



Utah Department of
Health & Human Services

**UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT 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. **CONTRACT NAME:** The name of this contract is San Juan Health Department Community and Clinical Interventions Amendment 3.
2. **CONTRACTING PARTIES:** This contract amendment is between the Utah Department of Health & Human Services (DEPARTMENT) 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".
4. **CHANGES TO CONTRACT:**
 1. The contract amount is being changed. The original amount was \$56,717.88. The funding amount will be increased by \$9,660.08 in federal funds. New total funding is \$66,377.96.
 2. Attachment "A", effective September 30, 2024, is replacing Attachment "A", which was effective July 2024. The document title is changed, Article "3" Responsibilities of Subrecipient, Section 3.3 and 3.6 is added, Article "4" Funding, is changed and Article "6" Outcomes, is changed.

UEI: WCVABP2FEVA2

Indirect Cost Rate: 0.0 %

Federal Funds

Federal Program Name	The purpose of this project is to reduce the prevalence of obesity among Utahns and to improve access to healthy food and physical activity.	Award Number	5NU58DP0075580200
Federal Awarding Agency	Centers for Disease Control and Prevention	Federal Award Identification Number	NU58DP007558
Assistance Listing Title	State Physical Activity and Nutrition (SPAN)	Federal Award Date	08/27/2024

Assistance Listing Number	93.439	Funding Amount	\$9,660.08
----------------------------------	--------	-----------------------	------------

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

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 09/30/2024 .
 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.
 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.
-

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.

CONTRACTOR

Signature

Signed by: _____

Jamie Harvey
County Commission Chair

Date Signed: _____

Attachment A: Scope of Work
San Juan Health Department- Community and Clinical Interventions Amendment 3

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 the State Physical Activity and Nutrition Program the Subrecipient shall:

- (1) implement state level policies and activities that promote food service and nutrition guidelines and associated healthy food procurement in facilities, programs, or organizations where food is sold, served, and distributed.
 - (A) identify food venues that have a mission that would support FSG guidelines; and
 - (B) partner with local government entities to adopt Eat Well Utah in their cafeterias.
- (2) implement state level policies and activities that coordinate uptake and expansion of existing fruit and vegetable voucher incentives and produce prescription programs.
 - (A) promote and educate community and clinical partners on the health benefits of SNAP and WIC and provide them with the tools and training required to offer help with SNAP and WIC enrollment to their patients and clients.
- (3) implement state-level policies and activities to connect pedestrian, bicycle, or transit transportation networks to everyday destinations.
 - (A) provide technical assistance to government agencies & communities working to improve PA safety and access on everyday routes to destinations; and
 - (B) engage with community organizations to identify & implement policy or environmental changes that support PA in local areas (e.g., walk audits, citizen science assessments).
- (4) implement state level policies and activities that achieve continuity of care for breastfeeding families.
 - (A) finalize a breastfeeding campaign with unified messages for hospitals, worksites, and ECEs based on existing platforms for partners and public; and
 - (B) utilize assessments conducted from previous years to make improvements to lactation accommodations.

3.4 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.

3.5 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.

3.6 For Prohibited Discriminatory Practices The subrecipient shall not use contract funds for any prohibited discriminatory practice as defined by Utah Code 538-1-118.

Article 4 FUNDING

4.1 Total funding is \$66,377.96.

- (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.

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

<u>Description</u>	<u>Amount</u>
Diabetes	\$11,558.37
Cardiovascular Health	\$11,970.53
SPAN	\$9,660.08
Total	\$33,188.98

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;
 - (2) HEAL Clinical Interventions Diabetes; and
 - (3) HEAL State Physical Activity and Nutrition.

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.

6.4 The desired outcome of this contract is to Increase state level policies and activities that improve nutrition and breastfeeding.

(1) Performance Measure: Number of policies and activities implemented that improve nutrition and breastfeeding.

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

6.5 The desired outcome of this contract is to Increase number of policies, plans, or community design changes that increase access to physical activity.

(1) Performance Measure: Number of places available for Physical Activity.

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