DEPARTMENT OF STATE HEALTH SERVICES
CONTRACT NO. HHS000812700025
AMENDMENT NO. 2

The **DEPARTMENT OF STATE HEALTH SERVICES ("SYSTEM AGENCY"** or **"DSHS")** and **HIDALGO COUNTY ("Grantee")**, who are collectively referred to herein as the "Parties," to that certain grant contract for COVID-19 activities effective August 1, 2020, and denominated DSHS Contract No. HHS000812700025 ("Contract"), as amended, now desire to further amend the Contract.

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

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

WHEREAS, the Parties desire to revise the Budget.

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, 2024.

2. **SECTION IV** of the Contract, **BUDGET,** is hereby deleted in its entirety and replaced with the following language:

   The total amount of this Contract will not exceed **$807,271.00** for COVID-19 response activities through July 31, 2024. Grantee is not required to provide matching funds.

   All expenditures under the Contract will be in accordance with **ATTACHMENT B-2, REVISED BUDGET**.

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

4. **ATTACHMENT B-1** of the Contract, **REVISED BUDGET,** is hereby deleted in its entirety and replaced with **ATTACHMENT B-2, REVISED BUDGET.**

5. This Amendment No. 2 shall be effective as of the date last signed below.

6. Except as amended and modified by this Amendment No. 2, all terms and conditions of the Contract, as amended, 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. 2
DSHS CONTRACT NO. HHS000812700025

SYSTEM AGENCY	**GRANTEE**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date of Execution: _____	Date of Execution: _____

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

ATTACHMENT A-3 - REVISED SUPPLEMENTAL STATEMENT OF WORK
ATTACHMENT B-2 - REVISED BUDGET

ATTACHMENT A-3
REVISED SUPPLEMENTAL STATEMENT OF WORK

I. GRANTEE RESPONSIBILITIES

Grantee will perform activities as submitted in their DSHS approved budgets for this specific funding Contract period. All activities must be listed below to be 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. Grantee may not incur COVID-19 contact tracing or contact tracing call center expenditures after 08/31/2021.

4. Build 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, etc.).

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, etc.) 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 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 be able to 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) 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. Completion of the implementation plan is DSHS verifying that the submitted electronic laboratory reporting (ELR) feeds have been successfully processed in National Electronic Disease Surveillance System (NEDSS).
   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 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 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.
   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. At the health department, enhance capacity to work with testing facilities to onboard and improve ELR, including 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 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, 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. 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.

   Note: Use of an existing DSHS system is preferred. If implementing new or replacement systems, develop an implementation plan, including the process for automatic transmission of data to DSHS in a machine-readable

format, 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.

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. 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. 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.
   c. Assist in identifying facilities that are not submitting data through ELR. Provide these facilities with information on the ELR onboarding process and the appropriate contact information of DSHS team who can onboard the facility to have their data be reported electronically and no longer sent by fax. Also provide the names of these facilities to the DSHS team.

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, other long-term care facilities, etc.).
   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.

Note: Utilization of an existing DSHS system is preferred. If implementing new or replacement systems, develop an implementation plan, including the process for automatic transmission of data to DSHS in a machine-readable format, 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.

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 CDC's National Healthcare Safety Network 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. 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. Each report must contain a summary of activities that occurred during the preceding quarter for each activity listed above in Section I, Subsections A through E. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

ATTACHMENT B-2
REVISED BUDGET

Categorical Budget	Epi CARES Funding	Epi Expansion Funding	
Budget Period	**August 1, 2020 to July 31, 2024**	**August 31, 2021 to July 31, 2024**	**Contract Total**
PERSONNEL	$233,892.00	$299,985.00	$533,877.00
FRINGE BENEFITS	$91,265.00	$120,114.00	$211,379.00
TRAVEL	$0.00	$2,417.00	$2,417.00
EQUIPMENT	$0.00	$0.00	$0.00
SUPPLIES	$8,133.00	$11,500.00	$19,633.00
CONTRACTUAL	$0.00	$0.00	$0.00
OTHER	$25,497.00	$14,468.00	$39,965.00
TOTAL DIRECT CHARGES	$358,787.00	$448,484.00	$807,271.00
INDIRECT CHARGES	$0.00	$0.00	$0.00
TOTAL	**$358,787.00**	**$448,484.00**	**$807,271.00**