the second operational period
	Time to complete a draft of an After Action Report (AAR) and Improvement Plan (IP)
Emergency Public Information and Warning	**Time to issue a risk communication message for dissemination to the public**
Fatality Management	**Percent of LHDs that have defined fatality management roles and responsibilities of public health in relation to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors)**
Information Sharing	**Proportion of LHDs that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs)** **HPP-PHEP 6.1: Percent of local partners that reported requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe**

Medical Countermeasure Dispensing and Medical Material Management and Distribution	**Medical Countermeasure Distribution and Dispensing (MCMDD) composite measure**
	MCMDD composite measure score will be calculated annually based on performance data collected from the following preparedness activities:
	• Technical Assistance Review
	• DSNS operational drills
	• Compliance with programmatic standards
	  o Points of dispensing standards data submission
	  o Medical countermeasure distribution standards data submission
	• Full-scale exercises (FSE)
	  o Medical countermeasure distribution
	  ▪ States are required to perform one FSE within the 2011-2016 performance period.
	  o Medical Countermeasure dispensing
	  ▪ Each local CRI jurisdiction is required to perform one FSE within the 2011-2016 performance period.

Public Health	**Proportion of reports of selected reportable diseases received by a**

Surveillance and Epidemiological Investigation	public health agency within the awardee-required timeframe
	Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate timeframe
	Percentage of infectious disease outbreak investigations that generate reports
	Percentage of infectious disease outbreak investigation reports that contain all minimal elements
	Percentage of EI of acute environmental exposures that generate reports
	Percentage of EI reports of acute environmental exposures that contain all minimal elements
Volunteer Management	Proportion of LHDs that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident HPP-PHEP 15.1: Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe

IV. Evidence-based Benchmarks and Pandemic Influenza Plans (PAHPA Benchmarks)

CDC specified a subset of measures and select program requirements as benchmarks as mandated by Section 319C-1 and 319C-2 of the PHS Act as amended by the Pandemic and All Hazards Preparedness Act (PAHPA). To substantially meet a benchmark, Contractors must provide complete and accurate information describing how the benchmark was met. DSHS and the CDC expect Contractors to achieve, maintain, and report on benchmarks throughout the five-year project period. CDC and DSHS reserve the right to modify benchmarks annually as needed and in accordance with CDC goals, objectives, and directives. Contractors shall maintain all documentation that substantiates achievement of benchmarks and make those documents available to DSHS staff as requested during site visits or through other requests.

DSHS has identified the following CDC benchmarks for year one.

1. Adherence to PHEP Reporting Deadlines

Deliverable 1 – Contractors will prepare and submit a PHEP Budget Period 1 mid-year progress report to DSHS using a template provided by DSHS that captures reporting information and data required by CDC. The report is due to DSHS on a date to be determined pending release of the report template from CDC and likely around mid-January 2013. More information on the report is found in the Statement of Work, Section II.

03

2. Receiving, Staging, Storing, Distributing, and Dispensing Medical Countermeasures: Texas must meet a minimum overall Medical Countermeasure Dispensing and Distribution (MCMDD) composite benchmark of 52 for Budget Period 1. Technical Assistance Review (TAR) performance scores from local health departments contribute to the Texas score.

   Contractors must participate in an annual Technical Assistance Review (TAR). The process includes reviews of documents to support compliance with established medical countermeasure distribution and dispensing standards, target measures, and metrics as described in CDC's MCMDD Composite Guide. The guide is available at DSHS SharePoint portal.

   Contractors will submit data elements for all dispensing sites and modalities that have been identified within the jurisdiction to support a mass prophylaxis scenario to DSHS as part of the TAR process.

   Contractors will conduct a minimum of three (3) different drills (not the same drill performed three times) conducted within each planning/local jurisdiction during year one. The range in scope of available drills provides Contractors with flexibility in meeting the annual drill requirements. The three (3) required drills may be chosen from any of the eight (8) available drills as indicated on the Division of Strategic National Stockpile (DSNS) Extranet website. Drill data and/or Homeland Security Exercise and Evaluation Program (HSEEP) After Action Reports/Improvement Plans for drills (as indicated) must be submitted to DSHS by April 13, 2013.

   Contractors must conduct one (1) full-scale Strategic National Stockpile (SNS) exercise within the five year performance period of 2011-2016 that tests and validates medical supplies distribution and dispensing plans. Results and documentation of medical countermeasure distribution and dispensing full-scale exercise(s) must be developed in accordance with HSEEP standards. Each Contractor will be required to participate in one (1) exercise that demonstrates capabilities for medical countermeasure dispensing operations during the five year performance period. Contractors are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details on the scope and format for reporting these exercise requirements will be provided by DSHS through subsequent guidance at a later date.

   Contractors will demonstrate compliance with established medical countermeasure distribution and dispensing standards. Target measures and required data submission will be detailed in supplemental guidance at a later date. Through these activities, contractors will meet the performance measures noted in Section II: Statement of Work Performance Measures of the Program Attachment associated with medical countermeasures.

3. Submission of Pandemic Influenza Plans

QA

Section 319C-1 of the PHS Act, as amended by the Pandemic and All Hazards Preparedness Act (PAHPA), currently requires annual submission of influenza pandemic plans. DSHS will provide further information on the 2012 submission upon release of such information from CDC.

95

Appendix 1

Definitions for the Public Health Capability Model

The **Capability Definition** defines the capability as it applies to state, local, tribal, and territorial public health.

The **Function** describes the critical elements that need to occur to achieve the capability.

The **Performance Measure(s)** section lists the CDC-defined performance measures, if any, associated with a function.

The **Tasks** section describes the steps that need to occur to complete the functions.

The **Resource Elements** section lists resources, including priority items and other considerations, needed to build and maintain the ability to perform the function and its associated tasks. These resource elements are organized as follows:

1) *Planning:* standard operating procedures or emergency operations guidance, including considerations for legal authorities and at-risk populations, for a Contractor's plans for delivering the capability.

2) *Skills and Training:* baseline competencies and skills personnel and teams should possess or have access to when delivering a capability.

3) *Equipment and Technology:* equipment Contractors should have or have access to in jurisdictionally defined quantities sufficient to achieve the capability.

4) **Note**: Certain resource elements have been identified as priority resource elements. Contractors may not require all resource elements to fully achieve all of the functions within a capability, but they must *have* or *have access to* the **priority** resource elements. Remaining resource elements are recommended for consideration by Contractors.

Appendix 2

Appendix 2

The public health preparedness capabilities are listed below in their corresponding domains. These domains are intended to convey the significant dependencies between certain capabilities:

Biosurveillance
- Public Health Laboratory Testing
- Public Health Surveillance/Epidemiological Investigation

Community Resilience
- Community Preparedness
- Community Recovery

Countermeasures and Mitigation
- Medical Countermeasure Dispensing
- Medical Material Management and Distribution
- Non-pharmaceutical Interventions
- Responder Safety and Health

Incident Management
- Emergency Operations Coordination

Information Management
- Emergency Public Information and Warning
- Information Sharing

Surge Management
- Fatality Management
- Mass Care
- Medical Surge
- Volunteer Management

DOCUMENT NO. 2013-041110-
ATTACHMENT NO. 006
PURCHASE ORDER NO. 0000385763

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: RLSS/LOCAL PUBLIC HEALTH SYSTEM-PnP

TERM: 09/01/2012 THRU: 08/31/2013

SECTION I. SCOPE OF WORK:

CONTRACTOR shall improve or strengthen local public health infrastructure within the State of Texas by:

- Developing objective(s) to address a public health issue;
- Utilizing resources provided through this contract Attachment to conduct activities and services that provide or support the delivery of essential public health services;
- Assessing, monitoring, and evaluating the essential public health activities and services provided through this Program Attachment; and
- Developing strategies to improve the delivery of essential public health service(s) to identified service area.

These tasks shall be performed in accordance with Department of State Health Services (DSHS) Division for Regional and Local Health Services Interlocal Application. The assessment and/or evaluation activities must include measurable standards. Acceptable standards include the National Public Health Performance Standards approved by the Centers for Disease Control and Prevention, Performance Standards developed by the Texas Association of Local Health Officials, Healthy People 2010, and any federal, state or local law or regulation governing the delivery of essential public health services. Other evaluation methods utilizing standards not listed in this Program Attachment must be pre-approved by DSHS.

CONTRACTOR shall comply with all applicable federal and state laws, rules, regulations and standards including, but not limited to, the following:

- Chapter 23-11 of the Healthy People 2010;
- Section 121.002, Texas Health & Safety Code, definition of ten essential public health services;
- Government Code, Section 403.1055, "Permanent Fund for Children and Public Health".

CONTRACTOR shall not use funds from the Permanent Fund for Children and Public Health for lobbying expenses under the Government Code, Section 403.1067.

CONTRACTOR shall comply with all applicable regulations, standards, and guidelines in effect on the beginning date of this Program Attachment.

DSHS shall inform CONTRACTOR in writing of any changes to applicable federal and state laws, rules, regulations, standards and guidelines. CONTRACTOR shall comply with the amended law, rule, regulation, standard or guideline except that CONTRACTOR shall inform DSHS Program in writing if it shall not continue performance under this contract Attachment within thirty (30) days of receipt of an amended standard(s) or guideline(s). DSHS may terminate the Program Attachment immediately or within a reasonable period of time as determined by DSHS.

SECTION II. PERFORMANCE MEASURES

CONTRACTOR shall complete the PERFORMANCE MEASURES as stated in the CONTRACTOR'S FY11 Local Public Health Service (LPHS) Service Delivery Plan, and as agreed upon by DSHS, hereby attached as Exhibit A.

CONTRACTOR shall provide activities and services as submitted by CONTRACTOR in the following county(ies)/area: Collin

SECTION III. SOLICITATION DOCUMENT: Exempt – Governmental Entity

SECTION IV. RENEWALS: N/A

SECTION V. PAYMENT METHOD: Cost Reimbursement

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) and include acceptable supporting documentation of the required services/deliverables if indicated in the attached Exhibit A. One of the following methods listed below should be selected and used consistently throughout the term of the contract for submitting vouchers and supporting documentation.

- Send as an email attachment to invoices@dshs.state.tx.us (preferred method)
- Fax to Claims Processing Unit at (512)776-7442
- Submit to the following address:

  Department of State Health Services
  Fiscal Claims Processing Unit
  P.O. Box 149347, MC 1940
  Austin, Texas 78714-9147

SECTION VII. BUDGET:

SOURCE OF FUNDS: State

DUNS Number: 074873449

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, Section **1.03 Reporting** Article, are revised to include the following paragraph:

Contractor shall submit quarterly and final performance reports that describe progress toward achieving the objectives contained in approved Contractor's Service Delivery Plan and any written revisions. Contractor shall submit the performance reports by the end of the month following the end of each quarter, in a format to be provided by DSHS. Failure to submit a required report of additional requested information by the due date specified in the Program Attachment (s) or upon request constitutes breach of contract, may result in delay payment, and may adversely affect evaluation of Contractor's future contracting opportunities with the department. Reports should be sent electronically to: LocalPHTeam@dshs.state.tx.us or by facsimile to 512-458-7154. A copy of the report should be sent to the respective DSHS Health Service Region, Attention: Deputy Regional Director. The report signature page should be sent via mail to:

DSHS Regional and Local Health Services
Attn: Local Services Team
1100 West 49th Street
P.O. BOX 149347 MC1908
Austin, Texas, 78714-9347.

General Provisions, Section 12.01 **Responsibilities and Restrictions Concerning Governing Board, Officers and Employees**, is not applicable to this program Attachment.

General Provisions, Section 12.20 **Equipment (Including Controlled Assets) Purchases**, is revised to include the following:

> For the purpose of this Program Attachment, equipment is not approved as part of the base budget for LPHS. The funds are for direct services. Although, at mid-year of the contract term, if funds are identified as not being used, the funds may be used to purchase equipment in the 3rd quarter of the contract or program attachment term. Contractor must submit proposal to redirect funds with justification as to how the equipment helps achieve the goals, objectives, and deliverables outlined in Exhibit A (Project Service Delivery Plan). The proposal must be submitted to the contract manager assigned to the program attachment.

Categorical Budget:

PERSONNEL	$16,518.00
FRINGE BENEFITS	$5,121.00
TRAVEL	$0.00
EQUIPMENT	$0.00
SUPPLIES	$0.00
CONTRACTUAL	$0.00
OTHER	$0.00
TOTAL DIRECT CHARGES	$21,639.00
INDIRECT CHARGES	$0.00
TOTAL	$21,639.00
DSHS SHARE	$21,639.00
CONTRACTOR SHARE	$0.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $21,639.00

Financial status reports are due: 12/31/2012, 03/29/2013, 06/28/2013, 10/30/2013

EXHIBIT A
FY 2013 Request for Local Public Health Services Funds
Project Service Delivery Plan

Texas Department of State Health Services

Local Health Department: COLLIN COUNTY HEALTH CARE SERVICES

Contract Term: September 1, 2012 through August 31, 2013

Indicate in this plan how requested Local Public Health Services (LPHS) contract funds will be used to address a public health issue through essential public health services. The plan should include a brief description of the public health issue(s) or public health program to be addressed by LPHS funded staff, and measurable objective(s) and activities for addressing the issue. List only public health issues/programs, objectives and activities conducted and supported by LPHS funded staff. List at least one objective and subsequent required information for each public health issue or public health program that will be addressed with these contract funds. The plan must also describe a clear method for evaluating the services that will be provided, including identification of a specific evaluation standard, as well as recommendations or plans for improving essential public health services delivery based on the results of the evaluation. Complete the table below for each public health issue or public health program addressed by LPHS funded staff. (Make additional copies of the table as needed)

Public Health Issue: ***Briefly describe the public health issue to be addressed. Number issues if more than one issue will be addressed.***

TB – There has been a significant increase in the number of TB cases over the past few years. The end of FY2011 there were 25 TB cases/suspects.

Essential Public Health Service(s): ***List the EPHS(s) that will be provided or supported with LPHS Contract funds***

EPHS#2 Diagnose and investigate community health hazards.

Objective(s): ***List at least one measurable objective to be achieved with resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc.)***

Offer patient therapy within the clinic as well as outreach DOT to all active TB cases and LTBIs.

Performance Measure: ***List the performance measure that will be used to determine if the objective has been met. List a performance measure for each objective listed above.***

Report will reflect all cases reported as well as treatment received and/or offered for LTBIs.

Activities *List the activities conducted to meet the proposed objective. Use numbering system to designate match between issues/programs and objectives.*	**Evaluation and Improvement Plan** *List the standard and describe how it is used to evaluate the activities conducted. This can be a local, state or federal guideline.*	**Deliverable** *Describe the tangible evidence that the activity was completed.*
Provide drug therapy to all active TB cases and LTBIs.		

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant. loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less that $10,000 and not more than $100,000 for each such failure.

Signature _____ Date _____

Print Name of Authorized Individual

2013-041110
Application or Contract Number

COLLIN COUNTY HEALTH CARE SERVICES
Organization Name

Fiscal Year 2013 Department of State Health Services Contract
General Provisions
(Core/Subrecipient)

ARTICLE I COMPLIANCE AND REPORTING

Section 1.01 **Compliance with Statutes and Rules.** Contractor shall comply, and shall require its subcontractor(s) to comply, with the requirements of the Department's rules of general applicability and other applicable state and federal statutes, regulations, rules, and executive orders, as such statutes, regulations, rules, and executive orders currently exist and as they may be lawfully amended. The Department rules are located in the Texas Administrative Code, Title 25 (Rules). To the extent this Contract imposes a higher standard, or additional requirements beyond those required by applicable statutes, regulations, rules or executive orders, the terms of this Contract will control. Contractor further agrees that, upon notification from DSHS, Contractor shall comply with the terms of any contract provisions DSHS is required to include in its contracts under legislation effective at the time of the effective date of this Contract or during the term of this Contract.

Section 1.02 **Compliance with Requirements of Solicitation Document.** Except as specified in these General Provisions or the Program Attachment(s), Contractor shall comply with the requirements, eligibility conditions, assurances, certifications and program requirements of the Solicitation Document, if any, (including any revised or additional terms agreed to in writing by Contractor and DSHS prior to execution of this Contract) for the duration of this Contract or any subsequent renewals. The Parties agree that the Department has relied upon Contractor's response to the Solicitation Document. The Parties agree that any misrepresentation contained in Contractor's response to the Solicitation Document constitutes a breach of this Contract.

Section 1.03 **Reporting.** Contractor shall submit reports in accordance with the reporting requirements established by the Department and shall provide any other information requested by the Department in the format required by DSHS. Failure to submit any required report or additional requested information by the due date specified in the Program Attachment(s) or upon request constitutes a breach of contract, may result in delayed payment and/or the imposition of sanctions and remedies, and, if appropriate, emergency action; and may adversely affect evaluation of Contractor's future contracting opportunities with the Department.

Section 1.04 **Client Financial Eligibility.** Where applicable, Contractor shall use financial eligibility criteria, financial assessment procedures and standards developed by the Department to determine client eligibility.

Section 1.05 **Applicable Contracts Law and Venue for Disputes.** Regarding all issues related to contract formation, performance, interpretation, and any issues that may arise in any dispute between the Parties, this Contract will be governed by, and construed in accordance with, the laws of the State of Texas. In the event of a dispute between the Parties, venue for any suit will be Travis County, Texas.

Section 1.06 **Applicable Laws and Regulations Regarding Funding Sources.** Where applicable, federal statutes and regulations, including federal grant requirements applicable to funding sources, will apply to this Contract. Contractor agrees to comply with applicable laws, executive orders, regulations and policies, as well as Office of Management and Budget (OMB) Circulars (as codified in Title 2 of the Code of Federal Regulations), the Uniform Grant and Contract Management Act of 1981 (UGMA), Tex. Gov. Code Chapter 783, and Uniform Grant Management Standards (UGMS), as revised by federal circulars and incorporated in UGMS by the Comptroller of Public Accounts, Texas Procurement and Support Services Division. UGMA and UGMS can be located through web links on the DSHS website at http://www.dshs.state.tx.us/contracts/links.shtm. Contractor also shall comply with all applicable federal and state assurances contained in UGMS, Part III, State Uniform Administrative Requirements for Grants and Cooperative Agreements §__.14. If applicable, Contractor shall comply with the Federal awarding agency's Common Rule, and the U.S. Health and Human Services Grants Policy Statement, both of which may be

located through web links on the DSHS website at http://www.dshs.state.tx.us/contracts/links.shtm. For contracts funded by block grants, Contractor shall comply with Tex. Gov. Code Chapter 2105.

Section 1.07 **Statutes and Standards of General Applicability.** Contractor is responsible for reviewing and complying with all applicable statutes, rules, regulations, executive orders and policies. To the extent applicable to Contractor, Contractor shall comply with the following:

a) the following statutes, rules, regulations, and DSHS policy (and any of their subsequent amendments) that collectively prohibit discrimination, exclusion from or limitation of participation in programs, benefits or activities or denial of any aid, care, service or other benefit on the basis of race, color, national origin, limited English proficiency, sex, sexual orientation (where applicable), disabilities, age, substance abuse, political belief or religion: 1) Title VI of the Civil Rights Act of 1964, 42 USC §§ 2000d et seq.; 2) Title IX of the Education Amendments of 1972, 20 USC §§ 1681-1683, and 1685-1686; 3) Section 504 of the Rehabilitation Act of 1973, 29 USC § 794(a); 4) the Americans with Disabilities Act of 1990, 42 USC §§ 12101 et seq.; 5) Age Discrimination Act of 1975, 42 USC §§ 6101-6107; 6) Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 USC § 290dd (b)(1); 7) 45 CFR Parts 80, 84, 86 and 91; 8) U.S. Department of Labor, Equal Employment Opportunity E.O. 11246; 9) Tex. Lab. Code Chapter 21; 10) Food Stamp Act of 1977 (7 USC § 200 et seq.; 11) Executive Order 13279, 45 CFR Part 87 or 7 CFR Part 16 regarding equal treatment and opportunity for religious organizations; 12) Drug Abuse Office and Treatment Act of 1972, 21 USC §§ 1101 et seq., relating to drug abuse; 13) Public Health Service Act of 1912, §§ 523 and 527, 42 USC § 290dd-2, and 42 CFR Part 2, relating to confidentiality of alcohol and drug abuse patient records; 14) Title VIII of the Civil Rights Act of 1968, 42 USC §§ 3601 et seq., relating to nondiscrimination in housing; and 15) DSHS Policy AA-5018, Non-discrimination Policy for DSHS Programs;
b) Immigration Reform and Control Act of 1986, 8 USC § 1324a, and Immigration Act of 1990, 8 USC 1101 et seq., regarding employment verification; and Illegal Immigration Reform and Immigrant Responsibility Act of 1996;
c) Pro-Children Act of 1994, 20 USC §§ 6081-6084, and the Pro-Children Act of 2001, 20 USC § 7183, regarding the non-use of all tobacco products;
d) National Research Service Award Act of 1971, 42 USC §§ 289a-1 et seq., and 6601 (PL 93-348 and PL 103-43), regarding human subjects involved in research;
e) Hatch Political Activity Act, 5 USC §§ 1501-1508 and 7324-28, which limits the political activity of employees whose employment is funded with federal funds;
f) Fair Labor Standards Act, 29 USC §§ 201 et seq., and the Intergovernmental Personnel Act of 1970, 42 USC §§ 4701 et seq., as applicable, concerning minimum wage and maximum hours;
g) Tex. Gov. Code Chapter 469, pertaining to eliminating architectural barriers for persons with disabilities;
h) Texas Workers' Compensation Act, Tex. Lab. Code Chapters 401-406 and 28 Tex. Admin. Code Part 2, regarding compensation for employees' injuries;
i) The Clinical Laboratory Improvement Amendments of 1988, 42 USC § 263a, regarding the regulation and certification of clinical laboratories;
j) The Occupational Safety and Health Administration Regulations on Blood Borne Pathogens, 29 CFR § 1910.1030, or Title 25 Tex. Admin. Code Chapter 96 regarding safety standards for handling blood borne pathogens;
k) Laboratory Animal Welfare Act of 1966, 7 USC §§ 2131 et seq., pertaining to the treatment of laboratory animals;
l) environmental standards pursuant to the following: 1) Institution of environmental quality control measures under the National Environmental Policy Act of 1969, 42 USC §§ 4321-4347 and Executive Order 11514 (35 Fed. Reg. 4247), "Protection and Enhancement of Environmental Quality;" 2)

Notification of violating facilities pursuant to Executive Order 11738 (40 CFR Part 32), "Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with respect to Federal Contracts, Grants, or Loans;" 3) Protection of wetlands pursuant to Executive Order 11990, 42 Fed. Reg. 26961; 4) Evaluation of flood hazards in floodplains in accordance with Executive Order 11988, 42 Fed. Reg. 26951 and, if applicable, flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (PL 93-234); 5) Assurance of project consistency with the approved State Management program developed under the Coastal Zone Management Act of 1972, 16 USC §§ 1451 et seq.; 6) Federal Water Pollution Control Act, 33 USC §1251 et seq.; 7) Protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, 42 USC §§ 300f-300j; 8) Protection of endangered species under the Endangered Species Act of 1973, 16 USC §§ 1531 et seq.; 9) Conformity of federal actions to state clean air implementation plans under the Clean Air Act of 1955, 42 USC §§7401 et seq.; 10) Wild and Scenic Rivers Act of 1968 (16 USC §§ 1271 et seq.) related to protecting certain rivers system; and 11) Lead-Based Paint Poisoning Prevention Act (42 USC §§ 4801 et seq.) prohibiting the use of lead-based paint in residential construction or rehabilitation;

m) Intergovernmental Personnel Act of 1970 (42 USC §§4278-4763) regarding personnel merit systems for programs specified in Appendix A of the federal Office of Program Management's Standards for a Merit System of Personnel Administration (5 CFR Part 900, Subpart F);
n) Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (PL 91-646), relating to fair treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs;
o) Davis-Bacon Act (40 USC §§ 276a to 276a-7), the Copeland Act (40 U.S.C. § 276c and 18 USC § 874), and the Contract Work Hours and Safety Standards Act (40 USC §§ 327-333), regarding labor standards for federally-assisted construction subagreements;
p) National Historic Preservation Act of 1966, §106 (16 USC § 470), Executive Order 11593, and the Archaeological and Historic Preservation Act of 1974 (16 USC §§ 469a-1 et seq.) regarding historic property to the extent necessary to assist DSHS in complying with the Acts;
q) financial and compliance audits in accordance with Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations;"
r) Trafficking Victims Protection Act of 2000, Section 106(g) (22 USC § 7104);
s) Executive Order, Federal Leadership on Reducing Text Messaging While Driving, October 1, 2009, if required by a federal funding source of the Contract; and
t) requirements of any other applicable state and federal statutes, executive orders, regulations, rules and policies.

If this Contract is funded by a federal grant or cooperative agreement, additional state or federal requirements found in the Notice of Grant Award are imposed on Contractor and incorporated herein by reference. Contractor may obtain a copy of any applicable Notice of Grant Award from the contract manager assigned to the Program Attachment.

Section 1.08 **Applicability of General Provisions to Interagency and Interlocal Contracts.** Certain sections or portions of sections of these General Provisions will not apply to Contractors that are State agencies or units of local government; and certain additional provisions will apply to such Contractors.

a) The following sections or portions of sections of these General Provisions will not apply to interagency or interlocal contracts:
   1) Hold Harmless and Indemnification, Section 13.19;
   2) Independent Contractor, Section 12.15 (delete the third sentence in its entirety; delete the word "employees" in the fourth sentence; the remainder of the section applies);
   3) Insurance, Section 12.03;
   4) Liability Coverage, Section 12.05;
   5) Fidelity Bond, Section 12.04;

6) Historically Underutilized Businesses, Section 12.10 (Contractor, however, shall comply with HUB requirements of other statutes and rules specifically applicable to that entity);
7) Debt to State and Corporate Status, Section 3.01;
8) Application of Payment Due, Section 3.02; and
9) Article XV Claims against the Department (This Article is inapplicable to interagency contracts only).

b) The following additional provisions will apply to interagency contracts:
1) This Contract is entered into pursuant to the authority granted and in compliance with the provisions of the Interagency Cooperation Act, Tex. Gov. Code Chapter 771;
2) The Parties hereby certify that (1) the services specified are necessary and essential for the activities that are properly within the statutory functions and programs of the affected agencies of State government; (2) the proposed arrangements serve the interest of efficient and economical administration of the State government; and (3) the services, supplies or materials contracted for are not required by Section 21 of Article 16 of the Constitution of the State of Texas to be supplied under contract given to the lowest responsible bidder; and
3) DSHS certifies that it has the authority to enter into this Contract granted in Tex. Health & Safety Code Chapter 1001, and Contractor certifies that it has specific statutory authority to enter into and perform this Contract.

c) The following additional provisions will apply to interlocal contracts:
1) This Contract is entered into pursuant to the authority granted and in compliance with the provisions of the Interlocal Cooperation Act, Tex. Gov. Code Chapter 791;
2) Payments made by DSHS to Contractor will be from current revenues available to DSHS; and
3) Each Party represents that it has been authorized to enter into this Contract.

d) Contractor agrees that Contract Revision Requests (pursuant to the Contractor's Request for Revision to Certain Contract Provisions section), when signed by a duly authorized representative of Contractor, will be effective as of the effective date specified by the Department, whether that date is prior to or after the date of any ratification by Contractor's governing body.

Section 1.09 **Civil Rights Policies and Complaints.** Upon request, Contactor shall provide the Health and Human Services Commission (HHSC) Civil Rights Office with copies of all Contractor's civil rights policies and procedures. Contractor shall notify HHSC's Office of Civil Rights of any civil rights complaints received relating to performance under this Contract no more than ten (10) calendar days after Contractor's receipt of the claim. Notice must be directed to –

HHSC Civil Rights Office
701 W. 51st St., Mail Code W206
Austin, Texas 78751
Toll-free phone (888) 388-6332
Phone (512) 438-4313
TTY Toll-free (877) 432-7232
Fax (512) 438-5885

Section 1.10 **Licenses, Certifications, Permits, Registrations and Approvals.** Contractor shall obtain and maintain all applicable licenses, certifications, permits, registrations and approvals to conduct its business and to perform the services under this Contract. Failure to obtain or any revocation, surrender, expiration, non-renewal, inactivation or suspension of any such license, certification, permit, registration or approval constitutes grounds for termination of this Contract or other remedies the Department deems appropriate. Contractor shall ensure that all its employees, staff and volunteers obtain and maintain in active status all licenses, certifications, permits, registrations and approvals required to perform their duties under this Contract

and shall prohibit any person who does not hold a current, active required license, certification, permit, registration or approval from performing services under this Contract.

Section 1.11 **Funding Obligation.** This Contract is contingent upon the availability of funding. If funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or health and human services agencies, amendment of the Appropriations Act, health and human services agency consolidation, or any other disruptions of current appropriated funding for this Contract, DSHS may restrict, reduce or terminate funding under this Contract. Notice of any restriction or reduction will include instructions and detailed information on how DSHS will fund the services and/or goods to be procured with the restricted or reduced funds.

ARTICLE II SERVICES

Section 2.01 **Education to Persons in Residential Facilities.** If applicable, Contractor shall ensure that all persons, who are housed in Department-licensed and/or -funded residential facilities and who are twenty-two (22) years of age or younger, have access to educational services as required by Tex. Educ. Code § 29.012. Contractor shall notify the local education agency or local early intervention program as prescribed by Tex. Educ. Code § 29.012 not later than the third calendar day after the date a person who is twenty-two (22) years of age or younger is placed in Contractor's residential facility.

Section 2.02 **Disaster Services.** In the event of a local, state, or federal emergency, including natural, man-made, criminal, terrorist, and/or bioterrorism events, declared as a state disaster by the Governor, or as a federal disaster by the appropriate federal official, Contractor may be called upon to assist DSHS in providing services, as appropriate, in the following areas: community evacuation; health and medical assistance; assessment of health and medical needs; health surveillance; medical care personnel; health and medical equipment and supplies; patient evacuation; in-hospital care and hospital facility status; food, drug, and medical device safety; worker health and safety; mental health and substance abuse; public health information; vector control and veterinary services; and victim identification and mortuary services. Contractor shall carry out disaster services in the manner most responsive to the needs of the emergency, be cost-effective, and be least intrusive on Contractor's primary services.

Section 2.03 **Consent to Medical Care of a Minor.** If Contractor provides medical, dental, psychological or surgical treatment to a minor under this Contract, either directly or through contracts with subcontractors, Contractor shall not provide treatment of a minor unless informed consent to treatment is obtained pursuant to Tex. Fam. Code Chapter 32, relating to consent to treatment of a child by a non-parent or child or pursuant to other state law. If requirements of federal law relating to consent directly conflict with Tex. Fam. Code Chapter 32, federal law supersedes state law.

Section 2.04 **Telemedicine Medical Services.** Contractor shall ensure that if Contractor or its subcontractor uses telemedicine/telepsychiatry that the services are implemented in accordance with written procedures and using a protocol approved by Contractor's medical director and using equipment that complies with the equipment standards as required by the Department. Procedures for providing telemedicine service must include the following requirements:

a) clinical oversight by Contractor's medical director or designated physician responsible for medical leadership;
b) contraindication considerations for telemedicine use;
c) qualified staff members to ensure the safety of the individual being served by telemedicine at the remote site;
d) safeguards to ensure confidentiality and privacy in accordance with state and federal laws;
e) use by credentialed licensed providers providing clinical care within the scope of their licenses;

f) demonstrated competency in the operations of the system by all staff members who are involved in the operation of the system and provision of the services prior to initiating the protocol;
g) priority in scheduling the system for clinical care of individuals;
h) quality oversight and monitoring of satisfaction of the individuals served; and
i) management of information and documentation for telemedicine services that ensures timely access to accurate information between the two sites.

Telemedicine Medical Services does not include chemical dependency treatment services provided by electronic means under Rule § 448.911.

Section 2.05 **Fees for Personal Health Services.** Contractor may develop a system and schedule of fees for personal health services in accordance with the provisions of Tex. Health & Safety Code § 12.032, DSHS Rule §1.91 covering Fees for Personal Health Services, and other applicable laws or grant requirements. The amount of a fee must not exceed the actual cost of providing the services. No client may be denied a service due to inability to pay.

Section 2.06 **Cost Effective Purchasing of Medications.** If medications are funded under this Contract, Contractor shall make needed medications available to clients at the lowest possible prices and use the most cost effective medications purchasing arrangement possible.

Section 2.07 **Services and Information for Persons with Limited English Proficiency.** Contractor shall take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities. Contractor shall identify and document on the client records the primary language/dialect of a client who has limited English proficiency and the need for translation or interpretation services and shall not require a client to provide or pay for the services of a translator or interpreter. Contractor shall make every effort to avoid use of any persons under the age of eighteen (18) or any family member or friend of the client as an interpreter for essential communications with a client with limited English proficiency, unless the client has requested that person and using the person would not compromise the effectiveness of services or violate the client's confidentiality and the client is advised that a free interpreter is available.

ARTICLE III FUNDING

Section 3.01 **Debt to State and Corporate Status.** Pursuant to Tex. Gov. Code § 403.055, the Department will not approve and the State Comptroller will not issue payment to Contractor if Contractor is indebted to the State for any reason, including a tax delinquency. Contractor, if a corporation, certifies by execution of this Contract that it is current and will remain current in its payment of franchise taxes to the State of Texas or that it is exempt from payment of franchise taxes under Texas law (Tex. Tax Code §§ 171.001 et seq.). Contractor, if a corporation, further certifies that it is and will remain in good standing with the Secretary of State's office. A false statement regarding franchise tax or corporate status is a material breach of this Contract. If franchise tax payments become delinquent during the Contract term, all or part of the payments under this Contract may be withheld until Contractor's delinquent franchise tax is paid in full.

Section 3.02 **Application of Payment Due.** Contractor agrees that any payments due under this Contract will be applied towards any debt of Contractor, including but not limited to delinquent taxes and child support that is owed to the State of Texas.

Section 3.03 **Use of Funds.** Contractor shall expend Department funds only for the provision of approved services and for reasonable and allowable expenses directly related to those services.

Section 3.04 **Use for Match Prohibited.** Contractor shall not use funds provided through this Contract for matching purposes in securing other funding unless directed or approved by the Department in writing.

Section 3.05 **Program Income.** Gross income directly generated from Department funds through a project or activity performed under a Program Attachment and/or earned only as a result of a Program Attachment during the term of the Program Attachment are considered program income. Unless otherwise required under the terms of the grant funding this Contract, Contractor shall use the addition alternative, as provided in UGMS § __.25(g)(2), for the use of program income to further the program objectives of the state or federal statute under which the Program Attachment was made, and Contractor shall spend the program income on the same Program Attachment project in which it was generated. Contractor shall identify and report this income in accordance with the Compliance and Reporting Article of these General Provisions, the Contractor's Financial Procedures Manual located at http://www.dshs.state.tx.us/contracts/cfpm.shtm and the provisions of the Program Attachment(s). Contractor shall expend program income during the Program Attachment term and may not carry forward to any succeeding term. Contractor shall refund program income not expended in the term in which it is earned to DSHS. DSHS may base future funding levels, in part, upon Contractor's proficiency in identifying, billing, collecting, and reporting program income, and in using it for the purposes and under the conditions specified in this Contract.

Section 3.06 **Nonsupplanting.** Contractor shall not supplant (i.e., use funds from this Contract to replace or substitute existing funding from other sources that also supports the activities that are the subject of this Contract) but rather shall use funds from this Contract to supplement existing state or local funds currently available for a particular activity. Contractor shall make a good faith effort to maintain its current level of support. Contractor may be required to submit documentation substantiating that a reduction in state or local funding, if any, resulted for reasons other than receipt or expected receipt of funding under this Contract.

ARTICLE IV PAYMENT METHODS AND RESTRICTIONS

Section 4.01 **Payment Methods.** Except as otherwise provided by the provisions of the Program Attachment(s), the payment method for each Program Attachment will be one of the following methods:

a) cost reimbursement. This payment method is based on an approved budget in the Program Attachment(s) and acceptable submission of a request for reimbursement; or
b) unit rate/fee-for-service. This payment method is based on a fixed price or a specified rate(s) or fee(s) for delivery of a specified unit(s) of service, as stated in the Program Attachment(s) and acceptable submission of all required documentation, forms and/or reports.

Section 4.02 **Billing Submission.** Contractors shall bill the Department in accordance with the Program Attachment(s) in the form and format prescribed by DSHS. Unless otherwise specified in the Program Attachment(s) or permitted under the Third Party Payors section of this Article, Contractor shall submit requests for reimbursement or payment monthly by the last business day of the month following the end of the month covered by the bill. Contractor shall maintain all documentation that substantiates billing submissions and make the documentation available to DSHS upon request.

Section 4.03 **Final Billing Submission.** Unless otherwise provided by the Department, Contractor shall submit a reimbursement or payment request as a final close-out bill not later than sixty (60) calendar days following the end of the term of the Program Attachment for goods received and services rendered during the term. If necessary to meet this deadline, Contractor may submit reimbursement or payment requests by facsimile transmission. Reimbursement or payment requests received in DSHS's offices more than sixty (60) calendar days following the end of the applicable term will not be paid. Consideration of requests for an exception will be made on a case-by-case basis, subject to the availability of funding, and only for an extenuating circumstance, such as a catastrophic event, natural disaster, or criminal activity that substantially

interferes with normal business operations or causes damage or destruction of a place of business and/or records. A written statement describing the extenuating circumstance and the last request for reimbursement must be submitted for review and approval to the DSHS Accounting Section.

Section 4.04 **Working Capital Advance.** If allowed under this Contract, a single one-time working capital advance per term of the Program Attachment may be granted at the Department's discretion. Contractor must submit documentation to the contract manager assigned to the Program Attachment to justify the need for a working capital advance. Contractor shall liquidate the working capital advance as directed by the Department. The requirements for the documentation justifying the need for an advance and the directions for liquidating the advance are found in the Contractor's Financial Procedures Manual located at http://www.dshs.state.tx.us/contracts/cfpm.shtm.

Section 4.05 **Financial Status Reports (FSRs).** Except as otherwise provided in these General Provisions or in the terms of the Program Attachment(s), for contracts with categorical budgets, Contractor shall submit quarterly FSRs to Accounts Payable by the last business day of the month following the end of each quarter of the Program Attachment term for Department review and financial assessment. Contractor shall submit the final FSR no later than sixty (60) calendar days following the end of the applicable term.

Section 4.06 **Third Party Payors.** A third party payor is any person or entity who has the legal responsibility for paying for all or part of the services provided. Third party payors include, but are not limited to, commercial health or liability insurance carriers, Medicaid, or other federal, state, local, and private funding sources. Except as provided in this Contract, Contractor shall screen all clients and shall not bill the Department for services eligible for reimbursement from third party payors. Contractor shall (a) enroll as a provider in Children's Health Insurance Program and Medicaid if providing approved services authorized under this Contract that may be covered by those programs, and bill those programs for the covered services; (b) provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs; (c) allow clients who are otherwise eligible for Department services, but cannot pay a deductible required by a third party payor, to receive services up to the amount of the deductible and to bill the Department for the deductible; (d) not bill the Department for any services eligible for third party reimbursement until all appeals to third party payors have been exhausted, in which case the thirty (30)-day requirement in the Billing Submission section will be extended until all such appeals have been exhausted; (e) maintain appropriate documentation from the third party payor reflecting attempts to obtain reimbursement; (f) bill all third party payors for services provided under this Contract before submitting any request for reimbursement to Department; and (g) provide third party billing functions at no cost to the client.

ARTICLE V TERMS AND CONDITIONS OF PAYMENT

Section 5.01 **Prompt Payment.** Upon receipt of a timely, undisputed invoice pursuant to this Contract, Department will pay Contractor. Payments and reimbursements are contingent upon a signed Contract and will not exceed the total amount of authorized funds under this Contract. Contractor is entitled to payment or reimbursement only if the service, work, and/or product has been authorized by the Department and performed or provided pursuant to this Contract. If those conditions are met, Department will make payment in accordance with the Texas prompt payment law (Tex. Gov. Code Chapter 2251). Contractor shall comply with Tex. Gov. Code Chapter 2251 regarding its prompt payment obligations to subcontractors. Payment of invoices by the Department will not constitute acceptance or approval of Contractor's performance, and all invoices and Contractor's performance are subject to audit or review by the Department.

Section 5.02 **Withholding Payments.** Department may withhold all or part of any payments to Contractor to offset reimbursement for any ineligible expenditures, disallowed costs, or overpayments that Contractor has not refunded to Department, or if financial status report(s) required by the Department are not submitted by the

date(s) due. Department may take repayment (recoup) from funds available under this Contract in amounts necessary to fulfill Contractor's repayment obligations.

Section 5.03 **Condition Precedent to Requesting Payment.** Contractor shall disburse program income, rebates, refunds, contract settlements, audit recoveries, and interest earned on such funds before requesting cash payments including any advance payments from Department.

Section 5.04 **Acceptance as Payment in Full.** Except as permitted in the Fees for Personal Health Services section of the Services Article of these General Provisions or under 25 Tex. Admin. Code § 444.413, Contractor shall accept reimbursement or payment from DSHS as payment in full for services or goods provided to clients or participants, and Contractor shall not seek additional reimbursement or payment for services or goods from clients or participants or charge a fee or make a profit with respect to the Contract. A fee or profit is considered to be an amount in excess of actual allowable costs that are incurred in conducting an assistance program.

ARTICLE VI ALLOWABLE COSTS AND AUDIT REQUIREMENTS

Section 6.01 **Allowable Costs.** For services satisfactorily performed, and sufficiently documented, pursuant to this Contract, DSHS will reimburse Contractor for allowable costs. Contractor must have incurred a cost prior to claiming reimbursement and within the applicable term to be eligible for reimbursement under this Contract. DSHS will determine whether costs submitted by Contractor are allowable and eligible for reimbursement. If DSHS has paid funds to Contractor for unallowable or ineligible costs, DSHS will notify Contractor in writing, and Contractor shall return the funds to DSHS within thirty (30) calendar days of the date of this written notice. DSHS may withhold all or part of any payments to Contractor to offset reimbursement for any unallowable or ineligible expenditures that Contractor has not refunded to DSHS, or if financial status report(s) required under the Financial Status Reports section are not submitted by the due date(s). DSHS may take repayment (recoup) from funds available under this Contract in amounts necessary to fulfill Contractor's repayment obligations. Applicable cost principles, audit requirements, and administrative requirements include-

Applicable Entity	Applicable Cost Principles	Audit Requirements	Administrative Requirements
State, Local and Tribal Governments	OMB Circular A-87 (2 CFR, Part 225)	OMB Circular A-133 and UGMS	UGMS, OMB Circular A-102, and applicable Federal awarding agency common rule
Educational Institutions	OMB Circular A-21 (2 CFR, Part 220)	OMB Circular A-133	OMB Circular A-110 (2 CFR, Part 215) and applicable Federal awarding agency common rule; and UGMS, as applicable
Non-Profit Organizations	OMB Circular A-122 (2 CFR, Part 230)	OMB Circular A-133 and UGMS	UGMS; OMB Circular A-110 (2 CFR, Part 215) and applicable Federal awarding agency common rule
For-profit Organization other than a hospital and an organization named	48 CFR Part 31, Contract Cost Principles	OMB Circular A-133 and UGMS	UGMS and applicable Federal awarding agency common rule

in OMB Circular A-122 (2 CFR Part, 230) as not subject to that circular.	Procedures, or uniform cost accounting standards that comply with cost principles acceptable to the federal or state awarding agency		

A chart of applicable Federal awarding agency common rules is located through a weblink on the DSHS website at http://www.dshs.state.tx.us/contracts/links.shtm. OMB Circulars will be applied with the modifications prescribed by UGMS with effect given to whichever provision imposes the more stringent requirement in the event of a conflict.

Section 6.02 **Independent Single or Program-Specific Audit**. If Contractor within Contractor's fiscal year expends a total amount of at least $500,000 in federal funds awarded, Contractor shall have a single audit or program-specific audit in accordance with the Office of Management and Budget (OMB) Circ. No. A-133, the Single Audit Act of 1984, P L 98-502, 98 Stat. 2327, and the Single Audit Act Amendments of 1996, P L 104-156, 110 Stat. 1396. The $500,000 federal threshold amount includes federal funds passed through by way of state agency awards. If Contractor within Contractor's fiscal year expends a total amount of at least $500,000 in state funds awarded, Contractor must have a single audit or program-specific audit in accordance with UGMS, State of Texas Single Audit Circular. For-profit Contractors whose expenditures meet or exceed the federal and/or state expenditure thresholds stated above shall follow the guidelines in OMB Circular A-133 or UGMS, as applicable, for their program-specific audits. The HHSC Office of Inspector General (OIG) will notify Contractor to complete the Single Audit Status Registration Form. If Contractor fails to complete the Single Audit Status Form within thirty (30) calendar days after notification by OIG to do so, Contractor shall be subject to DSHS sanctions and remedies for non-compliance with this Contract. The audit must be conducted by an independent certified public accountant and in accordance with applicable OMB Circulars, Government Auditing Standards, and UGMS, which is accessible through a web link on the DSHS website at http://www.dshs.state.tx.us/contracts/links.shtm. Contractor shall procure audit services in compliance with this section, state procurement procedures, as well as with the provisions of UGMS. Contractor, unless Contractor is a state governmental entity, shall competitively re-procure independent single audit services at least every five (5) years.

Section 6.03 **Submission of Audit.** Within thirty (30) calendar days of receipt of the audit reports required by the Independent Single or Program-Specific Audit section, Contractor shall submit one copy to the Department's Contract Oversight and Support Section, and one copy to the OIG, at the following addresses:

Department of State Health Services
Contract Oversight and Support, Mail Code 1326
P.O. Box 149347
Austin, Texas 78714-9347

Health and Human Services Commission
Office of Inspector General
Compliance/Audit, Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

If Contractor fails to submit the audit report as required by the Independent Single or Program-Specific Audit section within thirty (30) calendar days of receipt by Contractor of an audit report, Contractor shall be subject to DSHS sanctions and remedies for non-compliance with this Contract.

ARTICLE VII CONFIDENTIALITY

Section 7.01 **Maintenance of Confidentiality.** Contractor must maintain the privacy and confidentiality of information and records received during or related to the performance of this Contract, including patient and client records that contain protected health information (PHI), and any other information that discloses confidential personal information or identifies any client served by DSHS, in accordance with applicable federal and state laws, rules and regulations, including but not limited to 7 CFR Part 246; 42 CFR Part 2; 45 CFR Parts 160 and 164 (Health Insurance Portability and Accountability Act [HIPAA]); Tex. Health & Safety Code Chapters 12, 47, 81, 82, 85, 88, 92, 161, 181, 241, 245, 251, 534, 576, 577, 596, 611, and 773; and Tex. Occ. Code Chapters 56 and 159 and all applicable rules and regulations.

Section 7.02 **Department Access to PHI and Other Confidential Information.** Contractor shall cooperate with Department to allow Department to request, collect and receive PHI and other confidential information under this Contract, without the consent of the individual to whom the PHI relates, for funding, payment and administration of the grant program, and for purposes permitted under applicable state and federal confidentiality and privacy laws.

Section 7.03 **Exchange of Client-Identifying Information.** Except as prohibited by other law, Contractor and DSHS shall exchange PHI without the consent of clients in accordance with 45 CFR § 164.504(e)(3)(i)(B), Tex. Health & Safety Code § 533.009 and Rule Chapter 414, Subchapter A or other applicable laws or rules. Contractor shall disclose information described in Tex. Health & Safety Code § 614.017(a)(2) relating to special needs offenders, to an agency described in Tex. Health & Safety Code § 614.017(c) upon request of that agency, unless Contractor documents that the information is not allowed to be disclosed under 45 CFR Part 164 or other applicable law.

Section 7.04 **Security of Patient or Client Records.** Contractor shall maintain patient and client records in compliance with state and federal law relating to security and retention of medical or mental health and substance abuse patient and client records. Department may require Contractor to transfer original or copies of patient and client records to Department, without the consent or authorization of the patient or client, upon termination of this Contract or a Program Attachment to this Contract, as applicable, or if the care and treatment of the individual patient or client is transferred to another entity. Prior to providing services funded under this Contract to a patient or client, Contractor shall attempt to obtain consent from the patient or client to transfer copies of patient or client records to another entity funded by DSHS upon termination of this Contract or a Program Attachment to this Contract, as applicable, or if care or treatment is transferred to another DSHS-funded contractor.

Section 7.05 **HIV/AIDS Model Workplace Guidelines.** If providing direct client care, services, or programs, Contractor shall implement Department's policies based on the HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) Model Workplace Guidelines for Businesses, State Agencies, and State Contractors, Policy No. 090.021, and Contractor shall educate employees and clients concerning HIV and its related conditions, including AIDS, in accordance with the Tex. Health & Safety Code §§ 85.112-114. A link to the Model Workplace Guidelines can be found at http://www.dshs.state.tx.us/hivstd/policy/policies.shtm.

ARTICLE VIII RECORDS RETENTION

Section 8.01 **Retention.** Contractor shall retain records in accordance with applicable state and federal statutes, rules and regulations. At a minimum, Contractor shall retain and preserve all other records, including financial records that are generated or collected by Contractor under the provisions of this Contract, for a period of four (4) years after the termination of this Contract. If services are funded through Medicaid, the

federal retention period, if more than four (4) years, will apply. Contractor shall retain all records pertaining to this Contract that are the subject of litigation or an audit until the litigation has ended or all questions pertaining to the audit are resolved. Legal requirements for Contractor may extend beyond the retention schedules established in this section. Contractor shall retain medical records in accordance with Tex. Admin. Code Title 22, Part 9, § 165.1(b) and (c) or other applicable statutes, rules and regulations governing medical information. Contractor shall include this provision concerning records retention in any subcontract it awards. If Contractor ceases business operations, it shall ensure that records relating to this Contract are securely stored and are accessible by the Department upon Department's request for at least four (4) years from the date Contractor ceases business or from the date this Contract terminates, whichever is sooner. Contractor shall provide, and update as necessary, the name and address of the party responsible for storage of records to the contract manager assigned to the Program Attachment.

ARTICLE IX ACCESS AND INSPECTION

Section 9.01 **Access.** In addition to any right of access arising by operation of law, Contractor, and any of Contractor's affiliate or subsidiary organizations or subcontractors shall permit the Department or any of its duly authorized representatives, as well as duly authorized federal, state or local authorities, including the Comptroller General of the United States, OIG, and the State Auditor's Office (SAO), unrestricted access to and the right to examine any site where business is conducted or client services are performed, and all records (including financial records, client and patient records, if any, and Contractor's personnel records and governing body personnel records), books, papers or documents related to this Contract; and the right to interview members of Contractor's governing body, staff, volunteers, participants and clients concerning the Contract, Contractor's business and client services. If deemed necessary by the Department or the OIG, for the purpose of investigation or hearing, Contractor shall produce original documents related to this Contract. The Department and HHSC will have the right to audit billings both before and after payment, and all documentation that substantiates the billings. Payments will not foreclose the right of Department and HHSC to recover excessive or illegal payments. Contractor shall make available to the Department information collected, assembled or maintained by Contractor relative to this Contract for the Department to respond to requests that it receives under the Public Information Act. Contractor shall include this provision concerning the right of access to, and examination of, sites and information related to this Contract in any subcontract it awards.

Section 9.02 **State Auditor's Office.** Contractor shall, upon request, make all records, books, papers, documents, or recordings related to this Contract available for inspection, audit, or reproduction during normal business hours to any authorized representative of the SAO. Contractor understands that the acceptance of funds under this Contract acts as acceptance of the authority of the SAO, or any successor agency, to conduct an audit or investigation in connection with those funds. Contractor shall cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested, and providing access to any information the SAO considers relevant to the investigation or audit. The SAO's authority to audit funds will apply to Contract funds disbursed by Contractor to its subcontractors, and Contractor shall include this provision concerning the SAO's authority to audit and the requirement to cooperate, in any subcontract Contractor awards.

Section 9.03 **Responding to Deficiencies.** Any deficiencies identified by DSHS or HHSC upon examination of Contractor's records or during an inspection of Contractor's site(s) will be conveyed in writing to Contractor. Contractor shall submit, by the date prescribed by DSHS, a resolution to the deficiency identified in a site inspection, program review or management or financial audit to the satisfaction of DSHS or, if directed by DSHS, a corrective action plan to resolve the deficiency. A DSHS or HHSC determination of

either an inadequate or inappropriate resolution of the findings may result in contract remedies or sanctions under the Breach of Contract and Remedies for Non-Compliance Article of these General Provisions.

ARTICLE X NOTICE REQUIREMENTS

Section 10.01 **Child Abuse Reporting Requirement.** This section applies to mental health and substance abuse contractors and contractors for the following public health programs: Human Immunodeficiency Virus/Sexually Transmitted Diseases (HIV/STD); Family Planning (Titles V, X and XX); Primary Health Care; Maternal and Child Health; and Women, Infants and Children (WIC) Nutrition Services. Contractor shall make a good faith effort to comply with child abuse reporting guidelines and requirements in Tex. Fam. Code Chapter 261 relating to investigations of reports of child abuse and neglect. Contractor shall develop, implement and enforce a written policy that includes at a minimum the Department's Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers and train all staff on reporting requirements. Contractor shall use the DSHS Child Abuse Reporting Form as required by the Department located at www.dshs.state.tx.us/childabusereporting. Contractor shall retain reporting documentation on site and make it available for inspection by DSHS.

Section 10.02 **Significant Incidents.** In addition to notifying the appropriate authorities, Contractor shall report to the contract manager assigned to the Program Attachment significant incidents involving substantial disruption of Contractor's program operation, or affecting or potentially affecting the health, safety or welfare of Department-funded clients or participants within seventy-two (72) hours of discovery.

Section 10.03 **Litigation.** Contractor shall notify the contract manager assigned to the Program Attachment of litigation related to or affecting this Contract and to which Contractor is a party within seven (7) calendar days of becoming aware of such a proceeding. This includes, but is not limited to an action, suit or proceeding before any court or governmental body, including environmental and civil rights matters, professional liability, and employee litigation. Notification must include the names of the parties, nature of the litigation and remedy sought, including amount of damages, if any.

Section 10.04 **Action Against the Contractor.** Contractor shall notify the contract manager assigned to the Program Attachment if Contractor has had a contract suspended or terminated for cause by any local, state or federal department or agency or nonprofit entity within three (3) working days of the suspension or termination. Such notification must include the reason for such action; the name and contact information of the local, state or federal department or agency or entity; the date of the contract; and the contract or case reference number. If Contractor, as an organization, has surrendered its license or has had its license suspended or revoked by any local, state or federal department or agency or non-profit entity, it shall disclose this information within three (3) working days of the surrender, suspension or revocation to the contract manager assigned to the Program Attachment by submitting a one-page description that includes the reason(s) for such action; the name and contact information of the local, state or federal department or agency or entity; the date of the license action; and a license or case reference number.

Section 10.05 **Insolvency.** Contractor shall notify in writing the contract manager assigned to the Program Attachment of Contractor's insolvency, incapacity, or outstanding unpaid obligations to the Internal Revenue Service (IRS) or Texas Workforce Commission (TWC) within three (3) working days of the date of determination that Contractor is insolvent or incapacitated, or the date Contractor discovered an unpaid obligation to the IRS or TWC. Contractor shall notify in writing the contract manager assigned to the Program

Attachment of its plan to seek bankruptcy protection within three (3) working days of such action by Contractor's governing body.

Section 10.06 **Misuse of Funds and Performance Malfeasance.** Contractor shall report to the contract manager assigned to the Program Attachment, any knowledge of debarment, suspected fraud, program abuse, possible illegal expenditures, unlawful activity, or violation of financial laws, rules, policies, and procedures related to performance under this Contract. Contractor shall make such report no later than three (3) working days from the date that Contractor has knowledge or reason to believe such activity has taken place. Additionally, if this Contract is federally funded by the Department of Health and Human Services (HHS), Contractor shall report any credible evidence that a principal, employee, subcontractor or agent of Contractor, or any other person, has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds. Contractor shall make this report to the SAO at http://sao.fraud.state.tx.us, and to the HHS Office of Inspector General at http://www.oig.hhs.gov/fraud/hotline/ no later than three (3) working days from the date that Contractor has knowledge or reason to believe such activity has taken place.

Section 10.07 **Criminal Activity and Disciplinary Action.** Contractor affirms that no person who has an ownership or controlling interest in the organization or who is an agent or managing employee of the organization has been placed on community supervision, received deferred adjudication, is presently indicted for or has been convicted of a criminal offense related to any financial matter, federal or state program or felony sex crime. Contractor shall notify in writing the contract manager assigned to the Program Attachment if it has reason to believe Contractor, or a person with ownership or controlling interest in the organization or who is an agent or managing employee of the organization, an employee or volunteer of Contractor, or a subcontractor providing services under this Contract has engaged in any activity that would constitute a criminal offense equal to or greater than a Class A misdemeanor or if such activity would reasonably constitute grounds for disciplinary action by a state or federal regulatory authority, or has been placed on community supervision, received deferred adjudication, or been indicted for or convicted of a criminal offense relating to involvement in any financial matter, federal or state program or felony sex crime. Contractor shall make the reports required by this section no later than three (3) working days from the date that Contractor has knowledge or reason to believe such activity has taken place. Contractor shall not permit any person who engaged, or was alleged to have engaged, in an activity subject to reporting under this section to perform direct client services or have direct contact with clients, unless otherwise directed by DSHS.

Section 10.08 **Retaliation Prohibited.** Contractor shall not retaliate against any person who reports a violation of, or cooperates with an investigation regarding, any applicable law, rule, regulation or standard to the Department, another state agency, or any federal, state or local law enforcement official.

Section 10.09 **Documentation.** Contractor shall maintain appropriate documentation of all notices required under these General Provisions.

ARTICLE XI ASSURANCES AND CERTIFICATIONS

Section 11.01 **Certification.** Contractor certifies by execution of this Contract to the following:

a) it is not disqualified under 2 CFR §376.935 or ineligible for participation in federal or state assistance programs;
b) neither it, nor its principals, are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or state department or agency in accordance with 2 CFR Parts 376 and 180 (parts A-I), 45 CFR Part 76 (or comparable federal regulations);
c) it has not knowingly failed to pay a single substantial debt or a number of outstanding debts to a federal or state agency;

d) it is not subject to an outstanding judgment in a suit against Contractor for collection of the balance of a debt;
e) it is in good standing with all state and/or federal agencies that have a contracting or regulatory relationship with Contractor;
f) that no person who has an ownership or controlling interest in Contractor or who is an agent or managing employee of Contractor has been convicted of a criminal offense related to involvement in any program established under Medicare, Medicaid, or a federal block grant;
g) neither it, nor its principals have within the three(3)-year period preceding this Contract, has been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a private or public (federal, state or local) transaction or contract under a private or public transaction, violation of federal or state antitrust statutes (including those proscribing price-fixing between competitors, allocation of customers between competitors and bid-rigging), or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or false claims, tax evasion, obstruction of justice, receiving stolen property or any other offense indicating a lack of business integrity or business honesty that seriously and directly affects the present responsibility of Contactor or its principals;
h) neither it, nor its principals is presently indicted or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with the commission of any of the offenses enumerated in subsection g) of this section; and
i) neither it, nor its principals within a three(3)-year period preceding this Contract has had one or more public transaction (federal, state or local) terminated for cause or default.

Contractor shall include the certifications in this Article, without modification (except as required to make applicable to the subcontractor), in all subcontracts and solicitations for subcontracts. Where Contractor is unable to certify to any of the statements in this Article, Contractor shall submit an explanation to the contract manager assigned to the Program Attachment. If Contractor's status with respect to the items certified in this Article changes during the term of this Contract, Contractor shall immediately notify the contract manager assigned to the Program Attachment.

Section 11.02 **Child Support Delinquencies.** As required by Tex. Fam. Code § 231.006, a child support obligor who is more than thirty (30) calendar days delinquent in paying child support and a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least twenty-five percent (25%) is not eligible to receive payments from state funds under a contract to provide property, materials, or services or receive a state-funded grant or loan. If applicable, Contractor shall maintain its eligibility to receive payments under this Contract, certifies that it is not ineligible to receive the payments specified in this Contract, and acknowledges that this Contract may be terminated and payment may be withheld if this certification is inaccurate.

Section 11.03 **Authorization.** Contractor certifies that it possesses legal authority to contract for the services described in this Contract and that a resolution, motion or similar action has been duly adopted or passed as an official act of Contractor's governing body, authorizing the binding of the organization under this Contract including all understandings and assurances contained in this Contract, and directing and authorizing the person identified as the authorized representative of Contractor to act in connection with this Contract and to provide such additional information as may be required.

Section 11.04 **Gifts and Benefits Prohibited.** Contractor certifies that it has not given, offered to give, nor intends to give at any time hereafter, any economic opportunity, present or future employment, gift, loan,

gratuity, special discount, trip, favor, service or anything of monetary value to a DSHS or HHSC official or employee in connection with this Contract.

Section 11.05 **Ineligibility to Receive the Contract.** (a) Pursuant to Tex. Gov. Code § 2155.004 and federal law, Contractor is ineligible to receive this Contract if this Contract includes financial participation by a person who received compensation from DSHS to participate in developing, drafting or preparing the specifications, requirements, statement(s) of work or Solicitation Document on which this Contract is based. Contractor certifies that neither Contractor, nor its employees, nor anyone acting for Contractor has received compensation from DSHS for participation in the development, drafting or preparation of specifications, requirements or statement(s) of work for this Contract or in the Solicitation Document on which this Contract is based; (b) pursuant to Tex. Gov. Code §§ 2155.006 and 2261.053, Contractor is ineligible to receive this Contract, if Contractor or any person who would have financial participation in this Contract has been convicted of violating federal law, or been assessed a federal civil or administrative penalty, in connection with a contract awarded by the federal government for relief, recovery or reconstruction efforts as a result of Hurricanes Rita or Katrina or any other disaster occurring after September 24, 2005; (c) Contractor certifies that the individual or business entity named in this Contract is not ineligible to receive the specified Contract under Tex. Gov. Code §§ 2155.004, 2155.006 or 2261.053, and acknowledges that this Contract may be terminated and payment withheld if these certifications are inaccurate.

Section 11.06 **Antitrust.** Pursuant to 15 USC § 1, et seq. and Tex. Bus. & Comm. Code § 15.01, et seq. Contractor certifies that neither Contractor, nor anyone acting for Contractor has violated the antitrust laws of this state or federal antitrust laws, nor communicated directly or indirectly regarding a bid with any competitor or any other person engaged in Contractor's line of business for the purpose of substantially lessening competition in such line of business.

Section 11.07 **Initiation and Completion of Work.** Contractor certifies that it shall initiate and complete the work under this Contract within the applicable time frame prescribed in this Contract.

ARTICLE XII GENERAL BUSINESS OPERATIONS OF CONTRACTOR

Section 12.01 **Responsibilities and Restrictions Concerning Governing Body, Officers and Employees.** Contractor and its governing body shall bear full responsibility for the integrity of the fiscal and programmatic management of the organization. This provision applies to all organizations, including Section 501(c)(3) organizations as defined in the Internal Revenue Service Code as not-for-profit organizations. Each member of Contractor's governing body shall be accountable for all funds and materials received from Department. The responsibility of Contractor's governing body shall also include accountability for compliance with Department Rules, policies, procedures, and applicable federal and state laws and regulations; and correction of fiscal and program deficiencies identified through self-evaluation and Department's monitoring processes. Further, Contractor's governing body shall ensure separation of powers, duties, and functions of governing body members and staff. Staff members, including the executive director, shall not serve as voting members of Contractor's governing body. No member of Contractor's governing body, or officer or employee of Contractor shall vote for, confirm or act to influence the employment, compensation or change in status of any person related within the second degree of affinity or the third degree of consanguinity (as defined in Tex. Gov. Code Chapter 573) to the member of the governing body or the officer or any employee authorized to employ or supervise such person. This prohibition does not prohibit the continued employment of a person who has been continuously employed for a period of two (2) years prior to the election, appointment or employment of the officer, employee, or governing body member related to such person in the prohibited degree. These restrictions also apply to the governing body, officers and employees of Contractor's

subcontractors. Ignorance of any Contract provisions or other requirements contained or referred to in this Contract will not constitute a defense or basis for waiving or appealing such provisions or requirements.

Section 12.02 **Management and Control Systems.** Contractor shall comply with all the requirements of the Department's Contractor's Financial Procedures Manual, and any of its subsequent amendments, which is available at the Department's web site: http://www.dshs.state.tx.us/contracts/cfpm.shtm. Contractor shall maintain an appropriate contract administration system to ensure that all terms, conditions, and specifications are met. Contractor shall develop, implement, and maintain financial management and control systems that meet or exceed the requirements of UGMS and adhere to procedures detailed in Department's Contractor's Financial Procedures Manual. Those requirements and procedures include, at a minimum, the following:

a) financial planning, including the development of budgets that adequately reflect all functions and resources necessary to carry out authorized activities and the adequate determination of costs;
b) financial management systems that include accurate accounting records that are accessible and identify the source and application of funds provided under each Program Attachment of this Contract, and original source documentation substantiating that costs are specifically and solely allocable to the Program Attachment and are traceable from the transaction to the general ledger; and
c) effective internal and budgetary controls; comparison of actual costs to budget; determination of reasonableness, allowableness, and allocability of costs; timely and appropriate audits and resolution of any findings; billing and collection policies; and a mechanism capable of billing and making reasonable efforts to collect from clients and third parties.

Section 12.03 **Insurance.** Contractor shall maintain insurance or other means of repairing or replacing assets purchased with Department funds. Contractor shall repair or replace with comparable equipment any such equipment not covered by insurance that is lost, stolen, damaged or destroyed. If any insured equipment purchased with DSHS funds is lost, stolen, damaged or destroyed, Contractor shall notify the contract manager assigned to the Program Attachment to obtain instructions whether to submit and pursue an insurance claim. Contractor shall use any insurance proceeds to repair the equipment or replace the equipment with comparable equipment or remit the insurance proceeds to DSHS.

Section 12.04 **Fidelity Bond.** For the benefit of DSHS, Contractor is required to carry a fidelity bond or insurance coverage equal to the amount of funding provided under this Contract up to $100,000 that covers each employee of Contractor handling funds under this Contract, including person(s) authorizing payment of such funds. The fidelity bond or insurance must provide for indemnification of losses occasioned by (1) any fraudulent or dishonest act or acts committed by any of Contractor's employees, either individually or in concert with others, and/or (2) failure of Contractor or any of its employees to perform faithfully his/her duties or to account properly for all monies and property received by virtue of his/her position or employment. The bond or insurance acquired under this section must include coverage for third party property. Contractor shall notify, and obtain prior approval from, the DSHS Contract Oversight and Support Section before settling a claim on the fidelity bond or insurance.

Section 12.05 **Liability Coverage.** For the benefit of DSHS, Contractor shall at all times maintain liability insurance coverage, referred to in Tex. Gov. Code § 2261.102, as "director and officer liability coverage" or similar coverage for all persons in management or governing positions within Contractor's organization or with management or governing authority over Contractor's organization (collectively "responsible persons"). Contractor shall maintain copies of liability policies on site for inspection by DSHS and shall submit copies of policies to DSHS upon request. This section applies to entities that are organized as non-profit corporations under the Texas Non-Profit Corporation Act; for-profit corporations organized under the Texas Business Corporations Act; and any other legal entity. Contractor shall maintain liability insurance coverage in an amount not less than the total value of this Contract and that is sufficient to protect the interests of Department

in the event an actionable act or omission by a responsible person damages Department's interests. Contractor shall notify, and obtain prior approval from, the DSHS Contract Oversight and Support Section before settling a claim on the insurance.

Section 12.06 **Overtime Compensation.** Except as provided in this section, Contractor shall not use any of the funds provided by this Contract to pay the premium portion of overtime. Contractor shall be responsible for any obligations of premium overtime pay due employees. Premium overtime pay is defined as any compensation paid to an individual in addition to the employee's normal rate of pay for hours worked in excess of normal working hours. Funds provided under this Contract may be used to pay the premium portion of overtime only under the following conditions: 1) with the prior written approval of DSHS; 2) temporarily, in the case of an emergency or an occasional operational bottleneck; 3) when employees are performing indirect functions, such as administration, maintenance, or accounting; 4) in performance of tests, laboratory procedures, or similar operations that are continuous in nature and cannot reasonably be interrupted or otherwise completed; or 5) when lower overall cost to DSHS will result.

Section 12.07 **Program Site.** Contractor shall provide services only in locations that are in compliance with all applicable local, state and federal zoning, building, health, fire, and safety standards.

Section 12.08 **Cost Allocation Plan.** Contractor shall submit a Cost Allocation Plan in the format provided in the Department's Contractor's Financial Procedures Manual to the Department's Contract Oversight and Support Section, at Mail Code 1326, P.O. Box 149347, Austin, Texas 78714-9347, or by email to mailto:coscap@dshs.state.tx.us no later than the 60th calendar day after the effective date of the Contract, except when a Contractor has a current Cost Allocation Plan on file with the Department. Contractor shall implement and follow the applicable Cost Allocation Plan. If Contractor's plan is the same as the plan previously submitted to DSHS, by signing this Contract, Contractor certifies that its current Cost Allocation Plan for the current year is the same as the plan previously submitted. If the Cost Allocation Plan changes during the Contract term, Contractor shall submit a new Cost Allocation Plan to the Contract Oversight and Support Section within thirty (30) calendar days after the effective date of the change. Cost Allocation Plans must comply with the guidelines provided in the Department's Contractor's Financial Procedures Manual located at http://www.dshs.state.tx.us/contracts/cfpm.shtm.

Section 12.09 **No Endorsement.** Other than stating the fact that Contractor has a contract with DSHS, Contractor and its subcontractors are prohibited from publicizing the contractual relationship between Contractor and DSHS, and from using the Department's name, logo or website link in any manner that is intended, or that could be perceived, as an endorsement or sponsorship by DSHS or the State of Texas of Contractor's organization, program, services or product, without the express written consent of DSHS.

Section 12.10 **Historically Underutilized Businesses (HUBs).** If Contractor was not required to submit a HUB subcontracting plan and if subcontracting is permitted under this Program Attachment, Contractor is encouraged to make a good faith effort to consider subcontracting with HUBs in accordance with Tex. Gov. Code Chapter 2161 and 34 Tex. Admin. Code § 20.10 et seq. Contractors may obtain a list of HUBs at http://www.window.state.tx.us/procurement/prog/hub. If Contractor has filed a HUB subcontracting plan, the plan is incorporated by reference in this Contract. If Contractor desires to make a change in the plan, Contractor must obtain prior approval from the Department's HUB Coordinator of the revised plan before proposed changes will be effective under this Contract. Contractor shall make a good faith effort to subcontract with HUBs during the performance of this Contract and shall report HUB subcontract activity to the Department's HUB Coordinator by the 15th day of each month for the prior month's activity, if there was any such activity, in accordance with 34 Tex. Admin. Code § 20.16(b).

Section 12.11 **Buy Texas.** Contractor shall purchase products and materials produced in Texas when the products and materials are available at a price and time comparable to products and materials produced outside of Texas as required by Tex. Gov. Code § 2155.4441.

Section 12.12 **Contracts with Subrecipient and Vendor Subcontractors.** Contractor may enter into contracts with subrecipient subcontractors unless restricted or otherwise prohibited in a specific Program Attachment(s). Prior to entering into a subrecipient agreement equaling or exceeding $100,000, Contractor shall obtain written approval from DSHS. Contractor shall establish written policies and procedures for competitive procurement and monitoring of subcontracts and shall produce a subcontracting monitoring plan. Contractor shall monitor subrecipient subcontractors for both financial and programmatic performance and shall maintain pertinent records that must be available for inspection by DSHS. Contractor shall ensure that subcontractors are fully aware of the requirements placed upon them by state/federal statutes, rules, and regulations and by the provisions of this Contract.

Contracts with all subcontractors, whether vendor or subrecipient, must be in writing and include the following:

a) name and address of all parties and the subcontractor's Vendor Identification Number (VIN) or Employee Identification Number (EIN);
b) a detailed description of the services to be provided;
c) measurable method and rate of payment and total not-to-exceed amount of the contract;
d) clearly defined and executable termination clause; and
e) beginning and ending dates that coincide with the dates of the applicable Program Attachment(s) or that cover a term within the beginning and ending dates of the applicable Program Attachment(s).

Contractor is responsible to DSHS for the performance of any subcontractor. Contractor shall not contract with a subcontractor, at any tier, that is debarred, suspended, or excluded from or ineligible for participation in federal assistance programs; or if the subcontractor would be ineligible under the following sections of these General Provisions: Ineligibility to Receive the Contract section (Assurances and Certifications Article); or the Conflict of Interest or Transactions Between Related Parties sections (General Terms Article).

Section 12.13 **Status of Subcontractors.** Contractor shall require all subcontractors to certify that they are not delinquent on any repayment agreements; have not had a required license or certification revoked; and have not had a contract terminated by the Department. Contractors shall further require that subcontractors certify that they have not voluntarily surrendered within the past three (3) years any license issued by the Department.

Section 12.14 **Incorporation of Terms in Subrecipient Subcontracts.** Contractor shall include in all its contracts with subrecipient subcontractors and solicitations for subrecipient subcontracts, without modification (except as required to make applicable to the subcontractor), (1) the certifications stated in the Assurances and Certifications Article; (2) the requirements in the Conflicts of Interest section and the Transaction Between Related Parties section of the General Terms Article; and (3) a provision granting to DSHS, SAO, OIG, and the Comptroller General of the United States, and any of their representatives, the right of access to inspect the work and the premises on which any work is performed, and the right to audit the subcontractor in accordance with the Access and Inspection Article in these General Provisions. Each subrecipient subcontract contract must also include a copy of these General Provisions and a copy of the Statement of Work and any other provisions in the Program Attachment(s) applicable to the subcontract. Contractor shall ensure that all written agreements with subrecipient subcontractors incorporate the terms of this Contract so that all terms, conditions, provisions, requirements, duties and liabilities under this Contract applicable to the services provided or activities conducted by a subcontractor are passed down to that subcontractor. No provision of this Contract creates privity of contract between DSHS and any subcontractor of Contractor. If a subcontractor is unable to certify to any of the statements in Section 12.13 or any of the certifications stated in the Assurances

and Certifications Article, Contractor shall submit an explanation to the contract manager assigned to the Program Attachment. If the subcontractor's status with respect to the items certified in Section 12.13 or the assurances stated in the Assurances and Certifications Article changes during the term of this Contract, Contractor shall immediately notify the contract manager assigned to the Program Attachment.

Section 12.15 **Independent Contractor.** Contractor is an independent contractor. Contractor shall direct and be responsible for the performance of its employees, subcontractors, joint venture participants or agents. Contractor is not an agent or employee of tbe Department or the State of Texas for any purpose whatsoever. For purposes of this Contract, Contractor acknowledges that its employees, subcontractors, joint venture participants or agents will not be eligible for unemployment compensation from the Department or the State of Texas.

Section 12.16 **Authority to Bind.** The person or persons signing this Contract on behalf of Contractor, or representing themselves as signing this Contract on behalf of Contractor, warrant and guarantee that they have been duly authorized by Contractor to execute this Contract for Contractor and to validly and legally bind Contractor to all of its terms.

Section 12.17 **Tax Liability.** Contractor shall comply with all state and federal tax laws and is solely responsible for filing all required state and federal tax forms and making all tax payments. If the Department discovers that Contractor has failed to remain current on a liability to the IRS, this Contract will be subject to remedies and sanctions under this Contract, including immediate termination at the Department's discretion. If the Contract is terminated under this section, the Department will not enter into a contract with Contractor for three (3) years from the date of termination.

Section 12.18 **Notice of Organizational Change.** Contractor shall submit written notice to the contract manager assigned to the Program Attachment within ten (10) business days of any change to the Contractor's name; contact information; key personnel, officer, director or partner; organizational structure, such as merger, acquisition or change in form of business; legal standing; or authority to do business in Texas. A change in Contractor's name and certain changes in organizational structure require an amendment to this Contract in accordance with the Amendments section of these General Provisions.

Section 12.19 **Quality Management.** Contractor shall comply with quality management requirements as directed by the Department.

Section 12.20 **Equipment (Including Controlled Assets).** Equipment means an article of nonexpendable, tangible personal property having a useful lifetime of more than one year and an acquisition cost of $5,000 or more, and "controlled assets." Controlled assets include firearms regardless of the acquisition cost, and the following assets with an acquisition cost of $500 or more, but less than $5,000: desktop and laptop computers (including notebooks, tablets and similar devices), non-portable printers and copiers, emergency management equipment, communication devices and systems, medical and laboratory equipment, and media equipment. Prior approval by DSHS of the purchase of controlled assets is not required. Contractors on a cost reimbursement payment method shall inventory all equipment, including controlled assets. Contractor shall initiate the purchase of all equipment approved in writing by DSHS, in the first quarter of the Contract or Program Attachment term, as applicable. Failure to timely initiate the purchase of equipment may result in the loss of availability of funds for the purchase of equipment. Requests to purchase previously approved equipment after the first quarter of the Program Attachment must be submitted to the contract manager assigned to the Program Attachment.

Section 12.21 **Supplies.** Supplies are defined as consumable items necessary to carry out the services under this Contract including medical supplies, drugs, janitorial supplies, office supplies, patient educational supplies, software, and any items of tangible personal property other than those defined as equipment above.

Section 12.22 **Changes to Equipment List.** All items of equipment, other than controlled assets, to be purchased with funds under this Contract must be itemized in Contractor's equipment list as finally approved by the Department in the executed Contract. Any changes to the approved equipment list in the executed Contract must be approved in writing by Department prior to the purchase of equipment. Contractor shall submit to the contract manager assigned to the Program Attachment, a written description including complete product specifications and need justification prior to purchasing any item of unapproved equipment. If approved, Department will acknowledge its approval by means of a written amendment or by written acceptance of Contractor's Contract Revision Request, as appropriate; or, in the case of minor changes to Contractor's approved equipment list, by email in accordance with the Contractor's Financial Procedures Manual.

Section 12.23 **Property Inventory and Protection of Assets.** Contractor shall maintain an inventory of equipment, including controlled assets, and property described in the Other Intangible Property section of Article XIII and submit an annual cumulative report of the equipment and other property on Form GC-11 (Contractor's Property Inventory Report) to the Department's Contract Oversight and Support Section, Mail Code 1326, P.O. Box 149347, Austin, Texas 78714-9347, no later than October 15th of each year. The report is located on the DSHS website at http://www.dshs.state.tx.us/contracts/forms.shtm. Contractor shall maintain, repair, and protect assets under this Contract to assure their full availability and usefulness. If Contractor is indemnified, reimbursed, or otherwise compensated for any loss of, destruction of, or damage to the assets provided or obtained under this Contract, Contractor shall use the proceeds to repair or replace those assets.

Section 12.24 **Bankruptcy.** In the event of bankruptcy, Contractor shall sever Department property, equipment, and supplies in possession of Contractor from the bankruptcy, and title must revert to Department. If directed by DSHS, Contractor shall return all such property, equipment and supplies to DSHS. Contractor shall ensure that its subcontracts, if any, contain a specific provision requiring that in the event the subcontractor's bankruptcy, the subcontractor must sever Department property, equipment, and supplies in possession of the subcontractor from the bankruptcy, and title must revert to Department, who may require that the property, equipment and supplies be returned to DSHS.

Section 12.25 **Title to Property.** At the conclusion of the contractual relationship between the Department and Contractor, for any reason, title to any remaining equipment and supplies purchased with funds under this Contract reverts to Department. Title may be transferred to any other party designated by Department. The Department may, at its option and to the extent allowed by law, transfer the reversionary interest to such property to Contractor.

Section 12.26 **Property Acquisitions.** Department funds must not be used to purchase buildings or real property. Any costs related to the initial acquisition of the buildings or real property are not allowable.

Section 12.27 **Disposition of Property.** Contractor shall follow the procedures in the American Hospital Association's (AHA's) "Estimated Useful Lives of Depreciable Hospital Assets" in disposing, at any time during or after the Contract term, of equipment purchased with the Department funds, except when federal or state statutory requirements supersede or when the equipment requires licensure or registration by the state, or when the acquisition price of the equipment is equal to or greater than $5,000. All other equipment not listed in the AHA reference (other than equipment that requires licensure or registration or that has an acquisition cost equal to or greater than $5,000) will be controlled by the requirements of UGMS. If, prior to the end of the useful life, any item of equipment is no longer needed to perform services under this Contract, or becomes inoperable, or if the equipment requires licensure or registration or had an acquisition price equal to or greater than $5,000, Contractor shall request disposition approval and instructions in writing from the contract manager assigned to the Program Attachment. After an item reaches the end of its useful life, Contractor shall

ensure that disposition of any equipment is in accordance with Generally Accepted Accounting Principles, and any applicable federal guidance.

Section 12.28 **Closeout of Equipment.** At the end of the term of a Program Attachment that has no additional renewals or that will not be renewed (Closeout) or when a Program Attachment is otherwise terminated, Contractor shall submit to the contract manager assigned to the Program Attachment, an inventory of equipment purchased with Department funds and request disposition instructions for such equipment. All equipment purchased with Department funds must be secured by Contractor at the time of Closeout or termination of the Program Attachment and must be disposed of according to the Department's disposition instructions, which may include return of the equipment to DSHS or transfer of possession to another DSHS contractor, at Contractor's expense.

Section 12.29 **Assets as Collateral Prohibited.** Contractors on a cost reimbursement payment method shall not encumber equipment purchased with Department funds without prior written approval from the Department.

ARTICLE XIII GENERAL TERMS

Section 13.01 **Assignment.** Contractor shall not transfer, assign, or sell its interest, in whole or in part, in this Contract, or in any equipment purchased with funds from this Contract, without the prior written consent of the Department.

Section 13.02 **Lobbying.** Contractor shall comply with Tex. Gov. Code § 556.0055, which prohibits contractors who receive state funds from using those funds to pay lobbying expenses. Further, Contractor shall not use funds paid under this Contract, either directly or indirectly, to support the enactment, repeal, modification, or adoption of any law, regulation or policy at any level of government, or to pay the salary or expenses of any person related to any activity designed to influence legislation, regulation, policy or appropriations pending before Congress or the state legislature, or for influencing or attempting to influence an officer or employee of any federal or state agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any contract or the extension, continuation, renewal, amendment, or modification of any contract (31 USC § 1352 and UGMS). If at any time this Contract exceeds $100,000 of federal funds, Contractor shall file with the contract manager assigned to the Program Attachment a declaration containing the name of any registrant under the Lobbying Disclosure Act of 1995 who has made lobbying contacts on behalf of Contractor in connection with this Contract, a certification that none of the funds provided by Department have been or will be used for payment to lobbyists, and disclosure of the names of any and all registered lobbyists with whom Contractor has an agreement. Contractor shall file the declaration, certification, and disclosure at the time of application for this Contract; upon execution of this Contract unless Contractor previously filed a declaration, certification, or disclosure form in connection with the award; and at the end of each calendar quarter in which any event occurs that materially affects the accuracy of the information contained in any declaration, certification, or disclosure previously filed. Contractor shall require any person who requests or receives a subcontract to file the same declaration, certification, and disclosure with the contract manager assigned to the Program Attachment. Contractor shall also comply, as applicable, with the lobbying restrictions and requirements in 2 CFR Part 230 (OMB Circulars A-122), Appendix B paragraph 25; 2 CFR Part 225 (A-87) Appendix B section 24; 2 CFR §215.27 (A-110) and 2 CFR Part 220 (A-21) Appendix A, subsection J.17 and J.28. Contractor shall include this provision in any subcontracts.

Section 13.03 **Conflict of Interest.** Contractor represents to the Department that it and its -subcontractors, if any, do not have nor shall Contractor or its subcontractors knowingly acquire or retain, any financial or other

interest that would conflict in any manner with the performance of their obligations under this Contract. Potential conflicts of interest include, but are not limited to, an existing or potential business or personal relationship between Contractor (or subcontractor), its principal (or a member of the principal's immediate family), or any affiliate or subcontractor and the Department or HHSC, their commissioners or employees, or any other entity or person involved in any way in any project that is the subject of this Contract. Contractor shall establish safeguards to prohibit employees and subcontractors and their employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. If, at any time during the term of this Contract, Contractor or any of its subcontractors has a conflict of interest or potential conflict of interest, Contractor shall disclose the actual or potential conflict of interest to the contract manager assigned to the Program Attachment within ten (10) days of when Contractor becomes aware of the existence of the actual or potential conflict of interest. Contractor shall require each of its subcontractors to report to Contractor any conflict of interest or potential conflict of interest the subcontractor has or may have within ten (10) days of when the subcontractor becomes aware of the actual or potential conflict of interest.

Section 13.04 **Transactions Between Related Parties.** Contractor shall identify and report to DSHS any transactions between Contractor and a related party that is part of the work that the Department is purchasing under this Contract before entering into the transaction or immediately upon discovery. Contractor shall submit to the contract manager assigned to the Program Attachment the name, address and telephone number of the related party, how the party is related to Contractor and the work the related party will perform under this Contract. A related party is a person or entity related to Contractor by blood or marriage, common ownership or any association that permits either to significantly influence or direct the actions or policies of the other. Contractor, for purposes of reporting transactions between related parties, includes the entity contracting with the Department under this Contract as well as the chief executive officer, chief financial officer and program director of Contractor. Contractor shall comply with Tex. Gov. Code Chapter 573. Contractor shall maintain records and supply any additional information requested by the Department, regarding a transaction between related parties, needed to enable the Department to determine the appropriateness of the transaction pursuant to applicable state or federal law, regulations or circulars, which may include 45 CFR part 74, OMB Circ. No. A-110, 2 CFR § 215.42, and UGMS.

Section 13.05 **Intellectual Property.** Tex. Health & Safety Code § 12.020 authorizes DSHS to protect intellectual property developed as a result of this Contract.

a) "Intellectual property" means created property that may be protected under copyright, patent, or trademark/service mark law.
b) For purposes of this Contract intellectual property prepared for DSHS use, or a work specially ordered or commissioned through a contract for DSHS use is "work made for hire." DSHS owns works made for hire unless it agrees otherwise by contract. To the extent that title and interest to any such work may not, by operation of law, vest in DSHS, or such work may not be considered a work made for hire, Contractor irrevocably assigns the rights, title and interest therein to DSHS. DSHS has the right to obtain and hold in its name any and all patents, copyrights, registrations or other such protections as may be appropriate to the subject matter, and any extensions and renewals thereof. Contractor shall give DSHS and the State of Texas, as well as any person designated by DSHS and the State of Texas, all assistance required to perfect the rights defined herein without charge or expense beyond those amounts payable to Contractor for goods provided or services rendered under this Contract.
c) If federal funds are used to finance activities supported by this Contract that result in the production of intellectual property, the federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to use, for federal government purposes (1) the copyright in any intellectual property developed under this Contract, including any subcontract; and (2) any rights of copyright to which a Contractor purchases ownership with contract funds. Contractor shall place an acknowledgment of federal awarding agency grant

support and a disclaimer, as appropriate, on any publication written or published with such support and, if feasible, on any publication reporting the results of or describing a grant-supported activity. An acknowledgment must be to the effect that "This publication was made possible by grant number _____ from (federal awarding agency)" or "The project described was supported by grant number _____ from (federal awarding agency)" and "Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the (federal awarding agency)."

d) If the terms of a federal grant award the copyright to Contractor, DSHS reserves a royalty-free, nonexclusive, worldwide and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for DSHS, public health, and state governmental noncommercial purposes (1) the copyright, trademark, service mark, and/or patent on an invention, discovery, or improvement to any process, machine, manufacture, or composition of matter; products; technology; scientific information; trade secrets; and computer software, in any work developed under a grant, subgrant, or contract under a grant or subgrant; and (2) any rights of copyright, service or trade marks or patents to which a grantee, subgrantee or a Contractor purchases ownership with contract funds.

e) If the results of the contract performance are subject to copyright law, Contractor cannot publish those results without prior review and approval of DSHS. Contractor shall submit requests for review and approval to the contract manager assigned to the Program Attachment.

Section 13.06 **Other Intangible Property.** At the conclusion of the contractual relationship between Department and Contractor, for any reason, Department shall have the sole ownership rights and interest in all non-copyrightable intangible property that was developed, produced or obtained by Contractor as a specific requirement under this Contract or under any grant that funds this Contract, such as domain names, URLs, software licenses with a value of $500 or more, etc. Contractor shall inventory all such non-copyrightable intangible property. Contractor shall cooperate with Department and perform all actions necessary to transfer ownership of such property to the Department or its designee, or otherwise affirm Department's ownership rights and interest in such property. This provision will survive the termination or expiration of this Contract.

Section 13.07 **Severability and Ambiguity.** If any provision of this Contract is construed to be illegal or invalid, the illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated, but all other provisions will continue. The Parties represent and agree that the language contained in this Contract is to be construed as jointly drafted, proposed and accepted.

Section 13.08 **Legal Notice.** Any notice required or permitted to be given by the provisions of this Contract will be deemed to have been received by a Party on the third business day after the date on which it was mailed to the Party at the address specified by the Party to the other Party in writing or, if sent by certified mail, on the date of receipt.

Section 13.09 **Successors.** This Contract will be binding upon the Parties and their successors and assignees, except as expressly provided in this Contract.

Section 13.10 **Headings.** The articles and section headings used in this Contract are for convenience of reference only and will not be construed in any way to define, limit or describe the scope or intent of any provisions.

Section 13.11 **Parties.** The Parties represent to each other that they are entities fully familiar with transactions of the kind reflected by the contract documents, and are capable of understanding the terminology and meaning of their terms and conditions and of obtaining independent legal advice pertaining to this Contract.

Section 13.12 **Survivability of Terms.** Termination or expiration of this Contract or a Program Attachment for any reason will not release either Party from any liabilities or obligations in this Contract that (a) the

Parties have expressly agreed will survive any such termination or expiration, or (b) remain to be performed or (c) by their nature would be intended to be applicable following any such termination or expiration.

Section 13.13 **Direct Operation.** At the Department's discretion, the Department may temporarily assume operations of a Contractor's program or programs funded under this Contract when the continued operation of the program by Contractor puts at risk the health or safety of clients and/or participants served by Contractor.

Section 13.14 **Customer Service Information.** If requested, Contractor shall supply such information as required by the Department to comply with the provisions of Tex. Gov. Code Chapter 2114 regarding Customer Service surveys.

Section 13.15 **Amendment.** The Parties agree that the Department may unilaterally reduce funds pursuant to the terms of this Contract without the written agreement of Contractor. All other amendments to this Contract must be in writing and agreed to by both Parties, except as otherwise specified in the Contractor's Notification of Change to Certain Contract Provisions section or the Contractor's Request for Revision to Certain Contract Provisions section of this Article. Contractor's request for certain budget revisions or other amendments must be submitted in writing, including a justification for the request, to the contract manager assigned to the Program Attachment; and if a budget revision or amendment is requested during the last quarter of the Contract or Program Attachment term, as applicable, Contractor's written justification must include a reason for the delay in making the request. Revision or other amendment requests may be granted at the discretion of DSHS. Except as otherwise provided in this Article, Contractor shall not perform or produce, and DSHS will not pay for the performance or production of, different or additional goods, services, work or products except pursuant to an amendment of this Contract that is executed in compliance with this section; and DSHS will not waive any term, covenant, or condition of this Contract unless by amendment or otherwise in compliance with this Article.

Section 13.16 **Contractor's Notification of Change to Certain Contract Provisions.** The following changes may be made to this Contract without a written amendment or the Department's prior approval:

a) contractor's contact person and contact information;
b) contact information for key personnel, as stated in Contractor's response to the Solicitation Document, if any;
c) cumulative budget transfers that exceed 25% among direct cost categories, other than the equipment category, of cost reimbursement contract Program Attachments of less than $100,000, provided that the total budget amount is unchanged (This subsection does not apply to contracts funded by funding sources that have different percentage requirements);
d) minor corrections or clarifications to the Contract language that in no way alter the scope of work, objectives or performance measures; and
e) a change in Contractor's share of the budget concerning non-DSHS funding other than program income and match, regardless of the amount of the change, provided that in changing the budget, Contractor is not supplanting DSHS funds.

Contractor within ten (10) calendar days shall notify in writing the contract manager assigned to the Program Attachment of any change enumerated in this section. The notification may be by letter, fax or email. Except for contracts funded by funding sources that have different percentage requirements, cumulative budget line item transfers of 25% or less among direct cost categories, other than equipment, of cost reimbursement contracts of any amount do not require written amendment or prior approval or notification.

Section 13.17 **Contractor's Request for Revision of Certain Contract Provisions.** A Contractor's Revision Request is an alternative method for amending certain specified provisions of this Contract that is initiated by Contractor, but must be approved by DSHS. The following amendments to this Contract may be

made through a Contractor's Revision Request, rather than through the amendment process described in the Amendment section of this Article:

a) cumulative budget transfers among direct cost categories, other than the equipment category, that exceed 25% of Program Attachments of $100,000 or more, provided that the total budget amount is unchanged (This subsection does not apply to contracts funded by funding sources that have different percentage requirements);
b) budget transfer to other categories of funds for direct payment to trainees for training allowances;
c) change in clinic hours or location;
d) change in the equipment list substituting an item of equipment equivalent to an item of equipment on the approved budget;
e) changes in the equipment category of a previously approved equipment budget;
f) changes specified in applicable OMB Circular cost principles as requiring prior approval, regardless of dollar threshold (e.g., foreign travel expenses, overtime premiums, membership fees; and
g) cumulative budget transfers into or out of the equipment category that do not exceed 10% of any Program Attachment, provided that the total budget amount is unchanged (cumulative transfers from or to the equipment category that equal or exceed 10% of any Program Attachment require an amendment to this Contract as described in the Amendment section of this Article).

In order to request a revision of any of the enumerated provisions, Contractor shall obtain a Contract Revision Request form from the DSHS website available at http://www.dshs.state.tx.us/grants/forms.shtm, and complete the form as directed by the Department. Two copies of the completed form must be signed by Contractor's representative who is authorized to sign contracts on behalf of Contractor, and both original, signed forms must be submitted to the contract manager assigned to the Program Attachment. Any approved revision will not be effective unless signed by the DSHS Director of the Client Services Contracting Unit. A separate Contractor Revision Request is required for each Program Attachment to be revised. Circumstances of a requested contract revision may indicate the need for an amendment described in the Amendment section of this Article rather than a contract revision amendment under this section.

Section 13.18 **Immunity Not Waived.** THE PARTIES EXPRESSLY AGREE THAT NO PROVISION OF THIS CONTRACT IS IN ANY WAY INTENDED TO CONSTITUTE A WAIVER BY DEPARTMENT OR THE STATE OF TEXAS OF ANY IMMUNITIES FROM SUIT OR FROM LIABILITY THAT DEPARTMENT OR THE STATE OF TEXAS MAY HAVE BY OPERATION OF LAW.

Section 13.19 **Hold Harmless and Indemnification.** Contractor, as an independent contractor, agrees to hold Department, the State of Texas, individual state employees and officers, and the federal government harmless and to indemnify them from any and all liability, suits, claims, losses, damages and judgments; and to pay all costs, fees, and damages to the extent that such costs, fees, and damages arise from performance or nonperformance of Contractor, its employees, subcontractors, joint venture participants or agents under this Contract.

Section 13.20 **Waiver.** Acceptance by either Party of partial performance or failure to complain of any action, non-action or default under this Contract will not constitute a waiver of either Party's rights under this Contract.

Section 13.21 **Electronic and Information Resources Accessibility and Security Standards.** As required by 1 Tex. Admin. Code Chapters 213 and 206, as a state agency, DSHS must procure products that comply with the State of Texas Accessibility requirements for Electronic and Information Resources specified in 1 Tex. Admin. Code Chapter 213 and Website Accessibility Standards/Specifications specified in 1 Tex. Admin. Code Chapter 206 (collectively EIR Standards) when such products are available in the commercial marketplace or when such products are developed in response to a procurement solicitation. If performance

under this Contract includes the development, modification or maintenance of a website or other electronic and information resources for DSHS or for the public on behalf of DSHS, Contractor certifies that the website or other electronic and information resources comply with the EIR Standards. Contractor further certifies that any network hardware or software purchased or provided under this Contract has undergone independent certification testing for known and relevant vulnerabilities, in accordance with rules adopted by Department of Information Resources.

Section 13.22 **Force Majeure.** Neither Party will be liable for any failure or delay in performing all or some of its obligations, as applicable, under this Contract if such failure or delay is due to any cause beyond the reasonable control of such Party, including, but not limited to, extraordinarily severe weather, strikes, natural disasters, fire, civil disturbance, epidemic, war, court order, or acts of God. The existence of any such cause of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the cause of the delay or failure no longer exists and, if applicable, for any reasonable period of time thereafter required to resume performance. A Party, within a period of time reasonable under the circumstances, must inform the other by any reasonable method (phone, email, etc.) and, as soon as practicable, must submit written notice with proof of receipt, of the existence of a force majeure event or otherwise waive the right as a defense to non-performance.

Section 13.23 **Interim Contracts.** The Parties agree that the Contract and/or any of its Program Attachments will automatically continue as an "Interim Contract" beyond the expiration date of the term of the Contract or Program Attachment(s), as applicable, under the following circumstances: (1) on or shortly prior to the expiration date of the Contract or Program Attachment, there is a state of disaster declared by the Governor that affects the ability or resources of the DSHS contract or program staff managing the Contract to complete in a timely manner the extension, renewal, or other standard contract process for the Contract or Program Attachment; and (2) DSHS makes the determination in its sole discretion that an Interim Contract is appropriate under the circumstances. DSHS will notify Contractor promptly in writing if such a determination is made. The notice will specify whether DSHS is extending the Contract or Program Attachment for additional time for Contractor to perform or complete the previously contracted goods and services (with no new or additional funding) or is purchasing additional goods and services as described in the Program Attachment for the term of the Interim Contract, or both. The notice will include billing instructions and detailed information on how DSHS will fund the goods or services to be procured during the Interim Contract term. The Interim Contract will terminate thirty (30) days after the disaster declaration is terminated unless the Parties agree to a shorter period of time.

Section 13.24 **Cooperation and Communication.** Contractor shall cooperate with Department staff and, as applicable, other DSHS contractors, and shall promptly comply with requests from DSHS for information or responses to DSHS inquiries concerning Contractor's duties or responsibilities under this Contract.

ARTICLE XIV BREACH OF CONTRACT AND REMEDIES FOR NON-COMPLIANCE

Section 14.01 **Actions Constituting Breach of Contract.** Actions or inactions that constitute breach of contract include, but are not limited to, the following:

a) failure to properly provide the services and/or goods purchased under this Contract;
b) failure to comply with any provision of this Contract, including failure to comply with all applicable statutes, rules or regulations;
c) failure to pay refunds or penalties owed to the Department;
d) failure to comply with a repayment agreement with the DSHS or agreed order issued by DSHS;
e) failure by Contractor to provide a full accounting of funds expended under this Contract;
f) discovery of a material misrepresentation in any aspect of Contractor's application or response to the Solicitation Document;

g) any misrepresentation in the assurances and certifications in Contractor's application or response to the Solicitation Document or in this Contract; or
h) Contractor is on or is added to the Excluded Parties List System (EPLS).

Section 14.02 **General Remedies and Sanctions.** The Department will monitor Contractor for both programmatic and financial compliance. The remedies and sanctions in this section are available to the Department against Contractor and any entity that subcontracts with Contractor for provision of services or goods. HHSC OIG may investigate, audit and impose or recommend imposition of remedies or sanctions to Department for any breach of this Contract and may monitor Contractor for financial compliance. The Department may impose one or more remedies or sanctions for each item of noncompliance and will determine remedies or sanctions on a case-by-case basis. Contractor is responsible for complying with all of the terms of this Contract. The listing of or use of one or more of the remedies or sanctions in this section does not relieve Contractor of any obligations under this Contract. A state or federal statute, rule or regulation, or federal guideline will prevail over the provisions of this Article unless the statute, rule, regulation, or guideline can be read together with the provision(s) of this Article to give effect to both. If Contractor breaches this Contract by failing to comply with one or more of the terms of this Contract, including but not limited to compliance with applicable statutes, rules or regulations, the Department may take one or more of the following actions:

a) terminate this Contract or a Program Attachment of this Contract as it relates to a specific program type. In the case of termination, the Department will inform Contractor of the termination no less than thirty (30) calendar days before the effective date of the termination in a notice of termination, except for circumstances that require immediate termination as described in the Emergency Action section of this Article. The notice of termination will state the effective date of the termination, the reasons for the termination, and, if applicable, alert Contractor of the opportunity to request a hearing on the termination pursuant to Tex. Gov. Code Chapter 2105 regarding administration of Block Grants. Contractor shall not make any claim for payment or reimbursement for services provided from the effective date of termination;
b) suspend all or part of this Contract. Suspension is an action taken by the Department in which the Contractor is notified to temporarily (1) discontinue performance of all or part of the Contract, and/or (2) discontinue incurring expenses otherwise allowable under the Contract as of the effective date of the suspension, pending DSHS's determination to terminate or amend the Contract or permit the Contractor to resume performance and/or incur allowable expenses. Contractor shall not bill DSHS for services performed during suspension, and Contractor's costs resulting from obligations incurred by Contractor during a suspension are not allowable unless expressly authorized by the notice of suspension;
c) deny additional or future contracts with Contractor;
d) reduce the funding amount for failure to 1) provide goods and services as described in this Contract or consistent with Contract performance expectations, 2) achieve or maintain the proposed level of service, 3) expend funds appropriately and at a rate that will make full use of the award, or 4) achieve local match, if required;
e) disallow costs and credit for matching funds, if any, for all or part of the activities or action not in compliance;
f) temporarily withhold cash payments. Temporarily withholding cash payments means the temporary withholding of a working capital advance, if applicable, or reimbursements or payments to Contractor for proper charges or obligations incurred, pending resolution of issues of noncompliance with conditions of this Contract or indebtedness to the United States or to the State of Texas;
g) permanently withhold cash payments. Permanent withholding of cash payment means that Department retains funds billed by Contractor for (1) unallowable, undocumented, disputed, inaccurate, improper, or erroneous billings; (2) material failure to comply with Contract provisions; or

(3) indebtedness to the United States or to the State of Texas;

h) declare this Contract void upon the Department's determination that this Contract was obtained fraudulently or upon the Department's determination that this Contract was illegal or invalid from this Contract's inception and demand repayment of any funds paid under this Contract;

i) request that Contractor be removed from the Centralized Master Bidders List (CMBL) or any other state bid list, and barred from participating in future contracting opportunities with the State of Texas;

j) delay execution of a new contract or contract renewal with Contractor while other imposed or proposed sanctions are pending resolution;

k) place Contractor on probation. Probation means that Contractor will be placed on accelerated monitoring for a period not to exceed six (6) months at which time items of noncompliance must be resolved or substantial improvement shown by Contractor. Accelerated monitoring means more frequent or more extensive monitoring will be performed by Department than would routinely be conducted;

l) require Contractor to obtain technical or managerial assistance;

m) establish additional prior approvals for expenditure of funds by Contractor;

n) require additional or more detailed, financial and/or programmatic reports to be submitted by Contractor;

o) demand repayment from Contractor when it is verified that Contractor has been overpaid, e.g., because of disallowed costs, payments not supported by proper documentation, improper billing or accounting practices, or failure to comply with Contract terms;

p) pursue a claim for damages as a result of breach of contract;

q) require Contractor to prohibit any employee or volunteer of Contractor from performing under this Contract or having direct contact with DSHS-funded clients or participants, or require removal of any employee, volunteer, officer or governing body member, if the employee, volunteer, officer or member of the governing body has been indicted or convicted of the misuse of state or federal funds, fraud or illegal acts that are in contraindication to continued obligations under this Contract, as reasonably determined by DSHS;

r) withhold any payments to Contractor to satisfy any recoupment, liquidated damages, match insufficiency, or any penalty (if the penalty is permitted by statute) imposed by DSHS, and take repayment from funds available under this Contract in amounts necessary to fulfill Contractor's payment or repayment obligations;

s) reduce the Contract term;

t) recoup improper payments when it is verified that Contractor has been overpaid, e.g., because of disallowed costs, payments not supported by proper documentation, improper billing or accounting practices or failure to comply with Contract terms;

u) assess liquidated damages;

v) demand repayment of an amount equal to the amount of any match Contractor failed to provide, as determined by DSHS;

w) impose other remedies, sanctions or penalties permitted by statute.

Section 14.03 **Notice of Remedies or Sanctions.** Department will formally notify Contractor in writing when a remedy or sanction is imposed (with the exception of accelerated monitoring, which may be unannounced), stating the nature of the remedies and sanction(s), the reasons for imposing them, the corrective actions, if any, that must be taken before the actions will be removed and the time allowed for completing the corrective actions, and the method, if any, of requesting reconsideration of the remedies and sanctions imposed. Other than in the case of repayment or recoupment, Contractor is required to file, within fifteen (15) calendar days of receipt of notice, a written response to Department acknowledging receipt of such notice. If requested by the Department, the written response must state how Contractor shall correct the noncompliance (corrective action plan) or demonstrate in writing that the findings on which the remedies or sanction(s) are based are either invalid or do not warrant the remedies or sanction(s). If Department determines that a remedy

or sanction is warranted, unless the remedy or sanction is subject to review under a federal or state statute, regulation, rule, or guideline, Department's decision is final. Department will provide written notice to Contractor of Department's decision. If required by the Department, Contractor shall submit a corrective action plan for DSHS approval and take corrective action as stated in the approved corrective action plan. If DSHS determines that repayment is warranted, DSHS will issue a demand letter to Contractor for repayment. If full repayment is not received within the time limit stated in the demand letter, and if recoupment is available, DSHS will recoup the amount due to DSHS from funds otherwise due to Contractor under this Contract.

Section 14.04 **Emergency Action.** In an emergency, Department may immediately terminate or suspend all or part of this Contract, temporarily or permanently withhold cash payments, deny future contract awards, or delay contract execution by delivering written notice to Contractor, by any verifiable method, stating the reason for the emergency action. An "emergency" is defined as the following:

a) Contractor is noncompliant and the noncompliance has a direct adverse effect on the public or client health, welfare or safety. The direct adverse effect may be programmatic or financial and may include failing to provide services, providing inadequate services, providing unnecessary services, or using resources so that the public or clients do not receive the benefits contemplated by the scope of work or performance measures; or
b) Contractor is expending funds inappropriately.

Whether Contractor's conduct or noncompliance is an emergency will be determined by Department on a case-by-case basis and will be based upon the nature of the noncompliance or conduct.

ARTICLE XV CLAIMS AGAINST THE DEPARTMENT

Section 15.01 **Breach of Contract Claim.** The process for a breach of contract claim against the Department provided for in Tex. Gov. Code Chapter 2260 and implemented in Department Rules §§ 4.11-4.24 will be used by DSHS and Contractor to attempt to resolve any breach of contract claim against DSHS.

Section 15.02 **Notice.** Contractor's claims for breach of this Contract that the Parties cannot resolve in the ordinary course of business must be submitted to the negotiation process provided in Tex. Gov Code Chapter 2260, subchapter B. To initiate the process, Contractor shall submit written notice, as required by subchapter B, to DSHS's Office of General Counsel. The notice must specifically state that the provisions of Chapter 2260, subchapter B, are being invoked. A copy of the notice must also be given to all other representatives of DSHS and Contractor. Subchapter B is a condition precedent to the filing of a contested case proceeding under Tex. Gov. Code Chapter 2260, subchapter C.

Section 15.03 **Sole Remedy.** The contested case process provided in Tex. Gov. Code Chapter 2260, subchapter C, is Contractor's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by DSHS if the Parties are unable to resolve their disputes under this Article.

Section 15.04 **Condition Precedent to Suit.** Compliance with the contested case process provided in Tex. Gov. Code Chapter 2260, subchapter C, is a condition precedent to seeking consent to sue from the Legislature under Tex. Civ. Prac. & Rem. Code Chapter 107. Neither the execution of this Contract by DSHS nor any other conduct of any representative of DSHS relating to this Contract will be considered a waiver of sovereign immunity to suit.

Section 15.05 **Performance Not Suspended.** Neither the occurrence of an event nor the pendency of a claim constitutes grounds for the suspension of performance by Contractor, in whole or in part.

ARTICLE XVI TERMINATION AND TEMPORARY SUSPENSION

Section 16.01 **Expiration of Contract or Program Attachment(s).** Except as provided in the Survivability of Terms section of the General Terms Article, Contractor's service obligations stated in each Program Attachment will end upon the expiration date of that Program Attachment unless extended or renewed by written amendment. Prior to completion of the term of all Program Attachments, all or a part of this Contract may be terminated with or without cause under this Article.

Section 16.02 **Effect of Termination.** Termination is the permanent withdrawal of Contractor's authority to obligate previously awarded funds before that authority would otherwise expire or the voluntary relinquishment by Contractor of the authority to obligate previously awarded funds. Contractor's costs resulting from obligations incurred by Contractor after termination of an award are not allowable unless expressly authorized by the notice of termination. Upon termination of this Contract or Program Attachment, as applicable, Contractor shall cooperate with DSHS to the fullest extent possible to ensure the orderly and safe transfer of responsibilities under this Contract or Program Attachment, as applicable, to DSHS or another entity designated by DSHS. Upon termination of all or part of this Contract, Department and Contractor will be discharged from any further obligation created under the applicable terms of this Contract or the Program Attachment, as applicable, except for the equitable settlement of the respective accrued interests or obligations incurred prior to termination and for Contractor's duty to cooperate with DSHS, and except as provided in the Survivability of Terms section of the General Terms Article. Termination does not, however, constitute a waiver of any remedies for breach of this Contract. In addition, Contractor's obligations to retain records and maintain confidentiality of information will survive this Contract.

Section 16.03 **Acts Not Constituting Termination.** Termination does not include the Department's (1) withdrawal of funds awarded on the basis of Contractor's underestimate of the unobligated balance in a prior period; (2) withdrawal of the unobligated balance at the expiration of the term of a program attachment; (3) refusal to extend a program attachment or award additional funds to make a competing or noncompeting continuation, renewal, extension, or supplemental award; (4) non-renewal of a contract or program attachment at Department's sole discretion; or (5) voiding of a contract upon determination that the award was obtained fraudulently, or was otherwise illegal or invalid from inception.

Section 16.04 **Termination or Temporary Suspension Without Cause.**

a) Either Party may terminate this Contract or a Program Attachment, as applicable, with at least thirty (30) calendar days prior written notice to the other Party, except that if Contractor seeks to terminate a Contract or Program Attachment that involves residential client services, Contractor shall give the Department at least ninety (90) calendar days prior written notice and shall submit a transition plan to ensure client services are not disrupted.
b) The Parties may terminate this Contract or a Program Attachment by mutual agreement.
c) DSHS may temporarily suspend or terminate this Contract or a Program Attachment if funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or health and human services agencies, amendments to the Appropriations Act, health and human services consolidations, or any disruption of current appropriated funding for this Contract or Program Attachment. Contractor will be notified in writing of any termination or temporary suspension or of any cessation of temporary suspension. Upon notification of temporary suspension, Contractor shall discontinue performance under the Contract as of the effective date of the suspension, for the duration of the suspension.
d) Department may terminate this Contract or a Program Attachment immediately when, in the sole determination of Department, termination is in the best interest of the State of Texas.

Section 16.05 **Termination For Cause.** Either Party may terminate for material breach of this Contract with at least thirty (30) calendar days written notice to the other Party. Department may terminate this Contract, in whole or in part, for breach of contract or for any other conduct that jeopardizes the Contract objectives, by giving at least thirty (30) calendar days written notice to Contractor. Such conduct may include one or more of the following:

a) Contractor has failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction;
b) Contractor fails to communicate with Department or fails to allow its employees or those of its subcontractor to communicate with Department as necessary for the performance or oversight of this Contract;
c) Contractor breaches a standard of confidentiality with respect to the services provided under this Contract;
d) Department determines that Contractor is without sufficient personnel or resources to perform under this Contract or that Contractor is otherwise unable or unwilling to fulfill any of its requirements under this Contract or exercise adequate control over expenditures or assets;
e) Department determines that Contractor, its agent or another representative offered or gave a gratuity (e.g., entertainment or gift) to an official or employee of DSHS or HHSC for the purpose of obtaining a contract or favorable treatment;
f) Department determines that this Contract includes financial participation by a person who received compensation from DSHS to participate in developing, drafting or preparing the specifications, requirements or statement(s) of work or Solicitation Document on which this Contract is based in violation of Tex. Gov. Code § 2155.004; or Department determines that Contractor was ineligible to receive this Contract under Tex. Gov. Code §§ 2155.006 or 2261.053 related to certain disaster response contracts;
g) Contractor appears to be financially unstable. Indicators of financial instability may include one or more of the following:
    1) Contractor fails to make payments for debts;
    2) Contractor makes an assignment for the benefit of its creditors;
    3) Contractor admits in writing its inability to pay its debts generally as they become due;
    4) if judgment for the payment of money in excess of $50,000 (that is not covered by insurance) is rendered by any court or governmental body against Contractor, and Contractor does not (a) discharge the judgment, or (b) provide for its discharge in accordance with its terms, or (c) procure a stay of execution within thirty (30) calendar days from the date of entry of the judgment, or (d) if the execution is stayed, within the thirty (30)-day period or a longer period during which execution of the judgment has been stayed, appeal from the judgment and cause the execution to be stayed during such appeal while providing such reserves for the judgment as may be required under Generally Accepted Accounting Principles;
    5) a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of Contractor, and such writ or warrant of attachment or any similar process is not released or bonded within thirty (30) calendar days after its issuance;
    6) Contractor is adjudicated bankrupt or insolvent;
    7) Contractor files a case under the Federal Bankruptcy Code or seeks relief under any provision of any bankruptcy, reorganization, arrangement, insolvency, readjustment of debt, dissolution, receivership or liquidation law of any jurisdiction then in effect, or consents to the filing of any case or petition against it under any such law;
    8) any property or portion of the property of Contractor is sequestered by court order and the order remains in effect for more than thirty (30) calendar days after Contractor obtains knowledge of the sequestration;

9) a petition is filed against Contractor under any state reorganization, arrangement, insolvency, readjustment of debt, dissolution, receivership or liquidation law of any jurisdiction then in effect, and the petition is not dismissed within thirty (30) calendar days; or
10) Contractor consents to the appointment of a receiver, trustee, or liquidator of Contractor or of all or any part of its property;

h) Contractor's management system does not meet the UGMS management standards; or
i) Any required license, certification, permit, registration or approval required to conduct Contractor's business or to perform services under this Contract is not obtained or is revoked, is surrendered, expires, is not renewed, is inactivated or is suspended.

Section 16.06 **Notice of Termination.** Either Party may deliver written notice of intent to terminate by any verifiable method. If either Party gives notice of its intent to terminate all or a part of this Contract, Department and Contractor shall attempt to resolve any issues related to the anticipated termination in good faith during the notice period.

ARTICLE XVII VOID, SUSPENDED, AND TERMINATED CONTRACTS

Section 17.01 **Void Contracts.** Department may void this Contract upon determination that the award was obtained fraudulently or was otherwise illegal or invalid from its inception.

Section 17.02 **Effect of Void, Suspended, or Involuntarily Terminated Contract.** A Contractor who has been a party to a contract with DSHS that has been found to be void, or is suspended, or is terminated for cause is not eligible for expansion of current contracts, if any, or new contracts or renewals until, in the case of suspension or termination, the Department has determined that Contractor has satisfactorily resolved the issues underlying the suspension or termination. Additionally, if this Contract is found to be void, any amount paid is subject to repayment.

Section 17.03 **Appeals Rights.** Pursuant to Tex. Gov. Code § 2105.302, after receiving notice from the Department of termination of a contract with DSHS funded by block grant funds, Contractor may request an administrative hearing under Tex. Gov. Code Chapter 2001.

ARTICLE XVIII CLOSEOUT

Section 18.01 **Cessation of Services At Closeout.** Upon expiration of this Contract or Program Attachment, as applicable, (and any renewals of this Contract or Program Attachment) on its own terms, Contractor shall cease services under this Contract or Program Attachment; and shall cooperate with DSHS to the fullest extent possible upon expiration or prior to expiration, as necessary, to ensure the orderly and safe transfer of responsibilities under this Contract to DSHS or another entity designated by DSHS. Upon receiving notice of Contract or Program Attachment termination or non-renewal, Contractor shall immediately begin to effect an orderly and safe transition of recipients of services to alternative service providers, as needed. Contractor also shall completely cease providing services under this Contract or Program Attachment by the date specified in the termination or non-renewal notice. Contractor shall not bill DSHS for services performed after termination or expiration of this Contract or Program Attachment, or incur any additional expenses once this Contract or Program Attachment is terminated or has expired. Upon termination, expiration (with no renewal) or non-renewal of this Contract or a Program Attachment, Contractor shall immediately initiate Closeout activities described in this Article.

Section 18.02 **Administrative Offset.** The Department has the right to administratively offset amounts owed by Contractor against billings.

Section 18.03 **Deadline for Closeout.** Contractor shall submit all financial, performance, and other Closeout reports required under this Contract within sixty (60) calendar days after the Contract or Program

Attachment end date. Unless otherwise provided under the Final Billing Submission section of the Payment Methods and Restrictions Article, the Department is not liable for any claims that are not received within sixty (60) calendar days after the Contract or Program Attachment end date.

Section 18.04 **Payment of Refunds.** Any funds paid to Contractor in excess of the amount to which Contractor is finally determined to be entitled under the terms of this Contract constitute a debt to the Department and will result in a refund due, which Contractor shall pay within the time period established by the Department.

Section 18.05 **Disallowances and Adjustments.** The Closeout of this Contract or Program Attachment does not affect the Department's right to disallow costs and recover funds on the basis of a later audit or other review or Contractor's obligation to return any funds due as a result of later refunds, corrections, or other transactions.