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DEPARTMENT OF STATE HEALTH SERVICES
CONTRACT NO. HHS000812700013
AMENDMENT NO. 1

The **DEPARTMENT OF STATE HEALTH SERVICES ("SYSTEM AGENCY" OR "DSHS")** and **CITY OF SAN ANTONIO METROPOLITAN HEALTH DISTRICT ("GRANTEE"),** who are collectively referred to herein as the "Parties," to that certain grant contract for COVID-19 activities effective August 4, 2020, and denominated DSHS Contract No. HHS000812700013 ("Contract"), now desire to amend the Contract.

WHEREAS, the Parties desire to revise the Statement of Work;

WHEREAS, the Parties desire to revise the Budget to add additional funding; and

WHEREAS, the Parties desire to extend the term of the Contract.

NOW, THEREFORE, the Parties hereby amend and modify the Contract as follows:

1. **SECTION III** of the Contract, **DURATION,** is hereby amended to reflect a revised termination date of July 31, 2023.

2. **SECTION IV** of the Contract, **BUDGET,** is hereby amended to add **$2,730,605.00** to the Contract for a total not-to-exceed amount of **$4,915,089.00** for COVID-19 activities.

   The total amount of the Contract includes **$925,484.00** for the period beginning August 4, 2020, and ending April 30, 2022, and **$1,259,000.00** for the period beginning August 4, 2020 and ending October 31, 2022, and the addition of **$2,730,605.00** for the period beginning with the effective date of this Amendment and ending July 31, 2023. All expenditures under the Contract will be in accordance with **ATTACHMENT B-1, REVISED BUDGET**.

3. **ATTACHMENT A** of the Contract, **STATEMENT OF WORK,** is hereby deleted in its entirety and replaced with **ATTACHMENT A-1, REVISED STATEMENT OF WORK** and supplemented with the addition of **ATTACHMENT A-2, SUPPLEMENTAL STATEMENT OF WORK.**

4. **ATTACHMENT B** of the Contract, **BUDGET,** is hereby deleted in its entirety and replaced with **ATTACHMENT B-1, REVISED BUDGET**.

5. This Amendment No. 1 shall be effective as of the date last signed below.

6. Except as amended and modified by this Amendment No. 1, all terms and conditions of the Contract shall remain in full force and effect.

7. Any further revisions to the Contract shall be by written agreement of the Parties.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE FOR AMENDMENT NO. 1
DSHS CONTRACT NO. HHS000812700013

SYSTEM AGENCY

DocuSigned by:
Kirk Cole
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Signature

Kirk Cole

Deputy Commissioner

Date of Execution: September 2, 2021

GRANTEE

DocuSigned by:
Claude A. Jacob
C222BBF1E5D243B...

Signature

Claude A. Jacob

Director

Date of Execution: September 1, 2021

THE FOLLOWING ATTACHMENTS ARE ATTACHED AND INCORPORATED AS PART OF THE CONTRACT:

ATTACHMENT A-1	**REVISED STATEMENT OF WORK**
ATTACHMENT A-2	**SUPPLEMENTAL STATEMENT OF WORK**
ATTACHMENT B-1	**REVISED BUDGET**

ATTACHMENT A-1
REVISED STATEMENT OF WORK

I. GRANTEE RESPONSIBILITIES

Grantee will:

A. Enhance public health follow-up activities, including:

1. Conducting case investigations;
2. Eliciting or identifying individuals who may have been exposed to COVID-19;
3. Notifying individuals of COVID-19 exposure; and
4. Providing referrals to COVID-19 testing, vaccine resources and other follow-up services.

Data must be entered into the DSHS data system in accordance with DSHS published guidance. Grantee may not incur COVID-19 contact tracing Call Center expenditures beyond 8/31/2021.

B. Improve morbidity and mortality surveillance, including:

1. Establish or enhance community-based surveillance - Surveillance of populations and individuals includes but is not limited to those without severe illness, those with travel to high-risk locations, or those who are contacts to known cases.
2. Monitor and report daily COVID-19 probable and confirmed COVID cases (including deaths) to DSHS.
3. Track and send Emergency Department and outpatient visits for coronavirus (COVID)-like illness, as well as other illnesses, to Texas Syndromic Surveillance System (TxS2).
4. Send copies of all admission, discharge, and transfer (ADT) messages to the Centers for Disease Control and Prevention (CDC) National Syndromic Surveillance Program (NSSP).
5. Monitor and utilize available data in the CDC's National Healthcare Safety Network (NHSN) for confirmed 2019 novel coronavirus (COVID-19) infection or for COVID-like illness.
   a. Long-term care: https://www.cdc.gov/nhsn/ltc/covid19/index.html
   b. Acute care: https://www.cdc.gov/nhsn/acute-care-hospital/covid19/index.html
6. Work with long-term care facilities to enroll the facility in the NHSN Long-Term Care Facility (LTCF) COVID-19 Module.
7. Provide requested information on COVID-19 associated deaths to DSHS within three business days.

C. Enhance laboratory testing and reporting capacity:

1. Establish or expand capacity to test all symptomatic individuals, and secondarily expand capacity to achieve community-based surveillance. This capacity would entail increasing testing capabilities above the current number of specimens that can be tested

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at the jurisdiction's public health laboratory or by establishing new testing capabilities at the jurisdiction's laboratory.

2. Screen for past infection (e.g., serology) for health care workers, employees of high-risk facilities, critical infrastructure workforce, and childcare providers.
3. Obtain all jurisdictional laboratory test data electronically, including from new, non-traditional testing settings, and using alternative file formats (e.g., .csv or .xls) to help automate. In addition to other reportable results, this should include all COVID-19-related testing data, including all tests to detect severe acute respiratory syndrome coronavirus 2 (SAR-CoV-2) and serology testing.
4. Report all COVID-19-related line level testing data (negatives, positives, indeterminates, serology) daily to DSHS. Data must meet new federal Coronavirus Aid, Relief, and Economic Security (CARES) Act laboratory guidance. All public health data must be reported electronically to DSHS in compliance with the Texas Administrative Code and within appropriate reporting timeframes.

D. Prevent and control COVID-19 in healthcare settings and protect other vulnerable or high-risk populations:

1. Assess and monitor COVID-19 infections in healthcare workers across the healthcare spectrum.
2. Perform infection control assessments using preparedness tools approved by DSHS to ensure interventions are in place to protect high-risk populations.
3. Monitor and help implement mitigation strategies for COVID-19 in all high-risk healthcare facilities (e.g., hospitals, dialysis clinics, cancer clinics, nursing homes, and other long-term care facilities).
4. Monitor and help implement mitigation strategies for other high-risk employment settings (e.g., meat processing facilities) and congregate living settings (e.g., prisons, youth homes, shelters).
   a. This includes coordinating with the Texas Department of Criminal Justice when individuals are released from serving their prison term and will be returning to the jurisdiction. These individuals may have been exposed to COVID-19 while in prison and/or may be COVID-19-positive and require additional public health follow-up.

E. Monitor and mitigate COVID-19 introductions from connected jurisdictions (i.e., neighboring cities and states, including air travel).

F. Work with healthcare system to manage and monitor system capacity.

1. Assess and monitor the number and availability of critical care staff, necessary PPE and potentially life-saving medical equipment, as well as access to testing services.
2. Leverage NHSN data to **monitor** healthcare worker staffing, Patient Impact, Hospital Capacity, and healthcare supplies (PPE, PAPRs, ventilators, etc.). Grantee will request access to the NHSN database within 30 days of the execution of this Contract or within 30 days of hire for the position completing the data entry. Upon access approval,

Grantee will review available NHSN data (at least monthly) to assess gaps in the healthcare system.

G. Improve understanding of jurisdictional communities with respect to COVID-19 risk. Grantee must build an understanding of population density and high-risk population density (i.e., population of >65 yrs., proportion of population with underlying conditions, households with limited English fluency, healthcare-seeking behavior, populations without insurance and those below poverty level).

H. Submit a quarterly report on the report template to be provided by DSHS. Quarterly reports are due on or before the 15th of the month following the end of the quarter being reported on. Each report must contain a summary of activities that occurred during the preceding quarter for each activity listed above in Section I, A through G. Submit quarterly reports by electronic mail to COVID.Contracts@dshs.texas.gov. The email "Subject Line" and the name of the attached file for all reports should be clearly identified with the Grantee's Name, Contract Number, IDCU/COVID and the quarter the report covers.

I. May use funds to pay pre-award costs which date back to January 20, 2020, that are directly related to the COVID-19 outbreak response. All pre-award costs must be approved in writing by DSHS.

J. Not use funds for research, clinical care, fundraising activities, construction or major renovations, to supplant existing state or federal funds for activities, or funding an award to another party or provider who is ineligible. Other than normal and recognized executive-legislative relationships, no funds may be used for:

1. Publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body;
2. The salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative act or Executive order proposed or pending before any legislative body.

K. Controlled Assets include firearms, regardless of the acquisition cost, and the following assets with an acquisition cost of $500 or more, but less than $5,000: desktop and laptop computers (including notebooks, tablets and similar devices), non-portable printers and copiers, emergency management equipment, communication devices and systems, medical and laboratory equipment, and media equipment. Controlled Assets are considered Supplies.

L. Grantee shall maintain an inventory of Equipment, supplies defined as Controlled Assets, and real property and submit an annual cumulative report of the equipment and other property on the DSHS Contractor's Property Inventory Report located at https://www.dshs.state.tx.us/grants/forms.shtm to CMSInvoices@dshs.texas.gov and COVID.Contracts@dshs.texas.gov not later than October 15 of each year. If Grantee did not purchase Equipment or other property, this report is still required to be submitted.

M. DSHS funds must not be used to purchase buildings or real property without prior written approval from DSHS. Any costs related to the initial acquisition of the buildings or real property are not allowable without written pre-approval.

N. At the expiration or termination of this Contact for any reason, title to any remaining equipment and supplies purchased with funds under this Contract reverts to DSHS. Title may be transferred to any other party designated by DSHS. DSHS may, at its option and to the extent allowed by law, transfer the reversionary interest to such property to Grantee.

II. PERFORMANCE MEASURES

The System Agency will monitor the Grantee's performance of the requirements in Attachments A-1 and A-2 and compliance with the Contract's terms and conditions.

III. INVOICE AND PAYMENT

A. Grantee will request payments using the State of Texas Purchase Voucher (Form B-13) located at http://www.dshs.state.tx.us/grants/forms.shtm. Voucher and any supporting documentation will be mailed or submitted by fax or electronic mail to all addresses/number below.

Department of State Health Services
Claims Processing Unit, MC 1940
1100 West 49th Street
P.O. Box 149347
Austin, TX 78714-9347
FAX: (512) 458-7442
EMAIL: invoices@dshs.state.tx.us and
EMAIL: CMSInvoices@dshs.texas.gov and
EMAIL: COVID.Contracts@dshs.texas.gov

B. Grantee will be paid on a cost reimbursement basis and in accordance with the Revised Budget in Attachment B-1 of this Contract.

C. Grantee will submit requests for reimbursement (Form B-13) and financial expenditure template monthly by the last business day of the month following the month in which expenses were incurred or services provided. Grantee shall maintain all documentation that substantiates invoices and make the documentation available to DSHS upon request. In the event a cost reimbursed under the Contract is later determined to be unallowable, then the Grantee will reimburse DSHS for that cost.

D. Grantee will submit quarterly Financial Status Reports (FSRs) to DSHS by the last business day of the month following the end of each quarter of the Contract for DSHS review and financial assessment.

E. Grantee will submit request for reimbursement (B-13) as a final close-out invoice not later than forty-five (45) calendar days following the end of the term of the Contract.

Reimbursement requests received in the DSHS office more than forty-five (45) calendar days following the termination of the Contract may not be paid.

F. Grantee will submit a final FSR as a final close-out FSR not later than forty-five (45) calendar days following the end of the term of the Contract.

ATTACHMENT A-2
SUPPLEMENTAL STATEMENT OF WORK

I. GRANTEE RESPONSIBILITIES

Grantee will perform activities as submitted in their DSHS-approved budget for this specific funding contract period. Only activities listed below are approved for this funding and any additional activities not listed in the approved budget must be submitted for DSHS consideration and approval. The activities for this contract funding period are as follows:

A. Enhance Laboratory, Surveillance, Informatics and other Workforce Capacity, including:

1. Train and hire staff to improve laboratory workforce ability to address issues around laboratory safety, quality management, inventory management, specimen management, diagnostic and surveillance testing and reporting results.

2. Build expertise for healthcare and community outbreak response and infection prevention and control (IPC) among local health departments.

3. Train and hire staff to improve the capacities of the epidemiology and informatics workforce to effectively conduct surveillance and response of COVID-19 (including case investigation and public health follow-up activities) and other emerging infections and conditions of public health significance. This should include staff who can address unique cultural needs of those at higher risk for COVID-19.

4. Build Grantee staff expertise to support management of the COVID-19-related activities within the jurisdiction and integrate into the broader Epidemiology and Laboratory Capacity (ELC) portfolio of activities (e.g., additional leadership, program and project managers, budget staff).

5. Increase capacity for timely data management, analysis, and reporting for COVID-19 and other emerging coronavirus and other infections and conditions of public health significance.

B. Strengthen Laboratory Testing

1. Establish or expand capacity to quickly, accurately and safely test for SARS-CoV-2/COVID-19 and build infectious disease preparedness for future coronavirus and other events involving other pathogens with potential for broad community spread.
   a. Develop systems to improve speed and efficiency of specimen submission to clinical and reference laboratories.
   b. Strengthen ability to rapidly respond to testing (e.g., nucleic acid amplification test [NAAT], antigen) as necessary to ensure that optimal utilization of existing and new testing platforms can be supported to help meet increases in testing demand in a timely manner. Laboratory Response Networks (LRNs) and Local Health

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Departments (LHDs) with laboratories are strongly encouraged to diversify their testing platforms to enable them to pivot depending on reagent and supply availabilities.

c. Perform serology testing with an FDA Emergency Use Authorization (EUA) authorized serological assay as appropriate to respond to emerging pandemics in order to conduct surveillance for past infection and monitor community exposure.
d. Build local capacity for testing of COVID-19/SARS-CoV-2 including within high-risk settings or in vulnerable populations that reside in their communities.
e. Apply laboratory safety methods to ensure worker safety when managing and testing samples that may contain SARS-CoV-2/COVID-19.
f. Laboratories and LRNs are encouraged to implement new technologies to meet local needs.
g. Augment or add specificity to existing laboratory response plans for future coronavirus and other outbreak responses caused by an infectious disease. Provider must establish a plan to maintain the activity when the funds are no longer available. This is an optional activity.

2. Enhance laboratory testing capacity for SARS-CoV-2/COVID-19 by ensuring public/private laboratory testing providers have access to biosafety resources for SARS-CoV-2 specimen collection and/or testing.

C. Advance Electronic Data Exchange at Public Health Labs

1. Enhance and expand laboratory information infrastructure, to improve jurisdictional visibility on laboratory data (tests performed) from all testing sites and enable faster and more complete data exchange and reporting with DSHS.
   a. Employ a well-functioning Laboratory Information Management System (LIMS) system to support efficient data flows within the PHL and its partners. This includes expanding existing capacity of the current LIMS to improve data exchange and increase data flows through LIMS maintenance, new configurations/modules, and enhancements. Implement new/replacement LIMS where needed.

      Note: If implementing new or replacement systems, develop an implementation plan, including appropriate milestones and timeline to completion. Implementation plans will be reviewed and approved for consistency with the activities set forth by DSHS prior to start of implementation.
   b. Ensure ability to administer LIMS. Ensure the ability to configure all tests that are in LIMS, including new tests, EUAs, etc., in a timely manner. Ensure expanding needs for administration and management of LIMS system are covered through dedicated staff.
   c. Interface diagnostic equipment to directly report laboratory results into LIMS.

D. Improve Surveillance and Reporting of Electronic Health Data

1. Establish complete, up-to-date, timely reporting of morbidity and mortality to DSHS due to COVID-19 and other coronavirus and other emerging infections which impact

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conditions of public health significance, with required associated data fields in a machine-readable format, by:

a. Establishing or enhancing community-based surveillance, including surveillance of vulnerable populations, individuals without severe illness, those with recent travel to high-risk locations, or who are contacts to known cases; and
b. Monitoring changes to daily incidence rates of COVID-19 and other conditions of public health significance at the county or zip code level to inform community mitigation strategies.

2. Establish additional and ongoing surveillance methods (e.g., sentinel surveillance) for COVID-19 and other conditions of public health significance.

3. Enhance capacity to work with testing facilities to onboard and improve electronic laboratory reporting (ELR) to receive data from new or non-traditional testing settings. Use alternative data flows (e.g., reporting portals) and file formats (e.g., CSV or XLS) to help automate submissions where appropriate. In addition to other reportable results, this should include all COVID-19/SARS-CoV-2-related testing data (i.e., tests to detect SARS-CoV-2 including serology testing).

4. Improve understanding of capacity, resources, and patient impact at healthcare facilities through electronic reporting.
   a. Require expansion of reporting facility capacity, resources, and patient impact information, such as patients admitted and hospitalized, in an electronic, machine-readable, as well as human-readable, visual, and tabular manner, to achieve 100% coverage in jurisdiction and include daily data from all acute care, long-term care, and ambulatory care settings. Use these data to monitor facilities with confirmed cases of COVID-19/SARS-CoV-2 infection or with COVID-like illness among staff or residents and facilities at high risk of acquiring COVID-19/SARS-CoV-2 cases and COVID-like illness among staff or residents.
   b. Increase Admit, Discharge, and Transfer (ADT) messaging and use to achieve comprehensive surveillance of emergency room visits, hospital admissions, facility and department transfers, and discharges to provide an early warning signal, to monitor the impact on hospitals, and to understand the growth of serious cases requiring admission.

5. Implement new/replacement systems where needed. Ensure systems are interoperable and that data can be linked across systems (e.g., public health, healthcare, private labs), including adding the capacity for lab data and other data to be used by the software/tools that are being deployed for case investigation and public health follow-up activities.

6. Establish or improve systems to ensure complete, accurate and immediate (within 24 hours) data transmission that allows for automated transmission of data to DSHS in a machine-readable format.

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a. Submit all case reports in an immediate way to DSHS for COVID-19/SARS-CoV-2 and other conditions of public health significance with associated required data fields in a machine-readable format.
b. Report requested COVID-19/SARS-CoV-2-related data, including line level testing data (negatives, positives, indeterminates, serology, antigen, nucleic acid) daily by county or Zip code to DSHS.
c. Establish these systems in such a manner that they may be used on an ongoing basis for surveillance of, and reporting on, routine and other threats to the public health and conditions of public health significance.

E. Use Laboratory Data to Enhance Investigation, Response and Prevention

1. Use laboratory data to initiate and conduct case investigation and public health follow-up activities and implement containment measures.
   a. Conduct necessary case investigation and public health follow-up activities including contact elicitation/identification, contact notification, contact testing, and follow-up. Activities could include traditional case investigation and public health follow-up activities and/or proximity/location-based methods, as well as methods adapted for healthcare facilities, employers, elementary and secondary schools, childcare facilities, institutions of higher education or in other settings.
   b. Utilize tools (e.g., geographic information systems and methods) that assist in the rapid mapping and tracking of disease cases for timely and effective epidemic monitoring and response, incorporating laboratory testing results and other data sources.

2. Identify cases and exposure to COVID-19 in high-risk settings or within populations at increased risk of severe illness or death to target mitigation strategies and referral for therapies (for example, monoclonal antibodies) to prevent hospitalization.
   a. Assess and monitor infections in healthcare workers across the healthcare spectrum.
   b. Monitor cases and exposure to COVID-19 to identify need for targeted mitigation strategies to isolate and prevent further spread within high-risk healthcare facilities (e.g., hospitals, dialysis clinics, cancer clinics, nursing homes, and other long-term care facilities).
   c. Monitor cases and exposure to COVID-19 to identify need for targeted mitigation strategies to isolate and prevent further spread within high-risk occupational settings (e.g., meat processing facilities) and congregate living settings (e.g., correctional facilities, youth homes, shelters).
   d. Work with DSHS to build capacity for reporting, rapid containment and prevention of COVID-19/SARS-CoV-2 within high-risk settings or in vulnerable populations that reside in their communities.
   e. Jurisdictions should ensure systems are in place to link test results to relevant public health strategies, including prevention and treatment.

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3. Implement prevention strategies in high-risk settings or within vulnerable populations (including tribal nations as appropriate) including proactive monitoring for asymptomatic case detection.

   Note: These additional resources are intended to be directed toward testing, case investigation and public health follow-up activities, surveillance, containment, and mitigation, including support for workforce, epidemiology, use by employers, elementary and secondary schools, childcare facilities, institutions of higher education, long-term care facilities, or in other settings, scale-up of testing by public health, academic, commercial, and hospital laboratories, and community-based testing sites, mobile testing units, healthcare facilities, and other entities engaged in COVID–19 testing, and other related activities related to COVID–19 testing, case investigation and public health follow-up activities, surveillance, containment, and mitigation which may include interstate compacts or other mutual aid agreements for such purposes.

   a. Build capacity for infection prevention and control in long-term care facilities (LTCFs) (e.g., at least one Infection Preventionist [IP] for every facility) and outpatient settings.
      i. Build capacity for LTCFs to safely care for infected and exposed residents of LTCFs and other congregate settings.
      ii. Assist with enrollment of all LTCFs into NHSN at https://www.cdc.gov/nhsn/ltc/enroll.html.
   b. Build capacity for infection prevention and control in elementary and secondary schools, childcare facilities, and/or institutions of higher education.
   c. Increase Infection Prevention and Control (IPC) assessment capacity on site using tele-ICAR.
   d. Perform preparedness assessment to ensure interventions are in place to protect high-risk populations.
   e. Coordinate as appropriate with federally funded entities responsible for providing health services to higher-risk populations (e.g., tribal nations and federally qualified health centers).

F. May use funds to pay pre-award costs which date back to February 1, 2021, that are directly related to the COVID-19 outbreak response. All pre-award costs must be approved in writing by DSHS.

ATTACHMENT B-1
REVISED BUDGET

Categorical Budget	CARES Funding	LRN PPP Funding	Expansion Funding	
Budget Period	**August 4, 2020 to April 30, 2022**	**August 4, 2020 to October 31, 2022**	**Effective date to July 31, 2023**	**Contract Total**
Personnel	$0.00	$118,488.00	$1,367,559.00	$1,486,047.00
Fringe Benefits	$0.00	$41,649.00	$477,367.00	$519,016.00
Travel	$0.00	$0.00	$40,000.00	$40,000.00
Equipment	$0.00	$551,029.00	$0.00	$551,029.00
Supplies	$37,500.00	$43,004.00	$229,929.00	$310,433.00
Contractual	$887,984.00	$504,830.00	$335,000.00	$1,727,814.00
Other	$0.00	$0.00	$280,750.00	$280,750.00
Total Direct Charges	$925,484.00	$1,259,000.00	$2,730,605.00	$4,915,089.00
Indirect Charges	$0.00	$0.00	$0.00	$0.00
Total	**$925,484.00**	**$1,259,000.00**	**$2,730,605.00**	**$4,915,089.00**