



# Healthy Environments Active Living Program

2021-2026 Strategic Plan

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## Introduction

The Utah Department of Health's (UDOH) Healthy Environments Active Living Program (HEAL) (formerly known as the Healthy Living Through Environment, Policy, and Improved Clinical Care Program (EPICC)) plays a key role in improving the health of residents in the state of Utah. The Healthy Environments, Active Living Program was formed in July 2013, through funding from the Centers for Disease Control and Prevention (CDC). That funding merged three previously existing programs at the UDOH: the Heart Disease and Stroke Prevention Program, the Diabetes Prevention and Control Program, and the Physical Activity, Nutrition and Obesity Program, as well as the addition of a school health program. HEAL was recently restructured as part of this strategic planning process and the new model consists of three program areas, Healthy People, Healthy Communities, and Equitable Society. All of these program areas work together to address the social determinants of health and advance health equity.

## Background

In 2019, HEAL was asked by UDOH Leadership as well as local health officers (LHOs) to create a five-year strategic plan to guide their work. In January of 2020, HEAL contracted with consultants at ChangeLab Solutions and hired a previous UDOH employee, Karlee Walker, to assist their efforts to focus program strategies and activities more upstream, address social determinants of health, and advance health equity across the state of Utah.

In January of 2020, HEAL convened their partners for a strategic planning kick-off meeting to gather input on current and future goals and activities. Over the course of the next six months (January – June 2020), one on one and team interviews were held with HEAL staff and leadership, local health departments, select partners, and five other state programs. The information gained during these interviews was used to develop several memos to guide the strategic planning process. As a result of those interviews, ChangeLab Solutions provided HEAL with a suite of memos that address the following topics:

- 1) Overlaps and gaps in HEAL activities;
- 2) Recommendations for new HEAL vision, mission, and goals;

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- 3) Recommendations for the strategic planning process and structures for the program model;
  - 4) Evidence-based strategies being utilized by other states;
  - 5) A preemption analysis of potential policy strategies that HEAL may be interested in working on in the future;
  - 6) Recommendations for creating an equity action plan that is aligned with the new strategic plan and provides HEAL with guidance on how to center an equity approach in their work, first internally with staff and then externally with partners.

In November 2020, HEAL formed three workgroups (Healthy People, Healthy Communities and Equitable Society) made up of HEAL staff; local health department (LHD) partners; and other state, local, and community partners to provide input on workplan activities, strategies, goals, and evaluation outcomes. The three workgroups were formed based on the new program model being adopted by HEAL and each was led by a member of the HEAL leadership team. HEAL also held two engagement sessions with community partners to solicit feedback on the strategic plan, identify priorities within these communities, and find ways to partner in these efforts. HEAL is creating a healthy equity action plan, a comprehensive evaluation plan, a communication plan, and a policy agenda to complement the updated vision, mission, goals, strategies, and activities. These additional documents will be incorporated into the strategic plan at a later time.

Vision:

All Utahns have equitable opportunities to lead healthy, informed, safe, and productive lives.

Mission:

Create community-clinical linkages and improve education, policy, built environment, and access to quality care in preventing and managing chronic diseases.

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### Overarching Goals:

Healthy People: Increase access to resources that empower all people in Utah to reach their full health potential.

Healthy Communities: Increase the capacity of communities to support and promote healthy living for all individuals.

Equitable Society: Increase opportunities for people who are under-resourced and under-represented in Utah to live healthy and thriving lives.

### Burden

More than three million people live in Utah; four-fifths (75.2%) of whom reside in four urban counties. The other 25% of residents live in 12 rural and 13 frontier counties (U.S. Census, IBIS Version 2019) that comprise 94% of the state's land mass. Four out of the five fastest growing counties are rural, highlighting a need for expanding access to services for rural residents. The rapid growth has led to an increase in the state's population size of 15.5% since 2010. Much of the population growth is in minority racial and ethnic populations, resulting in increases in both diversity and disparity. Rapid increases in minority populations present unique challenges and require innovative approaches to prevent and control chronic conditions and their related risk factors. Minority populations generally fare worse on health measures than non-Hispanic white individuals. Lack of access to healthcare, inability to afford necessary care, and poverty are likely contributing factors. Currently more than one in five (22.2%) Utah residents belong to a minority racial or ethnic group (U.S. Census Bureau 2019). The Hispanic population makes up the largest minority group in Utah, at 14.5% of the total population. Many members of this population have less than adequate access to healthcare; more than one-third (38.8%) of Hispanic adults do not have health insurance compared to 8.6% of non-Hispanics (Behavioral Risk Factor Surveillance Survey (BRFSS) 2019). Sixteen percent (16.4%) of adults in the state live below the 133% poverty level (BRFSS 2019).

Residents of Utah are generally young, educated, and enjoy a strong economic climate. Utah is considered to be a "healthy" state. Nevertheless, there are pockets of the population that have excess rates of potentially debilitating chronic conditions, such as

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high blood pressure and diabetes. Some residents, especially those with lower socioeconomic status, tend to be less likely to engage in preventive health behaviors such as physical activity and maintaining a healthy weight.

Cardiovascular disease (CVD) has a high economic toll, accounting for about \$1 of every \$7 spent on healthcare in the country. Heart disease is the leading cause of death in Utah. In 2019, the number of heart disease deaths was 3,883, with the crude death rate rising from 102.8 per 100,000 in 2010 to 121.0 in 2019. Between 2010 and 2019, the number of deaths from heart disease alone increased by 35.9%. Controlling hypertension is an important step in preventing heart attacks, stroke, and other cardiac events. Hypertension that is not diagnosed is not controlled.

Prediabetes increases the risk of developing type 2 diabetes, heart disease, and stroke. Without intervention, 15% to 30% of people with prediabetes will develop diabetes within 5-10 years. The National Diabetes Prevention Program (National DPP) is a cost-effective lifestyle change program to help people at risk for diabetes make small changes that can cut their risk of developing diabetes by as much as 58%. About one in three Utah adults has prediabetes but many have not been diagnosed. Only about 10 percent (9.5%) of adults report they have been diagnosed (BRFSS 2018). Rates are higher for Hispanic adults compared to non-Hispanic adults, 14.6% vs. 8.7%. For those diagnosed with diabetes, self-management education support has been shown to be effective in improving glycemic control and systolic blood pressure, and may delay or prevent many diabetes-related complications. Unfortunately, only about 60% (59.2%; BRFSS 2016) of adults in Utah with diabetes report ever having taken a class or course on how to manage the condition.

Obesity is a risk factor for both prediabetes and heart disease. The proportion of Utah adults who were obese increased between 2010 and 2019, from 24.1% in 2010 to 29.2% in 2019. The highest rates of obesity were seen for adults aged 50–64 (35.0%). Obesity rates for the Native Hawaiian/Pacific Islander population were the highest in the state, at 46.3%. African American/Black and American Indian/Alaskan Native populations also had high rates, at 34.1% and 33.4%, respectively. An estimated 33.3% of Hispanic/Latino adults were obese, compared to 28.7% of non-Hispanic/Latino adults. Among adolescents in 2019, 9.8% of Utah public high school students were obese; boys were more than twice as likely

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as girls to be obese (13.2% compared to 6.3%). Racial/ethnic differences in obesity are evident in youth. Only 8.5% of non-Hispanic white adolescents are obese, compared to 11.0% of Hispanic adolescents and 20.0% of non-Hispanic non-white adolescents (Youth Risk Behavior Survey 2019). Achieving measurable reductions in obesity, hypertension, diabetes, and prediabetes requires addressing the health disparities and social determinants associated with these conditions.



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## Guiding Principles

**Collaborative:** We believe working collaboratively fuels growth, innovation, and creativity. We believe in working collaboratively with anyone directly impacted by our work and that strategic partnerships are fundamental to our success. We believe our partners and the general public should have access to program resources and expertise, and we will be clear about how to access these materials.

**Communication:** We will communicate openly, frequently, and respectfully. We will be clear and transparent in all of our communications and work cohesively to complete high quality work in a timely manner.

**Data-driven:** We believe data and evaluation should be incorporated into all stages of work to ensure interventions are evidence-based, inform continuous quality improvement, and monitor progress towards reaching our goals. We believe in sharing data back with staff, partners, and the public, where appropriate.

**Equitable:** We believe that the prioritization of issues and activities, and the distribution of resources, must be carried out in a manner that allows all Utahns the opportunity to attain their highest level of health. We believe that health equity cannot be advanced without the meaningful involvement of underserved communities in all stages of work.

**Innovative:** We believe in a culture of continuous learning and a willingness to apply new knowledge and ideas without the fear of failure. We understand that although every new idea may not produce the desired outcomes, there is always a lesson to extract from it that will contribute to the evidence base.

**Respect:** We value the differences in opinion, communication styles, and knowledge of our team and partners. We respect those differences by being kind, courteous, and valuing their work. We assume good intent in all situations.

**Work-life Balance:** The demands of one's career and the demands of one's personal life are equally important. We recognize that we are all individuals and value the flexibility to learn and adapt as needed to help meet demands in our work and in our personal lives

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## Glossary of Terms:

**Active transportation (AT):** any self-propelled, human-powered mode of transportation, such as walking or bicycling.

**Built environment:** man-made structures, features, and facilities viewed collectively as an environment in which people live and work.

**Community Health Worker (CHW):** a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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.

**CDC-recognized lifestyle change programs:** CDC-approved curriculum with lessons, handouts, and other resources to help people make healthy changes to prevent type 2 diabetes.

**Chronic conditions:** conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both, e.g. diabetes, hypertension, heart disease.

**Diabetes self-management education and support (DSMES):** ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care, as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training.

**Double Up Food Bucks:** Allow those using Supplemental Nutrition Assistance Program benefits at a participating farmers market to receive a dollar-for-dollar match, up to \$10 in free Double Up Food Bucks to spend on the locally-grown produce.

**Early childhood education (ECE):** a branch of education theory that relates to the teaching of children from birth up to the age of eight.

**Eat Well Utah:** a statewide program that encourages and supports food venues to offer and promote healthy foods by improving the nutritional quality of menu items, using

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methods of behavioral design, and increasing efficiency by buying local food and employing waste-reduction strategies. Eat well Utah is Utah's version of the National Food Service Guidelines.

**Evidence-based lifestyle change programs:** an evidence-based solution that can reduce a person's risk of developing type 2 diabetes by 58% (71% in individuals aged 65 and older). CDC-recognized lifestyle change programs are a key component of the National Diabetes Prevention Program and have proven to be more effective than certain medications at preventing type 2 diabetes.

**Healthy equity:** everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty; discrimination; and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.

**High or very high Health Improvement Index (HII):** Are composite measures of social determinants of health by geographic area. The Health Improvement Index (HII) was computed for each geographic area and standardized to a mean of 100 and a standard deviation of 20. The HII ranged from 72 to 160. Five HII categories were created: very high, high, average, low, and very low. The higher index indicates more improvement may be needed in that area.

**Hypertension (HTN):** another name for high blood pressure

**Full health potential:** all individuals have the knowledge which enables them to successfully prevent and manage chronic diseases and are actively accessing resources to help them prevent and manage chronic diseases.

**Local Education Agency (LEA):** a public board of education or other public authority legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a state, or for a combination of school districts or counties that is recognized in a state as an administrative agency for its public elementary schools or secondary schools.

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**Local health department (LHD):** governmental public health presence at the local level. In Utah there are 13 local health departments.

**Metropolitan planning organizations:** A Metropolitan planning organization is funded by the cities/towns it serves and does the long-term and regional planning for metropolitan statistical areas.

**Medication therapy management (MTM):** a distinct service or group of services provided by healthcare providers, including pharmacists, to ensure the best therapeutic outcomes for patients.

**National Diabetes Prevention Program (DPP):** created in 2010 to address the increasing burden of prediabetes and type 2 diabetes in the U.S.. This national effort created partnerships between public and private organizations to offer evidence-based, cost-effective interventions that help prevent type 2 diabetes in communities across the U.S.

**Priority population:** Very high and high HHI communities. The HHI is not a measure of health per se, but instead measures a combination of social and economic conditions that determine health. The HHI ranges from 72 to 160 and has five groups: very high, high, average, low, and very low. Higher HHI groups denote a greater need to improve these conditions, thereby also an opportunity to improve health.

**Produce RX:** A produce incentive program that provides fruit and vegetable vouchers to food insecure patients at participating clinics.

**National Association of Chronic Disease Directors (NACDD):** organization that improves the health of the public by strengthening state-based leadership and expertise for chronic disease prevention and control in states and at the national level.

**SHAPE Utah:** coalition that promotes physical activity and healthy lifestyles in Utah schools and community programs for health education, physical education, recreation, and dance.

**Sliding scale clinics:** bases prices for treatment on a patient's ability to pay instead of setting a fixed price for all patients. Sliding scales assist medical patients on low or fixed incomes. Fees based on a sliding scale take into account a person's income and often other factors such as family size.

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The Supplemental Nutrition Assistance Program (SNAP): is the largest federal nutrition assistance program. SNAP provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Social determinants of health (SDoH): conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Social and emotional learning: [Social and emotional learning](#) refers to a wide range of skills, attitudes, and behaviors that can affect student success in school and life such as critical thinking, emotion management, conflict resolution, and decision making.

Teaching Obesity Prevention in Childcare Settings (TOP Star): a program developed by the Utah Department of Health, local health departments, and other partners to help prevent obesity among children in childcare. The goal of TOP Star is to help childcare providers improve their nutrition and physical activity environments.

Utah Department of Health (UDOH): Utah's lead public health agency.

Under-represented: people and communities whose voices are not represented, considered, or heard when decisions are made within various systems; and those who don't have access to or the ability to utilize resources or opportunities.

Under-resourced: people or communities with insufficient resources and those with limited access and/or ability to use the sufficient resources.

Utah Transit Authority (UTA): the Utah public transportation system.

Utah State Board of Education (USBE): a constitutionally established, elected, non-partisan body that exercises "general control and supervision" over the public education system in Utah, including establishing the state educational core standards, state educator licensing policies, and state high school graduation requirements.

Whole Community, Whole School, Whole Child model: model that is student-centered and emphasizes the role of the community in supporting the school, the connections between

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health and academic achievement, and the importance of evidence-based school policies and practices.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Provides food, healthcare referrals, and nutritional education to low-income pregnant and postpartum women, breastfeeding women, and nutritionally at-risk infants and children up to age 5.

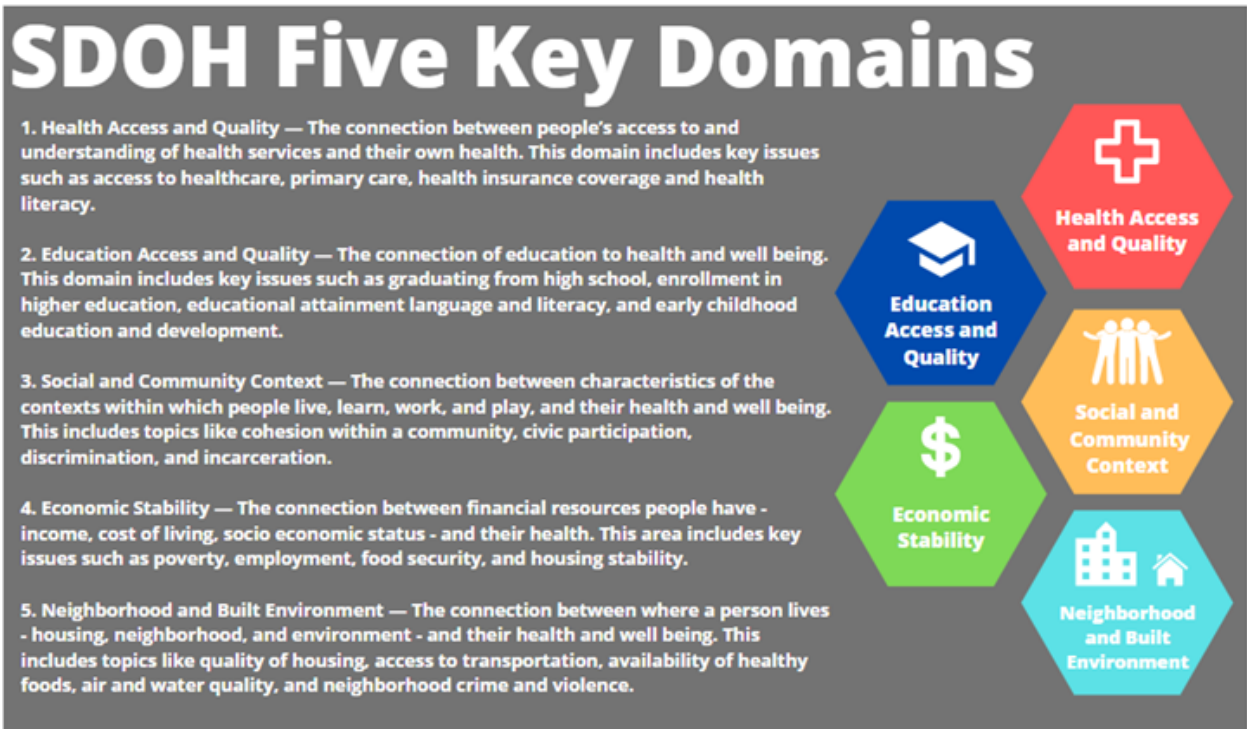
Guiding Framework

Healthy People	Healthy Communities	Equitable Society
<p>Current activities:</p> <ul style="list-style-type: none"> <li>• Community health workers</li> <li>• Health care/health systems</li> <li>• Community-clinical linkages</li> <li>• Physical activity and nutrition</li> <li>• HDSPP</li> <li>• DPCP</li> <li>• School health</li> </ul> <hr/> <p>[Placeholder for new activities/ focus areas based on shift upstream to address the SDOH]:</p> <ul style="list-style-type: none"> <li>• Capacity building around civic engagement</li> <li>• TBD</li> </ul>	<p>Current activities:</p> <ul style="list-style-type: none"> <li>• Community health workers</li> <li>• Health care/health systems</li> <li>• Community-clinical linkages</li> <li>• Physical activity and nutrition</li> <li>• HDSPP</li> <li>• DPCP</li> <li>• School health</li> </ul> <hr/> <p>[Placeholder for new activities/ focus areas based on shift upstream to address the SDOH]:</p> <ul style="list-style-type: none"> <li>• Complete Streets</li> <li>• Trauma-informed social-emotional learning in schools</li> <li>• Healthy housing</li> <li>• TBD</li> </ul>	<ul style="list-style-type: none"> <li>• TBD</li> </ul> <hr/> <p>[Placeholder for new activities/ focus areas based on shift upstream to address the SDOH]:</p> <ul style="list-style-type: none"> <li>• Health in All Policies</li> <li>• Benefits access (e.g., SNAP and Medicaid)</li> <li>• Community land trusts</li> <li>• Participatory planning/people-centered engagement</li> <li>• Equitable transit-oriented development</li> <li>• Universal preschool</li> <li>• Child care subsidies</li> <li>• Paid family leave</li> <li>• Paid sick leave</li> <li>• SNAP incentives</li> <li>• Income inequality</li> <li>• Structural and institutional discrimination</li> <li>• Workforce development</li> </ul>
<p style="text-align: center;"><b>Integrated across all three programs:</b></p> <ul style="list-style-type: none"> <li>• Epidemiology and Evaluation</li> <li>• Health Equity Lead (potential new role)               <ul style="list-style-type: none"> <li>• Other (?)</li> </ul> </li> </ul>		
<p style="text-align: center;"><b>Moving further upstream:</b></p>		

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## Social Determinants of Health

The CDC defines social determinants of health (SDOH) as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." They are shaped, molded, and developed by access to resources, geographic location, and the distribution of money and power within communities, states, and the nation. Social determinants of health are divided into five key domains.



The differences in social determinants of health can lead to health inequalities within communities. Long-standing differences and systemic health, social, and economic inequalities have put marginalized communities and people with lower incomes at an increased risk for sickness and chronic disease. An illustration of this principle is during the pandemic, the homeless, tribal communities, lower-income populations, and minority populations experienced higher rates of infection. This public health crisis demonstrated systematic isolation from crucial resources that were imperative to respond to the outbreak.



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HEAL's strategic plan is organized by the 5 key social determinants of health domains and seeks to create social, physical, and economic opportunities and environments that promote opportunities for all Utahns to attain their full potential for health and well-being.

The strategic plan is also influenced by the Social-Ecological Model; this model considers the complex interplay between individual, relationship, community, and societal factors. Within HEAL's plan, activities are grouped under each social determinant of health domain by Healthy People, Healthy Communities, and Equitable Societies.

### Strategies and Activities:<sup>1</sup>

Overarching Goal 1: Healthy People: Increase access to resources that empower all people in Utah to reach their full health potential.

Overarching Goal 2: Healthy Communities: Increase the capacity of communities to support and promote healthy living for all individuals.

Overarching Goal 3: Equitable Society: Increase opportunities for people who are under-resourced and under-represented in Utah to live healthy and thriving lives.

## I. Economic stability

### Long-term outcomes

1. Decreased heart disease, diabetes, and obesity-related chronic condition morbidity rates.
2. Decreased heart disease, diabetes, and obesity-related chronic condition mortality rates.
3. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among priority populations.
4. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among under-resourced/under-represented communities.

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<sup>1</sup> Note- Activities that fit in multiple areas have been consolidated to one area of the plan to avoid redundancy. Also, many activities not captured in this plan can be found in plan appendices such as the Health Equity Action Plan.

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Objective 1: Reduce household food insecurity and hunger.

Intermediate outcomes

1. Decreased number of Utah adults that report being food insecure (Healthy People).
2. Increased utilization of SNAP, WIC programs, etc. among people who are eligible (Healthy People).
3. Increased number of grocery stores with affordable healthy food options (Healthy Communities).
4. Decreased disparities in food security rates in HII communities compared to overall (Equitable Society).
5. Decreased disparities in fruit and vegetable consumption among priority populations (Equitable Society).

Short-term outcomes

1. Increased number of people that utilize Double Up Food Bucks at farmers markets (Healthy People).
2. Increased number of children participating in free school meal programs (Healthy People).
3. Increased number of schools participating in free school meal programs (Healthy Communities).
4. Increased number of schools in HII communities participating in free school meal programs (Equitable Society) .
5. Increased number of food pantries that facilitate food delivery or pickup for people with disabilities.
6. Increased number of worksites that provide lactation support with a focus on those serving low-income women.
7. Increased number of food pantries that provide healthy and culturally appropriate food (Healthy Communities)
8. Increased number of food pantries in HII communities that serve healthy and culturally appropriate foods (Equitable Society).
9. Increased number of food pantries that facilitate food delivery or pickup for people with disabilities. (Equitable Society)

Objective 2: Reduce the proportion of working adults with obesity-related diseases whose disease limits their work.

Intermediate outcomes

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1. Decreased number of Utah adults filing disability claims related to obesity-related diseases (Healthy People).
  2. Increased number of worksites providing or reimbursing for participation in National Diabetes Prevention Program (Healthy Communities).
  3. Decreased disparities in disability claims related to obesity-related diseases in priority populations compared to overall (Equitable Society).

#### Short-term outcomes

1. Increased number of worksites with worksite wellness policies, such as exercise release time and food service guidelines (Healthy Communities).

Objective 3: Increase access to affordable transportation.

#### Intermediate outcomes

1. Decreased number of people reporting transportation as a barrier to accessing services (Healthy People).

#### Short-term outcomes

1. Increased number of Utahns utilizing the Utah Transit Authority (UTA) (Healthy People).
2. Increased number of people utilizing free/discounted UTA passes (Healthy People).
3. Decreased disparities in access to mass transit in HII communities (Equitable Society).

Objective 4: Reduce the proportion of people who can't get medical care when they need it.

#### Intermediate outcomes

1. Increased medication adherence (Healthy People).
2. Increased percentage of adults that have a primary care provider (Healthy People).
3. Increased number of clinics that accept patients with Medicaid (Healthy Communities).
4. Increased number of insurers providing reimbursement for telehealth chronic condition management (Healthy Communities).
5. Increased Medicaid coverage for chronic disease prevention and management (Equitable Society).

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6. Increased number of people from under-represented populations with insurance coverage (low-income, refugee/immigrant populations, etc.) (Equitable Society).
  7. Increased number of CHWs being reimbursed by payers (Healthy People).
  8. Increased number of CHWs certified by the state (legislative certification) (Healthy People).
  9. Increased number of CHWs connecting Utah adults to resources (Healthy People).
  10. Increased number of CHW who are employed or affiliated by healthcare, NGOs, government, schools, food pantries, mental health providers, etc. (Healthy Communities).
  11. Increased number of CHWs employed or affiliated with healthcare, non-government organizations, government, schools, food pantries, mental health providers, etc. in high or very high HII areas (Equitable Society).
  12. Increased number of communities with access to mass transit (Healthy Communities).

#### Short-term outcomes

1. Increased number of Utah adults with access to medical benefits through their employer (Healthy People).
2. Increased number of adults utilizing discount prescription services (Healthy People).
3. Decreased percentage of uninsured adults and children in Utah (Healthy People).
4. Decreased percentage of Utah adults reporting cost as a barrier to accessing medical care (Healthy People).
5. Increased number of pharmacies that accept or promote discount prescription programs (Healthy Communities).
6. Increased number of clinics that offer affordable telehealth options (Healthy Communities).
7. Increased insurance rates among priority populations (Equitable Society).
8. Decreased percentage of adults reporting cost as a barrier to care in priority populations (Equitable Society) .
9. Increased number of CHWs going through the CHW Core Skills Training (Healthy People).
10. Increased number of funding opportunities secured for CHWs, including payer reimbursement (Healthy People).
11. Increased number of satellite sites offering the CHW Core Skills Training (Healthy Communities)
12. Increased number of organizations utilizing or employing CHWs (Healthy Communities).
13. Increased number of CHWs working in high or very high HII areas (Equitable Society).

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14. Increased number of satellite sites in high or very high HII areas offering the CHW Core Skills Training (Equitable Society).
  15. Increased number of organizations in high or very high HII areas utilizing or employing CHWs (Equitable Society).

Strategies and Activities:

- Objective 1: Reduce household food insecurity and hunger.
  - Healthy People
    - Strategy 1: Increase the number of eligible people on the Supplemental Nutrition Assistance Program (SNAP).
      - Activity: Work with the Utah Department of Workforce Services to increase the number of people enrolled to receive SNAP benefits.
    - Strategy 2: Increase access to universal school meals.
      - Activity: Work with schools to streamline the paperwork process for schools and families to complete applications for free and reduced meals.
      - Activity: Conduct the FRESH Foods Survey annually to assess changes in the number of people in communities who receive healthier foods from food pantries, food banks or other feeding sites.
  - Healthy Communities
    - Strategy 1: Work with partners to reduce food insecurity in local areas.
      - Activity: Identify and convene community partners working on food insecurity to conduct a food insecurity assessment and develop a food access action plan.
      - Activity: Increase adoption of Produce Rx and Double Up Food Bucks by eligible patients and clinics.
      - Activity: Establish fruit and vegetable prescriptions with a fulfillment partner such that prescriptions (Produce Rx) can be filled at no or low-cost.
      - Activity: Partner with the UDOH Comprehensive Cancer Control Program and the Community Food Security Program to explore opportunities to expand the number of farmers markets that accept programs like Double Up Food Bucks, vouchers, Produce Rx, etc. and to increase the number of locations where people can learn about and enroll in SNAP.
    - Strategy 2: Work with partners to increase access to affordable, healthy and culturally appropriate food in community settings.
      - Activity: Support community venues, such as farmers markets, to provide increased financial incentives ( Double Up Food

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- Bucks) or acceptance of federal or state food assistance (SNAP, WIC, Pandemic EBT) to purchase healthier foods.
  - Activity: Improve and support existing infrastructural programs (Double Up Food Bucks, food pantries, farm to school).
  - Activity: Educate food pantry staff about the benefits of providing healthy and culturally appropriate food options at facilities.
  - Activity: Increase use of the Thumbs Up Program in food pantries to let patrons know which foods are healthy.
  - Activity: Work with communities to ensure food pantries can be easily accessed by public transportation for all community members.
  - Activity: Collaborate with partners providing emergency food to measure the proportion of fresh produce.
  - Activity: Create a workgroup to connect and partner with organizations to streamline efforts around emergency food efforts in Utah.
  - Activity: Work with grocers to increase donations for fresh produce to food pantries and decrease donations of baked goods, soda, and candy.
  - Activity: Work with universities and other organizations to share emerging research about food insecurity.
  - Equitable Society
    - Strategy 1: Increase access to affordable healthy and culturally appropriate food.
      - Activity: Increase SNAP benefits and utilization of Double Up Food Bucks and school meal programs in high and very high HHI communities.
      - Activity: Introduce culturally appropriate food as a way to increase healthy food in pantries and decrease food insecurity. Identify at least two food banks, pantries, or feeding sites in each community which have seen an increase in demand since February 2020 will adopt nutrition standards.
      - Activity: Work with food pantries to facilitate ways for qualifying people with disabilities to access food from pantries (delivery or drive thru options)
    - Strategy 2: Ensure equal access to healthy food in all small areas of the state.
      - Activity: Develop tools to measure household food insecurity and hunger within high and very high HHI areas.
      - Activity: Work with food pantries to develop and administer a survey to patrons to identify causes of food insecurity.

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- Activity: Identify policies that reduce food insecurity.
  - Activity: Develop a plan to change power dynamics to ensure those who are under-represented and under-resourced are able to be part of policy decisions related to food insecurity and hunger.
  - Objective 2: Partner with the Worksite Wellness Council, CHWs, and other partners to increase the number of worksites with wellness policies that include health promotion programs and to increase participation in existing worksite wellness programs.
    - Healthy People
      - Strategy 1: Increase the number of employees who are aware of their worksite wellness policies and programs.
        - Activity: Identify worksites with employee wellness policies.
        - Activity: Assist worksites in advertising worksite wellness policies and programs to their employees.
      - Strategy 2: Increase the number of businesses that implement and promote worksite policies that allow remote workers the same programs and opportunities as workers on-site.
        - Activity: Work with businesses to create wellness policies that allow remote workers and people with living with disabilities the same programs and opportunities as workers on-site. An example of this is allowing remote workers release time for physical activity just as you would allow on-site employees release time.
    - Healthy Communities
      - Strategy 1: Promote worksite wellness policies that support evidence-based strategies to address healthy food, physical activity, breastfeeding, and tobacco prevention.
        - Activity: Work with worksites to improve employee wellness, such as referring employees to a local chronic disease self-management program, incorporating National Diabetes Prevention Program into a worksite wellness program, training the coordinators of evidence-based lifestyle change programs on adapting the programs for people with disabilities, or discussing coverage of evidence based self-management classes with their insurance provider.
        - Activity: Encourage worksites to support active transportation for employees by offering transit cards, bike parking, telecommuting options, etc.
        - Activity: Conduct education classes for employers to help them understand the benefit of wellness policies (benefits include money savings, reduced absenteeism etc.).

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- Activity: Partner with Utah Disabilities Program to increase # of worksites with wellness policies that include ways to adapt for people with disabilities.
  - Activity: Identify insurance providers at worksites throughout Utah and begin having conversations about covering the National Diabetes Prevention Program.
  - Equitable Society
    - Strategy 1: Promote wellness policies among worksites that primarily employ people from trade and service industries or lower-wage earning jobs.
      - Activity: Work with blue collar worksites to encourage them to implement worksite wellness policies.
      - Activity: Encourage worksites to extend existing worksite wellness programs to employees' families.
  - Objective 3: Increase access to affordable transportation.
    - Healthy Communities
      - Strategy 1: Work with partners to expand access to and make public transportation more affordable.
        - Activity: Identify potential policy solutions that increase access to UTA and other public transportation systems.
    - Equitable Society
      - Strategy 1: Improve health outcomes of under-resourced and under-represented communities by improving access to affordable and reliable public transportation.
        - Activity: Study the populations facing disparities in access to sidewalks, bike lanes, and other forms of physical activity as a form of transportation to identify potential solutions.
        - Activity: Work with communities in high or very high HII areas to better understand their access to affordable transportation.
        - Activity: Work with state and local transportation departments to ensure equitable transportation funding for transit for all communities.
      - Strategy 2: Work with city councils and planners to improve walkability in high and very high HII communities.
        - Activity: Work with the Utah Department of Transportation and Metropolitan Planning Organizations to prioritize walkability and other forms of alternative transportation in funding applications.
        - Activity: Create parcel maps with transit layers to assess walkability and access to public transportation.



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- Objective 4: Reduce the proportion of people who are unable to get medical care when they need it.
    - Healthy Communities
      - Strategy 1: Increase affordability and access of telehealth services.
        - Activity: Work with decision makers to improve laws related to telehealth and the internet.
        - Activity: Work with decision makers to implement reimbursement structures for telehealth.
        - Activity: Work with telehealth providers to educate them on the accommodations necessary for people with disabilities such as visual impairment.
      - Strategy 2: Increase support and availability for transit options to medical care.
        - Activity: Work with partners to increase affordable transit options for those who need transportation assistance in order to access medical care.
    - Equitable Society
      - Strategy 1: Increase insurance coverage for underserved populations (low-income, refugee/immigrant populations, etc.).
        - Activity: Work with partners to increase Medicaid coverage for chronic disease care and management.
        - Activity: Utilize CHWs to reach under-represented and under-resourced populations to improve understanding of qualifications for insurance coverage.
        - Activity: Utilize CHWs to help under-represented and under-resource populations enroll in insurance coverage.
      - Strategy 2: Expand reimbursement coverage for CHWs
        - Activity: Increase opportunities for CHWs to receive statewide certification recognition.
        - Activity: Work with decision makers, CHWs, and health plans for reimbursement coverage for CHWs working in clinics and serving underserved communities.

## II. Education Access and Quality

### Long-term outcomes

1. Decreased heart disease, diabetes, and obesity-related chronic condition morbidity rates.
2. Decreased heart disease, diabetes, and obesity-related chronic condition mortality rates.
3. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among priority populations.

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4. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among under-resourced/under-represented racial and ethnic groups.

Objective 1: Increase opportunities for physical activity and healthy eating in preschool and K-12 schools to enhance the ability to learn.

Intermediate outcomes

1. Increased percent of adolescents who are physically active at least 60 minutes per day (Healthy People).
2. Increased number of students that eat recommended servings of fruits and vegetables (Healthy People).
3. Increased number of schools that have adopted components of Comprehensive School Physical Activity Programs (CSPAP) (Healthy Communities),
4. Increased number of LEAs with policies to incorporate physical activity throughout the day (Healthy Communities).
5. Increase physical activity among Utah adolescents in priority populations compared to overall (Equitable Society).

Short-term outcomes

1. Increased number of students participating in PE classes (Healthy People).
2. Increased number of students participating in school meals (Healthy People).
3. Increased number of schools that have developed or enhanced Safe Routes to School maps and policies (Healthy Communities).
4. Increased number of schools with healthy eating policies (Healthy Communities).
5. Increased number of after-school programs that incorporate physical activity and healthy eating (Healthy Communities).
6. Increased proportion of schools in high and very high HII communities that have developed or enhanced Safe Routes to School maps and policies (Equitable Society).
7. Increase the number of adolescents who consume five servings of fruits and vegetables per day. (Equitable Society).

Objective 2: Increase the proportion of children who participate in high-quality early childhood education programs.

Intermediate outcomes

1. Increased physical activity rates among Utah children (Healthy People).

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2. Increased number of children in Utah that eat recommended servings of fruits and vegetables each day (Healthy People).
  3. Increased number of early childhood education facilities that adopt and implement physical activity and nutrition policies and standards (Healthy Communities).
  4. Increase physical activity rates among Utah children in priority populations compared to overall (Equitable Society).

#### Short-term outcomes

1. Increased number of children enrolled in TOP Star endorsed facilities (Healthy People).
2. Increased number of early childcare and education and Head Start facilities that have a TOP Star endorsement.
3. Increased number of TOP Star endorsed facilities in high and very high HII communities (Equitable Society).

Objective 3: Increase the proportion of children and adolescents who receive chronic disease prevention and management services in school.

#### Intermediate Outcomes

1. Increased number of children screened for chronic disease at schools (Healthy People).
2. Increased number of eligible students enrolled in the Children's Health Insurance Program (Healthy People).
3. Increased number of schools with preventive/screening services available for students (Healthy Communities).
4. Increased proportion of school nurses to children in schools and LEAs (Healthy Communities).
5. Decreased disparities in children with a primary care doctor in priority populations compared to overall (Equitable Society).

#### Short-Term Outcomes

1. Increased number of students with chronic conditions that have an individualized healthcare plan (Healthy People).
2. Increased number of students that have access to culturally appropriate information about healthy eating, physical activity, and healthy living (Healthy People).
3. Increased number of schools that utilize CHWs (Healthy Communities).
4. Increased number of schools that screen students for social determinants of health and provide resources (Healthy Communities).

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5. Increased number of screening opportunities in schools in high and very high HII communities (Equitable Society).

Strategies and Activities:

- Objective 1: Increase opportunities for physical activity and healthy eating in K-12 schools.
  - Healthy People
    - Strategy 1: Expand access to culturally appropriate healthy foods served to students.
      - Activity: Conduct an assessment to determine what foods students feel are culturally appropriate for them and would like to have served at school.
      - Activity: Work with food service directors to increase participation in breakfast and lunch.
      - Activity: Educate and support schools about the harvest of the season program.
      - Activity: Encourage and support LEAs to apply for the fresh fruit and vegetable program.
      - Activity: Work with food service directors to provide taste tests to students.
  - Healthy Communities
    - Strategy 1: Support the school system as a safe and healthy school environment that focuses on the whole community, whole school, and whole child.
      - Activity: Work with USBE to encourage LEAs to utilize the Health and Wellness Policy Model and evaluation tool.
      - Activity: Support work around USBE physical activity/education and health standards.
      - Activity: Work with schools to develop policies that promote healthy living and physical activities that are culturally appropriate.
      - Activity: Work with schools to promote, support, and implement evidence-based programs and wellness practices.
      - Activity: Work with SHAPE Utah to ensure that classroom teachers provide physical activity opportunities.
      - Activity: Work with USBE, LEAs and schools to provide professional development opportunities around health standards to school staff such as food service employees, aides, para professionals, etc.
    - Strategy 2: Enhance state, LEA, and school physical activity policies that increase physical activity opportunities throughout the school day.

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- Activity: Support USBE and Shape Utah to educate and provide ongoing resources to elementary school teachers to provide physical activity opportunities throughout the day.
  - Activity: Train teachers and physical education specialists on how to incorporate students with disabilities and chronic conditions in physical activity..
  - Activity: Educate and support LEAs to utilize the Physical Education Curriculum Analysis Tool and the Health Education Curriculum Analysis Tool.
  - Activity: Work with stakeholders and community partners to support and offer low-cost after-school programs.
  - Activity: Develop partnerships to work with schools to develop safe route policies and help schools apply for funding to ensure safe routes.
  - Activity: Educate LEAs on how to adopt USBE recess and health and wellness policies.
  - Strategy 3: Provide technical assistance to LEAs to strengthen local school wellness policies and increase participation in school nutrition programs (Farm to School, Breakfast, Harvest of the Month, etc.).
    - Activity: Educate and support schools about farm-to-fork programs and initiatives that support Utah-grown foods.
    - Activity: Work with USBE to ensure that all schools who participate in the school lunch program offer a breakfast program.
    - Activity: Implement healthy food vending policies in school settings.
  - Equitable Society
    - Strategy 1: Support the school system to be a safe and healthy school environment that focuses on the whole community, whole school, and whole child.
      - Activity: Work with LEAs and schools to utilize the CDC School Health Index to assess school health programs and identify the policies and practices most likely to be effective in reducing youth health risk behaviors.
      - Activity: Work with partners to address social and emotional learning (SEL) and adverse childhood experiences (ACEs) in schools
    - Strategy 2: Look for opportunities to increase physical activity and healthy eating education at low-income schools.
      - Activity: Create a structure and opportunity for community involvement in offering PE in underfunded schools (yoga teachers, etc.).

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- Activity: Identify schools and student populations within high and very high HHI communities that are in greatest need of more physical activity and healthy eating.
  - Activity: Engage with schools in under-resourced and under-represented communities to understand what they would consider to be "healthy eating" and what types of "physical activity" opportunities are most meaningful to them, their family, and their community.
  - Activity: Work with school community councils to ensure that Safe Routes to School policies and maps are current.
  - Objective 2: Increase the proportion of children who participate in high-quality early childhood education programs.
    - Healthy People
      - Strategy 1: Implement and integrate nutrition and physical activity standards into statewide early childhood education systems.
        - Activity: Educate Utahns on how to find an early childhood education (standard checklist).
        - Activity: Provide high quality materials and resources at the appropriate reading level to families to educate them on nutrition and physical activity.
        - Activity: Educate caregivers on healthy nutrition practices.
    - Healthy Communities
      - Strategy 1: Implement and integrate nutrition and physical activity standards into statewide early care and education systems.
        - Activity: Expand non-traditional partners' involvement in TOP Star (promotion, outreach, marketing and managing).
        - Activity: Implement multi-directional marketing and expand social media and communication campaigns with grassroots efforts that lead to improved health environments and policies.
        - Activity: Educate all early care and education providers about the TOP Star program, working towards early care and educations becoming certified TOP Star programs.
      - Strategy 2: Increase the sites offering high quality early care and education programs at universities, colleges, and worksites.
        - Activity: Work with universities, colleges, and worksites to increase the number offering high quality early care and education programs.
        - Activity: Educate all early care and educations about the TOP Star program, working towards early care and educations becoming certified TOP Star programs.

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- Strategy 3: Expand TOP Star into preschool facilities and early care and educations as a road map and pathway to the pre-K and school.
    - Activity: Work with preschool facilities to implement the TOP Star program.
    - Activity: Work with current TOP Star program to update and maintain program certification.
  - Equitable Society
    - Strategy 1: Work with high and very high HII communities to improve access to and availability of high quality ECE's that participate in TOP Star and other related services.
      - Activity: Use data to identify disparate populations in need of quality childcare services and target TOP Star programming.
      - Activity: Identify populations that do and do not participate in the TOP Star program to understand if certain populations are more or less likely to be engaged.
      - Activity: Expand access of TOP Star into refugee and other English as a second language communities with culturally appropriate content.
      - Activity: Expand continuing education and training to non-English speaking populations.
    - Strategy 2: Increase affordability of early care and education in high and very high HII communities.
      - Activity: Work with policy makers to ensure quality childcare is available and affordable to all Utahns.
  - Objective 3: Increase the proportion of children and adolescents who receive chronic disease prevention and management services in school.
    - Healthy People
      - Strategy 1: Provide culturally appropriate materials for children and adolescents about preventing and managing chronic conditions.
        - Activity: Provide resources to parents and teachers of students with chronic conditions and how they can manage the condition.
    - Healthy Communities
      - Strategy 1: Increase access to healthcare services at school.
        - Activity: Expand the number of affordable or no cost on-site preventive screenings at parent teacher conferences and other events.
        - Activity: Create a culture of prioritizing prevention and managing healthcare (allot time, adjust lesson plans, etc.).
        - Activity: Explore opportunities for students to have access to free health services.
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- Equitable Society
    - Strategy 1: Ensure broadband services are available for all students.
      - Activity: Work with LEAs to ensure that families have access to broadband services. These resources can help bridge the digital divide.
      - Activity: Compile a list of resources to ensure students have access to a variety of health services.
    - Strategy 2: Understand the specific needs of under-resourced and under-represented communities by engaging directly with the population as it relates to prevention and management.
      - Activity: Identify sustainable funding opportunities or policy opportunities to increase the proportion of children who receive healthcare for chronic disease prevention and management in schools.
      - Activity: Increase the number of eligible students and their families who are enrolled in and receive Medicaid and CHIP benefits.
      - Activity: Promote social determinants of health screenings for school-aged children along with their families.
      - Activity: Work with CHWs in schools to connect students and families to services outside of the school.
      - Activity: Hold an engagement session with the population of interest to learn more about their needs related to prevention and management of chronic conditions in school.

### III. Health Care Access and Quality

#### Long-Term Outcomes

1. Decreased heart disease, diabetes, and obesity-related chronic condition morbidity rates.
2. Decreased heart disease, diabetes, and obesity-related chronic condition mortality rates.
3. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among priority populations.
4. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among under-resourced/under-represented communities.

Objective 1: Increase the proportion of adults who get recommended evidence-based preventive healthcare.

#### Intermediate Outcomes



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1. Increased coverage of preventive care and services (Healthy People).
  2. Increased reimbursement for preventive care and services (Healthy Communities).
  3. Decreased disparities in undiagnosed conditions among priority populations (Equitable Society).
  4. Decreased disparities in the number of people screened for prediabetes (fasting blood glucose, A1C, or risk test), hypertension, and cholesterol among priority populations (Equitable Society).
  5. Decreased disparities in emergency room visits specific to heart disease, stroke, diabetes, kidney failure, and other related complications among priority populations (Equitable Society).
  6. Decreased disparities in hospitalizations specific to heart disease, stroke, diabetes, kidney failure, and other related complications among priority populations (Equitable Society).

#### Short-term Outcomes

1. Increased number of patients personally engaging with patient navigators or CHWs to prevent chronic conditions (Healthy People).
2. Increased percentage of adults with a primary care provider (Healthy People).
3. Increased percentage of adults who visited a doctor for a routine checkup in the past year (Healthy People).
4. Increased number of clinics who are following practice guidelines for chronic disease screenings or follow-ups (Healthy Communities).

Objective 2: Increase the utilization of Evidence-Based Lifestyle Change Programs (EBLCP) and Chronic Disease Self-management Programs (CDSMP) for the prevention and management of chronic disease.

#### Intermediate Outcomes

1. Increased number of participants in EBLCPs who complete their program (Healthy People).
2. Increased number of participants in EBLCPs who met their program-specific goals (Healthy People).
3. Increased coverage of EBLCPs (Healthy People).
4. Increased number of insurers providing reimbursement for EBLCPs (Healthy Communities).
5. Increased number of EBLCPs offered in high and very high HII areas (Equitable Society).
6. Increased number of participants in EBLCPs from high and very high HII areas (Equitable Society).

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### Short-term Outcomes

1. Increased number of trained National Diabetes Prevention Program lifestyle coaches (Healthy Communities).
2. Increased number of participants referred to EBLCPs from the healthcare systems, community-based organizations, and LHDs (Healthy Communities).
3. Increased participation in EBLCPs (Healthy People) (both enrollment and retention).
4. Increased number of EBLCPs offered through partners or other organizations (Healthy Communities).
5. Increased number of employers offering EBLCPs or referring employees (Healthy Communities).
6. Increased number of clinics which refer patients to EBLCPs (Healthy Communities).
7. Increased number of clinics within high and very high HII areas with EBLCP referral policies or procedures (Equitable Society).

Objective 3: Increase the ability of primary care professionals to provide high-quality care to patients.

### Intermediate Outcomes

1. Increased number of patients utilizing telehealth services (Healthy People).
2. Decreased number of emergency department visits and hospitalizations due to unmanaged chronic conditions (Healthy People).
3. Increased number of insurers providing reimbursement for enhanced pharmacy services (Healthy Communities).
4. Increased number of payers providing reimbursement for telehealth chronic condition management (Healthy Communities).
5. Increased number of insurers providing reimbursement for patient engagement with patient navigators/CHWs (Healthy Communities).
6. Increased number of clinics referring to social determinants of health resources (Healthy Communities).
7. Decreased disparities in the number of emergency department visits and hospitalizations due to unmanaged chronic conditions (Equitable Society).

### Short-term Outcomes

1. Increased number of patients with access to telehealth services (Healthy Communities).
2. Increased number of clinics utilizing telehealth for managing chronic conditions (Healthy Communities).

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3. Increased number of clinics utilizing electronic health records to identify patients with undiagnosed chronic conditions (Healthy Communities).
  4. Increased number of clinics with enhanced team-based care policies (Healthy Communities).
  5. Increased number of clinics screening for social determinants of health in healthcare settings (Healthy Communities).
  6. Increased number of clinics with policies in place to utilize enhanced pharmacy services (Healthy Communities).
  7. Increased number of pharmacies that provide enhanced pharmacy services (Healthy Communities).
  8. Increased number of clinics within high and very high HII areas with enhanced team-based care policy (Equitable Society).

Objective 4: Increase the proportion of women who have access to lactation services and accommodations.

#### Intermediate Outcomes

1. Increased number of women who breastfeed exclusively for the first six months of their infant's life (Healthy People).
2. Increased number of women who breastfeed for the first year of their infant's life(Healthy People).
3. Increased number of employers offering paid maternity leave (Healthy Communities).
4. Decreased disparities in the number of women within high and very high HII areas who breastfeed exclusively for the first six months of their infant's life (Equitable Society).
5. Decreased disparities in the number of women within high and very high HII areas who breastfeed for the first year of their infant's life (Equitable Society).

#### Short-term Outcomes

1. Increased number of worksites that are fully compliant with federal lactation accommodation laws (Healthy Communities).
2. Increased number of hospitals and birthing centers which meet the Stepping Up for Utah Babies program requirements (Healthy Communities).

#### Strategies and Activities:

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- **Objective 1:** Increase the proportion of adults who get the recommended evidence-based preventive healthcare.
    - Healthy People
      - **Strategy 1:** Increase the inclusion of CHWs into the healthcare team to help patients navigate the healthcare system to link patients to preventive services.
        - **Activity:** Facilitate engagement of patient navigators or CHWs in clinical settings to address chronic conditions.
        - **Activity:** Educate CHWs on how to help their clients navigate health insurance, benefits from social services connected to the healthcare system, evidenced-based preventative care and how to communicate with healthcare providers.
        - **Activity:** Provide training for CHWs and healthcare providers on how to incorporate CHWs effectively into their healthcare team.
      - **Strategy 2:** Increase the number of individuals receiving evidence-based preventive healthcare to address chronic conditions.
        - **Activity:** Work with insurance providers to provide incentives to members who get annual screenings for chronic conditions.
        - **Activity:** Facilitate education to providers on evidence-based programs to address chronic conditions.
        - **Activity:** Investigate and prioritize potential policies to increase reimbursement of evidence-based health care interventions (i.e. National DPP as a model).
        - **Activity:** Identify patients with diabetes and chronic kidney disease through electronic health records and data mining.
        - **Activity:** Increase awareness of the connection between hypertension and diabetes to chronic kidney disease with patients and healthcare providers.
        - **Activity:** Work with National Diabetes Prevention Program and Chronic Disease Self-Management Program leaders to ensure intake forms include questions regarding whether or not accommodations for the classes are needed for people living with disabilities.
    - Healthy Communities
      - **Strategy 1:** Increase the recruitment and hiring of CHWs by clinics.
        - **Activity:** Educate providers and healthcare systems on the role and benefit of utilizing CHWs to address chronic conditions.
    - Equitable Society<sup>2</sup>
      - **Strategy 1:** Provide education to healthcare providers and decision makers to increase their understanding of how social determinants

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<sup>2</sup> Activities around expanding insurance coverage can be found under “Equitable Society, Objective 4”

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- of health impacts access to preventive healthcare among underserved and underrepresented communities.
- Activity: Identify new partners to promote evidence-based preventive healthcare to priority populations to address chronic conditions.
  - Activity: Provide healthcare provider education around cultural humility.
  - Activity: Provide education to decision makers on the link between social determinants of health and how it impacts preventive healthcare access ( transportation to facility, income to access care, etc.) and how it affects under-resourced and under-represented communities.
  - Strategy 2: Educate healthcare providers on effective ways to talk to patients about obesity with a focus on healthcare providers physicians who work in sliding scale clinics.
    - Activity: Provide education on cultural humility on topics such as obesity, nutrition, Body Mass Index, etc.
  - Strategy 3: Promote provider training on inclusivity and accessibility.
    - Activity: Partner with the Uah Disabilities Program to promote training
  - Objective 2: Increase the utilization of Evidence Based Lifestyle Change Programs (EBLCP) and Chronic Disease Self-management Programs (CDSMP) for the prevention and management of chronic disease
    - Healthy People
      - Strategy 1: Increase participant enrollment in EBLCP and CDSMP.
        - Activity: Increase awareness of EBLCP and CDSMP to individuals and healthcare workers through provider education, CHWs, and risk assessment surveys provided through the NACDD website, etc.
    - Healthy Communities
      - Strategy 1: Provide support for EBLCP and CDSMP in Utah.
        - Activity: Develop and improve partnerships that lead to increased referrals to lifestyle change programs for eligible people.
        - Activity: Identify businesses that are ready to offer EBLCPs and CDSMPs to employees as well as employers that are ready to develop a process to refer at-risk employees to such programs.
        - Activity: Work with partners to increase the number of EBLCP and CDSMP in community settings.

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- Activity: Increase the number of sites that promote target EBLCP and CDSMP to under-resourced and under-represented individuals.
  - Activity: Work with partners to increase the number of trained lifestyle coaches for the National Diabetes Prevention Program.
  - Activity: Collaborate with partners to deliver the lifestyle change programs and chronic disease self-management programs through partners or collaboration with other organizations (American Diabetes Association, NACDD, Association of Diabetes Care & Education Specialists (ADCES)).
  - Activity: Increase referrals to and participation in lifestyle change programs and chronic disease self-management programs from the healthcare system.
  - Activity: Increase the number of payers who are providing reimbursement for the National Diabetes Prevention.
  - Activity: Increase the number of employers who opt-in to coverage of National Diabetes Prevention.
  - Strategy 2: Increase the number of community organizations that provide prevention services to those who are under-resourced and under-represented.
    - Activity: Educate community organizations on EBLCP and CDSMP and other chronic disease related programs and services they can provide.
    - Activity: Provide community organizations with resources to apply for funding for such services.
    - Activity: Assess the interest and capacity of community-based organizations to conduct health screenings.
  - Equitable Society
    - Strategy 1: Utilize social determinants of health to identify and address root causes of chronic disease.
      - Activity: Promote simple screening for social determinants of health in healthcare settings.
      - Activity: Educate care team members on how to address social determinants of health needs among their patient population.
      - Activity: Help healthcare administrators identify existing links between social determinants of health factors and chronic disease control rates among their patient population.

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- **Objective 3:** Increase the ability of primary care professionals to provide more high-quality care to patients.
    - Healthy People
      - **Strategy 1:** Engage pharmacists in providing enhanced services to improve access to quality care and health outcomes for individuals.
        - **Activity:** Educate providers on enhanced pharmacy services and how to effectively partner with pharmacists to improve patient health outcomes.
      - **Strategy 2:** Increase the use of non-physician team members in reducing chronic conditions
        - **Activity:** Develop a policy that promotes sustainable funding for CHWs.
        - **Activity:** Educate providers about how to utilize and increase the number of health care teams that include CHWs.
        - **Activity:** Increase awareness of and referrals to evidence-based programs.
        - **Activity:** Utilize non-physician team members such as diet techs, CHWs, care managers, office staff, etc. in prevention roles.
        - **Activity:** Partner with medical and physician assistant programs to educate students about interventions to prevent and control diabetes, heart disease, chronic kidney disease, and obesity.
    - Healthy Communities
      - **Strategy 1:** Increase utilization of health information technology by health systems, clinics, and public health.
        - **Activity:** Implement systems to facilitate bi-directional, e-referral between healthcare systems and CDC-recognized lifestyle change programs.
        - **Activity:** Build partnerships to increase interoperability and data sharing to assist with continuous quality improvement.
        - **Activity:** Work with health systems to adopt a policy that requires administrative staff to use electronic health records to identify undiagnosed hypertension.
        - **Activity:** Work with healthcare providers to add physical activity as a vital sign at check-ups.
        - **Activity:** Utilize large data sets to identify patterns and correlations to improve outcomes for chronic conditions.
        - **Activity:** Continue reviewing the Clinical Health Information Exchange (CHIE) infrastructure and support improvements to be able to effectively store, maintain, and transmit data to the UDOH for chronic disease surveillance.

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- Activity: Assess the availability of telehealth in terms of healthcare access and health programs or other services, including identification of platforms and populations served.
  - Inform clinics of ways to increase accessibility and ADA compliance of telehealth for people with disabilities
  - Strategy 2: Engage pharmacists in providing enhanced services to improve access to quality care and health outcomes for pharmacy patrons.
    - Activity: Work with payers in Utah to expand pharmacy reimbursement services and payment methods.
    - Activity: Increase the number of community pharmacies that are implementing or using medication therapy management for chronic disease management.
    - Activity: Increase the number of community pharmacies that are providing lifestyle modification and chronic disease management and education services.
    - Activity: Increase the number of community pharmacies that have collaborative or cooperative agreements with referring physicians.
    - Activity: Increase hypertension monitoring linkages between pharmacies and health systems.
    - Activity: Explore chronic care management opportunities for pharmacies with primary care and other systems.
    - Activity: Identify independent pharmacies to provide technical assistance for offering diabetes self-management education and support and support the launch of these programs.
    - Activity: Provide ongoing follow-up and technical assistance to pharmacies that were provided with diabetes self-management education and support accreditation.
    - Activity: Leverage partnerships with community pharmacies and the Utah Pharmacy Association to improve pharmacy engagement, processes, billing, and clinical documentation for offering diabetes self-management education and support.
    - Activity: Work with pharmacies to promote medication therapy management. Examples of activities may include providing blood pressure and cholesterol management evidence-based lifestyle modification resources to pharmacists; or working with pharmacies and providers to reduce patients' out-of-pocket costs by prescribing generic prescriptions, one-pill therapy, and promoting additional resources (Good Rx app).



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- Equitable Society
    - Strategy 1: Ensure that patients in high and very high HII have access to primary care including telehealth services.
      - Activity: Engage with health systems to provide telehealth services that are accessible to people who live in high and very high HII communities.
      - Activity: Train healthcare providers who treat patients who live in very high and high HII areas on resources available for medical assistance.
      - Activity: Provide a comprehensive guide to primary care providers about steps and tools to approach care from a health equity lens.
      - Activity: Develop a plan to determine how to maintain telehealth or digital technology gains, including policy implications and partnerships for expanding the reach and accessibility of broadband internet to under-resourced and under-represented communities.
    - Objective 4: Increase the proportion of women who have access to lactation services and accommodations.
      - Healthy People
        - Strategy 1: Increase environmental support for caregivers to initiate best practices to ensure healthy nutrition and physical activity.
          - Activity: Conduct training and learning collaboratives for healthcare providers and facilities around maternal and child health.
          - Activity: Provide nutrition resources for infants and children to families.
          - Activity: Utilize CHWs in healthcare settings to connect individuals with lactation support.
          - Activity: Increase provider coverage of lactation consultation services.
          - Activity: Include lactation training in residency programs for primary care providers.
          - Activity: Increase support systems for women returning to the workforce through improved worksite policies.
      - Healthy Communities
        - Strategy 1: Increase environmental support within communities to initiate best practices for lactating women to ensure healthy nutrition and physical activity.
          - Activity: Increase participation in the Stepping up for Utah Babies program in hospitals, birthing facilities, and institutions

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as a potential stepping stone to the Baby Friendly Hospital Initiative.

- Activity: Provide breastfeeding accommodations in public places.
  - Activity: Collaborate with community partners to increase environmental support within communities to initiate best practices for nutrition and physical activity.
  - Activity: Expand the workplace lactation support program into more businesses and all early childcare and education facilities.
  - Activity: Collaborate with healthcare systems to increase opportunities for prenatal education with programs such as Stepping Up for Utah Babies.
- Equitable Society
    - Strategy 1: Increase access to lactation services and accommodations in high and very high HII areas.
      - Activity: Utilize evidence-based strategies to address community differences and provide lactation services that meet population needs.
      - Activity: Engage community stakeholders within high and very high HII areas to assess their needs and wants around lactation services.
      - Activity: Work with Medicaid providers, Federally Qualified Health Centers (FQHCs), and other clinics that serve the under-resourced and under-represented to ensure that healthcare providers are being trained on lactation services and accommodations.

#### IV. Neighborhood and Built Environment

##### Long-term outcomes

1. Decreased heart disease, diabetes, chronic kidney disease and obesity-related chronic condition morbidity rates.
2. Decreased heart disease, diabetes, chronic kidney disease, and obesity-related chronic condition mortality rates.
3. Decreased disparities in heart disease, diabetes, chronic kidney disease, and obesity-related chronic condition morbidity and mortality rates among priority populations.
4. Decreased disparities in heart disease, chronic kidney disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among under-resourced/under-represented racial and ethnic groups.

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· Objective 1: Increase availability of healthy foods.

Intermediate outcomes

1. Increased consumption of healthy foods (Healthy People).
2. Increased number of eligible people on SNAP program benefits among residents in high and very high HII (Healthy People).
3. Increased number of community venues that adopt Eat Well Utah (Healthy Community).
4. Increased number of community venues that adopt Eat Well Utah in high and very high HII areas (Healthy Community).

Short-term outcomes

1. Increased number of food pantries that provide healthy and culturally appropriate food (Healthy Community).
2. Increased number of food pantries that provide healthy and culturally appropriate food in high and very high HII areas (Healthy Community)
3. Increased opportunities for eligible people in high and very high HII to enroll in SNAP.

Objective 2: Increase perceived safety and accessibility of sidewalks, streets, trails, parks, etc.

Intermediate outcomes

1. Increased number of people who are physically active (Healthy People).
2. Increased number of cities that implement changes to promote walkable communities (Healthy Community).
3. Increased number of enhancements to trails and parks to make them more user friendly and increase perception of safety (Healthy Community).
4. Increased actual safety of selected areas (Healthy Community).
5. Increased funds from city budgets dedicated to improving walkability of communities in high and very high HII areas (Healthy Community).
6. Increased number of people who use active transportation (who walk or bike to get places) (Healthy People).
7. Increased number of people who use parks and trails (Healthy People).
8. Increased number of people who use active transportation (who walk or bike to get places) in high and very HII areas (Healthy People).

Short-term outcomes

1. Increased number of city plans that incorporate active transportation in high and very high HII areas (Equitable Society).

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Objective 3: Increased use of mass transit.

Intermediate outcomes

1. Increased access to mass transit, particularly in areas around food pantries, healthcare clinics, and industry. (Healthy Communities)
2. Expanded mass transit schedules that accommodate people who get off work late at night or during “off” hours. (Healthy Communities)
3. Increased number of people in high HII using mass transit (Healthy People).
4. Increased number of TRAX stops in high and very high HII areas (Healthy Community).

Short-term outcomes

1. Increased number of people who have access to mass transit (Healthy People).
2. Increased number of under-resourced and under-represented communities served by transit (Healthy Community).
3. Increased number of workplaces that offer transit passes to their employees. (Healthy Communities)
4. Increased number of workplaces with bike parking. (Healthy Communities)

Objective 4: Increased number of worksites with wellness policies.

Intermediate outcomes

1. Increased number of employees with opportunities to engage in physical activity while at work or who have access to healthy foods at their worksite (Healthy Community).
2. Increased number of worksites in compliance with lactation accommodations (Healthy Community).
3. Increased number of worksites with wellness plans in high and very high HII areas (Healthy Community).

Short-term outcomes

1. Increased number of employees who work in worksites that have wellness policies (Equitable Society).
2. Increased number of worksites that implement wellness policies or plans (Healthy Community).
3. Increased number of worksites in high or very HII areas that have an exercise release time policy (Healthy Community).

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## Strategies and Activities:

- Objective 1: Increased availability of healthy foods.
  - Healthy People
    - Strategy 1: Increase environmental support for caregivers, infants, and children to ensure healthy nutrition.
      - Activity: Provide resources to caregivers of infants and children attending TOP Star endorsed ECEs about healthy nutrition practices, including information on breastfeeding.
      - Activity: Work with lactation consultants to provide educational classes for caregivers of infants to ensure best practices for healthy nutrition.
  - Healthy Communities
    - Strategy 1: Implement food service guidelines in community settings.
      - Activity: Implement Eat Well Utah into in-patient meals in at least one hospital.
      - Activity: Implement and expand Eat Well Utah into additional community or worksite venues.
    - Strategy 2: Increase and improve policies that support food security.
      - Activity: Work with cities to design mixed-use land policies that create neighborhoods with safe access to healthy foods, including grocery stores, farmers markets, etc.
      - Activity: Put memorandums of understanding (MOUs) in place with community-based organizations to to expand produce incentives and reach (such as farm to early childcare education, Harvest of the Season)
      - Activity: Partner with the UDOH Comprehensive Cancer Control Program and the Community Food Security Program to work with farmers market operators to create a set of standards regarding the percent of booths that have healthy food options.
      - Activity: Work with city planners to explore opportunities for healthy food options that are accessible to new housing development units.
- Equitable Society
  - Strategy 1: Increased availability of healthy foods.
    - Activity: Work to implement healthy checkout lanes in at least five grocery stores in under-resourced and under-represented communities.
    - Activity: Work with Grocery Rescue to donate more culturally diverse foods to community food pantries.

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- Activity: Identify gaps in transportation routes (mass transit and bike or walking lanes) to healthy food options, including farmers markets and community food pantries.
  - Activity: Work with food pantries to explore the possibility of creating drive-through pantries for people with disabilities.
  - Activity: Work with cities and towns to create community garden spaces in high and very high HII areas.
  - Activity: Meet with under-resourced and under-represented communities to understand what healthy foods means to them and what factors are impacting the availability of healthy food in their communities.
  - Activity: Identify food deserts and explore opportunities to incentivize grocers to move to low-income neighborhoods.
  - Activity: Partner with the UDOH Comprehensive Cancer Control Program and the Community Food Security Program to increase the number of farmers markets in high and very high HII areas, especially areas where mass transit or active transportation opportunities are available.
- Objective 2: Increased perceived safety and accessibility of sidewalks, streets, trails, parks, etc.
    - Healthy People
      - Strategy 1: Increased number of cities and counties with active transportation plans and components of general city and county plans.
        - Activity: Identify what factors influence people's perception of safety and accessibility.
        - Activity: Develop a plan to implement changes to the built environment so people living and working in the community feel safer using active transportation.
    - Healthy Communities
      - Strategy 1: Increased number of cities and counties with active transportation plans and components of general city and county plans.
        - Activity: Work with city or county planners to provide added security at trail heads, parks, etc.
        - Activity: Explore opportunities to make communities safer with decision makers in high and very high HII areas.
        - Activity: Work with communities to ensure pedestrian routes and safety are considered with every transportation plan.

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- Activity: Create walking school buses, bicycle trains, and safe routes to school to increase physical activity among school-aged children.
  - Activity: Assess routes and safety for people with disabilities
  - Strategy 2: Collaborate with partners to implement master plans and land use interventions that connect the built environment and active transportation.
    - Activity: Encourage city and county planners to develop active transportation plans.
    - Activity: Work with school districts and cities to implement safe routes to schools.
    - Activity: Work with communities to improve the safety and infrastructure within the first and last mile around transit stops.
    - Activity: Work with city planners to increase adequate crossing time at crosswalks.
    - Activity: Work with contractors of housing developments to provide residents with safety features in and around housing, such as street lights on sidewalks.
  - Equitable Society
    - Strategy 1: Collaborate with partners in high and very high HII areas to implement master plans and land use interventions that connect the built environment and active transportation.
      - Activity: Discuss the need for active transportation or connections to transit in underserved and under-represented communities with local community or neighborhood councils and divisions of transportation.
      - Activity: Develop fact sheets that emphasize the health impacts and areas of health disparities related to chronic disease with the Utah Department of Transportation and city transportation officials.
      - Activity: Use data to demonstrate where walking and biking infrastructure is lacking.
      - Activity: Work with city and county planners to consider mixed land use developments that create safe walking and biking networks with access to central services.
      - Activity: Work with high and very high HII areas to improve sidewalk safety and bike safety.
  - Objective 3: Increase use of mass transit among Utahns.
    - Healthy Communities
      - Strategy 1: Collaborate with community members and businesses to increase the number and frequency of transit stops.
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- Activity: Increase parking options at transit stops.
  - Activity: Create better connections from public transportation to communities where people live (shorter routes, more direct routes, etc.).
  - Equitable Society
    - Strategy 1: Ensure equitable transportation opportunities in all communities.
      - Activity: Conduct targeted and specific education for community leaders regarding transportation disparities.
      - Activity: Conduct engagement sessions or focus groups with community members to understand their needs and wants around mass transit.
    - Strategy 2: Work with partners to expand and maintain access to mass transit for people with disabilities.
      - Activity: Work with city and county planners to ensure access for people with disabilities is part of the city and county master plan.

## V. Social and Community Context

### Long-term outcomes

1. Decreased heart disease, diabetes, and obesity-related chronic condition morbidity rates.
2. Decreased heart disease, diabetes, and obesity-related chronic condition mortality rates.
3. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among priority populations.
4. Decreased disparities in heart disease, diabetes, and obesity-related chronic condition morbidity and mortality rates among under-resourced/under-represented communities.

Objective 1: Increased use of social marketing to promote Evidence-Based Lifestyle Change Programs (EBLCP) and Chronic Disease Self-Management Programs (CDSMP).

### Intermediate outcomes

1. Increased number of adults reached by social marketing (Healthy People).
2. Increased number of adults reached by targeted social marketing by HII (Equitable Society).
3. Increased number of EBLCPs and CDSMPs using social marketing campaigns (Healthy Communities).



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4. Increased number of adults talking to friends and family about their health (Healthy People).

#### Short-term outcomes

1. Increased number of social marketing campaigns developed (Healthy Communities).

#### Intermediate Outcomes

1. Decreased number of people putting off healthcare (Healthy People).
2. Increased number of medical interpreters working in healthcare settings (Healthy People).
3. Decreased number of avoidable emergency department visits among Utah adults (Healthy People).
4. Increased number of people working in the healthcare setting trained on cultural humility, implicit bias, discrimination, etc. (Healthy People).
5. Increased number of healthcare facilities employing or utilizing medical interpreters (Healthy Communities).
6. Decreased number of emergency department visits among residents of high and very HII areas (Equitable Society).
7. Decreased number of people from high or very high HII putting off healthcare (Equitable Society).
8. Increased number of medical interpreters working in healthcare settings in high or very high HII areas (Equitable Society).

#### Short-term Outcomes

1. Increased number of people working in healthcare settings being trained on cultural humility, implicit bias, discrimination, etc. (Healthy People).
2. Increased number of medical interpreters trained (Healthy People).
3. Increased number of anti-discrimination policies developed or updated in healthcare settings (Healthy Communities).
4. Increased number of policies in healthcare settings that include provisions for medical interpreters as needed with an emphasis on settings in high and very high HII areas. (Healthy Communities, Equitable Society)

Objective 2: Increased health literacy and/through the use of health information technology to improve outcomes for chronic conditions.

#### Intermediate outcomes

1. Increased number of healthcare providers using plain language (Healthy People).

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2. Increased health literacy among Utah adults (Healthy People).
  3. Increased number of health literacy policies in the healthcare setting focused on healthcare workers and how they approach patients and display information in the healthcare setting.
  4. Increased number of healthcare providers in high or very high HII using plain language (Equitable Society).
  5. Increased health literacy among Utah adults in high or very high HII. (Equitable Society)
  6. Increased number of healthcare providers utilizing electronic medical records (Healthy People).
  7. Increased number of adults accessing their electronic medical records (Healthy People).

#### Short-term outcomes

1. Increased culturally appropriate educational outreach for people with chronic conditions. (Healthy Communities).
2. Increased number of public education documents which receive a plain language review prior to publication (Healthy Communities).
3. Increased number of public education documents reviewed for cultural adaptability and appropriateness (Healthy Communities).
4. Increased number of education material and resources on health information technology (Healthy Communities).
5. Increased enrollment in evidence-based lifestyle change programs and chronic disease self-management programs.

#### Strategies and Activities:

- Objective 1: Increased use of social marketing to promote evidence-based lifestyle change programs and chronic disease self-management programs..
  - Healthy People
    - Strategy 1: Increased opportunities for healthcare providers to communicate with their patients through social media.
      - Activity: Use social media sites such as Facebook and Instagram, as well as program developed podcasts, etc. to promote evidence-based lifestyle change programs and chronic disease self-management programs.
      - Activity: Partner with a marketing agency to promote evidence-based lifestyle change programs and chronic disease self-management programs.

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- Equitable Society
    - Strategy 1: Increased opportunities for providers to communicate with their patients about evidence-based lifestyle change programs and chronic disease self-management programs.
      - Activity: Check that all communications materials meet health literacy standards and are provided in multiple languages before distribution.
  
  - Objective 2: Increased use of health information technology Healthy People
    - Strategy 1: Increased number of adults who use health information technology to track their personal healthcare or communicate with their healthcare providers.
      - Activity: Explore opportunities for embedding bi-directional referrals with the evidence-based lifestyle change programs and chronic disease self-management programs.
      - Activity: Work with providers to create workflow policies that increase utilization of bi-directional and electronic referral systems for evidence-based lifestyle change programs.
      - Activity: Work with healthcare providers to use health information technology to improve hypertension control rates.
  
  - Healthy Communities
    - Strategy 1: Increased number of adults who use health information technology to track personal healthcare data or communicate with healthcare providers.
      - Activity: Work with partners to improve the interoperability of data and electronic health records.
      - Activity: Work with stakeholders to create a chronic disease reporting rule.
      - Activity: Develop a layout of the potential costs associated with digital services and programs.
      - Activity: Help healthcare providers develop policies to encourage patient engagement with at-home health monitoring tools.

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