UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT AMENDMENT

Utah Department of Health & Human Services

PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

2317743 — DHHS Log Number

232702176 — State Contract Number

1. CONTRACT NAME: The name of this contract is San Juan Health Department Community and Clinical Interventions Amendment 2.

2. CONTRACTING PARTIES: This contract amendment is between the Utah Department of Health & Human Services (DHHS) and San Juan County (CONTRACTOR).

PAYMENT ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding UT, 84511

MAILING ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding UT, 84511

Vendor ID: 06866HL
Commodity Code: 99999

3. PURPOSE OF CONTRACT AMENDMENT: The purpose of this amendment is to increase the contract amount, replace Attachment “A”, in exchange for continued services.

4. CHANGES TO CONTRACT:

1. Attachment “A”, effective 6/30/2024, is replacing Attachment “A”, which was effective September 2023. Changes were made to Article “3” Responsibilities of Subrecipient, Section 3.1 and 3.2 . Article "4" Funding, Section 4.1 was increased.
2. The contract amount is being changed. The original amount was $33,188.98. The funding amount will be increased by $23,528.90 in federal funds. New total funding is $56,717.88.

UEI: WCVABP2FEVA2 — Indirect Cost Rate: 0%

Add

Federal Program Name:	The purpose of this project is to decrease type 2 diabetes among adults in Utah and to improve quality of care, early detection and prevention of diabetes.	Award Number:	6 NU58DP007417
Name of Federal Awarding Agency:	CDC	Federal Award Identification Number:	NU58DP007417

Assistance Listing:	COOPERATIVE AGREEMENTS FOR STATE-BASED DIABETES CONTROL PROGRAMS AND EVALUATION OF SURVEILLANCE SYSTEMS	Federal Award Date:	1/17/2024
Assistance Listing Number:	93.988	Funding Amount:	$11558.37

Add

Federal Program Name:	This project aims to prevent and manage cardiovascular diseases in populations at higher risk.	Award Number:	1 NU58DP007427
Name of Federal Awarding Agency:	CDC	Federal Award Identification Number:	NU58DP007427
Assistance Listing:	IMPROVING THE HEALTH OF AMERICANS THROUGH PREVENTION AND MANAGEMENT OF DIABETES AND HEART DISEASE AND STROKE-FINANCED IN PART BY 2018 PREVENTION AND PUBLIC HEAL	Federal Award Date:	6/21/2023
Assistance Listing Number:	93.426	Funding Amount:	$11970.53

All other conditions and terms in the original contract and previous amendments remain the same.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 06/30/2024.

6. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
   A. All other governmental laws, regulations, or actions applicable to services provided herein.
   B. All Assurances and all responses to bids as provided by the CONTRACTOR.
   C. Utah Department of Health & Human Services General Provisions and Business Associates Agreement currently in effect until 6/30/2028.

7. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract.

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Contract with Utah Department of Health & Human Services and San Juan County**, Log #** 2317743

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By: _____ _____
Jamie Harvey Date
County Commission Chair

STATE

By: _____ _____
Tracy S. Gruber Date
Executive Director, Department of Health & Human Services

Attachment A: Scope of Work
San Juan Health Department- Community and Clinical Interventions Amendment 2

Article 1
GENERAL PURPOSE

The general purpose of this contract is to promote engagement in community and clinical interventions toward the broader aim of preventing and managing chronic conditions such as diabetes, hypertension and obesity in priority populations.

Article 2
DEFINITIONS

In this contract, the following definitions apply:

"CHW" means Community Health Worker.

"Department" means the Utah Department of Health and Human Services, Healthy Environments Active Living program.

"DSMES" means Diabetes Self-Management Education and Support.

"**Healm"** means a new diabetes prevention employer learning collaborative platform for the National Diabetes Prevention Program.

"MDPP" means Medicare Diabetes Prevention Program.

"National DPP" means National Diabetes Prevention Program.

"Priority Population" means those identified to be at an increased risk of developing a chronic disease due to demographics.

"Qualtrics" means the Department's reporting system.

"SDOH" means Social Determinants of Health.

"SMBP" means self-measured blood pressure.

"Subrecipient" means San Juan Public Health Department.

Article 3
RESPONSIBILITIES OF SUBRECIPIENT

3.1 For a Strategic Approach to Advancing Health Equity for Priority Populations with or at risk for diabetes the Subrecipient shall:

(1) strengthen self-care practices by improving access, appropriateness, and feasibility of DSMES services for priority populations.

(A) engage referring providers and community/clinical partners (i.e. DSMES providers) in streamlined referral processes to DSMES/other diabetes support programs; and

(B) work with DSMES providers to identify needs related to increasing referrals (i.e. marketing materials, communication efforts, etc.).

(2) improve acceptability and quality of care for priority populations with diabetes.

(A) support existing or new clinic partners to implement diabetes care practices through QI projects, improving interpretation services offered, clinic workflow and follow up procedures, implementing team-based care, etc.

(3) increase enrollment and retention of priority populations in the National DPP lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.

(A) partner with new organizations (i.e. senior centers) to offer the National DPP LCP and assist organizations in registering to become CDC-recognized National DPPs through the Diabetes Prevention Recognition Program; and

(B) identify geographic areas that have gaps in access to culturally appropriate services, by using the information gleaned in 2.1. Additionally, find opportunities to use the Utah Healthy Places Index to expand health equity efforts in diabetes prevention.

3.2 For the National Cardiovascular Health Program the Subrecipient shall:

(1) track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at the highest risk of cardiovascular disease with a focus on hypertension and high cholesterol.

(A) work with local primary care clinic to implement or improve their SDOH screenings.

(2) implement team-based care to prevent and reduce cardiovascular disease risk with a focus on hypertension and high cholesterol prevention, detection, control and management through the mitigation of social support barriers to improve outcomes.

(A) build the capacity of clinical teams to provide and connect patients with social services to help with reducing hypertension and high cholesterol. This shall include conducting formal and informal assessments of the current multidisciplinary team employed by the clinic, and planning how to improve the team based on the assessment results;

(3) link community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address social determinants that put the priority populations at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.

(A) refer people in the community and in clinical settings with hypertension to lifestyle change programs, including the healthy heart ambassador program, SNAP-ED and EFNEP;

(B) conduct an inventory of CHWs in their areas to identify where they are working and the populations they serve;

(C) work with one clinic and one community partners in local areas to implement and improve SMBP programs.

3.3 For reporting the Subrecipient shall:

(1) submit detailed reports on progress, results and performance measure data by the following dates:
(A) October 15, 2024;
(B) January 15, 2025;
(C) April 15, 2025; and
(D) July 15, 2025.

(2) comply with the reporting format in Qualtrics to document the progress made on the activities. The Subrecipient shall ensure that necessary information is entered into all required reporting fields.

3.4 For contract responsibilities the Subrecipient shall:

(1) attend the annual Department Forum;

(2) attend the Chronic Conditions Disease Management group; and

(3) jointly review expenditures with the Department to determine if at least 35% of funds have been expended on activities as allocated:

(A) if Subrecipient is below 35% expenditures a written plan of action will be provided by Department to ensure utilization of remaining funds for contract and funding purposes; and

(B) over a three-year time period if the Subrecipient consistently underspends funds, the Department will work with the Health Promotion and Prevention Executive group and Governance to determine appropriate reallocation of funds.

Article 4
FUNDING

4.1 Total funding is $56,717.88.

(1) $23,528.90 for the period June 30, 2023 to June 29, 2024.

(2) $9,660.08 for the period September 30, 2023 to September 29, 2024.

(3) $23,528.90 for the period June 30, 2024 to June 29, 2025.

4.2 This is a Cost Reimbursement contract. The Department agrees to reimburse the Subrecipient up to the maximum amount of the contract for expenditures made by the Subrecipient directly related to the performance of this contract.

Cost Reimbursement – Budget

Description	Amount
Diabetes	$11,558.37
Cardiovascular Health	$11,970.53
Total	$23,529.90

Article 5
INVOICING

5.1 In addition to the General Provisions of the Contract, the Subrecipient shall include one column for each applicable funding source in the Monthly Expenditure Report.

(1) HEAL Clinical Interventions CVD; and

(2) HEAL Clinical Interventions Diabetes.

Article 6
OUTCOMES

6.1 The desired outcome of this contract is to increase the number of people with diabetes participating in DSMES or other approved diabetes management programs.

(1) Performance Measure: Number of people participating in DSMES.

(2) Reporting: The Subrecipient shall enter data in Qualtrics.

6.2 The desired outcome of this contract is to increase the number of eligible people participating in the National DPP.

(1) Performance Measure: Number of people participating in the National DPP.

(2) Reporting: The Subrecipient shall enter related data in Qualtrics.

6.3 The desired outcome of this contract is to increase the number of people whose diagnosed hypertension is considered under control.

(1) Performance Measure: Percent of people with a hypertension diagnosis who have their hypertension in control.

(2) Reporting: The Subrecipient shall enter related data in Qualtrics.