Utah Department of
Health & Human Services

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
AGREEMENT AMENDMENT
PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

2317743
Department Log Number

232702176
State Agreement ID

1. AGREEMENT NAME: The name of this contract is San Juan Health Department Community and Clinical Interventions Amendment 4.

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

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 AMENDMENT: The purpose of this amendment is to change the termination date, increase the contract amount, replace Attachment A and add Attachment B: Activity Selection.

4. CHANGES TO AGREEMENT:
   1. The agreement termination date is being changed. The original termination date was June 29, 2025. The agreement period is increased by 12 months. The new agreement termination date is June 29, 2026.
   2. The contract amount is being changed. The original amount was $66,377.96. The funding amount will be increased by $23,528.90 in federal funds. New total funding is $89,906.86.
   3. Attachment A, effective June 30, 2025, is replacing Attachment A, which was effective June 2024. The format of the document has been changed, the title has been changed, the content changes are; Article 2 Responsibilities of Subrecipient, Section 2.1, 2.2 and 2.3 are changed. Article 3 Funding, Section 3.1(5) is added and Section 3.2 is changed.
   4. The vendor information is being changed. The signer is being updated to Silvia Stubbs.

UEI: WCVABP2FEVA2 **Indirect Cost Rate:** 0.00 %

Federal Funds

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**	5 NU58DP007417-03-00

Federal Awarding Agency	Centers for Disease Control and Prevention	**Federal Award Identification Number**	5 NU58DP007417
Assistance Listing Title	Cooperative Agreements for State-Based Diabetes Control Programs and Evaluation of Surveillance Systems	**Federal Award Date**	06/24/2025
Assistance Listing Number	93.988	**Funding Amount**	$11,558.37

Federal Program Name	This project aims to prevent and manage cardiovascular diseases in populations at higher risk.	**Award Number**	5 NU58DP007427-03-00
Federal Awarding Agency	Centers for Disease Control and Prevention	**Federal Award Identification Number**	5 NU58DP007427
Assistance Listing Title	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**	07/03/2025
Assistance Listing Number	93.426	**Funding Amount**	$11,970.53

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

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 06/30/2025 .

Intentionally Left Blank

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

IN WITNESS WHEREOF, the parties enter into this agreement.

Signature

Signed by: _____

_____

Silvia Stubbs
County Commission Chair

Date Signed: _____

Attachment A: Scope of Work
San Juan Health Department- Community and Clinical Interventions Amendment 4

Article 1
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 Health Department.

Article 2
RESPONSIBILITIES OF SUBRECIPIENT

2.1 For a Strategic Approach to Advancing Health Equity for Priority Populations with or at risk for diabetes the Subrecipient shall select four to six activities from attachment B in the following areas:

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

(2) Prevent diabetes complications for priority populations through early detection.

(3) Improve acceptability and quality of care for priority populations with diabetes.

(4) Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.

(5) Improve the sustainability of Community Health Workers (CHWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence based diabetes prevention and management programs and services.

(6) Improve the capacity of the diabetes workforce to address factors related to the SDOH that impact health outcomes for priority populations with and at risk for diabetes.

2.2 For the National Cardiovascular Health Program the Subrecipient shall select four activities from attachment B in the following areas:

(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.

(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.

(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.

2.3 For reporting the Subrecipient shall:

(1) submit detailed reports on progress, results and performance measure data by the following dates:
(A) October 15, 2025;
(B) January 15, 2026;
(C) April 15, 2026; and
(D) July 15, 2026.

(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.

2.4 For contract responsibilities the Subrecipient shall:

(1) attend the annual Department Forum;

(2) attend the Healthy Living Workgroup and 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.

2.5 For Prohibited Discriminatory Practices the subrecipient shall not use contract funds for any prohibited discriminatory practice as defined by Utah Code 53B-1-118.

Article 3
FUNDING

3.1 Total funding is $89,906.86.

(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) $9,660.08 for the period September 30, 2024 to September 29, 2025.

(5) $23,528.90 for the period June 30, 2025 to June 29, 2026.

3.2 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	$23,528.90

Article 4
INVOICING

4.1 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 5
OUTCOMES

5.1 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.

5.2 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.

5.3 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.

Attachment B: Activity Selection
HEAL- FY26 Work Plan

HEAL- Customize Your FY26 Work Plan
FY26 Strategic Plan – LHD Menu of Activities for Diabetes, Hypertension and Schools.

- Please put an X in column 3 if your LHD is selecting the activity and add [x number of] in notes if necessary.
- Send a finalized document of your local health department work plan to mdrury@utah.gov by COB, May 1, 2025-
- The following activity number requirements were recommended by ULACHES and approved by leadership from DHHS and health officers from the Health Promotion and Prevention Executive Workgroup.
- HEAL Subject matter experts can be found at https://heal.utah.gov/staff/
- New employee orientation can be viewed at https://docs.google.com/presentation/d/11NboV8ki5BxMeTbG8gh1sqK4VloRITkz7hbC7ltMpvw/edit?usp=sharing

		Diabetes		Cardiovascular Health	
		funding range	**minimum # activities**	**funding range**	**minimum # activities**
tier 1	**Salt Lake County**	$80K and higher	12	$80K and higher	8-10
tier 2	Southwest	$40K - $79K	8-10	$40K - $79K	6-10
	Utah		8-10		6-10
	Weber-Morgan		8-10		6-10
tier3	Bear River	$30-$39	6-8	$30-$39	6
	Central		6-8		6
	Davis		6-8		6
tier 4	San Juan	$29K and under	4-6	$29K and under	4
	Southeast		4-6		4
	Summit		4-6		4
	Tooele		4-6		4
	Tri County		4-6		4
	Wasatch		4-6		4

Thank You, Please let me know if you have any questions.
San Juan County Public Health **HEAL Work Plan FY26**

Diabetes				
Strategy	Activity Description	Selecting activity for FY26	Details/Notes- please specify # if required.	Reporting Question(s)
Strategy 1. Strengthen self-care practices by improving access, appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority populations.	1.1 By June 30, 2026, work with X new organizations to complete the process of achieving DSMES accreditation/recognition, including assisting organizations with facilitating patient completion of a full DSMES cycle, while continuing to provide technical assistance to those who show interest in achieving accreditation/recognition.			1. How many prospective DSMES providers did your LHD work with this quarter? 2. Did any organizations achieve DSMES accreditation/recognition this quarter? Which organizations? 3. What technical assistance did your LHD provide to each prospective DSMES provider this quarter?
	1.2 By June 30, 2026, identify online/virtual DSMES programs that serve Utah as a way to provide non-English DSMES and to reach those who have decreased access to DSMES services related to the social drivers of health (i.e. transportation, mobility and need for child care).			1. What online/virtual DSMES programs did your LHD identify this quarter?
	2.1 By June 30, 2026, collaborate with USU Extension, Walk with Ease and the Living Well with diabetes/chronic disease programs to determine effective promotion strategies to communities and DSMES providers. Work to develop a consistent way to track participation in the named diabetes support programs.	X	SJPH Health Promotion program will continue to collaborate with USU Extension program on working with the communiti	1. Which diabetes support program(s) did your LHD collaborate with this quarter? 2. What promotion strategies did your LHD work on for diabetes support programs(s) this quarter? 3. How is your LHD working to track participation in the diabetes support program(s) you're working with?

			es in schools, senior centers, health fair, etc. To educate and promote diabetes prevention and management on nutrition and physical activities. We would like more information on Walk with Ease and Living Well.	
STRATEGY 3. Prevent diabetes complications for priority populations through early detection	1.1 By June 30, 2026, participate in the CKD workgroup, as part of the Utah Diabetes Coalition, by attending bimonthly meetings.	X	SJPH Health Promotion program will continue to attend the CKD workgroup.	1. How is your LHD working with/participating in the CKD workgroup to increase CKD screening, diagnosis, and follow-up care?
	1.3 By June 30, 2026, create community clinical linkages for follow up retinopathy care following retinal exams performed in primary care, which may include creating relationships with eye care professionals and resources for follow up care.			1. What community-clinical linkages has your LHD created relating to retinopathy care this quarter? 2. Has your LHD connected eye care professionals to primary care clinics? If so,

				what progress have you made?
STRATEGY 4. Improve acceptability and quality of care for priority populations with diabetes.	1.1 By June 30, 2026, work with the learning collaborative and/or clinical partners to increase the utilization of clinical tools such as team huddles, team based care, chart scrubbing, and EHR huddles to increase the number of referrals to programs such as 211, Unite Us, Park Rx, Senior Farmers Market, SNAP, Double Up Food Bucks, etc as a way to improve diabetes care practices.			1. Has your LHD worked with the Learning Collaborative or other clinical partners to increase utilization of clinical tools and referrals to programs? Please describe the work that was completed. 2. Which programs are clinics referring to?
	1.2 By June 30, 2026, work with clinical partners to implement SDOH screenings if not already in place.			1. How has your LHD worked with clinical partners to implement SDOH screenings this quarter? 2. Which clinics are implementing these screenings?
	2.2. By June 30, 2026, work collaboratively with clinics to ensure they are informed about nearest DSMES providers and National DPP providers, including how and when to refer to these services.	X	SJPH Health Promotion program will continue to collaborate with UNHS and Spanish Valley clinics.	1. Has your LHD informed clinics about nearest DSMES and National DPP providers this quarter? Please describe your efforts. 2. How have you informed clinics how and when to refer to these services?
STRATEGY 5. Increase	2.1 By June 30, 2026, promote MDPP and provide technical assistance to CDC			1. How have you provided technical assistance to

enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs	recognized organizations who have shown interest in becoming an MDPP supplier.			CDC-recognized organizations who are interested in becoming an MDPP supplier this quarter? Which organizations?
	2.2 By June 30, 2026, partner with X new organizations to offer the National DPP LCP and provide technical assistance to those interested in achieving CDC recognition.			1. How many organizations did your LHD partner with to offer the National DPP this quarter? Which organizations? 2. How has your LHD provided technical assistance to those organizations this quarter?
	2.3 By June 30, 2026, support existing National DPP and MDPP sites to increase referrals, enrollment and participation and improve reimbursement processes. Work with existing sites to increase the number of cohorts by 1.	X	SJPH Health Promotion program will continue to partner with UNHS Diabetes program on NDPP and MDPP referral, enrollment and participation to increase the number of cohorts.	1. How has your LHD supported existing National DPP and MDPP providers this quarter? Which providers were supported? 2. How has your LHD increased referrals, enrollment, and participation of National DPP and MDPP programs? 3. Are any sites working to increase the number of cohorts? Which sites?
STRATEGY 12. Improve the sustainability of	2.2 By June 30, 2026, provide and promote X trainings to CHWs regarding diabetes,			1. How many trainings did your LHD provide and/or promote to CHWs regarding

Community Health Workers (CHWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence based diabetes prevention and management programs and services.	prediabetes and chronic disease subject matter and other related topics related to mental health and chronic disease.			diabetes, prediabetes, and other chronic disease topics this quarter? 2. What were the topics of each training? How many CHWs attended?
STRATEGY 13. Improve the capacity of the diabetes workforce to address factors related to the SDOH that impact health outcomes for priority populations with and at risk for diabetes.	1.2 By June 30, 2026, offer 1 education opportunities in individual health districts on topics related to the impacts of the social drivers of health on diabetes health outcomes.	X	SJPH Health Promotion program will continue to provide Diabetes prevention and management education.	1. How many education opportunities did your LHD provide this quarter? 2. What were the topics and how many attended?
	1.3 By June 30, 2026, promote the Diabetes Community Care Coordinator Certificate Program as a way to educate CHW and other related groups on how to link individuals to resources, build relationships, and support people with or at risk for diabetes.			1. Did your LHD promote the Diabetes Community Care Coordinator Certificate Program this quarter? Please describe your efforts. 2. How many CHWs and other related groups received certification?
	2.2 By June 30, 2026, participate in the Utah Diabetes Coalition (UDC) by attending bimonthly			1. Did your LHD participate in the Utah Diabetes Coalition this quarter?

	meetings with 6 meetings per year. Share information and updates with partners who are unable to attend.			2. Did you share information and updates with partners? Which partners?

Cardiovascular Health				
Strategy	Activity Description	Selecting activity for FY26	Notes	Reporting Question(s)
STRATEGY 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 (CVD) with a Focus on Hypertension and High Cholesterol.	Activity 1b: By June 30, 2026, work with X clinics within your identified priority census tract areas to create/modify their workflows to identify, refer, and track social services and support needs. Encourage clinics to participate in the Million Hearts Learning Collaborative.			1. How many clinics did your LHD work with within your selected priority census tracts this quarter? 2. How are those clinics creating/modifying their workflows to identify, refer, and track social services and support needs? 3. How have you encouraged clinics to participate in the Learning Collaborative this quarter? Which clinics?
	Activity 2b: By June 30, 2026, implement an evidence based process for identifying, tracking, monitoring and referring to social services and support needs within clinics.			1. How many clinics did your LHD work with on this activity this quarter? Please describe your efforts. 2. What evidence-based process(es) did your LHD implement within clinics this quarter?
STRATEGY 2: Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through the Mitigation of Social Support Barriers to Improve Outcomes.	Activity 2b: By June 30, 2026 provide training and technical assistance to X clinics and community partners on bi-directional communication to facilitate care management (tracking, monitoring, consulting, referrals, and sharing treatments/encounters with clients).			1. How has your LHD provided training and TA to clinics regarding bi-directional communication to facilitate care management this quarter?
	Activity 1c: By June 30, 2026, in conjunction with DHHS, conduct X number of focus groups within high priority census tract areas in your local health district to identify barriers to accessing social services and support needs. Information will be			1. How many focus groups did your LHD conduct within your priority census tracts? How many attended these focus groups? 2. What barriers were identified in the focus group(s)? What information did your LHD learn that can

	shared back to the LC Social Services and Support Needs (SSSN) Workgroup.			be shared with the Learning Collaborative?
	Activity 2c: By June 25, 2026 in conjunction with DHHS, conduct an environmental scan of high priority census tracts within your local health district to identify community partners which address identified barriers to social services and support needs.			1. Did your LHD conduct an environmental scan within priority census tracts this quarter? 2. If yes, what community partners did your LHD identify? What barriers to social services and support needs can those community partners address?
	Activity 3c: By June 30, 2026 continue to build new partnerships with agencies that serve priority populations at highest risk of CVD and invite them to join and participate in the Learning Collaborative (LC). Retain and support current partners.	**X**	SJPH Health Promotion program will continue to build new partnerships to serve priority populations. We partner with UNHS and hope to partner with Navajo Nation Diabetes program. We would like more information on Learning Collaborative.	1. What partnerships did your LHD form with agencies that serve priority populations at highest risk of CVD this quarter? 2. Did you invite partners to join and participate in the Learning Collaborative? 3. How is your LHD retaining and supporting current partners?
STRATEGY 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	Activity 2a: By June 30, 2026 establish referral pathways between clinic and community partners identified in the environmental scan that address social service and support needs as well as evidence based and/or evidence-informed lifestyle change programs. (should select ONLY if Strategy 2, Activity 2c was also selected)			1. How many referral pathways did your LHD establish between clinics and community partners this quarter? Please describe your efforts. 2. Which clinics were connected with which community partners?
	Activity 1b: By June 30, 2026, provide education and training opportunities for up	**X**	SJPH Health Promotion program will	1. How many education and training opportunities did your LHD provide to clinics

increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.	to 1 clinics/community-based organization on the benefits of employing CHWs for providing continuum of care for patients		continue to work/partner with CHWx in providing continuum of care for patients	and/or community-based organizations on the benefits of employing CHWs this quarter?
	Activity 2b: By June 30, 2026 provide 2 number of CHWs with resources they can provide to clients to reduce the risk of cardiovascular disease within high risk populations.	**X**	SJPH Health Promotion program will work with the CHWs with information on how to reduce the risk of CVD.	1. What resources did your LHD provide to CHWs regarding cardiovascular health this quarter?
	Activity 3b: By June 30, 2026 explore supplemental training modules for CHWs related to the prevention of chronic disease including hypertension, cardiovascular disease, SMBP, lifestyle modifications such as nutrition and physical activity and addressing social services and support needs.	**X**	SJPH Health Promotion program will work with UNHS CHWs and SJPH CHWs to explore supplemental training modules to promote prevention and education in chronic disease and support needs.	1. What supplemental training modules for CHWs did your LHD explore this quarter?
	Activity 1c: By June 30, 2026, encourage X clinics to adopt /improveSMBP policies through participation in the Utah Million Hearts Award program.			1. Using data from the Million Hearts Award, how many clinics did your LHD work with to adopt/improve SMBP policies this quarter? 2. Which clinics adopted SMBP policies?
	Activity 3c: By June 30, 2026 work with DHHS, the LC SMBP workgroup, clinics and your "lending libraries" (aka loaner programs) to tie SMBP lending libraries to clinical support.			1. Did your LHD support SMBP lending libraries this quarter? 2. If yes, how has your LHD worked to tie SMBP lending libraries to clinical support this quarter? How many lending libraries did you work with?

Schools- REQUIRED ONLY FOR Tri County			
Strategy	Activity Description	Selecting activity for FY26	Notes
Whole School, Whole Community, Whole Child model	Work with LEA to accomplish grant requirements.		