At A Glance Summary of 2018 Salt Lake County CHIP Indicators

Reporting Period #1

KEY: ✅ **Completed** 🟰 **On Track** ⛔ **No Progress** 🚫 **Removed** ***(Last Updated: March 27, 2019)***

MENTAL HEALTH		
GOAL: DECREASE PERCENTAGE OF ADULTS WHO SELF-REPORTED NEGATUIVE MENTAL HEALTH DAYS.		
Objective	**Indicator**	**Status**
Work with community behavioral health agencies to reduce the stigma of mental	Indicator 1.1: Number of community presentations	🟰
Work with community behavioral health agencies to expand / support evidence- based programs to decrease suicide rates.	Indicator 2.1: Number of participants trained in Mental Health First Aid and Youth Mental Health First Aid	🟰
GOAL: DECREASE IN YOUTH REPORTING FEELING "SO SAD OR HOPELESS FOR ALMOST EVERY DAY FOR TWO WEEKS THAT IT STOPPED THEM FROM DOING USUAL ACTIVITIES".		
Work with community behavioral health agencies to reduce the stigma of mental illness	Indicator 1.1: Number of community presentations	🟰
Work with community behavioral health agencies to provide support for at-risk youth and their families, to include ways to minimize daily stress and general life stressors.	Indicator 2.1: ~~Increase~~ Maintain number of life skills classes	✅
	Indicator 2.2: ~~Increase~~ Maintain number of family management classes	✅
	Indicator 2.3: Increase number of referrals to hot-line and warm-lines	🟰
Work with community behavioral health agencies to increase education to parents and communities on how to access mental health services. Work with community behavioral health agencies to expand / support evidence- based programs to decrease suicide rates.	Indicator 3.1: Number of presentations	🟰
	Indicator 3.2: Number of Salt Lake County mental health/addiction referrals from 211	🟰
	Indicator 4.1: Increase number of ~~Golden Gate Clubs~~ Hope Squads in schools	***NEW***
	Indicator 4.2: Increase number of individuals trained in Mental Health First Aid	🟰

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AIR QUALITY		
GOAL: DECREASE IN EMISSION LEVELS THROUGH IMPLEMENTING NEW POLICIES AND PROGRAMS.		
Objective	**Indicator**	**Status**
Establish year-round solid fuel burning standard and parameters.	Indicator 1.1: Change in public policy for solid fuel burning standards	🟰
	Indicator 1.2: ~~Inclusion of~~ Advocate for public policy in state implementation plan.	***NEW***
	~~Indicator 1.3: Reduction in wood smoke on monitors in Salt Lake County~~	🚫
Pursue funding for a woodstove exchange program where woodstoves are replaced with gas fueled devices and gas fireplace inserts for wood fireplaces.	Indicator 2.1: Funding appropriated for ongoing and new wood stove exchange	✅
	Indicator 2.2: Number of replaced wood stoves in Salt Lake County	🟰
	~~Indicator 2.3: Reduction of wood smoke on monitors in Salt Lake County~~	🚫
Work with non-governmental organizations/communities to promote idle-free practices in communities with local ordinances, laws, regulations and idle-free zones at schools.	Indicator 3.1: Number of signs, agreements, ordinances, and policies enacted	🟰
	Indicator 3.2: Number of idle free zones at schools or idle free districts	🟰
	Indicator 3.3: Number of clear air school kits distributed	🟰
	Indicator 3.4: Number of students attending Air Aware classes ~~held~~	🟰
	Indicator 3.5: Number of attendees at professional development courses held	🟰
	Indicator 3.6: Emission reductions through idle-free practices	🟰
Reduce emissions from buildings.	Indicator 4.1: Number of ordinances put into practice in cities for stricter building codes	⛔
	Indicator 4.2: Number of builders building beyond code requirements	⛔

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Promote and support employer-based vehicle air pollution reduction policies.	Indicator 5.1: Reduction in emissions published in an annual report by Utah Clean Cities Coalition	=
	Indicator 5.2: Number of businesses who report to Utah Clean Cities Coalition	=
	Indicator 5.3: Number of businesses who adopted alternative vehicles and workplace fueling and charging stations	=
	Indicator 5.4: Increase in rider usage of Utah Transit Authority system	✓
	Indicator 5.5: Number of businesses/companies participating in incentive programs	=
	Indicator 5.6: Number of employees participating in employer-based incentive programs	=
Increase the overall proportion of electric vehicles in Salt Lake County.	~~Indicator 6.1: Number of electric vehicles available to purchase in Salt Lake County~~	⊘
	Indicator 6.2: Number of electric vehicles in Salt Lake County	=
	Indicator 6.3: Number of charging stations in Salt Lake County	=

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SUBSTANCE USE		
GOAL: INCREASE ADDICTION AWARENESS AND ACCESS TO TREATMENT.		
Objective	**Indicator**	**Status**
Work with community behavioral health agencies to reduce the stigma of addiction.	Indicator 1.1: Actively participate in two community events that are designed by partnering community agencies to reduce stigma and support recovery.	🟰
Work with community behavioral health agencies to increase access to treatment.	Indicator 2.1: Educate Salt Lake County Health Department staff regarding how county residents can access public funded treatment	🟰
	Indicator 2.2: Introduce local treatment providers to all healthy community and drug-free coalitions, and facilitate discussion on how communities and neighborhoods can support treatment and recovery, and how treatment agencies can participate in community events	🟰
	~~Indicator 2.3: Support and train health care providers in the Screening, Brief Intervention, Referral for Treatment program.~~	🚫
Work within communities to develop and implement evidence-based, grassroots community coalitions that help address factors linked with substance use.	Indicator 3.1: Increase by two coalitions in Salt Lake County that specifically address factors linked to substance use/misuse.	🟰
Increase access to naloxone kits for first-responders, identified community centers, and families and associates of people in recovery.	Indicator 1.1: Procure 150 additional naloxone kits through grants and partnerships	🟰
	Indicator 1.2: Provide kits and training to identified 10 county and city libraries	✅
	Indicator 1.3: Provide kits and training to identified County Parks and Rec for 8 centers	✅
	Indicator 1.4: Provide kits and training to 5 identified treatment providers	🟰
	Indicator 1.5: Provide ongoing kits and training to Utah Support Advocates for Recovery Awareness	🟰
Increase access and use of appropriate drug disposal locations.	Indicator 2.1: Partnering with two community-based pharmacies to install two new drop-boxes	✅
Increase public education regarding the risks of opioid use, and possible alternatives	Indicator 3.1: Provide six presentations to community coalitions and/or community-based agencies	🟰

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Increase access to evidence-based opioid dependency treatment, including medically assisted treatment.	Indicator 4.2: On a quarterly basis, share surveillance data and other opioid related data/reports with the treatment community.	🟰
	Indicator 4.3: Participate in monthly treatment provider meetings where evidence-based modalities are discussed.	🟰

SUBSTANCE USE		
GOAL: INCREASE PRESCRIPTION DRUG OVERDOSE PREVENTION EFFORTS.		
Objective	**Indicator**	**Status**
Increase access to naloxone kits for first-responders, identified community centers, and families and associates of people in recovery.	Indicator 1.1: Procure 150 additional naloxone kits through grants and Partnerships	✅
	Indicator 1.2: Provide kits and training to identified 10 county and city libraries	✅
	Indicator 1.3: Provide kits and training to identified County Parks and Rec for 8 centers	✅
	Indicator 1.4: Provide kits and training to 5 identified treatment providers	🟰
	Indicator 1.5: Provide ongoing kits and training to Utah Support Advocates for Recovery Awareness	🟰
Increase access and use of appropriate drug disposal locations	Indicator 2.1: Partnering with two community-based pharmacies to install two new drop-boxes	✅
	Indicator 2.2: Introduce local treatment providers to all healthy community and drug-free coalitions, and facilitated discussion on how communities and neighborhoods can support treatment and recovery, and how treatment agencies can participate in community events.	🟰
Increase public education regarding the risks of opioid use, and possible alternatives	Indicator 3.1: Provide six presentations to community coalitions and/or community-based agencies	🟰
Increase access to evidence-based opioid dependency treatment, including medically assisted treatment.	Indicator 4.2: On a quarterly basis, share surveillance data and other opioid related data/reports with the treatment community.	🟰
	Indicator 4.3: Participate in monthly treatment provider meetings where evidence-based modalities are discussed.	🟰

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HEALTHY WEIGHT		
GOAL: DECREASE THE PERCENTAGE OF ADULTS IN SALT LAKE COUNTY WHO ARE OVERWEIGHT AND OBESE.		
Objective	**Indicator**	**Status**
Adopt a meal planning guide for Food Pantries.	Indicator 1.1: Increased awareness of Food Design program	🟰
	Indicator 1.2: Number of cookbooks distributed	
	Indicator 1.3: Number of tool kits distributed	
Increase access to community gardens and Farmers Markets.	~~Indicator 2.1: Number of farmers markets/farm stands/mobile markets/community service agreements~~	🚫
	~~Indicator 2.2: Number of farmers markets/farm stands/mobile markets/community service agreements in areas designated as 'food deserts'~~	🚫
	Indicator 2.3: Number of school gardens in Utah	🟰
	Indicator 2.4: Salt Lake County Health Department analysis of community garden locations and diversity of users	🟰
	Indicator 2.5: Number of farmers markets/farm stands/mobile markets/Community Supported Agriculture that accept Supplemental Nutrition Assistance Program benefits.	🟰
Conduct walkability assessments of neighborhoods in Salt Lake County.	Indicator 3.1: Number of walk audits conducted	🟰
	~~Indicator 3.2: Number of adults who have access to communities that develop and/or implement plans to promote walking~~	🚫
Increase self-reported regular physical activity.	Indicator 4.1: Number and type of community venues that promote physical activity through signage, worksite policies and share-used/joint use agreements\	🟰
	Indicator 4.2: Number of policies developed and implemented	⛔
	Indicator 4.3: Number of Salt Lake County participants with access to ~~in~~ wellness programs	🟰
	Indicator 4.4: Number of Bike Share users	🟰
Increase the availability of healthy foods for all populations	Indicator 5.1: Number of policies developed at workplaces	🟰
	Indicator 5.2: Increase number of residents enrolled in Supplemental Nutrition Assistance Program.	🟰
	Indicator 5.3: Number of locations implementing with Healthy Checkout lanes	🟰

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	Indicator 5.4: Number of schools utilizing the national school lunch program	=
	Indicator 5.5: Number of childcare centers utilizing the child and adult care food program	=
	Indicator 5.6: Number of sites/students utilizing summer feeding programs including at-risk after-school programs.	=
	Indicator 5.7: Number of schools incorporating farm to school programing	
Assure hiking and biking trails are connected and mapping is completed of these trails.	Indicator 6.1: Number of ~~bicycle audits conducted~~ existing conditions analysis reports by cities when updating their general plans	=
	Indicator 6.2: Number of Active Transportation Plans developed	
	~~Indicator 6.3: Usage of existing trail systems/parks/free and/or low-cost recreation programs~~	⊘
	Indicator 6.4: Number of way finding signs placed	=
	Indicator 6.5: Number of Active Transportations Plans developed	
Increase locations for the implementation of evidence-based Lifestyle Change Programs.	Indicator 7.1: Number of people reached through evidence-based engagement strategies	=
	Indicator 7.2: Number of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit	=
	Indicator 7.3: Number of health care systems with an implemented community referral system for evidence-based lifestyle change programs for people with hypertension and prediabetes/high risk for type 2 diabetes	=
	Indicator 7.4: Number of people ~~reached through~~ who have access to evidence-based engagement strategies	=
	Indicator 7.5: Number of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit.	=
	Indicator 7.6: Number of health care systems with an implemented community referral system for evidence-based lifestyle change programs for people with hypertension and prediabetes/high risk for type 2 diabetes.	=
	Indicator 7.7: Number of people reached through evidence-based engagement strategies	=

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	Indicator 7.8: Number of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit	=