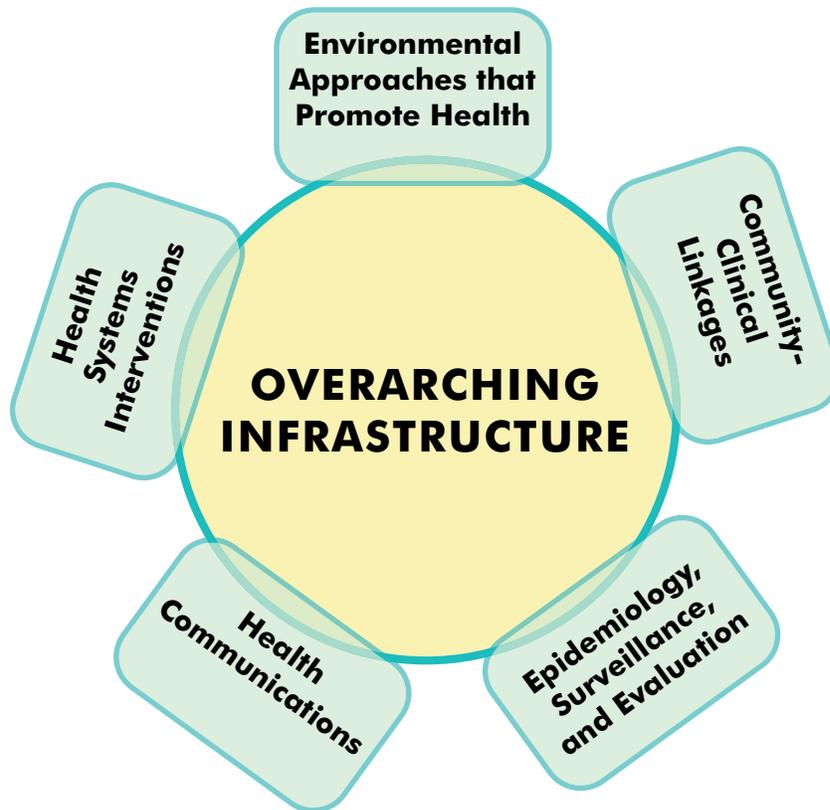# Utah
Chronic Disease Prevention and Health Promotion

State Plan

Partnering for a Healthy State
2014 to 2020

Utah Department of Health
Division of Disease Control and Prevention
Bureau of Health Promotion

UTAH DEPARTMENT OF
HEALTH

Suggested citation:

Utah Chronic Disease Prevention and Health Promotion State Plan, Partnering for a Healthy State, 2014 to 2020. Version 1.0. (2013). Salt Lake City, Utah: Utah Department of Health.

Acknowledgements

Letter of Support

Utah Department of Health
W. David Patton, PH.D
Executive Director

Robert Rolfs, MD
Deputy Director

Disease Control and Prevention
Teresa Garrett, RN MS
Division Director

Bureau of Health Promotion
Heather Borski, MPH, MCHES
Bureau Director

State of Utah

GARY R HERBERT
Governor

GREG BELL
Lieutenant Governor

July 15, 2013

Dear Fellow Utahns:

The State of Utah is widely recognized as healthy place to live, work, play, and conduct business. It provides an opportunity for a good quality of life for families and individuals, and is a driver for a number of key community and economic issues. Public health is a community focus on health. Where a physician works to improve the health of an individual, public health professionals strive to ensure the health of entire populations.

The mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles. The Bureau of Health Promotion accomplishes this with a focus on chronic disease , injury prevention and health promotion. We work with partners, such as local health departments, schools and early child education facilities, employers, health care organizations, and community leaders to ensure that all Utahns have the best chance to experience the benefits of good health.

This State Plan represents the work of public health professionals who have carefully considered and prioritized how our Bureau can best work with partners and contribute to public health in Utah. I encourage all of our partners to read the Plan and decide how you would like to be part of this effort as an individual, a family, or a community. We look forward to working with you.

Sincerely,

W. David Patton, PhD
Executive Director

Heather R. Borski, MPH, MCHES
Director, Bureau of Health Promotion

UTAH DEPARTMENT OF HEALTH

BUREAU OF HEALTH PROMOTION
288 North 1460 West · Salt Lake City, Utah
Mailing Address: P.O. Box 142107 · Salt Lake City, Utah 84114-2107
Telephone (801) 538-6141 · Facsimile (801) 538-9495 · www.health.utah.gov

Utah Leaders for Health
Optimal Health and Wellness for all Utahns

July 29, 2013

Dear Fellow Utahns:

The Utah Leaders for Health is pleased to support the State Chronic Disease and Health Promotion Plan ~ *Partnering for a Healthy State*. This plan is aligned with our current collaboration with the Department of Health's Bureau of Health Promotion to set priorities for chronic disease and health promotion programs statewide. The plan strategies and goals reinforce our objective to leverage resources in order to build support and encourage community engagement in health promotion and disease prevention efforts.

This plan supports the building of a sustainable infrastructure within communities so they can offer environmental supports, resources, and linkages that make health living accessible to all their residents. It also focuses on aligning resources from health care, the community and public health in order to target priority populations with the great potential for improving health risks and managing chronic diseases.

Our team is looking forward to working closely with all partners, including the Bureau of Health Promotion, to carry out the work detailed in this plan.

Sincerely,
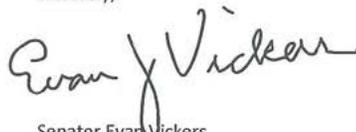
Senator Evan Vickers
Chair, Utah Leaders for Health

Letter of Support

Utah Association of Local Health Departments

Anna Dillingham, MPH
Acting Executive Director

Gary Edwards, MS
President
Salt Lake County Health Dept.

Cameron Mitchell, MPH, EHS
Past President
Wasatch County Health Dept.

Joseph Shaffer, EHS, MA, MBA
President Elect
TriCounty Health Dept.

Lloyd Berentzen, MBA
Member At Large
Bear River Health Dept.

July 10, 2013

Dear Fellow Utahns:

Utah often ranks as one of the top ten healthiest states in the United States. Though we applaud this ranking, there are health indicators that fall short and thus can be greatly improved. In an effort to continually strive to improve health outcomes, the Utah Association of Local Health Departments works together to protect and promote the public's health. The Association is comprised of representatives from all twelve local health departments throughout the state of Utah, promoting a collective voice while ensuring local perspectives are heard.

As a collaborative entity working to improve the health of Utahns, the Association welcomes the opportunity to partner with the Utah Department of Health and various statewide organizations and agencies to implement the *Utah Chronic Disease Prevention and Health Promotion Plan.* The Plan not only provides a path to addressing chronic disease and injury prevention and health promotion in Utah, but also places emphasis on partnerships and collaboration. Creating new partnerships and enhancing current ones is critical to improving the public's health in Utah.

The Association looks forward to participating in the *Plan* implementation.

Sincerely,

Anna Dillingham
Acting Executive Director

Gary Edwards
President

715 North 1890 West, Provo, UT 84601   801-691-1171

Partners

American Cancer Society
Brook Osterland, MPA

American Heart Association
Marc Watterson, BA
Victor Arredondo, BS

Association for Utah Community Health
Jennifer Lloyd, JD, DVM, MSPH

Bear River Health Department
Farrin Wiese

Central Utah Public Health Department
Bruce Costa, PhD

Davis County Health Department
Ivy Melton Sales, MBA, CHES

Division of Aging and Adult Services
Charlotte Vincent

Division of Substance Abuse and Mental Health
Craig Povey, MSW
Doug Thomas, LCSW
Leanne Huff

HealthInsight
Dave Cook, MBA

Intermountain Healthcare
Jack Ruckdeschel, MD
Liz Joy, MD

Jewish Family Services
Rebecca Turkanis, LCSW

Maliheh Free Clinic
Jeanie Ashby, BS

Molina Health Care
Lynette Hansen, MS

Primary Children's Medical Center
Janet Brooks, BS

Public Employees Health Program
Tracy Pali, RN, CCM

Salt Lake County Health Department
Beverly Hyatt Neville, PhD

Southwest Utah Public Health Department
Cambree Applegate, MS, CHES

Summit County Health Department
Richard Bullough, PhD
Geri Essen, BS
Carolyn Rose, RN

Tooele County Health Department
Jeff Coombs, EHS

Utah County Health Department
Eric Edwards, MPH, CHES
Patty Cross, MEd, MCHES
Steve Mickelson

Utah Department of Health
Arthritis Program
Rebecca Castleton, BS, CHES
Asthma Program
Rebecca Giles, MPH

Bureau of Emergency Medical Services
Jolene Whitney, MPA
Whitney Levano, MPH

Bureau of Maternal and Child Health
Laurie Baksh, MPH

Cancer Prevention and Control Program
Brad Belnap, MPA
Kalynn Filion, BS, CHES
Kristi Smith, BS
Meghan Balough, MPH, CHES
Annie Coyle

Community Transformation Grant
Brett McIff, PhD

Partners (continued)

Healthy Living through Environment, Policy and Improving Clinical Care (EPICC) Program
Karen Coats, BS, CHES
Catherine Sparks, MSN, RN, NCSN
Celsa Bowman, MS
Nicole Bissonette, MPH
Carolyn Croxall

Health Resource Center
Marie Nagata, BS

Office of Public Health Assessment
Kathryn Marti, MPH, BSN

Public Information Office
Cyndi Bemis, BA

Tobacco Prevention and Control Program
Adam Bramwell, BS
Rachel Cardon, BS

Violence and Injury Prevention Program
Trisha Keller, MPH, RN
Cristy Sneddon, RHIT

Utah Medicaid
Charlene Frail-McGeever, MBA

Utah Transit Authority
Jennifer McGrath, MS
Johanna Jamison, BA

Wasatch County Health Department
Jonelle Fitzgerald, BS

Wasatch Front Regional Council
Jory Johner, BS

Weber–Morgan Health Department
Claudia Price, BSN, RN

Executive Summary

The Utah Chronic Disease Prevention and Health Promotion State Plan was created with input from an variety of partners representing government, community-based organizations, faith-based organizations, business/industry, health care organizations, and private organizations. The plan was developed with funding from the Centers for Disease Control and Prevention (CDC) in order to unify statewide efforts to decrease chronic diseases and prevent injuries. The plan identifies goals and objectives which, if implemented, could decrease chronic diseases and injury statewide while increasing individual healthful behaviors. The intent of this plan is to present a common set of goals and objectives to align statewide partner activities to optimize results. The plan identifies five functional areas:

- Environmental approaches that promote health (including activities in people's homes, in communities, at schools, and at worksites)
- Health care systems (activities within the health care system at large and with individual physicians)
- Community-Clinical linkages (activities that link the health care system and individual physicians with resources in the community)
- Health communication (activities that promote healthful living)
- Data and evaluation (data-driven activities that support and evaluate the implementation of the plan)

Three overarching infrastructure strategies are also identified. The infrastructure strategies are:

- Collaborative partnerships and coalitions
- Address health equity
- Trainings

The Utah Department of Health (UDOH), Bureau of Health Promotion (BHP) is committed to working with statewide partners to implement this plan. The BHP will coordinate partner activities and provide support to all partners as they work to implement the plan. Support will include activities such as convening meetings, providing surveillance, epidemiology and evaluation expertise, providing networking opportunities for partners, identifying evidence-based interventions, and communicating progress.

This plan is a living document and, as such, will be evaluated periodically and updated as needed. The plan will guide future proposed BHP activities relative to grant opportunities.

This plan represents the future of chronic disease and injury prevention and health promotion in Utah. Implementation of the systems, environmental, and individual changes identified in this plan will lead to healthier individuals and a healthier state.

Table of Contents

Introduction

In November 2011, the Utah Department of Health, Bureau of Health Promotion (BHP), was awarded the Centers for Disease Control and Prevention (CDC), Coordinated Chronic Disease Prevention and Health Promotion grant. The purpose of the grant was to find ways to more fully leverage existing resources that would lead to improved coordination and integration of chronic disease prevention and health promotion.

In October 2012, following a nine-month planning process involving a steering committee comprising internal program managers and local health department staff, as well as BHP workgroups, a three-year Bureau of Health Promotion Strategic Plan was developed and implemented.

In January 2013, the BHP began the process of expanding the BHP Plan to create a statewide Chronic Disease Prevention and Health Promotion Plan that emphasizes statewide partner engagement, public health outcomes, and health equity. The plan expansion process utilized BHP program and workgroup expertise, BHP Priority Health People 2020 Objectives, the US Preventive Services Taskforce National Prevention Strategy, and comprehensive partner input. Supported by overarching infrastructure strategies (collaborative partnerships and coalitions, addressing health equity, and trainings), the following goal areas comprise the framework that is intended to achieve major population-level change and reach large numbers of people in the state:

1. Environmental Approaches that Promote Health
2. Health Care Systems
3. Community-Clinical Linkages
4. Health Communications
5. Data and Evaluation

This plan is written for public, private, and non-profit partners and the general public. The Plan includes a glossary (Appendix 1) describing terms, definitions, and concepts used within the document.

Development of the Utah Chronic Disease Prevention and Health Promotion Plan is an important step in helping Utah maintain a strong foundation in chronic disease prevention and management and health promotion during challenging times. The plan will be made available to partners and the general public by uploading it onto a website that is accessible to all.

The Plan will facilitate the creation of new partnerships, the strengthening of current statewide partners, as well as implement a leadership management plan focusing on chronic diseases that address people, capacity, and skills. It will help Utah become more efficient and effective in delivering prevention across chronic diseases and preventable injuries, positioning the State to be able to adapt and thrive over the coming years. The plan will be reviewed periodically and revised as needed.

Burden Statement

The Impact of Chronic Disease and Injury in Utah

Chronic disease and injury are leading causes of death and disability in Utah and contribute to high health care costs. Since chronic diseases disproportionately affect older adults, the costs associated with their treatment are frequently shouldered by taxpayers through public programs, especially Medicare. However, many chronic diseases and injuries can be prevented or managed through individual behavior change which can lead to long and healthy lives as well as cost reduction.

In the rest of this section, data will be used to answer questions about the general health of Utahns and the current burden of chronic disease and injury in Utah.

What are the costs of chronic disease and injury in Utah?

Data List			
Leading Causes of Death	*Number of Deaths*	*Number in the Population*	*Leading Causes of Death by Age-adjusted Rate, Deaths Per 100,000 Population*
Heart Disease	3,193	2,817,222	151.50
Cancer	2,837	2,817,222	129.70
Unintentional injuries	1,126	2,817,222	45.80
Stroke	826	2,817,222	39.80
Chronic Lower Respiratory Disease	648	2,817,222	30.29
Diabetes	571	2,817,222	26.40
Alzheimer's	409	2,817,222	20.40
Suicide	517	2,817,222	20.10
Influenza and pneumonia	370	2,817,222	17.70
Kidney Disease	232	2,817,222	11.17

Source: Utah Indicator-Based Information System, National Center for Health Statistics, 2011.

- Heart disease and stroke are the first and fourth leading causes of death in Utah respectively. Together, they account for 1 in every 4 deaths in the state.

- Cancer is the second leading cause of death – with over 2,800 deaths per year. Cancers of the lung, colon, breast, and prostate are the more common types of cancer resulting in death.

- Unintentional injury is the third leading cause of death for all age groups and the first leading cause of death for Utahns aged 1 to 44 years. In 2011, there were 435 unintentional injury deaths among Utahns aged 1 to 44 years.

- Diabetes, and its related complications, contributes to more than 500 deaths each year. In 2011, diabetes contributed to 571 deaths, was the primary reason for

Burden Statement

2,523 hospitalizations, and cost $50 million in treatment. (Source: Utah Inpatient Hospital Discharge Data, Office of Health Care Statistics, UDOH and Utah Death Certificate Database, Office of Vital Records and Statistics, UDOH)

- Arthritis is a leading cause of disability. In 2011, arthritis was the primary diagnosis for 11,442 inpatient hospital visits. (Source: Utah Hospital Discharge Database)

- Uncontrolled asthma leads to costly emergency room visits. Uncontrolled asthma resulted in nearly $20 million in emergency department visit charges in 2010. (Source: Utah Emergency Department Database)

- It is expensive to treat chronic diseases. In Utah in 2009, annual health care costs to treat the top 10 chronic diseases exceeded $586 million; this cost estimate excludes Medicaid and Medicare services. (Source: Utah All Payer Claims Database)

How common are chronic diseases and injury in Utah? Are they on the rise?

- Approximately 10,800 cases of cancer are expected in Utah in 2013. (Source: American Cancer Society 2013 Facts & Figures, www.cancer.org/research/cancerfactsfigures/cancerfactsfigures/cancer-facts-figures-2013)

- In 2012, about 1 in 4 (24.4%) Utah adults had high blood pressure (approximately 480,000 people). (Source: Utah Behavioral Risk Factor Surveillance System, 2012)

- From 2001 to 2012, the percentage of Utah adults with diabetes rose from 4.6% to 7.9% (age-adjusted rates). In 2012, about 130,000 Utah adults had been diagnosed with diabetes. (Source: Utah Behavioral Risk Factor Surveillance System, 2012)

Figure 1. Adult Diabetes Prevalence, Utah, 2001-2012 (Age Adjusted)
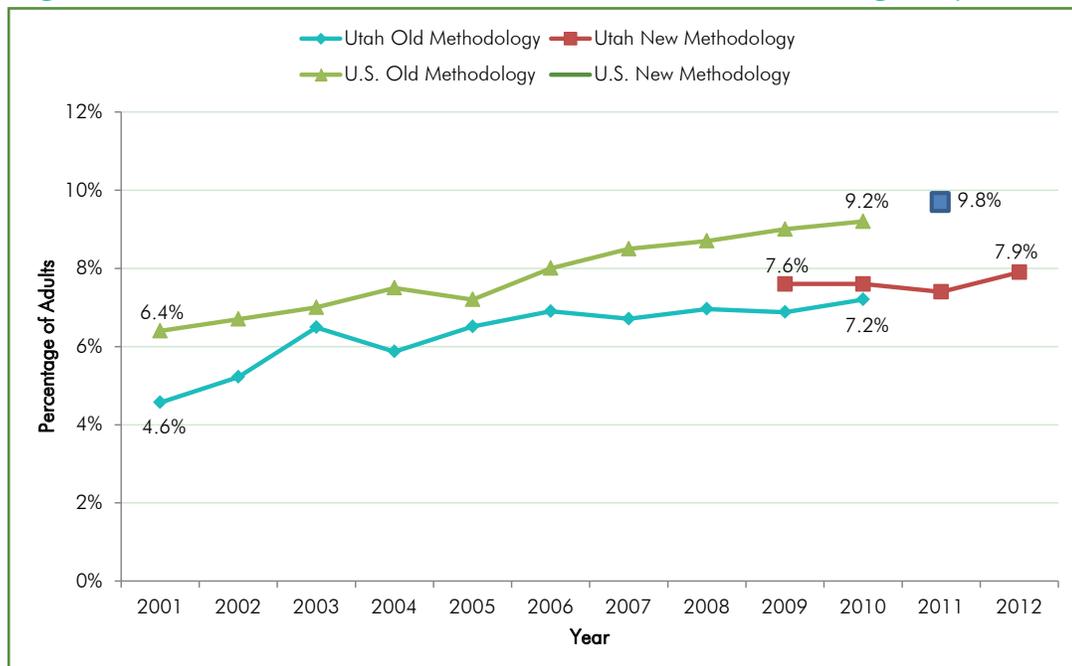
Source: Utah Behavioral Risk Factor Surveillance System; Age-adjusted to the U.S. 2000 standard population.

Burden Statement

Figure 2. Prevalence of Adults at an Unhealthy Weight, Utah & U.S. 2001-2012 (Age Adjusted)
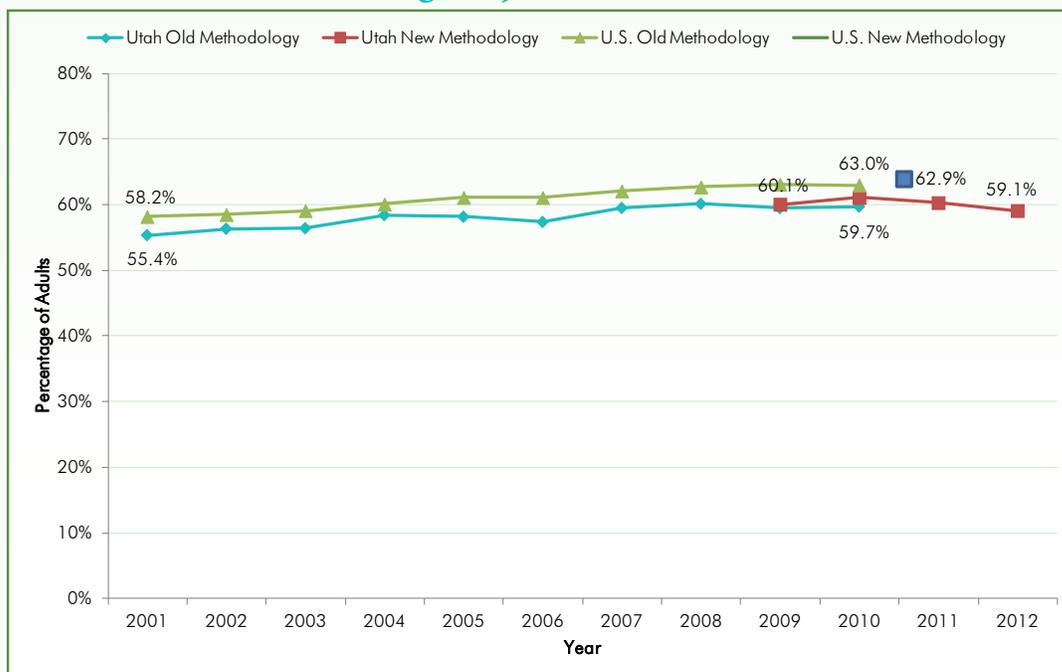
Source: Utah Behavioral Risk Factor Surveillance System; Age-adjusted to the U.S. 2000 standard population.

- Arthritis affects 19.8% of Utah adults, or approximately 384,000 people. (Source: Utah Behavioral Risk Factor Surveillance System 2011)

- In Utah in 2011, about 8.6% of adults and 6.7% of children had asthma. In Utah in 2010, about 40.9% of children with current asthma reported missing school because of their asthma. (Utah Behavioral Risk Factor Surveillance System 2010 and 2011)

- From 1996 to 2011, the percentage of Utah adults who were obese increased 52%. In 2013, 25.0% of adults, 6.4% of high school students, and 9.4% of elementary students were obese. (Source: High school student data from Youth Risk Behavior Survey, elementary school student data from Utah Height and Weight Measurement Project, and Utah Behavioral Risk Factor Surveillance System data for adults.)

- In Utah, injury is the cause of about 480 hospitalizations and emergency department visits per day. (Source: Utah Inpatient Hospital Discharge Database and Utah Emergency Department Encounter Database, Bureau of Emergency Medical Services, UDOH)

In Utah, who is most vulnerable to chronic disease, injury, and poor health?

- Racial and ethnic minority groups experience higher rates of diabetes, obesity, and not having health insurance compared to non-Hispanic whites (age-adjusted rates). (Source: Utah Behavioral Risk Factor Surveillance System)

Figure 3. Disease and Risk Factor Prevalence Rates, Utahns in Poverty and Utahns Statewide, 2011
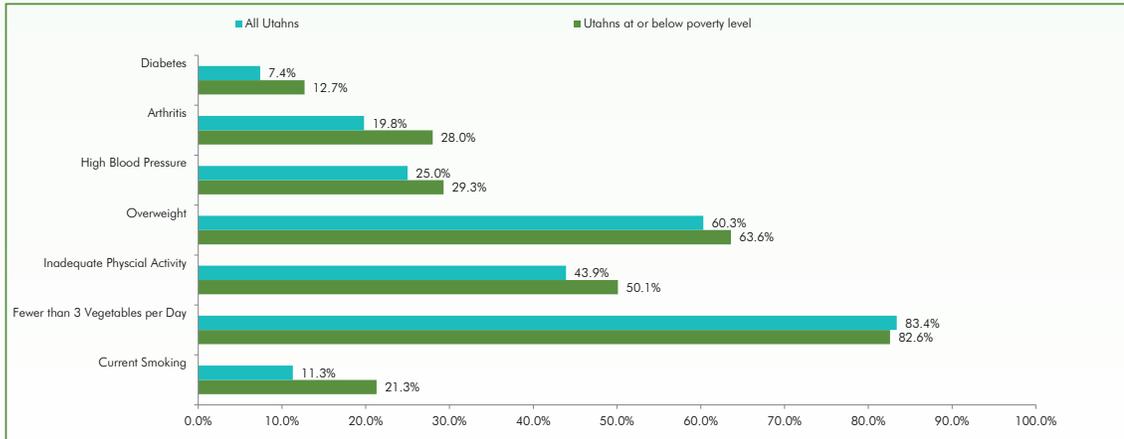
Legend: All Utahns / Utahns at or below poverty level

Category	All Utahns	Utahns at or below poverty level
Diabetes	7.4%	12.7%
Arthritis	19.8%	28.0%
High Blood Pressure	25.0%	29.3%
Overweight	60.3%	63.6%
Inadequate Physcial Activity	43.9%	50.1%
Fewer than 3 Vegetables per Day	83.4%	82.6%
Current Smoking	11.3%	21.3%

Source: Utah Behavioral Risk Factor Surveillance System, Age-adjusted to the U.S. 2000 population

Figure 4. Utah Disease and Risk Factor Prevalence Rates by Education, 2011
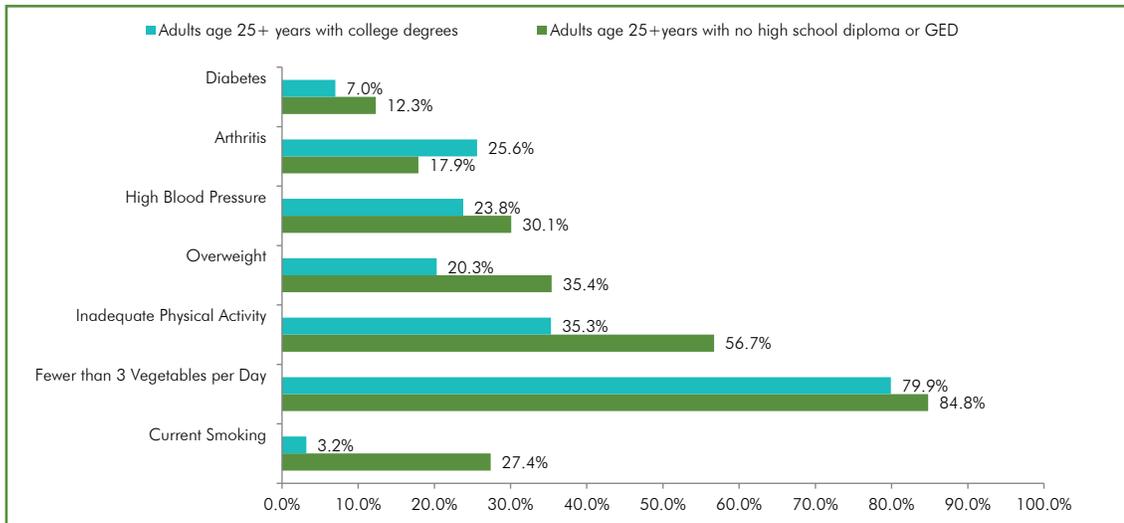
Legend: Adults age 25+ years with college degrees / Adults age 25+years with no high school diploma or GED

Category	Adults age 25+ years with college degrees	Adults age 25+years with no high school diploma or GED
Diabetes	7.0%	12.3%
Arthritis	25.6%	17.9%
High Blood Pressure	23.8%	30.1%
Overweight	20.3%	35.4%
Inadequate Physical Activity	35.3%	56.7%
Fewer than 3 Vegetables per Day	79.9%	84.8%
Current Smoking	3.2%	27.4%

Source: Utah Behavioral Risk Factor Surveillance System, Age-adjusted to the U.S. 2000 population

Burden Statement

- Some chronic conditions, injuries, and risk factors for chronic disease are higher among Utahns who identify themselves as gay, lesbian, bisexual, or transgender. Smoking rates in these groups of people are significantly higher than the statewide smoking rate. (Source: Utah Behavioral Risk Factor Surveillance System)

- Some chronic conditions, injuries, and risk factors for chronic disease are associated with age. Arthritis, diabetes, cancer, falls, and high blood pressure are associated with increased age. (Source: Utah Behavioral Risk Factor Surveillance System)

- Utahns in rural and frontier communities may experience limited access to primary medical care, dental care, and mental health services due to lack of providers. (Source: Utah Office of Primary Care and Rural Health)

- In 2011, 14.4% of Utahns lived below the federal poverty level. Utah adults in poverty have higher rates of some chronic diseases and risk factors for chronic diseases. One exception is the low consumption of vegetables, which is a problem for Utahns at all income levels. (Source: Utah Behavioral Risk Factor Surveillance System)

- In 2011, 9.7% of Utahns aged 25 years and older had not completed a high school diploma or GED, whereas 29.7% had completed a bachelor's degree. Utah adults aged 25 years and older without a high school diploma/GED had higher rates of some chronic diseases and risk factors for chronic diseases than those with bachelor's degrees. (Source: Utah Behavioral Risk Factor Surveillance System)

- Utah adults aged 25 years and older with lower levels of education and income have higher rates of fair/poor health and risk factors for chronic diseases compared to those with higher levels of education and income. In 2011, Hispanics had the highest rate of fair/poor health and the highest rate of adults without high school diplomas or GED. Among local health districts, TriCounty Health District had the highest rate of fair/poor health and the highest rate of adults without high school diplomas. (Source: Utah Office of Health Disparities Reduction)

What individual behaviors can reduce risk for chronic disease and injury?

- *Quitting smoking.* In 2011, 220,000 Utah adults and 9,000 high school students smoked cigarettes. (Sources: Utah Behavioral Risk Factor Surveillance System, Youth Risk Behavior Factor Survey and Utah Behavioral Risk Factor Surveillance System for adult data)

- *Moving more.* In 2011, 43.9% of Utah adults did not engage in the recommended amount of aerobic physical activity (Source: Utah Adult data from Behavioral Risk Factor Surveillance System). Also, in 2013, 80.3% of high school students didn't meet the guidelines (Note: estimates refer to CDC's new guidelines of 60 minutes of physical activity 7 days per week). (Source: Youth Risk Behavior Survey).

- *Eating more healthfully.* In 2011 in Utah, approximately 74.5% of adults (1.5 million people) ate fewer than 2 servings of fruit daily and 81.4% of adults ate fewer than 3 servings of vegetables daily (1.6 million people). (Source: Utah Behavioral Risk Factor Surveillance System)

Burden Statement

How can health systems help to prevent and manage chronic disease and injury?

Improve screening to diagnose chronic conditions. Some cancers, such as breast and cervical cancers, can be detected early through screening. In Utah, breast and cervical cancer screening rates are lower than the national rate. Between 2010 and 2012, 66.3% of Utah women aged 40 years and older received a mammogram within the last two years, compared to a rate of 74.9% nationally. In 2010 and 2012, only 72.3% of Utah women aged 18 years and older had a Pap test (which can detect cervical cancer) within the last three years, compared to a rate of 80.6% nationally. In 2010 and 2012, approximately 68.3% of Utahns aged 50 years and older reported ever receiving a colon cancer screening test (either a fecal occult blood test in the past year and/or a sigmoidoscopy in the past 5 years and FOBT in the past 3 years and/or a colonoscopy in the past 10 years) compared to a rate of 68.2% recommended nationally. (Source: Utah Behavioral Risk Factor Surveillance System)

Improve management of chronic conditions. Among adults who have health insurance and see a physician, management of diseases such as diabetes and high blood pressure could be improved. Among commercial health plan enrollees with diabetes, more than 1 in 5 people (22.2%) had poor control of their A1C levels, and among enrollees with high blood pressure, only about 2 in 3 people (68.4%) had their blood pressure under control. (Source: Healthcare Effectiveness Data and Information Set)

Use data from electronic health records (EHR) to improve quality. EHRs make health information available to authorized health care providers wherever and whenever a patient gets care, improve the coordination and continuity of care, and promote informed decision-making. Many primary care practices in Utah have yet to implement effective EHR systems.

Expand the roles of community health workers and other health care extenders, such as pharmacists. Engaging the community through the use of community health workers can help patients adopt and maintain healthful behaviors, such as taking medication as prescribed. Financial reimbursement and a statewide plan to utilize health care extenders throughout the health care system could increase both access to health care and quality of care, and close gaps that contribute to poor health.

Refer patients with chronic diseases to evidence-based community-based self-management resources. Programs such as Living Well with Chronic Conditions provide education to people about how they can better manage their chronic conditions and establish and maintain healthy lifestyles. These types of programs are commonly offered in community settings such as libraries, churches, senior centers, and hospitals.

How can we improve schools to prevent and manage chronic diseases and injury?

Utah schools are positioned to prevent and manage chronic diseases but are challenged by the lack of statewide policies and financial resources to improve school time physical activity, recess, and nutritional choices for students. School systems could work on the items listed on the next page.

Burden Statement

- *Implement policies that prohibit the sale of unhealthful foods in vending machines and school stores.* In Utah in 2012, 87.1% of schools allowed unhealthy foods to be sold in vending machines or school stores. (Source: Utah School Health Profiles Survey, 2012)

- *Increase opportunities for physical activity in schools.* In 2012, only 22.8% of high schools and 53.3% of middle schools included physical activity breaks in the classroom. Only 37.4% of middle and high schools had a school improvement plan to increase student physical activity. (Source: Utah School Health Profiles Survey, 2012)

- *Make sports safer.* In 2012, 86% of schools had a concussion policy that addressed each sporting event, as required by state law. (Source: Utah School Health Profiles Survey, 2012)

- *Establish a statewide database to help school nurses track students with chronic diseases such as asthma or diabetes, that could result in emergencies.* This information is tracked by individual schools and often does not transfer from year to year.

About Utah's Population

Population characteristics, such as poverty, employment, education, and housing affordability, can affect a person's health and contribute to differences in health status within the state. To be effective in preventing chronic disease and injury and in promoting health, health care systems, school systems, early childhood education programs, employers, and other partners must be aware of the state's population composition and how needs may differ by subgroup.

Utah's population is growing.

- In 2012, 2.86 million people resided in Utah. As Utah's population has grown, it has become more diverse (by race, ethnicity, religion, and socioeconomic status). Since 1970, migration to Utah from other states and countries has exceeded the rate of people leaving the state. This trend has been propelled by relatively favorable economic conditions and augmented by high fertility rates, especially among foreign-born residents. (Source: Utah Behavioral Risk Factor Surveillance System)

- Between 2000 and 2010, Utah's population grew by 24%. The five fastest-growing counties in the state were Wasatch (increased by 54.7%), Washington (increased by 52.9%), Tooele (increased by 42.9%), Utah (increased by 40.2%), and Iron (increased by 36.7%). (Source: Utah Heart Disease and Stroke Prevention Program. Impact of Heart Disease and Stroke in Utah. Salt Lake City, UT: Utah Department of Health, 2012)

Though the state is highly urbanized, many Utah residents live in rural and frontier areas.

Health status varies by geographic area, and local health districts in Utah confront different levels of chronic disease risk factors, health behaviors, and health care options.

- Utah is the sixth most urbanized state in the U.S. The majority of Utah's population resides along the Wasatch Front, a 75-mile strip of land running from Ogden in the North to Provo in the South, with the capital, Salt Lake City in the middle. (Source: Utah Heart Disease and Stroke Prevention Program. Impact of Heart Disease and Stroke in Utah. Salt Lake City, UT: Utah Department of Health, 2012)

Burden Statement

- The Wasatch Front comprises 5% of the state's land mass but is home to 75% of the state's population. The remainder of the population resides in 95% of the state's land mass comprised of rural areas (more than 6 but fewer than 100 persons per square mile) and frontier areas (fewer than six persons per square mile). (Source: Utah Heart Disease and Stroke Prevention Program. Impact of Heart Disease and Stroke in Utah. Salt Lake City, UT: Utah Department of Health, 2012)

- Approximately one-fifth (21%) of the state's population lives in rural areas (41% of the land mass) and 3.7% live in frontier areas (54% of the land mass). Having to travel long distances for primary medical care can make it harder for Utahns to be diagnosed with and manage chronic diseases. Additionally, emergency medical services (EMS) response times for injuries and other acute events may be compromised by greater distances to hospitals with the required facilities. (Source: Utah Heart Disease and Stroke Prevention Program. Impact of Heart Disease and Stroke in Utah. Salt Lake City, UT: Utah Department of Health, 2012)

Utah's population is younger than that of other states.
The state's high birth rate and young population presents Utah with an excellent opportunity to promote prenatal care and breastfeeding, and to promote health and prevention of chronic disease and injury in the youngest age groups.

- Utah has the youngest population and the highest birthrate of the 50 states. (Source: Utah Office of Public Health Assessment. 2012 Utah Statewide Health Status Report. Salt Lake City, UT: Utah Department of Health, 2013).

- In 2011, the state birth rate per 1,000 population was 18.2 compared to the national average of 12.7 births per 1,000. (Source: Birth Certificate Database, Office of Vital Records and Statistics, UDOH)

- In 2011, Utah's median age was 29.6 years compared with the national median age of 37.3 years. (Source: Population Census Estimates, Bureau of the US Census)

- Utah's relatively high birthrate is reflected in the fact that 31.3% of its population is younger than 18 years, compared with 24.2% nationally. (Source: Population Estimates, US Bureau of the Census)

- Only 9.2% of Utah's population is aged 65 and older, compared with 12.9% nationally. (Source: Population Estimates, US Bureau of the Census)

Utah is becoming more racially and ethnically diverse.
Utah's trend toward racial and ethnic diversity accelerated in the 1990s, with one-fifth of the population growth attributed to international immigrants and one-third to expanding racial and ethnic minority populations. **The racial and ethnic diversity creates important opportunities to ensure that all Utahns are able to access affordable, high quality health care and to live in communities that promote health and prevent injury.**

- For the years 2007-2011, the composition of Utah's population was 89.3% White and 12.7% Hispanic. Utah's largest racial minority populations were Asian (2.0%), Black (1.1%), American Indian (1.1%), and Pacific Islander (0.9%). A total of 3.3% of Utahns

Burden Statement

identified themselves as "some other race" and 2.2% identified themselves as being of two or more races. (Source: US Census Bureau, 2007 – 2011 and American Community Survey))

In Utah, educational achievement is comparable to the US.
Education is highly associated with positive health behaviors and access to quality health care. In addition, improving the likelihood of better employment and income opportunities, education affects health by increasing knowledge and cognitive skills and enhancing social and psychological factors such as sense of control, social standing, and social support. **In addition to the health benefits associated with educational achievement, Utah's high rates of participation in high school and college programs confirm the importance of schools as partners in implementing chronic disease and injury prevention strategies.**

- Between 2007 and 2011, 90.6% of Utah adults aged 25 years and older had a high school degree or higher and 29.6% had at least a bachelor's degree; similar to the national average. US Census Bureau, 2007-2011 and American Community Survey)
(Source: US Census Bureau, 2007 – 2011, American Community Survey)

Figure 5. Education, general health, poverty, and population estimates for each racial/ethnic group.
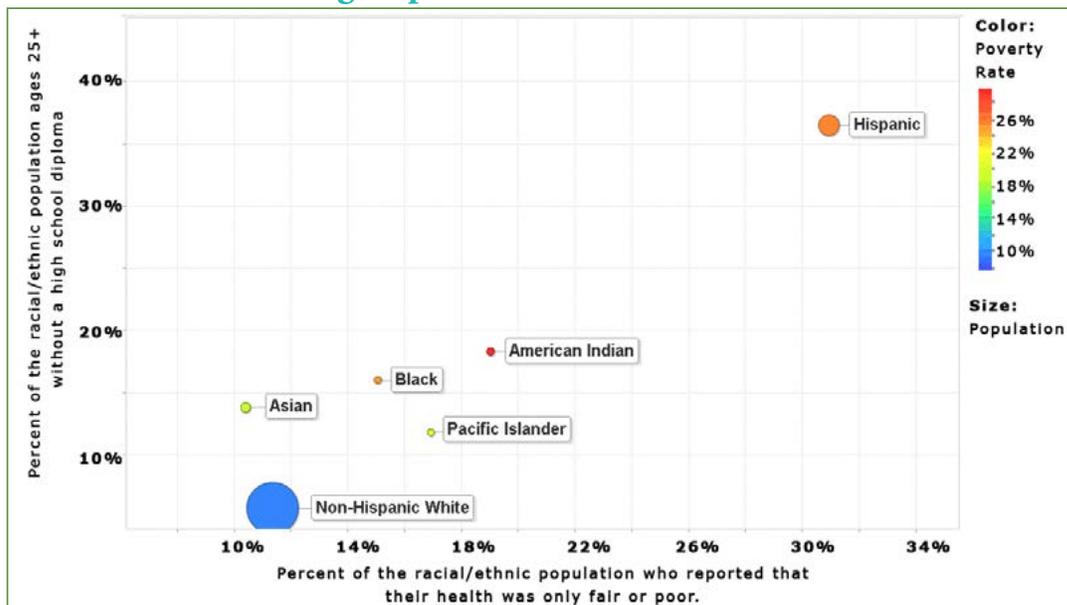
Burden Statement

Poverty and financial instability affect many Utah families.

Poverty affects health because income affects the ability to access health care and engage in health behaviors that promote health and reduce risk of chronic disease and injury. Additionally, people in poverty have fewer options to live, work, and play in environments that promote health. Local governments and communities can ensure that health promotion and injury prevention opportunities are available and accessible to all Utahns, with special attention to those who are struggling financially.

- Between 2007 and 2011, the median family income in Utah was $65,646, comparable to the national median family income of $64,293. (Source: American Community Survey)

- Among those employed full-time and year-round, women had a much lower median income compared to men ($32,948 vs. $47,690, respectively). (Source: American Community Survey)

- A total of 8.3% of Utah families had household incomes below the federal poverty level. In 2011, 14.4% of Utah adults earned less than 100% of the federal poverty level (FPL), 23.7% earned less than 133% of the FPL, and 38.2% earned less than 200% of the FPL. (Source: Utah Behavioral Risk Factor Surveillance System)

Figure 6. Education, general health, poverty, and population estimates for each local health district.
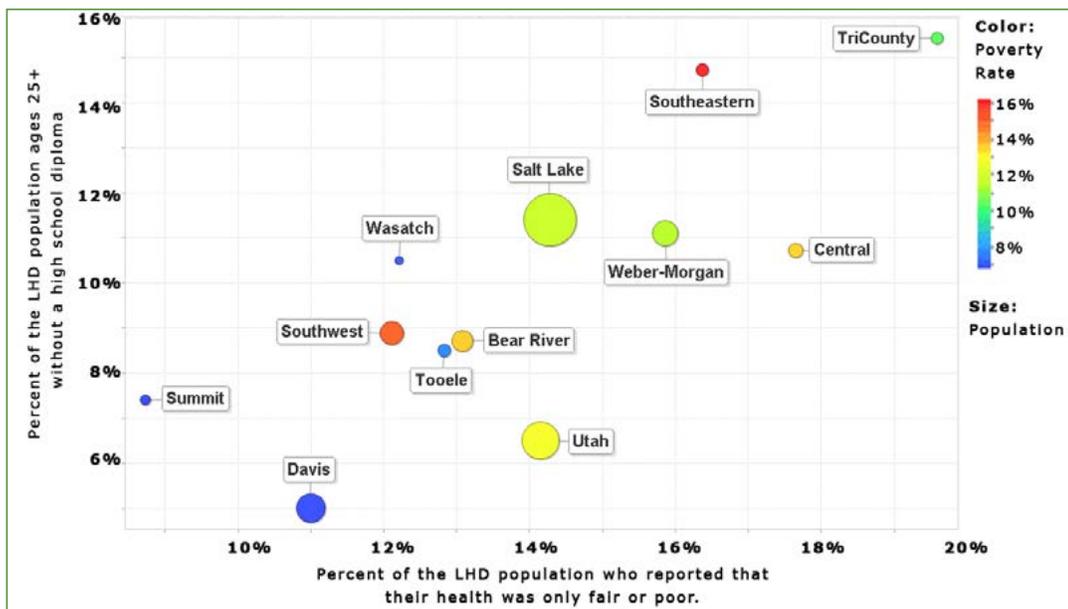
- A total of 7.3% of Utah households received Food Stamps and Supplemental Nutrition Assistance Program (SNAP) benefits within the last 12 months. (Source: American Community Survey)

- Among Utah public school districts in 2012, the percentage of students who qualified for and received free or reduced school lunch ranged from 17.9% in Morgan school district to 75.1% in Ogden school district, with a mean of 43.3% statewide. (Source: Utah State Office of Education)

Burden Statement

- For 24.8% of homeowners with a mortgage, selected monthly ownership costs consumed 35% or more of their gross income. (Source: American Community Survey)
- For 37.4% of renters, gross rent exceeded 35% of their gross income. (Source: American Community Survey)

Over two-thirds of Utah adults are employed.
Employers have a unique opportunity to promote health and prevent injury among working adults. From 2007 to 2011, among the Utah population aged 16 years and older:

- A total of 69.1% were employed in the civilian labor force, and the unemployment rate was 6.5%.(Source: American Community Survey)
- Among employed civilians, 78.8% worked in the private sector, 16% worked in state and local government, and 5.1% were self-employed. (Source: American Community Survey)
- Closely following U.S. trends, the more common industries for employment were education, healthcare and social assistance (21.2%); retail (12.3%); manufacturing (10.8%); entertainment, recreation, and hospitality (8.6%); and construction (7.5%). (Source: American Community Survey)
- A total of 76.9% of workers commuted to work in a private vehicle and 12.2% carpooled. A total of 2.8% of workers walked to work and 2.3% used public transportation. The average commute was 21 minutes long. (Source: American Community Survey)

Health opportunities may differ for foreign-born and U.S.-born Utahns.
Being U.S.-born and having English language proficiency does not guarantee good health or increased access to health care. However, the health care system is often less accessible to those who are foreign-born and who are not proficient in English. The rates of chronic disease risk factors and behaviors may also differ for foreign- and U.S.-born residents. **Schools, employers, health systems, and nontraditional health care providers can help ensure that health promotion and injury prevention resources are culturally and linguistically appropriate.**

For the time period 2007 to 2011:

- The percentage of foreign-born residents in Utah (8.3%) was higher than in past years, but lower than in the nation (12.8%). (Source: American Community Survey)
- Of those who were foreign-born, one-third were naturalized U.S. citizens. (Source: American Community Survey)
- A total of 61.3% of Utah's foreign-born population was of Latin American origin, 17.8% was of Asian origin, 11% was of European origin, and 3.7% was of Northern American origin. (Source: American Community Survey)
- For the population aged 5 years and older, 85.7% spoke only English at home. For those who spoke another language at home, 9.5% spoke Spanish, 2.1% spoke Asian or Pacific Islander languages, and 2% spoke other Indo-European languages. (Source: American Community Survey)

Planning Through Partnerships

Existing and potential partners currently working on public health goals and objectives focusing on prevention and management of chronic diseases and injury prevention were included in the process to create this plan. These partners represent the following sectors: government, community-based organizations, faith-based organizations, business/industry, health care organizations, and private organizations.

All of the partners who helped create this plan and new partners are invited to participate in the implementation of the plan. Five functional goal areas (Environmental Approaches that Promote Health, Health Care Systems, Community-Clinical Linkages, Health Communication, and Data and Evaluation) serve as the units of implementation for this plan. A diverse group of partners with specialties in one or more of the goal areas will work collaboratively to achieve the identified objectives.

The interaction diagram (diagram 1, page 26) shows how data and evaluation, partnerships, and health communication activities are designed to support the work in the areas of health care systems, community clinical linkages and environmental approaches that promote health. Though these groups appear to function separately in the figure, the reality is that there will be many times when working together across functional areas will the most efficient way to proceed.

Initially, partner activities will be facilitated by the Utah Department of Health (UDOH), Bureau of Health Promotion (BHP), including convening meetings and supporting/establishing partner coalitions. Partner meetings will be held routinely (e.g., annually or semi-annually) to review progress and determine future direction. Additionally, partners are invited to represent their organizations in relevant, established coalitions. Electronic options will be explored to establish and maintain communication across partners/coalitions to update partners on achievements. The UDOH, BHP will always support partners in areas such as trainings, public health interventions, surveillance, data, evaluation, etc.

Partners will be identified to fill gaps in partner expertise and reach as they become apparent, and the partnership will be routinely evaluated.

An annual report will be created and distributed to all partners summarizing progress and successes. This report will be distributed electronically and will be available in an archive location. An electronic location where partners can post resource lists, newsletters and upcoming events, will be identified.

The UDOH BHP will support implementation of this plan by providing partner trainings, surveillance, epidemiology, and evaluation services, providing technical assistance, staffing or facilitating workgroups, and by aligning their day-to-day activities with the goals and objectives in this plan.

Workgroups

Bureau of Health Promotion Workgroups

The Bureau of Health Promotion has developed two key structures to support the implementation of the Utah Chronic Disease and Health Promotion State Plan: 1) coordinated workgroups focused on plan development, implementation, and evaluation, and 2) policies that encourage dynamic representation on workgroups from categorical BHP programs. Leveraging the resources and coordination resulting from this capacity development effort, workgroups will collaborate with partners to implement the new Utah Chronic Disease Prevention and Health Promotion State Plan. Aligned with the 5 goal areas, the BHP workgroups are:

1. Environmental Approaches that Promote Health;
2. Health Care Systems;
3. Community-Clinical Linkages;
4. Health Communication and websites;
5. Data and Evaluation;
6. School Health and
7. Infrastructure.

These workgroups developed and implemented the Bureau of Health Promotion Strategic Plan. The workgroup structure includes a chair and co-chair, and at least one representative from most of the Bureau's programs. The frequency of workgroup meetings and involvement of partners and stakeholders are based on each group's workplan.

To integrate coordinated workgroup responsibilities with categorical program workloads, for the past year BHP programs have been required and will continue to be required to dedicate 5% of FTEs (8 hours per month) to the implementation of the State Plan and to include active workgroup participation in the performance plans of staff.

Plan Diagram

Diagram 1: Connecting Resources for Sustainability

Clinical Care Delivery Systems

Private Non-Profit Associations

Community-Based Organizations

Health Care Systems

Community-Clinical Linkages

Environmental Approaches that Promote Health

Federal Agencies

Educational Institutions

Increase the number of Utahns who are healthy at every stage of life.

Data and Evaluation

Health Communications

State Agencies Other than Public Health

Private Industry

Partnerships

Media

State, Tribal, and Local Health Depts.

Data and evaluation, partnerships, and health communications support the activities that are carried out in the areas of community and clinical linkages, health care systems, and environmental approaches that promote health.

Vision, Mission and Values

Mission and Values

This plan is designed to play a critical role in preventing chronic diseases and injuries and promoting good health in Utah by addressing chronic disease, risk factors for chronic disease, and violence and injury prevention. The plan helps to connect people and organizations to the common cause of creating healthful and safe communities and eliminating health disparities. Data-driven, evidence-based policies and interventions will be used to affect system changes; promote healthy lifestyles and behaviors; detect and prevent injury and disease; and improve access to quality health care. Statewide efforts and the health of the population will be monitored by collecting, analyzing, and sharing data.

The Statewide Chronic Disease and Health Promotion Mission Statement

A diverse group of stakeholders provide information, education, and resources that encourage responsible choices and policies to decrease the incidence of premature death and disability, improve quality of life, and reduce the economic impact of poor health and injury for all Utahns.

The Statewide Chronic Disease and Health Promotion Vision Statement

Utah is a state free from preventable disease, injury, and premature death. Utahns value prevention, and enjoy healthy living and lifestyles.

The Statewide Chronic Disease and Health Promotion Values

Collaboration	We engage each other and the people of Utah in decision-making, planning, and integrating efforts.
Effective	We are both efficient and timely in decisions, and action. We collaborate to produce the greatest health benefit.
Evidence-based	We use science and data to guide our priorities and select interventions.
Innovation	We foster creativity to meet challenges and continually identify opportunities for improvement.
Integrity	We are honest and straightforward with each other and the people of Utah. We embrace high standards of ethical conduct, responsiveness, and quality performance.
Respect	We honor and appreciate each other and the people of Utah.
Service	We strive to benefit the people of Utah and are consistent with their values and diversity. We seek to exceed internal and external customer expectations.
Transparency	We operate with open communication and processes.
Trustworthy	We are ethical, competent, and effective stewards of the public interest and public confidence.

Planning for Change

The logic model on the next page describes how working with the five functional goal areas (health communication; epidemiology, surveillance, and evaluation; environmental approaches that promote health; health systems interventions; and community-clinical linkages) and the goals and objectives contained in this State Plan will impact health and lead to reduced morbidity and mortality from chronic disease and injury.

Logic Model (next page)

The strategic goal areas, goals, and objectives listed in the next section were chosen with consideration for sustainability. Sustainability will be considered whenever a new program is considered and every time a program is evaluated.

The strategic goal areas, goals, and objectives listed in the next section were chosen with consideration for sustainability. Sustainability will be considered whenever a new program is considered and every time a program is evaluated.

Logic Model

Diagram 2. Logic Model

Utah Chronic Disease and Health Promotion Plan

Inputs — Resources We Leverage
- Leadership
- Partnerships
- Training
- Infrastructure
- Data Systems
- Funding/In-Kind
- Standards/Guidelines
- Staff Time

Strategies — Our Approach to Problem-Solving
- Health Communications
- Epidemiology, Surveillance, and Evaluation
- Environmental Approaches that Promote Health
- Health Systems Interventions
- Community-Clinical Linkages

Intervention Outcomes — The Impact of Our Interventions on Policies, Systems, and Environments
- Increased state, community, worksite, school, and early care education environments that promote and reinforce healthy behaviors and practices across the lifespan
- Improved quality, effective delivery, and use of clinical and other preventive services to promote health and prevent chronic disease and injury
- Increased community-clinical linkages to support prevention, self-management, and control of chronic disease and injury

Health Outcomes — The Resultant Changes That Improve Public Health Opportunities
- Increased prevention
- Increased screening and early detection
- Increased management
- *...of chronic disease, injury, and risk factors*
- Improved prenatal/infant health
- Increased quality of life for people with chronic conditions and injury

Health Impact — ...and Public Health
- Reduced
  - Morbidity
  - Mortality
  - Costs
  - Disparities
- *...associated with chronic disease and injury*

State Plan Intervention Diagram

Diagram 3. Intervention Outcomes

Environmental Approaches that Promote Health

Community-Clinical Linkages

Health Systems Interventions

OVERARCHING INFRASTRUCTURE

Health Communications

Epidemiology, Surveillance, and Evaluation
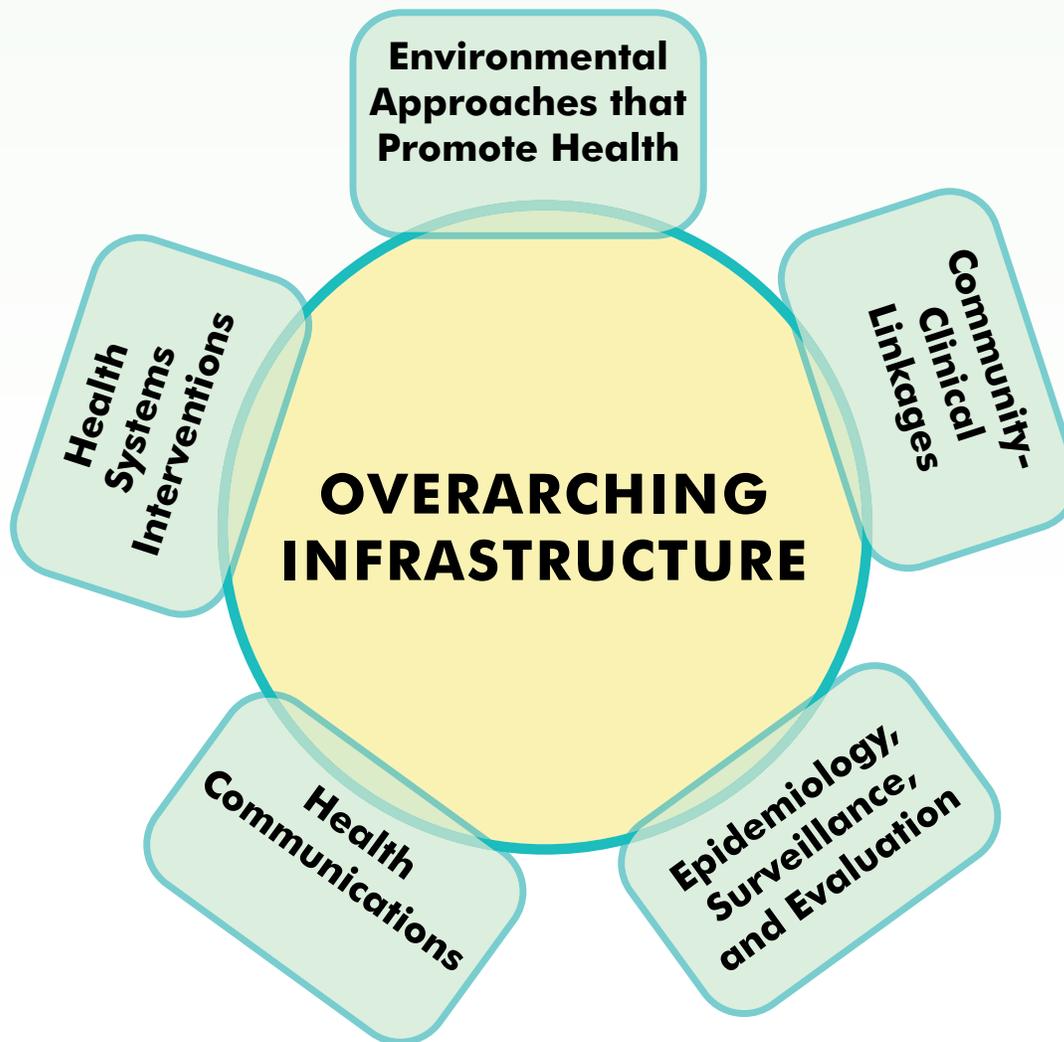
State Plan Intervention Outcomes

1. Increased state, community, worksite, school, and early care education environments that promote and reinforce healthy behaviors and practices across the lifespan.

2. Improved quality, effective delivery, and use of clinical and other prevention services to promote health and prevent chronic disease and injury.

3. Increased community-clinical linkages to support prevention, self-management, and control of chronic disease and injury.

Priority Public Health Outcomes

Priority Public Health Outcomes (Long Term Objectives) and Indicators[1]

Reduced Mortality from Chronic Disease and Injury			
Indicator	Baseline	Target	Data Source
Rate of suicide deaths among Utahns 10 years of age and older	22.5 per 100,000 population (2011)	20.2 per 100,000 population (2018)	Utah Death Certificate Database
Rate of prescription opioid deaths among Utahns 18 years of age and older	12.7 per 100,000 population (2011)	12.1 per 100,000 population (2018)	Utah Violent Death Reporting System
Cancer deaths	132.0 (Age-Adjusted 2009-2011)	118.8 per 100,000 (2020)	Utah Death Certificate Database
Cardiovascular disease deaths	200.8 (Age-Adjusted 2009-2011)	150.2 per 100,000 (2020)	

Reduced Tobacco Use and Secondhand Smoke Exposure			
Indicator	Baseline	Target	Data Source
Proportion of adults who are current smokers	10.2% (Age-Adjusted 2012)	9.0% (2020)	Utah Behavioral Risk Factor Surveillance System
Proportion of students in grades 9-12 who smoked cigarettes in the past 30 days	4.4% (2013)	3.0% (2020)	Utah Youth Risk Behavior Survey
Proportion of adults who were exposed to secondhand smoke in any location	39.5% (2012)	35% (2020)	Utah Behavioral Risk Factor Surveillance System

[1]*Age-adjusted to the 2000 U.S. Standard Population*

Priority Public Health Outcomes

Reduced Overweight and Obesity			
Indicator	Baseline	Target	Data Source
Proportion of adults who are obese	24.8% (Age-Adjusted 2012)	24.0% (2020)	Utah Behavioral Risk Factor Surveillance System
Proportion of children who are obese	6.4% high school students (2013) 9.4% elementary school students (2012)	6.4% (2020) 9.4% (2020)	Utah Youth Risk Behavior Survey – for high school
Proportion of adults who meet physical activity guidelines for aerobic physical activity	56.1% (Age-Adjusted 2011)	61.7% (2020)	Utah Behavioral Risk Factor Surveillance System
Proportion of youth who meet the guidelines of 60 minutes of physical activity seven days a weeks	19.7% (2013)	24.0% (2020)	Utah Youth Risk Behavior Survey

Reduced Intentional and Unintentional Injury			
Indicator	Baseline	Target	Data Source
Rate of fall hospitalizations among Utahns age 65 and older	75.4 per 10,000 population (2011)	73.9 per 10,000 population (2018)	Utah Hospital Discharge Database
Number of public school (K-12) days missed as a result of student injuries	4,532 school days (2009-2010 school year)	4,075 school days (2017-2018 school year)	Student Injury Reporting System

Improved Prenatal/Infant Health			
Indicator	Baseline	Target	Data Source
Proportion of pregnant females who receive prenatal care in first trimester	74.8% (2011)	77.9% (2020)	Utah Birth Certificate Database
Proportion of infants who are breastfed exclusively through 6 months	24.8% (2012)	25.5% (2020)	National Immunization Survey

Priority Public Health Outcomes

Increased Screening/Earlier Detection for Chronic Disease, and Their Risk Factors			
Indicator	Baseline	Target	Data Source
Proportion of adults who report having been screened, in accordance with recent guidelines, for:			
• breast cancer	66.3% (Age-Adjusted 2010-2012)	72.9% (2020)	Utah Behavioral Risk Factor Surveillance System
• colon cancer	68.3% (Age-Adjusted 2010, 2012)	72.2% (2020)	Utah Behavioral Risk Factor Surveillance System
• high blood pressure awareness	24.5% (Age-Adjusted 2012)	27.0% (2020)	Utah Behavioral Risk Factor Surveillance System
• prediabetes	5.7% (Age-Adjusted 2012)	6.5% (2020)	Utah Behavioral Risk Factor Surveillance System

Improved Management of Chronic Disease, Injury, and Their Risk Factors			
Indicator	Baseline	Target	Data Source
Proportion of Utah health plan members age 18-75 with diabetes who have an A1C>9 %	Commercial: 22.2% (2012) Medicaid: 35.5% (2012)	Commercial: 20.0% (2020) Medicaid: 32.0% (2020)	Healthcare Effectiveness Data and Information Set (HEDIS)
Proportion of adults age 18-25 with high blood pressure who have their blood pressure under control (<140/90 mmHg)	Commercial: 68.4% Medicaid: 63.7% (2012)	Commercial: 75.0% (2020) Medicaid: 70.0% (2020)	Healthcare Effectiveness Data and Information Set (HEDIS)
Percentage of adults with diabetes who have ever had diabetes education	59.6% (Age- Adjusted 2012)	65.5% (2020)	Utah Behavioral Risk Factor Surveillance System
Proportion of children aged 5 to 17 years with asthma who missed school days in the past 12 months	42.3% (2007-2009)	38.1% (2020)	Utah Behavioral Risk Factor Surveillance System
Rate of emergency department visits for asthma	(2008-2009) <5 years: 51.9/10,000 5-64 years: 23.5/10,000 65+ years: 18.1/10,000	(2020) < 5 years: 46.7/10,000 5-64 years: 21.2/10,000 65+years: 16.3/10,000	
Proportion of adults with arthritis who report that their activities are limited	51.7% (Age-Adjusted 2011)	46.5% (2020)	Utah Behavioral Risk Factor Surveillance System

Goals and Objectives

Strategic Goal Areas, Goals, and Objectives

The goals and objectives in this section are aligned to integrate with current public health programs that focus on chronic diseases, prevention, education, and service delivery.

This section is divided into two parts: overarching infrastructure strategies and strategic goal areas.

Overarching Infrastructure Strategies

There are three overarching infrastructure strategies that are critical to the effective implementation the goals and objectives listed in this plan. Specific strategies to implement each overarching infrastructure item are found below under, "We will achieve this by:".

Building strong, effective partnerships and coalitions allows for everyone's voice to be heard during the implementation of this plan. The partnerships and coalitions are the venue by which work will be conducted as this plan is implemented.

Addressing health equity across the whole state will ensure that members of high priority populations (e.g., ethnic minority, low income, low education, low socioeconomic-status, senior citizens, children, etc.) are considered during planning and implementation of this plan.

Training of partners in current practices in health promotion, chronic disease prevention and management, and injury prevention is crucial to ensure that the best interventions/activities are chosen to accomplish the goals set forth in this plan.

Strategic Goal Areas

Five strategic goals were identified as critical to address chronic disease and injury in Utah (environmental approaches that promote health, health care systems, community clinical linkages, health communications, and data and evaluation). For each of these strategic goals, a vision is offered and specific, measureable goals and short term and intermediate objectives are stated in this section; long term objectives are found in the Priority Public Health Outcomes section.

- Short term objectives are those that address changes in processes.
- Intermediate objectives are those that address changes in the physical and social environment, policy, and systems.
- Long term objectives are those that address changes in health status, e.g., reduced mortality from chronic disease and injury or reduced tobacco use and secondhand smoke exposure.

Overarching Infrastructure Strategies

Vision: State and local partners have the leadership and capacity to address chronic disease, injury, and health promotion. This necessitates collaborative partnerships and coalitions, and a coordinated approach to health equity and professional training.

Goals and Objectives

1. Collaborative Partnerships and Coalitions

- Strong statewide and local coalitions/partners collaborate with each other and with public health agencies.
- Utah public health departments and partners are engaged and work together.
- The statewide leadership team, Utah Leaders for Health, is used as a key resource for identifying priorities for preventing and managing chronic diseases and injury and promoting health.
- Partners are satisfied with communication across partner organizations.

The partners will achieve this by:

- Engaging public health departments in the development of statewide planning activities.
- Developing an online contracting process for the state to work with partners.
- Facilitating collaboration and alignment across coalitions and partnerships.
- Developing coordinated approaches to recruit, mobilize, and sustain partners.
- Sharing data and other resources with partners and providing education.
- Facilitating the identification and dissemination of practices (e.g., guidelines, evidence based-practices, etc.) to optimize coalition and partnership efforts.
- Collaborating with partners and coalitions to create and disseminate health messages.

2. Address Health Equity

- Reduce health inequities associated with chronic disease and injury priorities.

The partners will achieve this by:

- Reviewing current interventions for opportunities to reduce health inequities.
- Educating partners and policymakers about social determinants of health and health inequities and strategies for addressing those inequities.
- Convening stakeholders (e.g., state and local governments, community partners, and existing coalitions addressing health disparities) to share statewide efforts that address health inequities.

3. Trainings

- Streamline partner trainings and expand offerings to reflect current practices in health promotion, chronic disease prevention and management, and injury prevention.

The partners will achieve this by:

- Reviewing current partner trainings to identify overlap and gaps.
- Training partners in current public health trends/measurement systems (e.g., policy analysis, economic impact/cost) and cultural competency.
- Coordinating opportunities that provide continuing education (e.g., Continuing Education Units [CEUs] and Continuing Medical Education [CMEs]).
- Work with academic partners to share public health best practices, policies, and guidelines.

Strategic Goal Area 1: Environmental Approaches that Promote Health

Vision: Create healthful and safe environments where Utahns can thrive.

Goal 1: Partners collaborate to support the creation of healthful and safe environments and systems for Utahns.

Short Term Objectives

1.1   By June 30, 2015, publish a statewide agenda addressing systems and environmental change to impact health promotion, chronic disease prevention and management, and injury prevention.

1.2   By June 30, 2015, create a process to collect, track, and analyze policies related to systems and environmental changes (e.g., local, state, schools, community, worksites).

Intermediate Term Objectives

1.3   By June 30, 2017, engage partners in implementation of the statewide agenda (see Objective 1.1).

1.4   By June 30, 2017, measure the effect of implementing the statewide agenda (see Objective 1.1).

Goal 2: Support families to create a healthful and safe home environment.

Short Term Objectives

2.1   By June 30, 2014, work with property managers/owners to adopt smoke-free policies in multiple-unit housing.

2.2   By June 30, 2014, create a process to educate families to eat healthful meals together.

2.3   By June 30, 2014, coordinate efforts to create healthful and safe home environments (e.g., efforts to eliminate asthma triggers, secondhand smoke, radon gas, infant sleep-related deaths, falls).

2.4   By June 30, 2014, coordinate efforts to support healthful and safe transportation for families (e.g., smoke-free vehicles, seat belt use, no texting and driving, safe routes to schools, safe public transit, use of public transit or bicycles for short trips).

Why is this goal area important?

Healthful and safe environments affect large numbers of people.

Healthful and safe environments where people live, learn, work and play lead to behavior change and better health.

How will this goal area address health equity?

Healthy and safe environments will exist for people regardless of age, gender, race, ethnicity, location, income, education, etc.

Goals and Objectives

2.5   By June 30, 2014, create a process to address fall prevention and prescription drug safety in the aging population.

Intermediate Term Objectives

2.6   By June 30, 2017, increase the number of Utah multiple-unit housing properties with smoke-free policies by 120 properties.

2.7   By June 30, 2017, establish a baseline and annually measure the number of families who eat healthful meals.

2.8   By June 30, 2017, decrease environmental home asthma triggers by 10%.

2.9   By June 30, 2017, decrease emergency department visits due to injury by 10%.

Goal 3: Support schools, and child care providers to create healthful and safe environments for children and staff.

Short Term Objectives

3.1   By June 30, 2014, collaborate with child care providers, schools, school partners (such as local pediatricians, Parent-Teacher Associations [PTA], school district wellness councils), and school superintendents to review school-based surveillance data and make recommendations for improving health- and safety-related school policies.

3.2   By June 30, 2014, educate and train school district personnel, PTA members, and Utah State Office of Education (USOE) staff regarding new regulations, best practices, and validated interventions to maintain a healthful and safe environment (e.g., healthful food, physical activity, Safe Routes to School, Recess Guidance for Schools, Asthma Action Plan, mental health issues, and student injury reporting).

3.3   By June 30, 2014, identify a pilot school district where five to eight components of the Centers for Disease Control and Prevention's (CDC) Coordinated School Health model can be implemented.

3.4   By June 30, 2015, identify a system to track school absences due to asthma, diabetes, and injuries that occurred at school.

3.5   By June 30, 2014, implement a healthy child care initiative (e.g., TOP Star program or other CDC Early Care and Education programs such as: SPARK; Healthier Child and Adult Care Food Program award; Let's Move!; I am Moving, I am Learning), and Asthma Child Care Training statewide.

Intermediate Term Objectives

3.6   By June 30, 2016, annually track school absences due to asthma, diabetes, and injuries sustained at school.

3.7   By June 30, 2017, measure the environment, policy, and social changes that have occurred in Utah schools.

3.8   By June 30, 2017, 100% of local health districts are implementing a healthy child care initiative.

3.9   By June 30, 2017, the number of asthma-missed school days has decreased by 10%.

3.10   By June 30, 2017, 50% of schools will utilize Asthma Action Plans.

Goal 4: Support healthful and safe communities by working with policy makers.

Short Term Objectives

4.1   By June 30, 2014, educate and train local and county policy makers on healthful and safe community guidelines (e.g., healthful eating, active living, tobacco-free environments, improved air quality, sun safety, street connectivity, and access to potable drinking water).

4.2   By June 30, 2014, work with city planners to influence retail environments to promote healthful behaviors (e.g., prescription drug "take back" programs, menu labeling for fast food restaurants, restricting tobacco product sales near schools, installation of bike racks).

4.3   By June 30, 2014, work with the Utah Department of Transportation (UDOT), cities, and municipalities to enhance the safety, access, and perceived safety of communities to improve walkability, bikeability and public transit (e.g., implementing the Utah Bicycle and Pedestrian Master Plan Design Guide, Neighborhood Watch).

4.4   By June 30, 2014, work with local governments and businesses to increase availability of and access to safe, affordable, or free recreation opportunities for physical activity.

4.5   By June 30, 2014, work with the Utah Department of Agriculture and the Utah State University Extension program to increase availability of fresh fruits and vegetables in communities especially in areas of highest need.

4.6   By June 30, 2014, educate persons with asthma and their caregivers about the UDOH Air Quality Index Symptom Tracking System to manage chronic diseases such as asthma.

4.7   By June 30, 2014, advocate for local community groups and coalitions to be engaged when state and local initiatives impacting health are reviewed.

4.8   By June 30, 2014, key state and local public health policies are documented in Catalyst®.

Intermediate Term Objectives

4.9   By June 30, 2017, use policy data from Catalyst® to identify gaps, needs, and priorities to update policy agendas.

4.10   By June 30, 2017, 20 cities or municipalities have implemented policies that support active transportation.

4.11   By June 30, 2017, work with local health districts to publish a local guide on free recreation opportunities and sources for fresh fruits and vegetables (e.g., farmers markets, co-op shares, retail stores).

Goals and Objectives

4.12   By June 30, 2017, 10 local/county governments have adopted healthful and/or safe community guidelines (e.g., Healthy Communities, injury prevention coalitions).

4.13   By June 30, 2017, 50% of Utah counties have community coalitions focused on health and safety.

4.14   By June 30, 2017, 10% of people with asthma and caregivers are aware of the UDOH Air Quality Index Symptom Tracking System.

Goal 5: Support worksites to create a healthful and safe environment.

Short Term Objectives

5.1   By June 30, 2014, implement a process to educate employers about the Affordable Care Act, including identification of new coverage for prevention of chronic diseases, health promotion, mental health parity, and worksite wellness (e.g., breastfeeding, physical activity, healthy eating, tobacco cessation, mental health, utilization of Employee Assistance Program services).

5.2   By June 30, 2014, develop a process to assess mental health resources available for employees at worksites.

Intermediate Term Objectives

5.3   By June 30, 2017, educate/train 100 employers about the Affordable Care Act.

5.4   By June 30, 2017, increase the number of worksites that encourage employees to use evidence-based clinical preventive services by 25%.

5.5   By June 30, 2017, increase the number of worksites with tobacco-free policies by 50 worksites.

5.6   By June 30, 2017, increase the number of worksites supporting opportunities for employees to be physically active by 25% (e.g.walking trails including marking and mapping local sidewalks, bike racks, on-site fitness rooms that include family access, showers for cyclists/walkers, flex-time policies, stairwell use, partnering with local fitness facilities, corporate public transit pass programs).

5.7   By June 30, 2017, 25% of worksites support opportunities for employees to eat healthfully (e.g., healthy choices are identified in the cafeteria and vending machines, a refrigerator is available for packed lunches, and fresh fruits and vegetables are available at the worksite).

5.8   By June 30, 2017, increase the number of worksites with policies supporting breastfeeding in the workplace by 25 percent.

Strategic Goal Area 2: Health Care Systems

Vision: Health care practices to prevent and manage chronic diseases and injuries are available to all Utahns.

Goal 1: There is a systematic approach to support health systems and professionals in achieving quality of care outcomes and health equity for the prevention, detection, and treatment of asthma, hypertension, hyperlipidemia, diabetes, cancer, obesity, arthritis, injury, and tobacco use.

Short Term Objectives

1.1 By June 30, 2014, develop shared goals and priorities with heath care partners (e.g., Medicaid, Association for Utah Community Health, HealthInsight, Intermountain Healthcare, and University of Utah, Health Plan Partnership) regarding quality of care outcomes and improving health equity.

1.2 By June 30, 2015, create a pilot with multiple health systems and public health to improve care coordination.

1.3 By June 30, 2015, create a process to make recommendations for health care systems to use electronic health records for chronic disease prevention and management and injury prevention.

1.4 By June 30, 2015, create a process to support health care systems the meaningful use of electronic records.

1.5 By June 30, 2015, create a process for coordinating and promoting trainings for providers about current guidelines and referrals for chronic disease prevention and management and injury prevention.

1.6 By June 30, 2015, educate health care systems and providers on the use of community health workers to help patients access health care services and community of resources.

1.7 By June 30, 2015, identify opportunities to link health care systems to community health workers (e.g. information in electronic health records, searchable website).

1.8 By June 30, 2015, identify screening tools for mental health which health care providers can utilize.

Why is this goal area important?

Improvements in how health care systems detect, manage and control chronic diseases, their risk factors and injury can improve the health of Utahns.

Better coordination of care can result in higher quality of care and lower costs.

How will this goal area address health equity?

By addressing health care systems, the quality of health care in Utah will more equitable.

Goals and Objectives

Intermediate Term Objectives

1.9   By June 30, 2017, increase the reach of the implemented national health care system innovation, and other identified measures by 10%.

1.10   By June 30, 2017, increase the number of health systems that use team-based care to prevent and manage chronic diseases by 10%.

1.11   By June 30, 2017, increase the percentage of health system partners submitting chronic disease and injury outcome data by 10%.

1.12   By June 30, 2017, increase the number of health systems using electronic health records to treat and prevent chronic diseases by 10%.

1.13   By June 30, 2017, track referrals and reimbursement for evidence-based programs in communities and identified priority areas/populations.

1.14   By June 30, 2017, implement the system identified above to link health care systems to community health workers.

1.15   By June 30, 2017, increase the percentage of health care providers who are trained in the use of mental health screening tools by 10%.

Strategic Goal Area 3: Community Clinical Linkages

Vision: There is a link between health care and community organizations to deliver evidence-based programs to prevent chronic diseases and injuries and improve management of chronic diseases, especially in high priority populations.

Goal 1: State, local, and community organizations provide evidence-based programs (e.g., diabetes self-management education [DSME], chronic disease-self management programs [CDSMP], Green and Healthy Homes, and Question, Persuade, and Refer [QPR] suicide risk screening) in local communities.

Short Term Objectives

1.1   By June 30, 2014, identify gaps in and opportunities for internal and external partners to improve community clinical linkages in the general and high priority populations.

1.2   By June 30, 2014, create a process to educate health care providers and health care extenders on evidence-based programs available in their communities and how they can help their patients.

1.3   By June 30, 2014, create a process to support the effective and efficient use of evidence-based chronic disease self-management programs (e.g., Living Well with Chronic Conditions, New Leaf: Choices for Healthy Living, and Question, Persuade and Refer).

1.4   By June 30, 2015, create a process to educate health care system administrators and providers about community programs and the benefits of using their services. Create a listing of community programs/resources.

1.5   By June 30, 2014, create a process to measure access, referrals, patient satisfaction and reimbursement for evidence-based programs in communities and identify priority areas/populations.

Intermediate Term Objectives

1.6   By June 30, 2017, increase the number of Utahns who participate in and complete evidence-based programs in the community by 10%.

Why is this goal area important?

Though preventive services are traditionally delivered in the clinic, some can be delivered in community settings.

Community policies, programs, and resources help support patients' management of chronic diseases and connect people to important health care services.

How will this goal area address health equity?

Community health workers and health care extenders know the local community culture and are able to work within it to prevent and manage health conditions.

Extending health care support into under-served communities links patients, health care providers, and community resources.

Goals and Objectives

1.7 By June 30, 2017, increase the number of chronic disease identification and management trainings provided to health care extender associations from 0 to 3 trainings.

1.8 By June 30, 2017, increase the number of evidence-based chronic disease self-management workshops to 720 workshops and injury prevention programs to 50 programs.

1.9 By June 30, 2017, measure the reach of evidence-based programs in general and high priority populations.

1.10 By June 30, 2017, track access, patient satisfaction, and reimbursement for evidence-based programs in communities and identified priority areas/populations.

Goal 2: Create and maintain partnerships that link health care, public health, health clinics, community health workers, health extenders, and community organizations and build capacity to provide evidence-based programs in local communities.

Short Term Objectives

2.1 By June 30, 2014, collaborate with partners to create a process to identify and address training needs for community health workers and health care extenders in Utah.

2.2 By June 30, 2015, work with partners to establish a statewide community health worker association.

2.3 By June 30, 2015, identify possible funding sources to compensate community health workers.

2.4 By June 30, 2015, create a process to educate health care providers about community health workers and health extenders, and the benefits of using their services.

2.5 By June 30, 2015, a current coalition (or new coalition) will meet routinely to discuss how to effectively link clinicians with community resources and how to use community health workers (community health worker coalition).

Intermediate objectives

2.6 By June 30, 2016, increase the proportion of identified training needs that are addressed through the Utah Community Health Worker Association.

2.7 By June 30, 2017, increase the number of trained community health workers who are working in the state by 10%.

2.8 By June 30, 2017, establish training standards for the community health workers association.

2.9 By June 30, 2017, collect and distribute statewide examples describing how health care providers and community health workers are working together.

2.10 By June 30, 2017, the community health worker coalition routinely reports to both health care providers and community health workers about the work of the coalition.

Strategic Goal Area 4: Health Communications
Vision: Utahns know about health screening recommendations, health promotion, chronic disease prevention and management, and injury prevention.

Goal 1: There is a systematic approach to educating the public about the prevention, early detection, and management of chronic diseases and injury.

Short Term Objectives

1.1 By June 30, 2014, create a process to increase the capacity for social marketing and health communications.

1.2 By June 30, 2014, create a tool to capture and share stories of health promotion in Utah.

1.3 By June 30, 2014, create coordinated messaging to increase public awareness about the US Preventive Services Task Force recommended screenings available through the Affordable Care Act.

1.4 By June 30, 2014, create a process to utilize the Health Resource Center at the Utah Department of Health to track and evaluate health information and/or campaigns.

1.5 By June 30, 2014, create a process to develop and assess/evaluate multi-purpose media campaigns.

1.6 By June 30, 2014, develop and implement a statewide communications plan that effectively uses social marketing and health communication strategies to effect behavior change.

1.7 By June 30, 2014, create coordinated messaging to raise awareness of the importance of chronic disease, health promotion, and injury among policy makers.

1.8 By June 30, 2014, in partnership with the BHP Data and Evaluation Workgroup, develop a process to market coordinated data reports to targeted audiences.

Why is this goal area important?
Effective health messages can inform the public about important health issues, and promote available services that can lead to behavior change and better health.

How will this goal area address health equity?
Languages and cultural differences are addressed through health messaging and social marketing campaigns.

Goals and Objectives

Intermediate Term Objectives

1.9   By June 30, 2017, 60% of the public is aware of services available to manage chronic diseases and injury prevention (e.g., chronic disease self-management classes, the Tobacco Quit Line and violence and injury hotlines).

1.10   By June 30, 2017, 10% of the public is aware of recommended screenings available through the Affordable Care Act.

1.11   By June 30, 2017, health messages for policy makers are aligned with current policy agendas for partners/coalitions to promote the prevention, early detection, and management of chronic diseases and injury.

Strategic Goal Area 5: Data and Evaluation

Vision: Coordinated surveillance and evaluation activities are routinely conducted; results are published and used to optimize local and statewide public health activities.

Goal 1: The Bureau of Health Promotion (BHP), within the Utah Department of Health (UDOH), collaborates with partners to systematically conduct surveillance and evaluate local and statewide programs/interventions and promote the use of data for intervention planning.

Short Term Objectives

1.1   By June 30, 2014, a process is developed to support the Office of Public Health Assessment (OPHA), including development of data sets, updating of Indicator-Based Information System for Public Health (IBIS-PH) indicators, and collaborating to improve the usability of IBIS-PH.

1.2   By June 30, 2014, a process is developed to work with OPHA to educate partners on using and interpreting IBIS data.

1.3   By June 30, 2014, a process is established to share social determinants of health data, including Adverse Childhood Experiences, with relevant organizations (e.g., housing authority, food bank, and advocacy groups).

1.4   By June 30, 2014, data from the BHP Surveillance Plan are used to inform surveillance priorities and to coordinate state-added questions on health surveys (i.e., BRFSS, YRBS, PNA, and Profiles surveys).

1.5   By June 30, 2015, a clinical data set that reflects the Plan priorities is established.

1.6   By June 30, 2014, develop a process to market strategic releases of coordinated data reports to targeted audiences, in partnership with the BHP Health Communications Workgroup.

Intermediate Term Objectives

1.7   By June 30, 2017, chronic disease and injury prevention data are routinely accessed and used by partners for planning of coordinated interventions.

Goal 2: Document progress of the Statewide Comprehensive Chronic Disease and Health Promotion State Plan (the Plan) objectives and use evaluation results to update the Plan.

Short Term Objectives

2.1   By June 30, 2014, evaluation results are routinely used to refine and adapt the State Plan to engage partners in implementation, to ensure that the interventions are culturally and linguistically appropriate for target populations, and to justify resource allocation.

2.2   By June 30, 2014, a process is developed to systematically report progress on the implementation of the State Plan to stakeholders and decision makers.

2.3   By June 30, 2014, develop and implement a process to provide data, expertise, and technical assistance to BHP and partners to support implementation of the State Plan.

Intermediate Term Objectives

2.4   By June 30, 2015, progress on the State Plan is systematically reported to stakeholders and decision-makers.

2.5   By June 30, 2016, the State Plan is updated to reflect evaluation results and changes in inputs and activities.

Why is this goal area important?

Data review is an effective tool to identify health issues, manage resources, and measure the effectiveness of programs.

How will this goal area address health equity?

Review of data helps to identify differences in health status and risk factors among all Utahns.

Evaluation can help determine program effectiveness with different populations.

Measuring Progress

Measuring Progress

Progress will be measured through implementation of Strategic Goal Area 5: Data and Evaluation. This goal area will document process and outcome evaluation that will be used to assess activities and interventions initiated as a result of this plan.

Evaluation

Evaluation is generally categorized into process or outcome evaluation. The purpose of process evaluation is to measure change in the level of effort or activity and the purpose of outcome evaluation is to measure changes that have occurred, accomplishments that have been achieved, and needs that have been met. Within the context of this plan, process evaluation will be used to evaluate current and future processes and organizations. Programs and interventions will be evaluated using either or both process and outcome evaluation, depending on what is appropriate.

An evaluation plan for the implementation of this Utah Chronic Disease Prevention and Health Promotion Plan is contained in a separate document. The primary targets for outcome evaluation are listed below.

State Plan Intervention Outcomes

Increased state, community, worksite, school, and early care education environments that promote and reinforce healthy behaviors and practices across the lifespan.

Improved quality, effective delivery, and use of clinical and other preventive services to promote health and prevent chronic disease and injury.

Increased community-clinical linkages to support prevention, self-management, and control of chronic disease and injury.

Continuous Process Improvement

As the current plan is implemented, there will be time points when process evaluations will be conducted to identify potential areas for improvement. These evaluations could focus on partner relations, intervention processes and outcomes, and other topics that become relevant to the implementation of this plan. Information from these evaluations will be used to continuously improve the implementation of this plan.

Communicating Results

The communication plan, found in Appendix 2, details how evaluation, surveillance, and epidemiology data will be shared with partners and the general population of Utah. Additionally, there is a section describing how this plan will be shared with partners and the general population.

Appendices

Appendix 1: Definition of Terms and Concepts

Active transportation

Active transportation refers to any form of human-powered transportation such as walking, cycling, using a wheelchair, in-line skating, or skateboarding. www.phac-aspc.gc.ca/hp-ps/hl-mvs/pa-ap/at-ta-eng.php

Catalyst

A web-based tool used to manage collaborative linkages between planning and evaluation. It can be used by public health programs and across programs to advance efforts in coordination and integration. The tool has the capacity to add and use databases to monitor specific activities.

Chronic Disease Self-Management Program (CDSMP)

The Chronic Disease Self-Management Program is a workshop given two-and-a-half hours, once a week, for six weeks in community settings such as senior centers, churches, libraries, and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain, and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) decision making, and 7) how to evaluate new treatments.

Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives. http://patienteducation.stanford.edu/programs/cdsmp.html

Collaboration

The process by which two or more people or programs work together to achieve a shared goal.

Community-Clinical Linkages

The linkages that help connect health care providers, community organizations, and public health agencies so they can improve patients' access to preventive and chronic care services.

Community health worker (CHW)

A frontline public health worker who is a trusted member, or has a close understanding of the community served. The trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. www.apha.org/membergroups/sections/aphasections/chw/

Appendix 1: Definition of Terms and Concepts

Coordination
Organizing and interlinking people and activities to work together to achieve a common goal.

Department of Health (DOH) Air Quality Index Symptom Tracking System
A tool to assist with tracking outdoor air quality levels in conjunction with a person's symptoms in order to plan physical activity.

Electronic health records
Systems that keep track of medical information. Such software frequently allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, and generate reports.

Dymek C, Johnson M Jr, McGinnis P, Buckley D,   L, Mardon R, Hassell S, Carpenter D. Clinical-Community Relationships Measures Atlas. (Prepared under Contract No. HHSA 290-2010-00021. Westat prime contractor) AHRQ Publication No. 13-0041-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2013.

Evaluation
A process used by public health organizations to make decisions about the value and effectiveness of public health programs.

Evidence-based
Approaches and strategies for improving public health that have been demonstrated to be successful in other settings.

Health care extenders
Health care practitioners with formal education and clinical training who are credentialed through certification, registration, and/or licensure. They collaborate with physicians and other members of the health care team to deliver high quality patient care services for the identification, prevention, and treatment of diseases, disabilities, and disorders.

Health equity
A situation where all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance. www.health.utah.gov/disparities

High priority population
A high priority population is a subpopulation with a disease burden that is significantly worse than the state rate and has been identified by BHP and/or partners as a target population for intervention.

Indicator-Based Information System for Public Health (IBIS-PH)
A Utah Department of Health (UDOH) website providing statistical numerical data, as well as contextual information on the health status of Utahns and the state of Utah's health care system.

Appendix 1: Definition of Terms and Concepts

Integration
 The strategic alignment of categorical program resources to increase the effectiveness and efficiency of each program in a partnership without compromising the integrity of categorical program objectives. (National Association of Chronic Disease Directors).

Outcome
The effect of public health interventions on the health of the populations they are designed to influence.

Quality of care
A measure of the ability of a doctor, hospital, or health plan to provide services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results. According to the mantra for the quality improvement movement, care should be "safe, effective, patient-centered, timely, efficient, and equitable."

www.rwjf.org/en/research-publications/find-rwjf-research/2013/04/quality-equality-glossary.html

Social determinants of health
Conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities-the unfair and avoidable differences in health status seen within and between countries. Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)

Appendix 1: Definition of Terms and Concepts

- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

Social marketing

The application of marketing and other concepts to influence target audience behavior to improve personal and societal outcomes.

Strategy

Articulates HOW we intend to progress toward our strategic goals.

Systems and environmental changes

Systems and environmental changes allow large health issues to be tackled on a population level, making healthier choices an option for every community member. Systems changes influence how organizations interact or operate, such as influencing worksites to adopt a healthy food policy. Environmental changes refer to policies designed to make the entire environment more health promoting, such as installing community bike paths.

Surveillance

The practice of systematically collecting and analyzing data that describe health in a population or community. Surveillance helps public health organizations identify possible emergencies, populations affected by a disease or health problem, and the progress of a specific intervention toward health outcomes.

Team-based care

The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers toward shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable.

Naylor MD, Coburn KD, Kurtzman ET et.al. Team-Based Primary Care for Chronically Ill Adults: State of Science. Advancing Team-Based Care. Philadelphia PA. American Board of Internal Medicine Foundation, 2010

Appendix 2: Communications Plan

Utah Chronic Disease Prevention and Health Promotion Communications Plan

September 1, 2013–August 31, 2014

Internal communication within the Utah Department of Health (UDOH) regarding the Utah Chronic Disease Prevention and Health Promotion Plan (State Plan)

Goal 1: Increase and improve internal Bureau of Health Promotion (BHP) communications regarding the Utah Chronic Disease Prevention and Health Promotion Plan.	
Objective 1: By August 31, 2014, increase and improve internal communication channels about the State Plan to establish regular avenues for information dissemination and feedback.	
Overall Strategy: Create or improve infrastructure to provide regular or as needed internal State Plan updates and create readiness to facilitate communications with external partners. The Health Communications (HCOMM) Workgroup (WG) will provide oversight.	
Target Audience(s): BHP Staff, Public Information Office (PIO), Executive Director's Office (EDO), Division Director, and Office of Performance Improvement.	

Actions	Timeline	Budget	Staff Responsible	Notes
1. Provide brief updates to BHP Managers and DCP Division Director via Bureau Director's BHP Weekly e-mail update.	Weekly	Staff Time	Bureau Director (BD)	
2. Provide updates to Program Managers at Manager Meetings and provide time during meetings for Program Managers to discuss implementation process.	Monthly	Staff Time	BD/PMs	
3. Provide updates at BHP Workgroup meetings and provide time during meetings for feedback on implementation.	Monthly	Staff Time	Workgroup (WG) Leaders	
4. Maintain alignment of BHP staff performance plans involvement in State Plan.	Ongoing	Staff Time	Program Supervisors	
5. Meet regularly with PIO to share updates.	Monthly	Staff Time	BD	

Activity	Frequency	Resources	Responsible	Rationale
6. BHP Workgroups share annual State Plan workplans with BHP Director and BHP Program Managers.	Annually	Staff Time	BD/WG Leaders	This will facilitate increased cross-program awareness regarding workgroup and program staff State Plan activities.
7. Hold a BHP Retreat/Meeting to discuss/re-evaluate BHP priorities.	Annually	Staff Time	BD	
8. Meet with the Executive Director's Office to share updates and discuss alignment of the State Plan with the UDOH Strategic Plan.	Quarterly	Staff Time	BD	
9. Meet with the Office of Performance Improvement to share updates and discuss alignment of the State Plan with UDOH's performance improvement initiatives.	Quarterly	Staff Time	BD	

External Communication with partners throughout Utah and for Targeted Audiences Regarding Health Promotion, Chronic Disease and Injury Burden and Proposed Solutions

Goal 2.1: Create external Bureau of Health Promotion (BHP) communications regarding the State Plan and improve communication among partners.

Objective 1: By August 31, 2014, increase and improve external communication channels for the State Plan to establish regular avenues for information dissemination and feedback.

Actions	Timeline	Budget	Staff Responsible	Notes
1. Hold partner meeting to discuss State Plan communication strategies among partners and share updates.	2013 & January 2014	UDOH BHP Staff Time/External Partners' Time	UDOH BHP	
2. Create and publish a statewide Communications Plan based on partner feedback to correlate with the State Plan.	September 2013 & update as needed in 2014	UDOH BHP Staff Time/External Partners' Time	UDOH BHP	
3. Create and send a survey to additional potential partners to assess their interest in partnering on the Plan implementation.	2013	UDOH BHP Staff Time/External Partners' Time	UDOH BHP	
4. Provide State Plan implementation updates to partners via email.	Quarterly		UDOH BHP	
5. Create a process for statewide coalitions to attend each others' meetings and provide presentations about their work.	2013	UDOH BHP Staff Time/External Partners' Time	UDOH BHP	This will foster relationship building and provide a venue for coalitions to learn about each entity's work.

Appendix 2: Communications Plan

Activity	Timeline	Resources	Responsible Party
6. Present the Plan and provide updates at state agency coalition meetings.	As needed	UDOH BHP Staff Time/External Partners' Time	UDOH BHP
7. House the Plan electronically in a location accessible to partners.	Ongoing	UDOH BHP Staff Time/External Partners' Time	UDOH BHP
8. Create an electronic short update form for partners to add project/activity notes.	2013	UDOH BHP Staff Time/External Partners' Time	UDOH BHP
9. Send electronic short update form to partners to add project/activity notes.	Quarterly	UDOH BHP Staff Time/External Partners' Time	UDOH BHP
10. Workgroups will share workplans with other workgroups.	2013	UDOH BHP Staff Time/External Partners' Time	UDOH BHP
11. Provide Plan updates at Utah Prevention Advisory Council (UPAC) meetings.	Ongoing	UDOH BHP Staff Time/External Partners' Time	UDOH BHP
12. Create and share an annual Plan report with partners.	August 2014	UDOH BHP Staff Time/External Partners' Time	UDOH BHP

Appendix 2: Communications Plan

Goal 2.2 Improve external Bureau of Health Promotion (BHP) communications and collaboration regarding chronic disease coordination, health messaging, and social marketing to targeted audiences and the general public.

Objective 2: By August 31, 2014, increase coordination and collaboration for health promotion, chronic disease and injury prevention.

Objective 3: By August 31, 2014, increase education among the public and stakeholders regarding health promotion, the burden of chronic disease and injury, their associated risk factors, and the impact of effective interventions.

Target Audience(s): BHP partners, chronic disease target audience(s), and general public

Actions	Timeline	Budget	Staff Responsible	Notes
1. Work with statewide partners to create a process to increase the capacity for social marketing and health communications.	Ongoing	Staff Time/External Partners' Time	BHP HCOMM WG	
2. Work with partners to create a tool to capture and share stories of health promotion in Utah.	Ongoing	Staff Time/External Partners' Time	BHP HCOMM WG	
3. Work with partners to increase public awareness about recommended screenings available through the Affordable Care Act.	Ongoing	Staff Time/External Partners' Time	BHP HCOMM WG	
4. Develop and assess a multi-purpose media campaign.	Ongoing	Staff Time/External Partners' Time	BHP HCOMM WG	
5. Work with external health care partners on a health care innovations project.	Ongoing	Staff Time/External Partners' Time	BHP Health Care Systems (HCS) WG	

Appendix 2: Communications Plan

Communications Strategy to Maximize Visibility of the Utah Chronic Disease Prevention and Health Promotion Plan, as well as of the BHP and BHP partners

Goal 3: Create a strategy to maximize the visibility of the Utah Chronic Disease Prevention and Health Promotion Plan and solutions proposed in it.

Objective 1.1: By August 31, 2014, increase visibility of the BHP Plan to new and existing partners and the public.

Objective 1.2: By August 31, 2014, increase visibility of the BHP and BHP partner activities.

Overall Strategy: Use public relations strategies and partnership networks to maximize visibility of the State Plan, BHP, and BHP partners.

Target Audience(s): Primary: Internal and external stakeholders with common interests in chronic disease prevention and health promotion. Secondary: General public

Actions	Timeline	Budget	Staff Responsible	Notes
1. E-mail State Plan to all local health department (LHD) officers, nursing directors, and identified partners.	September 2013	Staff Time	BHP BD	
2. Link State Plan to UDOH home page.	September 2013	Staff Time	BHP BD	

Action	Timeline	Resources	Responsible	Notes
3. Work with UDOH's Public Information Office (PIO) to provide a news release to the media about the State Plan.	September 2013, December 2013, March 2014, June 2014	Staff Time	BHP HCOMM WG leader or other assigned member	PIO will send news release. Provide UDOH PIO-approved speaking points. Utilize and emphasize data to show disease burden, need for coordination, etc.
4. Follow up with subsequent media requests for interviews/additional stories.	As needed	Staff Time	UDOH PIO/ BHP HCOMM lead	Highlight different areas of the plan each time. Quote individuals such as UDOH's EDO and similar counterparts from partner entities.
5. Disseminate hard copies of the State Plan at statewide conferences and meetings that involve chronic disease prevention and health promotion.	Ongoing	Staff Time	UDOH BHP/ Various	

6. Present information on the State Plan at statewide conferences and meetings that involve chronic disease prevention and health promotion.	Ongoing	Staff Time	BHP BD
7. Schedule meetings with statewide high profile decision makers and invite representatives from each workgroup to attend.	As needed	UDOH BHP Staff Time/ External Partners' Time	UDOH BHP