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DEPARTMENT OF STATE HEALTH SERVICES

This contract, number 2013-041111 (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 (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 $1,159,830.00, 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:

2013-041111-001 Tuberculosis Prevention and Control - State
2013-041111-002 CPS - CITIES READINESS INITIATIVE
2013-041111-003 Preparedness and Prevention Community Preparedness Section / Bioterrorism Discre
2013-041111-004 Public Health Emergency Preparedness (PHEP)
2013-041111-005 IMMUNIZATION BRANCH - LOCALS
2013-041111-006 RLSS/LOCAL PUBLIC HEALTH SYSTEM-PnP
2013-041111-007 Tuberculosis Prevention and Control - Federal

c. General Provisions (Sub-recipient)

8-8-12 copy received

d. Solicitation Document(s) **(NA)**, and
e. Contractor's response(s) to the Solicitation Document(s) **(NA)**.
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: FORT BEND COUNTY
Address: 301 JACKSON ST STE 533
RICHMOND, TX 77469-3108
Vendor Identification Number: 17460019692055

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

_____
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

FORT BEND COUNTY

By:_____
Signature

8-7-2012
Date

Robert E. Hebert, County Judge
Printed Name and Title

_____
Address

_____
City, State, Zip

_____
Telephone Number

_____
E-mail Address for Official Correspondence

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

8-7-2012
Date

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

2013-041111
Application or Contract Number

FORT BEND COUNTY
Organization Name

Fiscal Federal Funding Accountability and Transparency Act (FFATA) CERTIFICATION For Fiscal Year (FY13)

The certifications enumerated below represent material facts upon which DSHS relies when reporting information to the federal government required under federal law. If the Department later determines that the Contractor knowingly rendered an erroneous certification, DSHS may pursue all available remedies in accordance with Texas and U.S. law. Signor further agrees that it will provide immediate written notice to DSHS if at any time Signor learns that any of the certifications provided for below were erroneous when submitted or have since become erroneous by reason of changed circumstances. ***If the Signor cannot certify all of the statements contained in this section, Signor must provide written notice to DSHS detailing which of the below statements it cannot certify and why.***

Legal Name of Contractor:	**FFATA Contact # 1 Name, Email and Phone Number:**
Fort Bend County	**Robert E. Sturdivant, County Auditor** **Ed.sturdivant@co.fort-bend.tx.us** **281-341-3769**
Primary Address of Contractor: **301 Jackson St., Suite 533** **Richmond, TX**	**FFATA Contact #2 Name, Email and Phone Number:** **Dr. Mary desVignes-Kendrick** **Director, Health & Human Services** **md.kendrick@co.fort-bend.tx.us** **281-238-3512**
ZIP Code: 9-digits Required www.usps.com 7 7 4 6 9 - 3 1 0 8	**DUNS Number: 9-digits Required www.ccr.gov** 0 8 1 4 9 7 0 7 5
State of Texas Comptroller Vendor Identification Number (VIN) 14 Digits 1 7 4 6 0 0 1 9 6 9 2 0 5 5	

Printed Name of Authorized Representative	**Signature of Authorized Representative**
Robert E. Herbert	
Title of Authorized Representative	**Date**
County Judge	8-7-2012

Fiscal Federal Funding Accountability and Transparency Act (FFATA) CERTIFICATION For Fiscal Year (FY13)

As the duly authorized representative (Signor) of the Contractor, I hereby certify that the statements made by me in this certification form are true, complete and correct to the best of my knowledge.

Did your organization have a gross income, from all sources, of less than $300,000 in your previous tax year? ☐ Yes ☒ No

If your answer is "Yes", skip questions "A", "B", and "C" and finish the certification.
If your answer is "No", answer questions "A" and "B".

A. Certification Regarding % of Annual Gross from Federal Awards.

Did your organization receive 80% or more of its annual gross revenue from federal awards during the preceding fiscal year? ☐ Yes ☒ No

B. Certification Regarding Amount of Annual Gross from Federal Awards.

Did your organization receive $25 million or more in annual gross revenues from federal awards in the preceding fiscal year? ☐ Yes ☒ No

If your answer is "Yes" to both question "A" and "B", you must answer question "C".
If your answer is "No" to either question "A" or "B", skip question "C" and finish the certification.

C. Certification Regarding Public Access to Compensation Information.

Does the public have access to information about the compensation of the senior executives in your business or organization (including parent organization, all branches, and all affiliates worldwide) through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986? ☐ Yes ☐ No **n/a - Government**

If your answer is "Yes" to this question, where can this information be accessed?

If your answer is "No" to this question, you must provide the names and total compensation of the top five highly compensated officers below.

For example:

John Blum:500000;Mary Redd:50000;Eric Gant:400000;Todd Platt:300000; Sally Tom:300000

Provide compensation information here:

CONTRACT NO.2013-041111
PROGRAM ATTACHMENT NO.001
PURCHASE ORDER NO.0000385035

CONTRACTOR: FORT BEND COUNTY HEALTH AND HUMAN 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 Fort Bend, 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%,

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

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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 #081497075

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.

2013-041111-001

Categorical Budget:

PERSONNEL	$87,467.00
FRINGE BENEFITS	$38,780.00
TRAVEL	$8,309.00
EQUIPMENT	$0.00
SUPPLIES	$610.00
CONTRACTUAL	$4,962.00
OTHER	$0.00
TOTAL DIRECT CHARGES	$140,128.00
INDIRECT CHARGES	$0.00
TOTAL	$140,128.00
DSHS SHARE	$140,128.00
CONTRACTOR SHARE	$0.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $140,128.00

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

DSHS CONTRACT NUMBER: 2013-041111
FORT BEND COUNTY HEALTH AND HUMAN SERVICES
EXHIBIT A WORK PLAN

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 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, LFT's, CBC's, hepatitis profile (if indicated), HIV testing and tuberculosis therapy as prescribed by the physician. 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 patients 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. LTBI patients are followed according to the appropriate standard of care. FBCCH subcontracts with a local hospital for patient chest x-rays and CT Scans when indicated through grant funding. We have two LVN's, grant funded positions, which assist the 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?**

   Organization: FBCCHS is a subordinate department to Fort Bend County Health and Human Services, which is the public health department for Fort Bend County, TX. The Health Authority of Fort Bend County and Medical Director of FBCCHS is Mary des Vignes-Kendrick, MD. Dr. Jean Galloway, MD, our previous Director, is currently contracted by Fort Bend County for Tuberculosis Control services. Clinical Health Services consists of the director, Nancy Drake RN, along with 18 other employees. The TB Program consists of four RN's including a state grant funded program manager, three RN case managers and two LVN's whose responsibilities include DOT visits and contact investigation. The two LVN's often work tandem shifts with one beginning earlier in the morning and the other begins later working into early 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 LVN is funded by the federal grant.

   The immunization branch of Clinical Health Services is staffed by one RN, three LVN's, three community service aides and an ImmTrac/PICS Coordinator. The department is supported by excellent Clerical, administrative and data management staff. (See organization chart).

FBCCHS has followed, treated and provided case management for residents with TB for many years. FBCCHS contracts with a local hospital for x-ray services. FBCCHS has a good and long standing relationship with the hospital. DOT is the standard of care for all cases/suspects and FBCCHS utilizes cinic staff along with contracted, non-departmental individuals to accomplish this goal. Our grant funded LVN's 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, be 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 with the department, quarterly reviews of expenditures allow for amendment requests 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. Describe how you will determine the number of persons who received from the CONTRACTOR in 2012 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.

   Monthly activity data sheets in excel format tabulate TB services including TB skin tests and readings, patient clinic visits, DOT and home visits along 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. Clinical Health Services also maintains a database for reporting purposes that identifies how many TB skin tests were placed with county purchased PPD material. We are also now tracking the number and characteristics of clients who are being given QFT-GIT testing in our clinic.

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 including active surveillance activities for laboratories (specify names of labs) in your service area that perform acid-fast bacilli smears and cultures for *Mycobacterium tuberculosis* complex. 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 TWICES. We continue to utilize the TWICES database for LTBI patients only as this has proven to be a useful tracking system for this group of patients. Data for TB suspects is entered on state forms 400A and 400B and maintained in a hard copy file by the case registry until the outcome of the investigation is complete and diagnosis is finalized. If the suspect is determined to be a TB 0, the TB Suspected Case Verification Report is closed and faxed to the Central Office for entry into the PAM system for TB suspects. If the suspect is diagnosed as a TB case, the RVCT form is completed as data is obtained during the course

of the patient's treatment and sent to the central office for entry into PAM. Data is maintained in chronological order by the case registry 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. When TB PAM access is granted to FBCCHS, the RVCT data will be entered directly into this reporting system by the case registry as soon as it becomes available.
In addition to the above data collection and reporting, in-house Access and Excel Databases have been developed by the program manager and are continuously updated so that we are able to assess the quality of patient care delivery and track our progress on attaining the state mandated performance goals.

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. 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 (substance abuse programs, programs for homeless persons, other community based organizations, private providers, hospitals, and service organizations). Describe plans for TB educational opportunities to be offered to community health-care providers and community-based organizations that serve populations at high risk for TB.

   Local health care providers, including the 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. 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, use of field outreach staff who are trained to present information appropriately to diverse cultures, 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 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 in-person 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 (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 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 at the centrally located main clinic in Rosenberg, the Missouri City clinic on the east end of the county, or at the North Annex clinic in Katy.

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. In privately managed cases that compliance may be compromised, the FBCCHS physician may choose to interact directly with the patient's physician pointing out the advantages of improved compliance and regular professional assessment offered by our nurses DOT visits. Non-compliant patients, or those with complex medical conditions can be referred to, or quarantined, in theTexas Center for Infectious Disease in San Antonio, or the UT Health Center in Tyler by the recommendation of the local Health Authority and order of the Fort Bend County Court. Individual nurses offer small rewards to their patients for positive compliance in the form of blankets, surprise foods and bottled water. Their pleasant and supportive 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. Our medical services physician participates via 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 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.

The first Cohort Review analysis of cases was held in October of 2010 with six cases. Since that time, formal reviews have been held quarterly. In November, 2011, we were pleased to host some of the members of the state audit committee who provided helpful and enthusiastic feedback. The next review is scheduled for July 19, 2012. The format is as follows: Analysis of the demographic data for the cohort of patients that will be presented, presentation of the cases by the case managers, the questions from team members regard actions taken. Preliminary analysis of performance outcomes is presented by the program

manager immediately after the case manager review of cases. Finally, members of the review team discuss less successful performance measures for this cohort, and ideas for improvements that can be implemented with future cases. Thus we hope to meet the overall goal of the cohort review which is to improve our TB program by delivering better care with more successful outcomes for our future patients. The supervisory function of our case management is actually an ongoing peer review which takes place each Monday morning. Since the DOT workers on our staff carry out much of the contact investigation, they are an integral part of the cohort review team. Their input as to barriers/resolution in successful completion of the medical regime as well as to evaluating contacts fully will be essential in evaluating the effectiveness of our program.

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 resources allow.

    Staff LVNs who regularly give DOT and 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 CIR we discuss investigations that are in process with present contacts, results, barriers, solution 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 whom 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. Low completion rates continue to be a concern. We are considering possible solution for improvement such as maintaining a flow-sheet tabulating when a 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 patient 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 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 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. HEPA 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.

14. Describe plans to conduct targeted TB screening programs for high-risk populations. Include steps to ensure effective interventions are implemented so that foreign-born and U.S.-born minorities at highest risk for developing TB are identified, evaluated, and treated for TB 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 TDCJ or ICE 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. The new TB 101 curriculum has been added to the current training program. FBCCHS attends courses on TB nurse case management, contact investigation, 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 frequently attend cost free webinars that are offered by Heartland and other TB centers around the country. Implementation of new technology requires new training and this is an ongoing process, most notably this year several of our nurses have received special training in the use of the latest TB GIMS expanded capabilities. A newly developed

Excel spreadsheet tracks all staff training courses for the current year with the course attendee, hours of attendance and a current total hours earned for the year.

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 – Extra-pulmonary (evidence of extra-pulmonary tuberculosis); Class B2 (LTBI Evaluation – Applicants who have a tuberculin skin test ≥ 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 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 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 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.