

DEPARTMENT OF STATE HEALTH SERVICES



This contract, number 2012-040154 (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 FORT BEND COUNTY CLINICAL HEALTH 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 \$102,645.00, 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 01/01/2012 and ends on 12/31/2012. 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:
 

2012-040154-001 Tuberculosis Prevention and Control - Federal
  - c. General Provisions (Sub-recipient)
  - d. Solicitation Document(s), N/A
  - 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.

3-2-12 copy received

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: FORT BEND COUNTY  
Address: FORT BEND COUNTY AUDITOR 301 JACKSON ST STE 533  
RICHMOND, TX 77469-3108  
Vendor Identification Number: 17460019692047

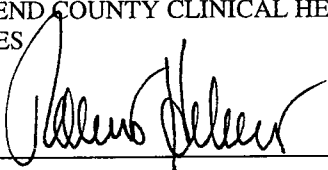
9. **Entire Agreement.** The Parties acknowledge that this Contract is the entire agreement of the Parties and that there are no agreements or understandings, written or oral, between them with respect to the subject matter of this Contract, other than as set forth in this Contract.

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

FORT BEND COUNTY CLINICAL HEALTH SERVICES

By: \_\_\_\_\_  
Signature of Authorized Official

By:   
Signature

\_\_\_\_\_  
Date

February 28, 2012  
\_\_\_\_\_  
Date

Bob Burnette, C.P.M., CTPM

Robert E. Hebert, County Judge  
\_\_\_\_\_  
Printed Name and Title

Director, Client Services Contracting Unit

4520 Reading Road, Suite A  
\_\_\_\_\_  
Address

1100 WEST 49TH STREET  
AUSTIN, TEXAS 78756

Rosenberg, Texas 77471  
\_\_\_\_\_  
City, State, Zip

(512) 458-7470

281-238-3548  
\_\_\_\_\_  
Telephone Number

Bob.Burnette@dshs.state.tx.us

drakenan@co.fort-bend.tx.us  
\_\_\_\_\_  
E-mail Address for Official Correspondence

2012-040154-001

Categorical Budget:

PERSONNEL	\$34,714.00
FRINGE BENEFITS	\$16,933.00
TRAVEL	\$9,767.00
EQUIPMENT	\$0.00
SUPPLIES	\$3,833.00
CONTRACTUAL	\$37,398.00
OTHER	\$0.00
TOTAL DIRECT CHARGES	\$102,645.00
INDIRECT CHARGES	\$0.00
TOTAL	\$102,645.00
DSHS SHARE	\$102,645.00
CONTRACTOR SHARE	\$0.00
OTHER MATCH	\$0.00

Total reimbursements will not exceed \$102,645.00

Financial status reports are due: 04/30/2012, 07/31/2012, 10/31/2012, 03/01/2013

# FORT BEND COUNTY WORK PLAN

## 2012-040154

1. Summarize the proposed services, service area, population to be served, location (counties to be served), etc. List subcontractors you will work with in your area. Also, address if and how you will serve individuals from counties outside your stated service area.

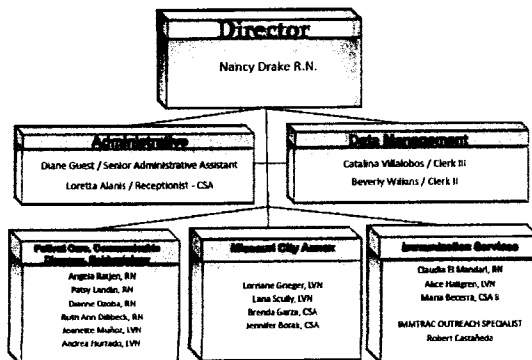
Fort Bend County Clinical Health Services (FBCCHS) receives referrals of suspected or diagnosed Tuberculosis (TB) patients with a residence of Fort Bend County or from other counties. When patients reside in another county, a referral is sent to the responsible entity. Residents of surrounding counties are served by FBCCHS if the patient chooses to utilize our clinic. FBCCHS confirms diagnostic status and if indicated, performs case management for these patients. The agency provides sputum specimen collection and submission for testing, chest x-rays, liver function tests, complete blood counts, and hepatitis profile if indicated. Human Immunodeficiency Virus (HIV) testing and tuberculosis therapy as prescribed by the physician are also provided. Directly Observed Therapy (DOT) is the preferred method of medication administration. Initial evaluation includes health assessment, weight check, vision check, Ishihara's color chart, blood pressure check, etc. Program paperwork and documentation of consent is completed at the initial clinic visit. Periodic assessment includes monitoring of all the above health status markers, and renewal of documentation as necessary.

At the initial visit the patient is interviewed to determine any contacts to the case/suspect that may need to be evaluated. Contacts are interviewed for signs and symptoms, skin-tested and/or followed up as appropriate. Latent Tuberculosis Infection (LTBI) patients are followed according to the appropriate standard of care.

FBCCHS subcontracts with a local hospital for patient chest x-rays and computerized tomography (CT) when indicated through grant funding. We have two grant funded Licensed Vocational Nurse (LVN)s, who assist the Registered Nurse (RN)'s with DOT, contact investigation, and data entry; we also contract DOT workers to deliver medications. Through our purchasing department, there is a contract for translation services including sign language we can utilize through grant funding.

2. Describe delivery systems, workforce (attach organizational chart), policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. What resources do you have to perform the project, who will deliver services and how will they be delivered?

### FORT BEND COUNTY CLINICAL HEALTH SERVICES



Organization: Fort Bend County Clinical Health Services (FBCCHS) is a subordinate department to Fort Bend County Health & Human Services, which is the public health department for Fort Bend County, Texas. The Interim Director of FBCCHS is Kaye Reynolds, MPH. Dr. Jean Galloway, MD, our previous Director who retired February 28, 2011, is currently contracted by Fort Bend County to cover Clinical Health Services and

serve as the Local Health Authority. Clinical Health Services consists of the director, Nancy Drake, RN, with 18 employees. The TB program consists of four RNs including a state grant funded program/case manager and three case managers, and two LVNs whose responsibilities include DOT visits and contact investigation.

These two LVNs work tandem shifts, one beginning early morning and the other through later evening hours to expand the hours of availability for home visits thus accommodating our clients' schedules more conveniently. One LVN is state grant funded and the other is funded by federal grant.

The immunization branch of Clinical Health Services is staffed by one RN, three LVNs, three community health aides, and an ImmTrac/Pharmacy Inventory Central System (PICS) Coordinator. The department is supported by excellent clerical, administrative and data management staff. (See organizational chart)

FBCCHS has followed, treated and provided case management for residents with TB for many years. FBCCHS contracts with a local hospital for x-rays. FBCCHS has a good and long standing relationship with the hospital. DOT is the standard of care for all cases/suspects and FBCCHS utilizes clinic staff along with contracted, non-departmental individuals to accomplish this goal. Our grant funded LVNs provide DOT and contact investigations and work a flexible shift schedule when indicated to meet client time constraints. Our RN's provide DOT as needed. Resources limit our ability to provide DOPT, but we are providing this service where required and deemed most essential.

Fort Bend County Health & Human Services and Clinical Health Services are all experienced with grant funded programs, primarily with Texas Department of State Health Services. The County provides experienced purchasing, auditing and human resources departments to assist in grants management and appropriate and timely expenditure of funds. Activities of the FBCCHS staff are recorded into a database to monitor proportion of effort related to various programs within the department, quarterly reviews of expenditures allow for amendment request to reprogram funds, if necessary. Should the County ever experience a hiring freeze, grant funded positions would be prioritized for hiring. The Human Resources Department provides timely posting, processing and hiring of prospective new employees.

*3. Determine the number of persons who received from the CONTRACTOR in 2010 at least one 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.*

**Client services in 2010 totaled 2,989 and these included TB skin tests and readings, patient clinic visits, DOT visits, home visits, and other TB services. Patients receiving one or more TB medications are recorded on inventory medication data sheets and patients receiving chest radiographs are tabulated in an appropriate log for this activity. These services were included in the above total services. In 2011 we started testing with the Quantiferon Gold (QFT-G) test which involves at least two clinic or field visits for each person tested, and then additional clinical services if the person is diagnosed as an LTBI or active case.**

*4. Describe how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur. Describe how you will conduct community surveillance, to identify unreported cases of TB and individuals suspected of having TB infection. Describe how you will maintain a record of outbreaks, in your area, with a description of the outbreak and how it was managed.*

Data is collected by the FBCCHS nursing staff on forms provided by the state health departments. LTBI's diagnosed at FBCCHS since 2008 are entered into the Texas Wide-Integrated Client Encounter System, (TWICES). Data for TB suspects is entered on state forms 400A and 400B and maintained in a hard copy file until the outcome of the investigation is complete and diagnosis is finalized. If the suspect is determined to be a TB 0, the 400s are mailed to the Central Office for entry into TB Program Area Module. At the present time FBCCHS has not been given access to or training in the use of TB Program Area Module (PAM) as was anticipated earlier this year. TB suspects who subsequently become a verified TB case have data entered into the hardcopy Report of Verified Case of Tuberculosis (RVCT) form and sent to the Central Office as soon as laboratory results are available and the diagnosis is clinically confirmed. Data is then maintained in chronological order by the program manager and follow up RVCT parts two and three are sent to the Central Office when susceptibilities are obtained and then when the case is completed.

In addition to the above data collection and reporting, in-house Excel and Access Databases have been developed and are continuously updated as patient events occur, so that we are able to assess the timeliness and quality of patient care delivery and track our progress on attaining the state mandated performance goals.

FBCCHS has followed, treated and provided case management for residents with TB for many years. Beginning in 2010 we were given training and access to the TB Genotyping System (GIMS) as standard users. Now we are able to query the patient results section of this database to generate a line list of all Fort Bend County patients with a specific PCRTyp that were entered into the National Tuberculosis Genotype Service (NTGS) since 2000. This has enabled us to confirm epidemiologic links of cases with previously suspected connections such as family, social, or neighborhood ties. It has also suggested the need for a more detailed analysis of ties within clusters with previously unidentified connections to determine the completeness of our contact investigations.

*5. Describe how the accuracy, timeliness and completeness of data collected will be assessed and verified. If not already in place, describe how you will develop a written plan to assess the quality of data collected.*

Data is collected from the patient on the initial and subsequent interviews and recorded in the medical record, the 400A, 400B, and progress notes. Patient historical data from physicians, hospitals, and labs is added to the medical record in a timely manner as it becomes available. Contacts of the suspect are identified early in the interview process and listed on the 340 and 341 TB Forms. Additional data is added to these forms as the contact investigation progresses along including results of the Tuberculin Skin Test (TST), Quantiferon (GFT) and Chest X-ray when they are obtained. As rapport is developed with the patient and family by the case manager, additional data is collected, and previous data is verified to assure accuracy. Written guidelines are provided by the Standards of Performance and clinic policy to ensure that essential, quality data is collected. This data is reviewed

by the program manager for completeness on a regular basis, and the quality, accuracy and completeness is also reviewed for individual cases during monthly quality assurance meetings.

*6. Describe coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided. List other community programs you will be working with in your jurisdiction (community based organizations, private providers, hospitals, and service organizations).*

Local health care providers, including the Federally Qualified Health Center (FQHC) in our jurisdiction, refer their TB patients to the FBCCHS clinic for evaluation and treatment. The program works closely with staff from the FQHC, with the local hospitals and with several local medical providers who frequently see TB patients. Also, FBCCHS is able to make referrals to other Fort Bend County agencies who provide medical, surgical, and dental care, psychological counseling, financial assistance, and social services when needed to improve the client's success in completing their prescribed TB treatment. As new community programs such as homeless shelters and substance abuse clinics arise in our burgeoning county population, we will seek to build working relationships with those providers as well. Our nurses are experienced and knowledgeable in all areas of caring for TB patients and serve as an ever-ready resource to provide education for our community. We have purchased DVDs to loan or use in teaching on such topics as "TB skin tests", and TB in the Workplace".

*7. Describe ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, location, hours of service delivery, and other means to ensure accessibility for the defined population).*

FBCCHS has a nursing staff which is bilingual in English/Spanish which accommodates a large proportion of the patients seen in the clinic. The program will use the county contracted certified translation services for face to face and telephone translation as needed. Additionally, FBCCHS has obtained written translations of TB literature in a number of other languages and dialects that can be given to patients to *supplement translator* assistance. We realize that pamphlets and brochures are not an adequate substitute for person to caring person contact. As our culturally diverse client population grows (almost 1/3 of our population is of Asian origin) we look forward to an opportunity to add field staff with similar cultural background. In the meantime our field staff utilizes utmost sensitivity in trying to understand the unique perspective of the cultural, religious, and linguistic character of all of our patients and to convey respect and positive regard in all of our interactions. The primary clinic location is Americas Disability Act (ADA) compliant. The clinic is open during normal business hours, with weekend clinics twice a month. Contract language services can also be provided on an emergency basis on evenings and weekends. Home visits and DOT visits to TB patients can be arranged on an early morning, early evening, and if specifically ordered by the

physician weekend schedule. DOT is provided either in the clinic or the patient's home or other mutually agreed upon location.

Contacts can be evaluated and DOT medication can be given as scheduled at the patient's home, the Rosenberg Clinic, one of the satellite clinics in Missouri City on the east end of the county or in Katy in the north side of the county.

*8. Describe your strategy for the management of TB cases and suspects, with emphasis on provision of directly observed therapy (DOT); and use of incentives and enablers.*

The strategy as described above is to follow the recommended standard of care for all referred TB patients. All patients managed at the FBCCHS clinic are placed on DOT. Every effort is made to assist patient in keeping their DOT appointments. Those managed by private providers are offered DOT, but this cannot be enforced. Non-compliant patients, or those with complex medical conditions can be referred to, or quarantined, in the Texas Center for Infectious Disease in San Antonio, or the UT Health Center in Tyler by order of the Local Health Authority. Individual nurses offer small rewards to their patients for positive compliance in the form of blankets, surprise foods and bottled water. Their supportive and cheerful presence is often sufficient incentive to encourage DOT clients to complete their therapy as ordered.

*9. Describe your process for review of cases under management.*

The case management team, composed of all case managers, clinical services director, the program case manager, and DOT providers, meets each Monday morning for case management review. The acting Medical Director participates by teleconference line. Each case manager presents her open cases and receives input from other members of the team. Our case management Excel database is used as a tool to track cases and is updated by the program manager at the conclusion of each meeting and throughout the week as patient events occur.

*10. Describe your strategy for the implementation of cohort analysis of cases at least quarterly.*

Administrative reviews of TB cases have previously been conducted at monthly Quality Assurance meeting in the context of reviewing individual charts to monitor that the Department of State Health Services (DSHS) Standards of Performance for the Prevention and Control of Tuberculosis are being met and documented. Beginning 2010 the quarterly cohort analysis approach was adopted in order to improve patient outcomes and increase our overall program effectiveness. Our strategy has been first to introduce the method to the case management staff defining what exactly the method is and what the potential benefits to our program are. As with any change in management approach, success depends on the motivation of the participants. FBCCS staff quickly embraced the concept and at

**this time we have completed four quarterly scheduled cohort reviews. Since our program does not have a Data Analyst or Supervisor of Case Management, these roles are formally vacant but functionally filled as follows: The program/case manager will assume the task of collecting TB patient and contact investigation information on a database from which the cohort list will be drawn. This list is distributed two months prior to the Cohort Review will include requests for specific data elements that will be needed to evaluate program effectiveness and meet State and National Performance Objectives.**

**The first Cohort Review of cases was held in October of 2010 with six cases comprising the January, February, and March, 2010 cohort. Since that time, formal reviews have been held on January 6, 2011 (eight cases) and March 17, 2011 (nine cases), and for July 21, 2011 (eight cases). This last review was made up of a cohort of eight suspects and cases counted between October 1, 2010 and December 31, 2010. Feedback regarding analysis of the demographic data and preliminary scoring of performance outcomes is presented by the program manager immediately after the case manager review of cases, and then written copies of the quarter performance scores are distributed. The cohort review ends with questions, discussion and suggestions for improvement. One learning experience has been a renewed realization of how great an extent the treatment of our patients and their contacts really is a team process; we really depend on all members of the team for success. It was also pointed out that, even though you hope each successive cohort will have improved performance scores, in actuality scores fluctuate because the patient and their family are part of the team and their ability and willingness to participate fully varies with each cohort. The next cohort of January, February, and March 2011 will be presented in mid October, 2011.**

*11. Describe your strategy for the management of contacts and positive reactors, with emphasis on directly observed preventive therapy (DOPT); for all contacts diagnosed with LTBI who are less than five years of age or HIV infected or live in the same residence as a case receiving directly observed therapy. DOPT may be provided to other persons at high risk for progression to TB disease as time and resources allow.*

**Staff LVNs who regularly give DOT and Directly Observed Preventative Therapy (DOPT) visits to required patients (LTBIs less than five years of age, HIV infected, living in household with a case receiving DOT), will also be able to do DOPT visits to other persons who are at high risk or need special assistance in taking their medications regularly. Where possible, for children in school, DOPT is provided by the school nurse.**

*12. Describe your process for the review of ongoing contact investigations and your strategy to assess reasons for identification of fewer than three contacts for each case; for delays in interviewing cases or evaluating contacts, and low completion of preventive therapy for infected contacts.*

Review of ongoing contact investigations takes place immediately following our Monday morning case review session. During Contact Investigation Review we discuss investigations that are in progress with present contacts, results, barriers, solutions and the need for additional follow up. New activity/results is documented and added to our case contact Access database after meeting. The contact investigation process and outcome is an integral part of our quarterly cohort review. Our investigations are conducted promptly after the contacts are identified, and delay most often occurs when close contacts are family that lives in a nearby jurisdiction with which we must coordinate our efforts. Delay also occurs when family members or friends are named as a contact, but this person does not respond by coming to the clinic or agreeing to meet with us at a location convenient for them. Another source of delay occurs when the contact occurred in the local jail and this person is transferred or released soon after the contact occurs. Identification of fewer than three contacts for each case is extremely rare, and if it occurs we will endeavor to educate the patient in knowledge of TB disease and in the importance of preventing spread of the disease to friends, relatives and coworkers. Confidentiality of the patient's identity is assured and carefully guarded.

Low completion rates continue to be a concern. We are considering possible solutions for improvement such as maintaining a flow-sheet tabulating when an LTBI is due to return to the clinic for medication. In this way we would quickly begin our efforts to contact and remind the LTBI that it is time for them to come to the clinic for their next bottle of medication. We try to be very encouraging and supportive for them to complete therapy even if it takes numerous phone calls and letters. We do not have the resources for taking the medication to them except in a few cases at this time. We anticipate decreasing low preventative therapy completion rates with the advent of new shorter alternative dosing schedule such as that using Rifapentine/INH once a week for three months. Also, now that we are using the Quantiferon Gold In-tube test (QFT-GIT) on a patient selective basis, we hope to decrease the number of low risk patients who begin LTBI unnecessarily and then fail to complete therapy.

*13. Describe your infection control procedures.*

Chest clinic is scheduled at a time apart from other clinic activities to avoid infection of other patients. Patients who are cases/suspects are instructed to wear a mask while in the clinic until two weeks of therapy are completed and symptoms have abated. A supply of surgical procedure masks is kept at the reception desk so that patients who may forget to wear their mask when coming to appointments can be supplied one. High Efficiency Particulate Air Filters have been installed in the clinic waiting room and chest clinic interview room and Ultraviolet lights have been installed in the waiting room area. All equipment is regularly inspected and maintained. Clinic staff wears N-95 masks when interacting with potentially infective patients. Clinic staff who interact directly with tuberculosis patients/suspects have been fit-tested for N95 filter masks. Sputum specimens are collected in the negative pressure isolation room. The program staff monitors the operation of the negative pressure examination room two times daily and documents

this on a flow sheet. A sputum collection booth has also been purchased through grant funding as we only have one negative pressure clinic room; this enhances our capabilities as space often becomes an issue on our chest clinic days. This chamber also allows for observation of the collecting of the initial sputum specimen while maintaining the privacy of the patient. Staff members are skin-test yearly if appropriate. All suspected TB patients sent for chest x-ray prior to treatment are provided with and instructed to wear a mask while in the radiology office. All patients are instructed on how to avoid infecting family members and other close contacts. FBCCHS staff provides patients with disposable nebulizer kits for sputum induction. Contract DOT providers are offered TB testing at the beginning of employment and yearly. Staff are given either a yearly Protein Purified Derivative test or if they prefer a Quantiferon blood test.

*14. Describe plans to conduct targeted TB screening programs for high-risk populations including steps to ensure effective interventions are implemented to identify foreign born and U.S. born minorities at highest risk for developing T.B. are evaluated and treated for T.B. or LTBI.*

FBCCHS provides PPD, syringes, tuberculosis medication, and sputum collection containers for the Fort Bend County Jail, which serves approximately 1800 inmates annually. FBCCHS nurses work closely with the jail nurses in the management of LTBI patients and the management of cases/suspects who are incarcerated there. Employees of the jail who have a positive PPD are also referred to FBCCHS for follow up. Released inmates are referred to FBCCHS for continuing treatment of TB or LTBI. Every attempt is made by our nursing staff to see that they complete their therapy. Inmates that are transferred to Texas Department of Criminal Justice or Immigration Customs Enforcement have a referral letter sent to the receiving agency outlining the needed follow up care and requesting that a record of that care be forwarded to FBCCHS. Clinical Health Services also does targeted screening for students arriving from any foreign country who will enter our local school district. Treatment and follow up are provided as needed.

*15. Describe your strategy to provide professional education and training programs for new and current TB staff.*

All tuberculosis staff members are encouraged to take advantage of the Core Curriculum training. FBCCHS attends courses on TB nurse case management, TB program management, TB Intensive and other appropriate courses when newly hired and as continuing education when available during employment. Several excellent new courses continue to be offered by Heartland National TB Center at various locations in Texas; however, budget constraints may limit our travel capabilities this year. Staff members regularly participate in cost free webinars that are offered by Heartland and other TB centers around the country. A training log

is maintained by the program/case manager for all employees' attendance in training and continuing education opportunities.

16. Describe your strategy to document the evaluation of immigrants and refugees with the following notifications: Class A (Applicants who have tuberculosis disease diagnosed [sputum smear positive or culture positive] and require treatment overseas but who have been granted a waiver to travel prior to the completion of therapy.); Class B1 – Pulmonary (No treatment: - Applicants who have medical history, physical exam, or CXR findings suggestive of pulmonary tuberculosis but have negative AFB sputum smears and cultures and are not diagnosed with tuberculosis or can wait to have tuberculosis treatment started after immigration. Completed treatment: - Applicants who were diagnosed with pulmonary tuberculosis and successfully completed directly observed therapy prior to immigration.); Class B1 – Extrapulmonary (evidence of extrapulmonary tuberculosis); Class B2 (LTBI Evaluation – Applicants who have a tuberculin skin test  $\geq$  10 mm but who otherwise have a negative evaluation for tuberculosis.); Class B3 (Contact Evaluation – applicants who are a contact of a known tuberculosis case.)

Arrivals of all immigrants and refugees are now retrieved from the newly activated Electronic Disease Notification (EDN) along with all scanned documents brought to the quarantine center. After the evaluation is completed, our case managers document the data electronically into the EDN system. Secondary migration of the immigrant/refugee before, during, or after the evaluation is complete is entered into the system, and we anticipate that follow up will be increasingly efficient as well. The different classes of immigrants are managed as follows:

**Class A –** upon receiving notification of impending arrival, a letter is sent to the given address. If patient has not responded after 7 days, a home visit is made and efforts are made to locate the patient. Once located, DOT is either resumed or started and a clinic visit is scheduled. At the clinic visit, sputum specimens are collected, the patient is sent for a chest x-ray and lab work is performed as indicated.

**Class B1 –** Upon receiving notification of impending arrival, a letter is sent to the patient at the given address. If patient does not respond within one week, a phone call is attempted if a number is given. If the patient responds, they are scheduled for a clinic visit for follow up. A PPD is placed when applicable, patient is sent for a chest x-ray, lab work is performed as indicated and sputum specimens are collected (the majority of our referrals do not have culture results).

**Completed Treatment –** Upon receiving notification of arrival or impending arrival, a letter is sent to the patient at the given address. If patient does not respond within one week, a phone call is attempted if a number is given. If we are unable to contact patient by phone, a letter is resent. If the patient responds, they are scheduled for a clinic visit to be evaluated by our MD.

**Class B1, Extrapulmonary –** Upon receiving notification of arrival or impending arrival, a letter is sent to the patient at the given address. If the patient does not respond within one week, a phone call is attempted if a number is given. At this point, if we are unsuccessful if contacting them, a home visit will be made. If no one

is home, a letter is left for the identified person to contact our clinic. If the patient responds or is located, a clinic appointment is scheduled for Medical Doctor (MD) evaluation. If we are unable to locate the patient, the reporting forms are sent back to DSHS in Austin to be returned to the Centers for Disease and Control (CDC).

**Class B2 – We would send a letter. If the patient does not respond within one week, we would attempt a telephone call if a number is given, if we are unable to contact patient by telephone, a letter is resent. If the patient responds, they are scheduled for a clinic visit to be evaluated by our MD.**

**Class B3 – If we received a notification of this type, we would attempt to contact the patient by sending a letter or calling on the telephone if a number is given. If the patient is contacted, we would schedule a clinic visit to have a tuberculin skin test placed or a chest x-ray if indicated; depending on the results of these, we would schedule patient to see our MD.**

CONTRACT NO. 2012-040154  
PROGRAM ATTACHMENT NO. 001  
PURCHASE ORDER NO. 0000378936

CONTRACTOR: FORT BEND COUNTY CLINICAL HEALTH SERVICES

DSHS PROGRAM: Tuberculosis Prevention and Control - Federal

TERM: 01/01/2012 THRU: 12/31/2012

SECTION I. STATEMENT OF WORK:

Throughout the Contractor's defined service area of Fort Bend, 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](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](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 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 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 December 2012 shall also be submitted in a format provided by DSHS. The narrative program report shall be

sent to the Department of State Health Services, Tuberculosis Services Branch, Mail Code 1939, PO Box 149347, Austin, Texas 78714-9347 via regular mail, or by fax to (512) 776-7787, and sent by e-mail to [charles.wallace@dshs.state.tx.us](mailto:charles.wallace@dshs.state.tx.us) and [mitra.kookma@dshs.state.tx.us](mailto:mitra.kookma@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:

<b>PERIOD COVERED</b>	<b>DUE DATE</b>
January 2011– December 2011	March 1, 2012
January 2012 – May 2012	July 1, 2012

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 1939, 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.

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 Bacillus (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 know 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% 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 March 1, 2012, 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 two (2) additional one-year terms, at DSHS's sole discretion.

### SECTION V. PAYMENT METHOD:

Cost Reimbursement

Funding is further detailed in the attached Categorical Budget.

### 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 49<sup>th</sup> 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](mailto:invoices@dshs.state.tx.us).

### SECTION VII. BUDGET

SOURCE OF FUNDS: CFDA Funding #93.116

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 hereby revised to add:

Quarterly Financial Status Reports (Form 269A) from Contractor shall be provided to DSHS in the format provided by the DSHS. These reports shall be mailed to Department of State Health Services, Attention: Accounting Section, Claims Processing Unit, Mail Code 1940, 1100 West 49<sup>th</sup> Street, PO Box 149347, Austin, Texas 78714-9347. These reports shall be submitted on a quarterly basis as follows:

<b>PERIOD COVERED</b>	<b>DUE DATE</b>
January, February March	April 30, 2012
April, May, June	July 31, 2012
July, August, September	October 31, 2012
October, November December	February 28, 2013

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.

CONTRACT NO. 2012-040154  
PROGRAM ATTACHMENT NO. 001  
PURCHASE ORDER NO. 0000378936

CONTRACTOR: FORT BEND COUNTY CLINICAL HEALTH SERVICES

DSHS PROGRAM: Tuberculosis Prevention and Control - Federal

TERM: 01/01/2012 THRU: 12/31/2012

SECTION I. STATEMENT OF WORK:

Throughout the Contractor's defined service area of Fort Bend, the Contractor shall provide: (1) basic services and associated activities for tuberculosis (TB) prevention and (2) expanded outreach services to individuals of identified special populations 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/dshsstndrds4clinciservs.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](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>;

10/2/12  
11/20/12  
REVISED  
[Signature]

- 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
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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).

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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 December 2012 shall also be submitted in a format provided by DSHS. The narrative program report shall be

sent to the Department of State Health Services, Tuberculosis Services Branch, Mail Code 1939, PO Box 149347, Austin, Texas 78714-9347 via regular mail, or by fax to (512) 776-7787, and sent by e-mail to [charles.wallace@dshs.state.tx.us](mailto:charles.wallace@dshs.state.tx.us) and [mitra.kookma@dshs.state.tx.us](mailto:mitra.kookma@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.

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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.

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 Bacillus (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 know 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% 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 March 1, 2012, 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 two (2) additional one-year terms, at DSHS's sole discretion.

### SECTION V. PAYMENT METHOD:

Cost Reimbursement

Funding is further detailed in the attached Categorical Budget.

### 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 49<sup>th</sup> 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](mailto:invoices@dshs.state.tx.us).

### SECTION VII. BUDGET

SOURCE OF FUNDS: CFDA Funding #93.116

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 hereby revised to add:

Quarterly Financial Status Reports (Form 269A) from Contractor shall be provided to DSHS in the format provided by the DSHS. These reports shall be mailed to Department of State Health Services, Attention: Accounting Section, Claims Processing Unit, Mail Code 1940, 1100 West 49<sup>th</sup> Street, PO Box 149347, Austin, Texas 78714-9347. These reports shall be submitted on a quarterly basis as follows:

<b>PERIOD COVERED</b>	<b>DUE DATE</b>
January, February March	April 30, 2012
April, May, June	July 31, 2012
July, August, September	October 31, 2012
October, November December	February 28, 2013

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.



## 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 than \$10,000 and not more than \$100,000 for each such failure.

A handwritten signature in black ink, appearing to read "Robert E. Hebert", written over a horizontal line.

Signature

February 28, 2012

Date

Robert E. Hebert, County Judge  
Print Name of Authorized Individual

2012-040154

Application or Contract Number

FORT BEND COUNTY CLINICAL  
HEALTH SERVICES

Organization Name