UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT

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

2317743 Department Log Number	232702176 State Contract Number

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

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

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

Vendor ID: 06866HL
Commodity Code: 99999

3. GENERAL PURPOSE OF CONTRACT: 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.

4. CONTRACT PERIOD: The service period of this contract is 06/30/2023 through 06/29/2024, unless terminated or extended by agreement in accordance with the terms and conditions of this contract.

5. CONTRACT AMOUNT: The DEPARTMENT agrees to pay $23,528.90 in accordance with the provisions of this contract. This contract is funded with 100% federal funds, 0% state funds, and 0% other funds.

6. CONTRACT INQUIRIES: Inquiries regarding this Contract shall be directed to the following individuals:

CONTRACTOR	**DEPARTMENT**
Grant Sunada (435) 587-3838 gsunada@sanjuancounty.org	Population Health Health Promotion and Prevention McKell Drury

(801) 538-6896
mdrury@utah.gov

7. SUB – RECIPIENT INFORMATION:

UEI: WCVABP2FEVA2 Indirect Cost Rate: 0%

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:	1 NU58DP007417-01-00
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:	6/16/2023
Assistance Listing Number:	93.988	Funding Amount:	$11558.37

Federal Program Name:	This project aims to prevent and manage cardiovascular diseases in populations at higher risk.	Award Number:	1 NU58DP007427-01-00
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

8. REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT:

   Attachment A: Scope of Work

9. 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 6/30/2023.

10. 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: _____ _____
Bruce Adams 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

Effective Date: June 30, 2023

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:

"Catalyst" means the Department's reporting system.

"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 Medicaid 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.

“SDOH” means Social Determinants of Health.

“SMBP” means self-measured blood pressure.

“Subrecipient” means San Juan Public Health Department.

Article 3

PROGRAM CONTACT

The Department contacts are:

(A) for day to day operations, Linnea Fletcher, linneafletcher@utah.gov, (385) 443-0871; and

(B) for disputes, McKell Drury, mdrury@utah.gov, 801-538-6896.

Article 4

RESPONSIBILITIES OF SUBRECIPIENT

4.1 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) identify one new organization, assess interest and evaluate capacity to provide DSMES;

(B) engage referring providers, community and clinical partners in streamlined referral processes to DSMES or other diabetes support programs; and

(C) distribute DSMES marketing materials to increase awareness of DSMES programs in priority populations and among referring providers.

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

(A) support two existing or new clinic partnes 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) support existing MDPP sites to increase referrals and participation and improve reimbursement processes.

(4) Expand availability of the National DPP lifestyle intervention as a covered health benefit for Medicaid

Beneficiaries, employees and covered dependents at high risk for type 2 diabetes.

(A) explore becoming trained and recognized as a Healm guide to promote National DPP to worksites.

4.2 For the National Cardiovascular Health Program the Subrecipient shall:

(1) 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) work with two local clinics to implement or improve team based care; and

(B) work with two clinics to assist clinical teams with providing and connecting patients with social services to help with reducing hypertension and high cholesterol.

(2) 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 social service programs, including the National DPP as well as traditional social service programs, including 211;

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

(C) work with two clinics in local areas to implement and improve SMBP programs.

4.3 For reporting the Subrecipient shall:

(1) Submit detailed reports on progress, results and performance measure data by the following dates:
(A) October 15, 2023;
(B) January 15, 2024;
(C) April 15, 2024; and
(D) July 15, 2024.

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

4.4 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 5

FUNDING

5.1 Total funding is $23,528.90.

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

5.2 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.

(1) Cost Reimbursement – Budget

Description	Amount
Diabetes	$ 11,558.37
Cardiovascular Health	$ 11,970.53
Total	$23,528.90

Article 6

INVOICING

6.1 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 Diabetes; and

(2) HEAL Cardiovascular.

Article 7

AMENDMENTS AND TERMINATION

If the Contract is not amended to add funds, the Contract shall terminate as of June 29, 2024.

Article 8

OUTCOMES

8.1 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 Catalyst.

8.2 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 Catalyst.

8.3 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 Catalyst.