MURRAY
CITY COUNCIL

Council Meeting
July 16, 2013

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NOTICE OF MEETING
MURRAY CITY MUNICIPAL COUNCIL

PUBLIC NOTICE IS HEREBY GIVEN that there will be a meeting of the Murray City Municipal Council on Tuesday, July 16, 2013, at the Murray City Center, 5025 South State Street, Murray, Utah.

6:00 p.m. **Budget & Finance Committee:** To be held in the Conference Room #107
Jim Brass conducting.

1. **Approval of Minutes**

   1.1 Budget & Finance Committee – May 23, 2013
   1.2 Budget & Finance Committee – May 28, 2013

2. **Adjournment**

6:01 p.m. **Committee of the Whole:** To be held in the Conference Room #107
Brett Hales conducting.

3. **Approval of Minutes**
   3.1 None scheduled.

4. **Business Items**

   4.1 Salt Lake County Health Department Update– Linda Bogdanow & Tom Trevino (15 minutes)

5. **Announcements**

6. **Adjournment**

6:30 p.m. **Council Meeting:** To be held in the Council Chambers
Darren Stam conducting.

7. **Opening Ceremonies**
   7.1 Pledge of Allegiance
   7.2 Approval of Minutes

      7.2.1 May 21, 2013

   7.3 Special Recognition

      7.3.1 Murray City Council **Employee of the Month JoAnn Miller,** Payroll Coordinator, Finance Department. (Justin Zollinger presenting.)

8. **Citizen Comments** (Comments are limited to 3 minutes unless otherwise approved by the Council.)

9. Consent Agenda

9.1 None scheduled.

10. Public Hearing

10.1 Public Hearing #1

10.1.1 Staff and sponsor presentations, and public comment prior to Council action on the following matter:

Consider an ordinance amending the City's Fiscal Year 2012 – 2013 Budget. (Justin Zollinger presenting.)

10.1.2 Council consideration of the above matter.

11. Unfinished Business

11.1 None scheduled.

12. New Business

12.1 Consider a resolution appointing poll workers for the City's 2013 Primary and General Elections. (Jennifer Kennedy presenting.)

13. Mayor

13.1 Report
13.2 Questions of the Mayor

14. Adjournment

NOTICE

SPECIAL ACCOMMODATIONS FOR THE HEARING OR VISUALLY IMPAIRED WILL BE MADE UPON A REQUEST TO THE OFFICE OF THE MURRAY CITY RECORDER (801-264-2660). WE WOULD APPRECIATE NOTIFICATION TWO WORKING DAYS PRIOR TO THE MEETING. TDD NUMBER IS 801-270-2425 or call Relay Utah at #711.

Council Members may participate in the meeting via telephonic communication. If a Council Member does participate via telephonic communication, the Council Member will be on speaker phone. The speaker phone will be amplified so that the other Council Members and all other persons present in the Council Chambers will be able to hear all discussions.

On Friday, July 12, 2013, at 9:15 a.m., a copy of the foregoing notice was posted in conspicuous view in the front foyer of the Murray City Center, Murray, Utah. Copies of this notice were provided for the news media in the Office of the City Recorder and also sent to them by facsimile copy. A copy of this notice was posted on Murray City's internet website www.murray.utah.gov. and the state noticing website at http://pmn.utah/gov .

Janet M. Lopez
Council Administrator
Murray City Municipal Council

MURRAY
CITY COUNCIL

Budget & Finance Committee

Budget & Finance Committee Minutes

MURRAY
CITY COUNCIL

DRAFT

MURRAY CITY MUNICIPAL COUNCIL
BUDGET AND FINANCE COMMITTEE
Fiscal Year 2013-14

The Murray City Municipal Council met as the Budget and Finance Committee on Thursday, May 23, 2013, in the Murray City Center, Conference Room #107, 5025 South State Street, Murray, Utah.

Members in Attendance:

Jim Brass	Budget Chair
Dave Nicponski	Budget Vice-Chair
Jared Shaver	Committee Member
Brett Hales	Committee Member
Darren V. Stam	Committee Member

Others in Attendance:

Doug Hill	Public Services	Tim Tingey	ADS
Mike Terry	HR	Diane Turner	Citizen
Larry Walters	Centurylink	Georganne Weidenbach	Centurylink
Jackie Sadler	MCEA	Jan Wells	Mayor's office
Jan Lopez	Council office	Blair Camp	Citizen
Frank Nakamura	Attorneys	Briant Farnsworth	Attorney

Mr. Brass called the Budget and Finance Committee Meeting to order at 4:45 p.m. He stated this was a Budget meeting to address the contingency list and items to be discussed needed some questions answered.

Retained Risk Fund

Mr. Zollinger wanted to first address Mr. Shaver's ideas on this fund. The budget this year is about $1 million less than last year. This allowed other funds to provide some compensation for the employees. In addition, another reason was that the current deductible was deemed sufficient. With that in mind, the reserves should be fairly adequate for several years to come, even with several claims.

Mr. Shaver expressed concern about catastrophic events. In the past, the City has experienced catastrophic events with the electrical storm that was due to mismanagement of other corporations. That impacted Murray and also multiple people. He said insurance is a

gamble, and should provide some security for future events. The goal is to foresee those events as best as you can. The idea is that if you are paying too much insurance, there isn't a benefit. It needs to be looked at to see what the City can get away with paying. The retained risk states that it would be better for the City to cover itself than to pay a premium that isn't necessary. This conversation has been going on for years. Is the City sufficiently covered, and is that a budget issue, he asked. The question is does the City continue to pay a premium for coverage or set some aside for retained risk, he asked. This year has been a tough year for unanticipated legal fees and causes the consideration of it being a trend or just a bad year. Is it just Murray or is it widespread throughout the state as people are becoming more litigious, he noted.

Mr. Nakamura stated that he has participated in the discussions over the years. Based on the experience of the last year, staff felt that it was in the best interest of the City to keep the insurance coverage the way it is. He admits that initially he thought about self-insurance, based on the history of zero claims, no payments to the insurance company, and no involvement from the insurance company. This year there have been a few cases that the City is in the middle of and is unsure of the direction they are going to go. He would like to remain status quo; and as a result of that decision, Briant Farnsworth is now on the State Board of Insurance. This allows him to advocate for the City's best interest.

Mr. Nakamura stated that it isn't possible to know whether this is a trend or not. He hasn't seen this much litigation in the past. The insurance companies will tell you that they are seeing more lawsuits and claims. He believes that this is the best choice for the City's protection but that it is always open for evaluation. The number of claims, and the type of claims that have come in have caused Mr. Nakamura to back off of the idea of self-insurance. The deductible is $250,000 with catastrophic coverage after that. It seems like a good idea, particularly given the two or three cases he currently has. It would be nice to build up a Retained Risk Fund over the next few years, he noted.

Mr. Brass said that everyone dislikes paying insurance, but that is what it is there for. In his company this year, they decided to self-insure based on the history of zero claims, and it was a difficult year.

Mr. Nakamura said that Murray would take advantage of the specialized training that is provided by the insurance companies, and that has not been done in the past. He has spoken with Mr. Zollinger at length discussing the safety program. If the City is paying an insurance premium, staff should take advantage of the training and expertise that they offer. He showed a list of training classes available, including workers compensation and labor and commission. That would be included in the premium that the City is paying.

Mr. Zollinger noted that if there was a visible pattern of accidents that are occurring, that type of training specific to those accidents would be selected. Hopefully, that would remedy and prevent those type of accidents.

Mr. Shaver asked if the insurance premium increased. Mr. Zollinger said the increase was around $9,000. Mr. Shaver said sometimes the increase was a percentage, and sometimes a graduated fee. Mr. Zollinger said the liability went from an estimated $187,000 to $196,000.

Mr. Stam asked if accidents were included in that. Mr. Nakamura stated that all tort claims, accidents and car accidents are included.

Mr. Shaver said that based on the discussion, the recommendation would be to continue with the insurance as far as the retained risk was concerned.

Fire Department

The contingency list item was the turnout gear. Mr. Brass said the budgeted amount for turnout gear wasn't in question, just the process of handling it. Mr. Zollinger said that right now it isn't in the General Fund budget. That simply means cuts would have to be made to get it in there, or an increase in revenue. Currently, it is in the Capital Project Fund and is being funded with savings. He acknowledged Mr. Shaver's concern that this should be something that should be funded every year.

Mr. Brass said that looking at the list of preventable versus non-preventable accidents, he believes that this is lifesaving equipment and would hate to see that expense postponed a year due to lack of funding. Mr. Shaver said this is considered necessary equipment and based on information from Chief Rodriguez, this gear has a specific shelf life, and needs to be replaced at that time. Mr. Shaver said he would like to see the turnout gear considered the same way as computers, knowing that they wear out over time. Mr. Zollinger said it is just a case of finding the money for it in the General Fund. Mr. Brass said that this year it isn't a problem, because the money is there in Capital Projects and it would be paid for. In the future, he believes it needs to be looked at differently. Life-saving equipment should not be at the whim of the committee, he noted.

Mr. Zollinger said he would try and work that into the General Fund for next year's budget.

Police Department

Mr. Zollinger said in the past the beer tax money had been used to pay for the Police DARE officer. The program has changed and those proceeds can no longer be used to pay for the DARE officer. It is restricted as to what the money can be used for. That left a shortage of $75,000 for that officer's salary. Mr. Stam asked if the Department is still receiving the money and could be used elsewhere, creating a line shift in the budget. Mr. Zollinger said that was possible, but the grant is so restrictive it can only be used for alcohol related purposes or purchasing alcohol equipment. Mr. Zollinger said this is one example of how he would prefer not to have specific things, particularly personnel, funded by grants. When the grant goes away, the personnel is still there and this causes problems.

Mr. Shaver asked what the restrictions are. Mr. Zollinger said it is for specific equipment; such as Breathalyzers, cameras, and specific DUI shift vehicles. Currently, there are not police officers that only work DUI shifts. Mr. Zollinger spoke with Asst. Chief Burnett and he said that in a few years, there would not be items available on the list to purchase. Mr. Zollinger found a few items that could be shifted, but also found Drug Enforcement Agency (DEA) funds available in the budget for $38,717. That money could possibly be used to help cover the shortfall. That

money has no restrictions and can be used for any need. The Police Department may not like switching that unrestricted money for this restricted money, but it is one way to help close the gap.

Mr. Brass said that may be an internal discussion for the Police Department, since it wasn't initially on the contingency list. Mr. Shaver said that the shortfall in years to come would still need to be addressed. Mr. Stam asked if the Police have any plans to possibly include a DUI specific shift. He believes that at certain times of the year they do have DUI shifts. Could an Officer be designated to that shift, he questioned.

Roadways

The specific item in question is Radar Speed Signs, and the additional funding for more signs. Mr. Zollinger noted that the City Attorney budget had been funded $8,900 for equipment and software, and those items were able to be purchased this year. The HR Department had requested an extra $1,000 for a printer that was purchased this year also. With those two purchases, the total amount of money freed up would be $9,900.

Mr. Shaver said that in the CIP project fund, there is a specific budget for Radar Signs, and the intent was to double that amount to $20,000 instead of $10,000.

Mr. Hill said the signs are $2,500 each, so that would allow for four more. Mr. Zollinger said to give credit to Mr. Terry, Mr. Williams and Mr. Nakamura for working their budgets in a way that this money could be available.

Mr. Nicponski said that the citizens like and appreciate the Radar Speed Signs and recognize the City's efforts.

Mr. Hill commented that it would be helpful as the intent language is being developed to have intent language as to the locations of the speed signs. One option would be for each Council Member to put it in a location of their choosing in their District. The other option would be to leave that decision to the Traffic Safety Committee. Mr. Brass stated that they received a list from Traffic Safety. He would love to see one on Atwood, which was also on the list. Mr. Hill said if there are specific areas in the districts, then he is fine with the Council members making those decisions. Mr. Stam stated that he believes the Traffic Safety Committee may know best about the most dangerous situations. Mr. Nicponski said he has one in his district, and Mr. Brass has one. Mr. Shaver said that the list is already there, and those are listed by priorities. Mr. Brass commented that it could be a discussion in the Committee of the Whole as to determine the locations. Mr. Hill said for example, one district may have five locations that are prioritized higher than other districts.

Mr. Shaver said it is important to recognize the most dangerous places first. The safety concern is slowing traffic down. Mr. Nicponski said it would be a good idea to work in conjunction with the Traffic Safety Committee.

The next issue is the Taylorsville pedestrian bridge. Mr. Nicponski said Taylorsville wanted $100,000. Mr. Nicponski declared a conflict because he does work for Taylorsville on

Capitol Hill. He believes an amount of $40,000 may be more manageable, if there is flexibility in the Public Works budget. The City would be approached for these inter-local agreements, and believes some have merit. This pedestrian bridge is located at 4500 South, just west of 700 West. It is an area that transitions between the Murray Parkway and the Taylorsville Parkway and would bridge the river as a walkway.

Mr. Hill said that currently there is not a sidewalk on the north side of 4500 South from 5th West to 10th West in Taylorsville. Taylorsville wants pedestrian access along the north side of 4500 South. This would include the bridge, and installing sidewalks to connect the areas. Mr. Shaver asked about the amount of foot traffic on 4500 South. Mr. Brass asked how citizens are crossing there now. Mr. Hill said that one would cross the street and then cross the bridge then continue to walk down the street. Right now there is not a good safe crossing. Mr. Shaver said the overall improvement would be a sidewalk taking a person from the Murray side to the Taylorsville side, by way of a bridge. Mr. Hill said Taylorsville is taking the lead on it and has also applied for sidewalk money from UDOT (Utah Department of Transportation), and also UTA (Utah Transit Authority), as a joint project.

Mr. Stam asked if Murray has a park on the east side, or just the walkway going through there. Mr. Hill said it just goes to the river in that location.

Taylorsville has estimated the total cost of the project to be $400,000. They have asked UDOT for $200,000, UTA for $25,000, Murray for $75,000 and Taylorsville would pay the remaining $100,000.

Mr. Shaver clarified that the current proposal is to fund the bridge for $40,000. He asked what the City would get from that. Mr. Nicponski believes that the State would make up the difference.

Mr. Stam asked what the Murray citizens would gain from this in that location, and what the citizens do there. The other bridge provided the citizens access to the dog park, and to the park on the other side. The Parks & Recreation Board voted against it, and the Mayor voted for it. One of the agreements made by Taylorsville for that bridge was that the citizens would have access to the dog park. Currently, the fee is double for any residents other than their own, so the access isn't really there. His concern is that the City participated in that bridge and the Murray citizens should also be considered as residents as far as the entrance fee is concerned. He questions the benefits that the Murray residents would get from the bridge. Mr. Shaver said it would be safe access for the citizens to Redwood Road, Taylorsville High School and shopping. The issue is walking along the shoulder of the road without any protection.

Mr. Brass said he has had those same questions as to the benefit for Murray citizens. He looked at a map showing the Fairfield Inn and the Hampton Inn, and if there was access to Jordan River Parkway, those customers would have a place to exercise. He believes that is a benefit to Murray businesses, and would be an appealing element to those traveling to those hotels. He would like to bridge 4500 South and continue the trail safely, but could argue both sides of the foot bridge all day long. The issue is where the money comes from. Right now, the City has a lot of other expenses, so he would propose to set that aside momentarily and

continue down the list.

Mayor's Office- Retirement Open House

Mr. Zollinger said that there is a small amount in the Mayor's budget that can take care of the Open House.

Council Office

There is $25,000 proposed for a grant writer, $30,000 proposed for a lobbyist, and there was also the recent question of benefits for the Council Members.

Mr. Nicponski stated that the lobbyist discussion is to decide whether the amount should be $30,000 or $40,000. Mr. Shaver asked if the lobbyist expense is shared with the administration. The answer was that it was paid out of the Council Office budget.

Mr. Shaver asked if the grant writer position of $25,000 would be a one-time only expense or if every department head was contributing to this position. Mr. Stam said this $25,000 was for seed money. If a grant writer was hired to write grants for this City, this would be the payment for them to start. Once the grants start coming in, most of their wages would be paid for by the grant. Mr. Shaver believes some of the grants might be specific as to where the money goes. Most grants are tagged for specific purposes, and may not be allowed to pay for personnel costs. He doesn't think it is a good idea to hire a person with the intention of paying their salary with a grant. Possibly, if extra money is found, then the salary could be subsidized. The $25,000 needs to be looked at as the cost for hiring the grant writing consultant.

Ms. Wells said there are personnel in Police and Fire that write those grants. Those people also manage the grants. Usually they are very time intensive and specific in their scope. The Police and Fire Departments do well in obtaining grants. She isn't sure that $25,000 would get very far in a grant writer. If there was a specific need, it might be better to hire and manage a specific grant for a period of time. She doesn't see it as a successful thing unless it is a staff position. There are not as many grants as there used to be, and most are very specific. She spent a lot of time researching this issue to determine if it is worth it. Ms. Wells believes the City would need to be a little bigger with more specific needs to make it worthwhile.

Mr. Nicponski said that Police and Fire use their budget to pay for a grant writer, but other departments may not have the money to pay for it. He stated that it may be a departmental decision. Mr. Brass said it is a philosophical discussion, and possibly Ms. Lopez could look at available grants and it could be determined whether it was worthwhile to pursue. Mr. Stam said he understands that the money might be available to hire an outside person for a specific grant but is not enough to hire a full time person. Mr. Shaver said they should look at what grants are available and ensure that grants are not being missed by departments that may not have enough money to have an employee working on grants. Mr. Brass said Mary Ann Kirk goes after and manages grants for the arts. Mr. Brass said, for example look at how the CDBG funds have decreased, and Ms. Wells stated that there may not be as many grants out there. The cost of managing that money is also a factor. He believes a little more research needs to be done.

Mr. Hill said that several years ago stimulus money was being given out, and his department would have liked to go after some of that stimulus money for roads. It was almost too much to have the staff write the grants. It was discovered that there are consultants out there that can be hired to write the grants for you. If the money would have been in the budget, they would have gone out and hired a consultant to write it for them and go after the stimulus money. There is no guarantee that the money would have been received, especially considering the size of the City. That money could also be used to hire professional services if there is a grant that the City deems worth going after. There are a lot of contract grant writers available for hire. Ms. Wells said it is important to remember that most of the grants request a matching fund also, that must be budgeted for. Mr. Shaver said he believes it would be a good idea to leave the money in place and call it professional services and then Department heads could request that money if there is a need.

Mr. Stam asked Mr. Hill if someone would have been hired to write that specific grant, did he have the resources to manage it once it was received. Mr. Hill said that does become the secondary problem. For example, there was a grant called the Tiger grant and one could apply for up to $40 million for a regionally significant road. Murray hired a consultant to write the grant. The grant was written to widen 3rd West from the bridge on 5300 South to Winchester. If Murray had received that grant, the City would have had to come up with $2 million to receive the $40 million. The consultant would have to manage the paperwork and design, etc. Mr. Shaver asked if that road project would have been part of the CIP process. Mr. Hill said that was correct. Mr. Shaver said that if the department could hire a consultant to write it, then possibly the person hired to manage the grant could be paid for out of professional services, making it a dual project and investment.

Mr. Zollinger added that by leaving it in the Council budget, he would never think about touching it. There needs to be a process, otherwise the Department heads won't come to the Council and request it. Mr. Stam asked if it should be moved from the Council budget to the CIP. Mr. Brass said he believes that professional services in Non-Departmental makes the most sense. Mr. Zollinger said that he can manage the budget but wouldn't make the decision as to whether they should receive it or not. Mr. Shaver said it could probably be decided in a Department Head meeting with the Mayor's office giving approval. The decision was made to move the money to professional services in Non-Departmental.

Lobbyist

Mr. Shaver asked who the lobbyist would be, before deciding what how much money should be budgeted. Mr. Nicponski said that the City has someone that continually secures the City a million to a million and a half every year, and only costs about $40,000. It is a good deal and believes it is a sound investment for the City. Mr. Hales said that they talked about doing a bid process before the end of the year, and keep the $40,000 salary the same. Mr. Hales said this year the lobbyist reported well because of the discussions with him, and is coming back to report. It shouldn't be a guaranteed salary and be a bid process. The Council should make that decision as to who would represent the City at the Capitol. Mr. Shaver stated that it should be similar to the process for the outside auditors. It is a contract for so many years, and then goes out to bid again and it is the City's choice whether or not to renew. That way, it would not

change every year, but possibly every two years.

Mr. Brass asked if the compensation should go to $40,000 instead of $30,000 and where that money will come from. He said if the Council is setting aside $25,000 for professional services in the hopes of getting grant money someday, why not take the $10,000 from that fund and give it to someone that is getting the City money.

Mr. Stam commented that a lobbyist is more than a person that goes to the Capitol. It requires relationships and contacts. He believes that Dave Stewart, the current lobbyist, does have those relationships built up and that is important. He understands the part about the bid process, but doesn't want to offend someone. Mr. Hales believes that is business and they shouldn't be offended. Mr. Brass stated that good will is important and believes the lobbyist has done a good job and has relationships on the Hill. He said history and the track record is important. Mr. Nicponski said upcoming Legislation is very tricky. Mr. Stam said Mr. Stewart was instrumental in getting the money this time. Mr. Nicponski commented that he was really impressed after meeting with him. Mr. Stam said that he believes Mr. Stewart will do a lot more than the City asks of him. Mr. Brass reiterated that the salary will remain at $40,000, taking $10,000 from professional services. Mr. Zollinger expressed his appreciation at the balancing of the budget.

Benefits

The Murray City Council gets paid a small amount annually to do the job. The job description states attendance at a few meetings and a few hours a week. In reality, it is a lot of hours and a lot of meetings, stated Mr. Brass. According to the agreement, insurance benefits are not included. The insurance company has deemed that the Council Members are eligible for insurance benefits, but have never taken it. That discussion is taking place now, due to changes in the insurance law, and the ability to get insurance. Frankly, if this position had insurance, it would affect the number of people that sign up to run. More candidates would always be a positive thing for the City.

Mr. Hales said that after talking with Mr. Zollinger, he wanted to ensure that this would not increase the rates or add cost for an opt-out program. He is aware that if the pool is reduced, then the insurance rates go up. Mr. Terry said that is true if the people that are pulled out of the pool have low claims, and the people with the higher claims remain in the pool. Mr. Brass said that is often the case, that the healthy people opt-out and leave the non-healthy people in the plan.

Mr. Zollinger stated that if the opt-out option is so rich that the healthy people leave the plan, then it does hurt the City. There is a balance there to offer an amount to opt-out that isn't so rich that employees leave and go get their own insurance. Mr. Nicponski said the opt-out option could save the City money if it was done responsibly. Mr. Zollinger agreed that it had to be done correctly.

Mr. Stam said he had the opt-out option with his previous employer. He didn't receive the full amount that would have been paid for his premium, but received around 50% to 60% of the amount. Mr. Brass said he believes that is the norm. Mr. Hales said the Council absolutely

doesn't want to cost the City any more money. He said that if all five Council Members took the insurance at the family rate it would cost $58,000 per year. Mr. Zollinger said he believes the range would be closer to $40,000 to $60,000. That doesn't include the opt-out option; that amount is if everyone took the insurance. Mr. Brass said the opt-out option should be available as a benefit for all the employees. If a family had two sources of insurance, then they could choose to opt-out of one of them.

Mr. Nicponski asked about double coverage. Mr. Terry said that the next contract beginning in July would remove language stating that a person could not be double covered by two insurance plans.

Mr. Brass stated that there are two discussions, a philosophical one and a financial one.

Mr. Nicponski said he supports the addition of benefits with the opt-out plan. The target being to save money. He doesn't want to be apologetic suggesting that his colleagues receive health insurance.

Mr. Shaver said he agreed, but this is in correlation with the fact that the City is looking at benefit packages for the entire City. If the Council decides against it, then there would be no cost increase. If the Council decides for it, then the money has to be found to keep the budget balanced. Mr. Shaver asked where that $40,000 to $60,000 is going to be found. Setting aside any philosophical reasons, the money still needs to be found. Mr. Shaver said some of the issues that are discussed may fit for this year, but will require an increase in money every year thereafter. It isn't a guarantee for 2014-2015, but it is more likely that there could be a property tax increase for the citizens. Even if the costs come in around $40,000, where is it going to be found, asked Mr. Shaver.

Mr. Zollinger said that some of the money could come from the grant writer position, and a small amount could be pulled from Non-Departmental funds, due to the flexibility there. Although, that fund is diminishing he stated. Most of his financial tools in getting this budget to work, are becoming very limited. If this proposal did require $60,000 or more, then the flexibility would be gone. It can be done, but does leave things pretty tight.

Mr. Stam said he doesn't see a problem with an opt-out program. The City might have a few opt-out of the plan, and save $40,000 and then the money would be available. His concern is if this is the right time to do it, even though he believes it would be a positive thing down the road. If the City wasn't still digging out of this hole, he would be all for it. Once the economy turns around, and the City has more money, then it would not be an issue.

Mr. Nicponski believes the economy is turning around. The City has two new hotels being built, and multiple renovations at the Fashion Place Mall and the car dealerships. Mr. Stam said there is still $30 million requested for CIP projects, and $1.8 million to allocate.

Mr. Terry said he is in favor of the opt-out, but would like more time to figure out the details of the opt-out plan and establish rules and policies. Mr. Terry said the decision to opt-out of healthcare requires a lot of time and consideration. He would hate to rush through that right now.

Mr. Shaver said he is well covered in his insurance. He is on an 85/15 policy that costs him $700 per month for his family. This would be a nice thing, but not something he is necessarily interested in. Many of the employees have spouses that have other insurance, and the opt-out may be a great option, but he believes any decision made today would be premature. It is an issue that needs to be looked at, possibly for next year.

Mr. Terry said the two issues need to be separated; insurance benefits for the Council is a separate issue than the opt-out option. They are being mixed in the conversation and should remain separate. He has no concerns with the insurance coverage for the Council, but thinks the opt-out needs more discussion. Mr. Stam said the opt-out option could provide the money for the insurance coverage for the Council. Mr. Brass said to set this discussion aside for a moment, while other dollars are looked at.

Non-Departmental- Murray Fiber

Mr. Zollinger said the amount of $364,000 in question would be funded from reserves. Mr. Stam clarified that this was one-time money. Mr. Zollinger said yes, that is the hope that it is one-time money.

Mr. Nicponski said $364,000 is a lot of money, considering the fact that a decision could not be made on the last issue which was $40,000. That issue made sense, but nothing is known about this money.

Ms. Wells said it has been discussed at length, and a decision needs to be made at some point. If not now, it has to be decided sometime.

Mr. Stam said that the decision could change at another time. It could be a lot worse, or it could be a little better. Mr. Shaver asked for a description of the $364,000 that would go towards Murray fiber.

Mr. Stam said he understands that it would help pay for the operations shortfall until the decision is made on the utility model. Ms. Wells said it is to pay for the months of February 2013 to December 2013. This is the dollar amount that the other cities are paying also. Mr. Shaver asked if this same issue would need to be addressed next January. Ms. Wells said the point is that this is a timeline to get to the utility model, when this possibly wouldn't be needed. Unless the decision is made to pursue that, then the City is kind of stuck. The utility model will take some time to complete, and there are no guarantees. If the utility model is what the City would like to pursue, then there is some direction needed, and the City must stay in the game to do it. If the City doesn't want to, then the City would have to handle the consequences as they come.

Ms. Sadler asked if the $364,000 would cover the 3 to 4 year plan and if this is the extra that was requested for this budget year, and could decrease every year thereafter. She said it seems higher than was thought. Mr. Shaver said that the other figure of $160,000 would have taken the City to the end of June 2013. This amount of $364,000 would cover the City until the end of 2013. Ms. Sadler understands that now the amount is all lumped together.

Mr. Brass said that $160,000 of the $364,000 is the money that the Council voted to not

provide to UTOPIA. If this money is funded, it reverses the decision made by the Council. The argument is if the City has the ability to take the network in Murray, this would give Murray the freedom to do what they choose with that money. It is essentially a roll of the dice.

If the Council chooses to fund this, then more money is given on a promise that has not been kept, Mr. Brass commented. Mr. Hales stated that promises not being kept concerns him. Mr. Stam said that now he is part of the Board, and isn't sure of what promises Mr. Brass is referring to. Mr. Brass stated that the numbers that are being seen now are looking a little better, and possibly they are hanging on by their fingernails, and that is great. There is still a $215 million debt, of which the City is paying a $1.7 million per year. That is what bothers him, is that the entire organization isn't being discussed. The average return on connections is $30 per month, and he doesn't think the debt service payments can be made, let alone go forward. The $215 million still has to be repaid. The question is whether Murray wants to continue to pay. If this fails to happen, and there is a bond, then that goes into the yearly payment which is already increasing 2% a year. Mr. Zollinger said at the end, the number would be $2.7 million with total payments. Any decision that is made is fine, the Council Members have all been elected to represent their districts.

Mr. Stam noted that there is no crystal ball. Right now, the comments bet on the side of UTOPIA not being successful, and the City carrying the debt. He believes UTOPIA can be successful and the City would not have to carry the debt. What if the City said no, and is still stuck with the debt and UTOPIA ends up being successful, he noted.

Mr. Hales said he doesn't quite understand the operations shortfall. When there is a debt of $1.6 million per year, how could UTOPIA shut someone down if the extra money requested is not granted, he asked. The City is struggling with its own operations. Mr. Zollinger is moving money to make ends meet, and UTOPIA is asking for an additional $364,000 to a risk that has not been performing. He asked if it had been in the hole the entire time. The answer was yes. Most businesses would not have survived, but this is being funded by governmental entities. How can UTOPIA threaten to "go dark" on Murray, when the City has paid the debt that they agreed to pay, he asked.

Mr. Stam stated that the debt service the City is paying is $185 million; the additional bonding that they had is being covered with revenues that have been made. The operations are the part that UTOPIA is short on. UTOPIA doesn't want to use bond money for operations anymore. They had used that in the past, and that was the change. Mr. Shaver said that the City had been paying the debt and UTOPIA was taking money from that bond and using it to pay for operations. The Legislature said that wasn't allowed anymore. Mr. Hales believes that the money for operations should be there if this is working. Mr. Stam said it does take a period of time, even in a new company. It is taking a little longer than expected; it has been ten years. Mr. Stam said the point is to look at where they are today.

UTOPIA is asking for help with operations. If they don't get the help for operations, and can't use bond money; what they are going to do, he asked. The easy way to explain "going dark" is if you were an employee and not being paid your wages to work, one would get up, turn off the lights, and go work somewhere else. This is the problem that they are going to face if

they cannot pay their employees. If there is no one there to run the network, then it will "go dark". If the system "goes dark", then the City will still pay the debt, without any revenue coming in. That is the situation that Murray is facing. This money would help to pay the wages of the people running the system.

The finance committee at UTOPIA evaluated expenses to see where they could cut back. They are not in a position to be able to cut back anywhere without hurting the network. One comment that Mr. Stam has heard that if wages of employees at UTOPIA are compared with employees in the same industry; they are not overpaid. They are in the same range, and possibly even less when comparing salaries. Some employees have been offered more money to go work for Google or other companies, but have turned it down, wishing to complete this project. The bottom line is if the employees don't get paid, they will go somewhere else. Mr. Brass said it is the same dilemma that the City has and elsewhere. Mr. Nicponski said that if all the money requested is added up, with the exception of the City-wide salary adjustments, it is only half of this $364,000 that UTOPIA is asking for. Murray is scratching for money, and this is a lot of money. Mr. Stam said that it covers the salaries of UTOPIA and UIA. Mr. Brass said it affects the staff; when decisions are made that deny employees increased raises and benefits, so that UTOPIA can cover their employees, it concerns him.

Ms. Sadler asked if the money had to be paid all at this time. Mr. Brass responded that it is a line item in the budget and must be looked at for approval. Nothing would be paid all at once, it could still be a monthly payment. Mr. Brass said that they would have to pay the amount back to February 2013. Ms. Sadler asked if there would be another six months. Mr. Brass confirmed that and said they would be looking at this issue again in December. Ms. Sadler asked about the specific amount that they asked for each year. She asked if this issue would continue over the next few years. Ms. Wells answered yes, unless the City goes to a different model and takes it over, and it becomes a City infrastructure. Mr. Shaver said that is what the City would hope to buy.

Mr. Shaver asked what the result was of Murray recently saying that they were not going to pay. He said Mr. Zollinger and Ms. Wells have had conversations with the other cities.

Mr. Shaver noted that part of the challenge is when an individual that sits on the Board can squash an idea. It is similar to comparing it to if he said something and the others really had no choice, so the other opinions are squashed. The dislike of the management at UTOPIA was not directed at one person in particular. The business model is a whole bunch of Indians telling one Chief what to do, and is causing bedlam. That model will not work. In his estimation, the model that would work would be for the City to take it over and manage it. The City has the greatest infrastructure of any of the Cites that joined UTOPIA and Murray knows how to do it. If the utility model works, then this becomes a moot point. If it doesn't work, then Mr. Brass and Ms. Sadler are correct that this issue will be looked at over and over again. Mr. Shaver said that one concern about the recent Google acquisition, is that that City is stuck with Google completely. Mr. Brass commented that the debt didn't go away either with that acquisition.

Mr. Zollinger said that the current plan that UTOPIA provided still doesn't make them financially viable at the end of the plan. There is still a shortfall. Mr. Stam commented that the

plan goes from a $225,000 shortfall per month to $5,000 per month. Nonetheless, it is still a shortfall, commented Mr. Zollinger.

Mr. Zollinger said one concern is that their bonding is running out. He has been told that they can't continue to grow without bonding. They only have two to three more years of bond capacity the way that it is being used. He thinks a direction that is agreed upon is needed, and go from there and try to make it work. He has heard many ideas from the conversations, but some unity is needed.

Mr. Stam said the amount of bonding that would take them from $225,000 to $5,000 per month was only using 2/3 of the remaining bonding. Mr. Stam said there was still $11 to $12 million left. Mr. Zollinger said that UTOPIA has said they cannot grow without more bond money. At that point, people drop off, money is lost and you go further in the hole. There are no more bonds to go after to be able to put out more fiber. He is looking at this with the highest perspective possible and wondering how that can change.

Mr. Hales said that the challenge is the other cities involved, and there are other people that need to agree with the City's decision. He said he is not comfortable paying the $364,000. Mr. Stam said the point is not having more bond money to add more people, and if subscribers go down, then the debt increases. Mr. Zollinger said UIA is covering their debt currently, but with a close margin of about $200,000. That is a slim margin on a $2 million budget. Mr. Zollinger is trying to share his perspective from a financial basis.

Mr. Shaver said the difficulty is looking at Murray Fiber and not UTOPIA versus UIA. It is hard to separate the two. UIA may be in a better position and be able to create revenue; UTOPIA on the other hand is not. He is uncomfortable with a past due debt that the City has not paid. Whether or not, the $364,000 is funded, UTOPIA has serviced the City over the last several months. Mr. Hales respectfully disagreed that portion is the City's debt. The City paid what it agreed to, and he doesn't think that additional amount is a debt that the City is responsible for.

Mr. Stam said the time will come when there isn't any money to pay the employees of UTOPIA and they will walk out. Mr. Nicponski said that is an answer that those employees should receive from their management.

Mr. Brass asked if the City agreed to pay operations in any of the signed agreements. Mr. Nakamura said the agreements state that it is a capital assessment or fee subject to appropriation; it is not a debt. The bond obligations are debts. This is subject to appropriation and is reflected in the resolution that was passed, and they recognize that. Murray did not want to be obligated to open-ended debt, and the response was that the City was not obligated and could decide by appropriation. He believes that there are five other cities not paying the shortfall.

Mr. Brass said he understands Mr. Stam, but he has worked for companies that had to lay-off 30% of their employees because revenue wasn't being generated. The company valued the employees but couldn't lose the company. If there is a business that hasn't made any money for a decade, at what point do you say enough is enough, he asked. Murray has worked

very hard to keep the employees employed, and have cut budgets. There are still discussions on whether employees can be given raises.

Mr. Stam said he brought information to the last Committee of the Whole stating how many of the employees at UTOPIA would have to be cut in order for them to break even. It was basically impossible. Mr. Brass said he understands that, but doesn't see where it is possible to ever catch up.

Ms. Wells said this comes down to the fact that Murray is a part of UTOPIA. She feels that Murray should pay this debt unless there is another way to not pay it. If Murray chooses to not pay anymore, that is fine, but the City will pay that bond debt. If Murray chooses to take it over as Murray fiber, that is the last ditch effort to make this work. That is the decision from her perspective.

Mr. Brass said he agrees, and if it becomes the City's network it is a different thing. Murray provides many services to the citizens and they are happy. Everyone knows that right now Murray doesn't control it, and is betting $364,000 on a promise. Ms. Wells said that unless the City chooses to pursue this, it won't go anywhere. UTOPIA is waiting on the larger cities. The five smaller cities have said that they would not pay the fee but haven't said they would go to this different model. Mr. Brass noted that it might be easier to market Murray's piece of it, if Murray were to own it. Mr. Zollinger stated that all of the other cities would have to agree to go to the utility model. Ms. Wells said that the other cities seem to be agreeable to that in the conversations with them. Mr. Hales pointed out the difference between conversations and agreements. Ms. Wells said she understands that and feels comfortable saying that the majority would agree to that. The bigger cities want to do it, and the smaller cities are immaterial.

Mr. Nicponski complimented Ms. Wells on the job she has done with UTOPIA, and what she has had to put up with. Ms. Wells stated that there isn't a 100% right or wrong decision, but simply wants to point out the options. She will understand and support either decision.

Mr. Shaver said the issue is that the City is still saying that they would like to move forward with the utility model, and also making the decision on the $364,000. That decision doesn't change the resolve to test the utility model. Ms. Wells said she looks at this money as transitional instead of operational. There needs to be some time to look into the utility model, while keeping the system operational. Otherwise, what is the value of taking over a non-working system, she asked.

Mr. Brass commented that if the $364,000 is looked at as buying a seat at the table, in order to take over what is the City's; maybe it is worth it. With the revenue per customer, that doesn't cover the debt service, debt will continue to grow. His concern is that the more debt is added, the more the City is tied to paying, when the network fails. The network will inevitably fail; if the revenue is not more than the debt service, the business cannot survive. His concern when he voted against it, was that he didn't want that number to be greater when it fails. That debt will need to be paid, one way or another. He doesn't agree that it isn't an asset that somebody will buy; it does have a value and believes it won't stay "dark" for long. The customers that have been on failed networks before remained on the networks and they were

bought. It will cost money one way or another; in people and equipment. If it is Murray's cost then it is Murray's choice to market it. Does the City take the risk and have the chance to buy it, he asked. Do you invest the $364,000 into the possibility of creating Murray Fiber, or decide that it isn't going to work regardless, and keep with the original decision, he questioned. He feels like the Council is being asked to change that vote.

Mr. Stam said that Murray owns 12.24% of the system. Mr. Brass said that is true, but without any control over anything. He feels like there is conflict when something is said against the norm, but yet when we go along with everything, the City does not have a seat at the table. UTOPIA is now talking to City staff for the first time. Mr. Stam said he disagrees because he feels like since he has been on the Board, Murray has had a seat at every table. Mr. Brass asked what has been accomplished. Mr. Stam said the direction of the first phase has been changed to make it more profitable, the financial reporting has improved, as well as other changes. He went to the UIA Board and initiated discussions after the vote. There are very few meetings that Mr. Stam has not attended. Previously, those meetings had been going on without a seat at the table. He has seen a big change in what was happening there.

Mr. Shaver agrees with Mr. Brass that the $364,000 is for a place at the table for a possibility of a model that takes control of the fiber for each city. If Murray owns 12%, and still doesn't have a voice; it is similar to the situation with the Canal Company and the ten shares that Murray owns, without any control. If Murray controls it, then Murray controls the profit margins and the budget strategy. It could be compared it to an enterprise fund that has to pay for itself.

Mr. Brass asked if that could happen by December, when the money runs out. Ms. Wells said there are no promises, but if that is the direction the City is going to take, then there is a chance.

Mr. Stam said in his conversations with the UIA Board, there could be a possible vote on a Utility Model in September or October. At that point, how quickly could it be turned over, asked Mr. Brass. Mr. Stam said that all eleven cities would have to agree and that could be an interesting discussion.

Mr. Zollinger is concerned that the City is funding something out of reserves that has the potential to be on-going. He doesn't encourage that kind of budget strategy.

The Council Members voted. Mr. Nicponksi, Mr. Hales, Mr. Shaver and Mr. Brass all voted against the additional funding.

Non-Departmental- Homeless Shelter Funding

The amount set aside for the homeless shelter was $16,361. Mr. Brass asked if this was coming out of the Mayor's budget. Mr. Zollinger said it is currently in the Non-Departmental fund. It was initially placed there because the Non-Departmental fund isn't allocated out to other departments. The General Fund was paying for the homeless shelter.

Mr. Stam believed there was more to discuss, and whether the money from the RDA

low-income housing 20% allowance could be used for this. Mr. Tingey said that the RDA Code states that the money can be utilized to lend, grant or contribute to a person or entity for income targeted housing within the boundary of the agency. There are homeless populations in Murray that utilize the shelter services in Murray. The only concern may be that the 20% allowance has been designated for Neighborworks. There may be a way to make it work, but if it is an ongoing thing, the 20% allowance will not always be there. It would also mean pulling some of the money back from Neighborworks, and they already have their programs running. He doesn't encourage that. Mr. Shaver commented that the RDA money has already been established to the specific places. Salt Lake County has asked the Mayors of all the cities to contribute. He feels like either the Non-Departmental Fund or the Mayor's Fund would be appropriate.

Mr. Brass asked if there was a better way to fund that which didn't involve the General Fund. He doesn't dispute the idea of that. It was decided to leave it in the Non-Departmental Fund.

Capital Improvement Program

There needs to be a retreat to review and decide if they are in agreement with the committee's decisions. Ms. Wells said it was presented in a Committee of the Whole. Mr. Stam said according to the Official CIP plan, there should be a retreat as a Council and review and reallocate or agree with the committee. Mr. Nicponski suggested that it be done off-site and scheduled for another date, before the budget is adopted. It was decided that the retreat would be held on May 28th, 2013, at the Crystal Inn, depending on availability.

Court Requests

Mr. Zollinger said the Court needed $3,700 for a service contract. Those other expenses were taken care of in the 2012-13 budget.

The meeting recessed for a short break.

Citywide Salary Adjustments

There were several scenarios to choose from. Mr. Terry showed a matrix of the different choices. The top line was the Mayor's proposed budget where compression adjustments are looked at. Compression adjustments only involve the bottom quartile of all of the ranges. These are employees that are in the 80 to 90% of midpoint, and depending on how long they have been in that job would receive a compression adjustment. There is a cap of a 7% increase. Under that scenario, 98 employees fall into that category. The compression adjustments average $2,200, or a 5.5% average increase. The remaining 276 employees would receive a .48 cent raise or a $1,000 lump sum bonus if they are already at the top of the range. The increased dollars to salary equal $448,000 and the estimated benefit dollars to be another $170,000. Pension and Federal Insurance Contributions Act (FICA) are both tied to salary; when salaries increase so does the cost that the City pays to Utah Retirements Systems (URS) and to FICA. The total increase would be $659,000, of which $527,000 comes from the General Fund. Mr. Zollinger said these benefit increases are in addition to those that had already been absorbed. These are in addition to the one that the Mayor previously reported. In the Mayor's

report the total increase overall to the budget was $1 million, approximately $550,000 of that was benefit cost increases. The $170,000 increase in benefit costs was in addition to the $550,000 already mentioned.

Scenario #2 is identical with the exception of the raise going from a 48 cent raise to a 75 cent raise for those that don't receive compression adjustments. Under that scenario, the number of people receiving adjustments is fewer. In the first scenario, an employee may be receiving a 65 cent adjustment for example; in scenario #2 it would be better for the employee to receive the 75 cent raise instead of the 65 cent compression adjustment. In this scenario, the average adjustment would be $2,523 or a 6.1%. That leaves 299 employees receiving a 75 cent increase. This scenario adds to a total cost of $871, 545 versus the Mayor's proposed cost of $659,013.

Scenario #3 is identical but is a $1.00 raise, instead of the 75 cent raise. The number of employees receiving the compression adjustment is now down to 60. That amount would equal a $2,080 raise for the remaining 314 employees.

Scenario #4 is Mr. Terry's least favorite. This one allows for 77 employees getting a compression adjustment, and the remaining 297 employees getting a 3% raise. He doesn't prefer this version because a 3% raise is much more generous to a higher paid employee than a lower paid employee. He believes the focus needs to be more on the lower end employees. A $1.00 raise to a lower paid employee is a much greater raise than a $1.00 rise to a higher paid employee.

Mr. Hales said it is interesting that the Mayor's proposal has nearly 100 employees receiving the compression adjustment, and Scenario #3 has only 60 employees receiving adjustments. Mr. Zollinger commented that this was due to the increased amount of the raise that is more money than the compression adjustments.

Mr. Hales stated that he knows it is crunch time and this may not be resolved this year. He asked about those employees receiving unacceptable evaluations receiving the same as other employees receiving great evaluations. Mr. Stam said the money could be approved and then there would be time to decide if it should be tied to evaluations for the employees or not. Ms. Wells said that a merit increase is totally different than this salary increase proposal. Mr. Stam said he believes he is talking about employees receiving unacceptable scores still getting the same amount as others. Mr. Terry said the difficulty is that merit pay is based on the evaluation. The employees are scheduled to have evaluations at all different times throughout the year, depending on their hire date. It would be very difficult to make this proposed increase contingent on evaluations. Mr. Hales commented that by giving a sub-par employee a raise of $2,000 it contradicts the evaluation, and is a little bit of a risk. He has been in cases where the Judge has showed that a raise equated to good performance. Mr. Terry agrees that the merit system is pay for performance, but thinks this is different. Ms. Wells stated the reason the Mayor has budgeted this in this manner is that all the employees have not received any increases for so long. This is to help all the employees feel valued and keep up with the cost of living adjustments.

Mr. Zollinger said the other three scenarios are more costly than the Mayor's proposal. He said by choosing one of the other three it may require an increase in revenue to balance next year's budget. Mr. Terry reminded them that an employee raise is a raise forever on the books. Mr. Shaver said adjustments are made based on a projection what might happen as far as tax revenue is based. Property taxes are constant, but the retail taxes vary. It is possible that the City's numbers this year would be similar to last year. If that doesn't happen, and sales tax revenue decreases there would need to be increased revenue to counter the expenses; such as a property tax increase. The Council is all in favor of increases to the employees, but need to keep in mind that a property tax increase could be needed. Mr. Zollinger said the reality is the City is dependent on sales tax. Ms. Wells said the reason the money was found in the Mayor's budget was due to some tools that Mr. Zollinger found.

Mr. Zollinger said that this year the Retained Risk Fund and the Central Garage Fund were lowered. That provided more money available for all of the other funds. This year the staffing document was looked at closely and some unfilled positions that shouldn't be there were removed. The Court reduced a position that wasn't necessary. The Power Fund agreed to pay for the streetlights in the amount of $168,000. All the above things added up for some extra money to use for employee raises. Those same tools won't be available for use again next year.

Mr. Zollinger stated that there is one more increase scheduled for retirement next year.

Mr. Brass said it is important to take care of the employees but never run the risk that if the City has a downturn and nowhere else to cut, and have to lay-off employees. The City has worked very hard the last couple years to not lay-off employees. There have been several concerns from different people about only a few receiving the compression adjustments, and some of those adjustments are substantial. The reality is that the City is losing good employees. Several years ago, there was an adjustment for journeyman, because they were leaving. Now, the Police Department is losing officers and that costs the City money. It costs money to train employees and the employee goes through a variety of training cycles, and then leaves for another job that is paying $1.00 to $2.00 more an hour. The loss of officers needs to be addressed. There just isn't enough money to fix everybody at this time.

Ms. Sadler likes the Mayor's proposal because it gives everybody something. It isn't going to fix everybody and that is understood and she believes it would be done if it could. Ms. Sadler believes it is a good starting point. This will help the employees that have never received a raise and will also help the employees that have been here longer and have stuck it out without raises. She understands it is not a merit increase, because it is not based on evaluations, and that it should just be called a raise, even though it is a cost of living adjustment. She believes raises will need to be addressed again in the next year and thereafter.

Mr. Brass stated that he would love to give a $1.00 raise, but the money just isn't there this year. If money starts rolling in, and this could be put in the intent document, it could be reviewed again mid-year. Ms. Wells suggested end of year bonuses might be nice also. Mr. Brass said at mid-year, especially after Christmas, the City would have a better idea of the amount of sales tax being generated. There would be a better feel for the numbers for the year. He believes the economy is coming back. He said West Jordan was named one of the top five

boom cities in the Country; that is a good sign that the economy in the valley is improving.

Mr. Shaver commented that this would be a great step in moving forward cautiously. Mr. Brass agreed that a mid-year review with a possible bonus might be a good idea. Mr. Brass liked the idea of a bonus because it is a one-time gift. Ms. Sadler agreed and restated that Mr. Zollinger pulled money from budgets this year that won't be available next year. Mr. Shaver commented that he was glad that Ms. Sadler was in attendance to hear the financial discussions involving employee increases. Ms. Sadler expressed appreciation to Mr. Stam and Mr. Zollinger for attending a Murray City Employee Association (MCEA) meeting and explaining the budgets to the other employees. She thought that was very helpful in helping the employees understand better. She thought that a bonus mid-year would go a long way with the employees also. She also appreciates the extra time off around the Holidays. These things really help to keep the employees' morale up.

Mr. Stam asked about the Wasatch Comp Survey done this year. He suggested that those people that were red-lined in their grade could possibly be moved up a grade so that they are not red-lined. Mr. Shaver said it would be beneficial to look at the employee structure and review that also.

Mr. Brass asked if everyone was comfortable moving forward with the Mayor's proposal for employee increases. Mr. Stam asked if a review of the employee structure and grade levels could be put in the intent document. Mr. Brass said yes, it is not budgetary, it is an administrative topic. Mr. Stam thought it would really boost morale to bump some people up a grade level. Mr. Terry said there have been market adjustments, but those have cost money to increase the grade of the employee. Those employees were thought to be underpaid, and were brought up a level with increased pay.

Mr. Brass thanked Ms. Sadler for her input. Mr. Nicponski said to inform the employees that they would have liked the raise to be more substantial but just couldn't at this time.

Miscellaneous Items

Mr. Brass said that Mr. Zollinger found an additional $10,000 to put into speed signs. A meeting would be held to determine the locations of the new signs.

Mr. Brass said he would like to look at the Taylorville pedestrian bridge to see the benefit for Murray residents and the nearby businesses. Mr. Nicponski and Mr. Stam agreed and said it would be good to talk to the surrounding business owners. Mr. Zollinger reminded them it would be one-time money. No decision was made on the bridge, until further research was done.

Mr. Nicponski said he doesn't believe benefits for the Council need to be waited on. Mr. Brass said the opt-out portion is a separate discussion that could be looked at later. Mr. Brass said all the Council Members currently have insurance.

Mr. Stam suggested looking at what kind of revenue savings the opt-out option gives the City, and then review again after getting that information. If there is a savings that would cover the Council Members insurance, then it would be fine. Possibly enough employees would opt-

out, creating enough revenue to cover the cost, without having to find the money. This could be reviewed mid-year with several other items that are being reviewed mid-year.

Mr. Hales stated that the Council is in agreement that the Council Members definitely work enough hours to qualify for insurance. Mr. Stam said he is in agreement, but the current Council puts in the hours, but possibly future Council Members would not. Mr. Brass said the question is whether it is the right thing to do or not.

He stated there was $364,000 that was just taken out of the budget from reserves. Mr. Hales said that Mr. Zollinger has stated that the money would be found to cover the insurance costs.

Mr. Hales would like to hear the opinions of others. He knows that Mr. Terry has supported it, but what about the others, he questioned. Ms. Wells said this is a Council decision. She said the perception could be a little rough at election time, and that might be a concern. She doesn't think the amount of money it would cost is outrageous, it is just what the Council feels comfortable with. Mr. Nakamura said he doesn't believe the Council Members should be treated differently than the other employees that receive the insurance benefit. He said that Ms. Wells comment makes sense to him. Mr. Nakamura stated that no one is saying that the Council would be getting more than the other employees. Mr. Brass commented that the Council would not be receiving raises this year. Mr. Hales said he is fine with the decision if the Council chooses to add insurance benefits.

Mr. Zollinger asked about the opt-out for Council, because not all the Council Members would choose to take the insurance, so some would have an added benefit. Ms. Wells said she believes the opt-out plan would have to be implemented City-wide. Mr. Zollinger said it poses the problem of double coverage or no coverage at all. Mr. Stam said he believes the ones that would opt-out would have dual coverage.

Mr. Terry said the timing of open enrollment is the problem, and a decision needs to be made by the end of May, in order for coverage to begin July 1, 2013. Mr. Brass commented that it is either now or this same time next year. Mr. Terry believed the opt-out plan would be a future item to work on down the road. Ms. Wells commented that the employees that opt-out now don't receive anything.

Mr. Zollinger said some money could be pulled from the grant writer position and also the Non-Departmental Fund. Mr. Nicponski said he is supportive of the decision to offer benefits to the Council Members. He would not be taking the insurance, but supports the others right to have it. Mr. Brass said he hates to deny someone the opportunity to get better coverage. It is getting increasingly difficult to get good affordable insurance. Mr. Hales said he may not take the insurance either, but supports the right to have it. He suggests looking at the opt-out plan next year and make it universally available to all the employees.

Mr. Brass said he believes the future Council should have that ability. He has been a Council Member for ten years, and it has taken that long to come to this conclusion. He recognizes the amount of time that they all put in, and believes it is an earned benefit.

Mr. Zollinger asked for a rough estimate of who would actually take the insurance to estimate costs. The Council Members agreed that they would need the chance to compare the City's plan against their existing plans. There are at least three of the Council Members that would not take the insurance. Mr. Zollinger said he would budget for two Council Members taking the insurance, and adapt from there. Mr. Brass said if the coverage was similar to his existing plan, he may not change. Mr. Stam said the difference would probably be in the cost of the premiums. Mr. Brass said he would have to look into a few issues with his existing insurance before giving an answer.

Mr. Stam stated that he believes it should be looked into at some point, but doesn't believe the timing is good right now. Mr. Terry handed out information packets on the insurance.

Mr. Nicponski clarified that the retiree insurance program had ended, and that is why he would be reticent at changing plans. Mr. Terry asked Mr. Nicponski if he was fearful of being denied coverage if he dropped this plan. Mr. Nicponski said yes. Mr. Terry stated that under Healthcare Reform, insurance companies would not be able to deny individuals coverage beginning in 2014. Mr. Nicponski stated that there was still a lot of uncertainty with Obamacare. Mr. Terry said that coverage could be expensive; the insurance company could charge more based on the health history, but could not deny coverage. Mr. Nicponski asked if the PEHP plan was portable. Mr. Terry said that a person would be eligible for COBRA for 18 months.

Mr. Terry asked if the Council Members would be taking the single, double or family coverage, and if they could let Mr. Zollinger know. It was decided to evaluate the costs and then a decision would be made.

Meeting was adjourned at 8:20 p.m.

Kellie Challburg
Council Office Administrator II

MURRAY
CITY COUNCIL

DRAFT

MURRAY CITY MUNICIPAL COUNCIL
BUDGET AND FINANCE COMMITTEE
Fiscal Year 2013-14

The Murray City Municipal Council met as the Budget and Finance Committee on Tuesday, May 28, 2013, in the Amethyst Room, Crystal Inn, 818 E. Winchester Street, Murray, Utah.

Members in Attendance:

Jim Brass	Budget Chair
Dave Nicponski	Budget Vice-Chair
Jared Shaver	Committee Member
Brett Hales	Committee Member
Darren V. Stam	Committee Member

Others in Attendance:

Justin Zollinger	Finance	Ted Eyre	Resident
Jan Lopez	Council Office	Frank Nakamura	Attorney

Capital Improvement Program (CIP)

Mr. Hales welcomed everyone to the Capital Improvement Program (CIP) discussion. The intent is to review the CIP recommendations for 2013-2014. The CIP committee is made up of Mr. Stam, Mr. Hales, Mr. Zollinger, Mayor Snarr and Ms. Wells.

Mr. Shaver asked if the purpose of this discussion was to review the committee's suggestions. Mr. Stam said the process is that the committee makes recommendations and then gives them to the Council to review and make changes if necessary. Mr. Hales said that the recommendations are based on the requests from Department Heads. The committee asked the specific departments to prioritize their requests. Mr. Stam stated that there was only a minimal amount of money to use at the committee's discretion. Mr. Zollinger said that the money spent on fiber and Police cars took any money that was discretionary. Mr. Stam said that unless there was a particular project that one wished to fund and pull money from another project, there really is not a lot of play there. Mr. Shaver commented that there were a couple projects and Mr. Stam agreed and said it had been discussed.

Mr. Brass stated that during the Budget Reconciliation, everything was squared away, so that nothing would alter the CIP list. There was additional money found by Mr. Zollinger to add more Radar Speed Signs. Mr. Shaver asked if the savings of $364,000 that was not promised

for fiber would affect the CIP recommendations. Mr. Zollinger answered that it would not, because that money was coming from the reserves in the General Fund. Mr. Brass said he would prefer the $364,000 to go back into reserves. Mr. Zollinger said the money is still there.

Mr. Shaver asked if the process for handling computers had been compared to the handling of the Fire safety equipment. He asked if the breathing apparatus equipment and turn-out gear for the Fire Department was going to remain in the CIP fund. Mr. Brass said he feels strongly that life-saving equipment should not be subject to the whim of the committee. Although, the City is going to have a new administration in six months and will come up with a new budget. Mr. Shaver asked if the Fire Department budget should have the breathing apparatus in their budget, similar to the way computers are budgeted.

Mr. Brass said the Council could make that direction and appropriate funds for that specific gear. Mr. Shaver asked if the Fire Department budget needed to be increased by approximately $36,000 to cover the purchase of the breathing apparatus. It would then be on rotation to purchase some every year. Mr. Shaver asked if that amount could be taken from reserves and moved to the Fire Department budget. Mr. Brass said that by law, equipment in the Fire Department has to be visually inspected and tested every year. Ultimately, the tanks get to a certain age and need to be replaced.

Mr. Brass said his primary concern is turn-out gear for the Fire Department. Mr. Shaver said there are 12 units of turnout gear listed on the CIP list. He recommended those also be moved to the General Fund for the Fire Department, and make them an ongoing expense. Mr. Stam clarified that reserve money would be used this one time in order to balance the budget. Mr. Zollinger said that he wouldn't recommend using reserves for ongoing expenses. Mr. Stam said he understands, but the money needs to come from somewhere this year only to balance the budget. Mr. Brass suggested leaving it for this year, and put it on the Intent Document to move it to the Fire Department budget moving forward.

Mr. Stam asked about police handguns, and what budget they belong in. Mr. Zollinger replied that they are in the regular Police Department budget. Mr. Stam said this should be the same thing. Mr. Shaver asked if the committee should look at the items listed on the CIP list and possibly see which items could be put on the Intent Document to be moved later. Mr. Brass said that the language in the Intent Document could say that life-saving equipment should not be on the CIP list. Mr. Hales asked Mr. Shaver if there were some items in particular that he would like to discuss. Mr. Shaver replied that the two items discussed were on his list; the breathing apparatus and the turn-out gear. This year they would be funded from the CIP budget but the Intent Document would state that those items would be moved to the regular budgets thereafter.

Mr. Brass replied that after making a quick scan, he didn't see any other life-saving equipment listed.

Mr. Stam said that the committee tried to have the philosophy of putting as much money into roads as possible. This was due to the Class C funds the City would receive, providing that the City matches the funds. The CIP discussions this year went much faster and easier than the previous year, simply because departments were able to choose what they wanted. He said the

incentive of giving the departments money back, made a big difference in the attitudes of how to proceed.

Mr. Hales asked for any more questions on the CIP discussion.

Budget Intent Document

Personnel

Mr. Brass stated that everyone should have had the opportunity to review the Council Intent Document. This document will state for the record the intentions for the upcoming year.

It was decided to go with the Mayor's recommendation for employee compensation, with the thought of reviewing it again mid-year. The Wasatch Compensation Survey is included in the Intent Document also.

Health Insurance Coverage

Mr. Shaver asked about the health insurance coverage. He clarified that Mr. Terry stated that the insurance and the opt-out were two separate things and should be looked at as such. Should the opt-out option be part if this discussion or just left alone, he asked. Mr. Brass said that there wasn't enough information to make a decision on the opt-out option. Mr. Nicponski said it had been suggested that the opt-out should be offered to all of the employees, and the problem with that is the timing of Open Enrollment.

Mr. Brass said that Mr. Terry noted all changes need to be done during Open Enrollment, with the exception of new hires or newly elected officials, if applicable. There are also certain life changing events that allow for changes mid-year. Life changing events include the loss of insurance for reasons other than choice. For example, a job change for the individual or the spouse, or marriage for dependents would qualify as a life changing event.

Mr. Stam said it was recommended that the opt-out option be made available to all employees; it could be done first for the Council and then reviewed for the entire City for the following year. Mr. Hales said he is uncomfortable having the Council receive the opt-out option, but not all of the employees. Mr. Nicponski agreed that it may be a problem.

Mr. Brass said the difference is that the health insurance is a benefit offered to all qualified employees, and the Council has been qualified for a very long time also. The opt-out is a whole different game. Mr. Nicponski said he believes the opt-out might be better for the following year. Mr. Brass stated that the philosophical discussion is whether the Council takes the benefit of insurance or not. His concern is that everyone should have health insurance without concerns; and it is a benefit that is available. He is personally still looking at the comparisons between his existing health insurance, and is unsure whether or not he would take it. Mr. Hales said the decision needs to be made as a group; he is unsure of whether he would take it also.

Mr. Nicponski said he liked the idea of putting the opt-out on the Intent Document for next year.

Mr. Shaver clarified that the existing Mayor has the insurance; the language should be health insurance coverage for all elected officials. Mr. Stam said the language also states that the City has provided health insurance benefits for full time employees for many years; it also provides insurance to many part-time employees. Mr. Zollinger said there are five part-time positions that qualify for health insurance benefits. Mr. Nakamura said that is one of the corrections that he had made on the document, changing it to "qualified employees", instead of only full-time. The classification of regular part-time employees are employees qualified to receive insurance. That is important because the Council has the regular part-time status in the City. Mr. Nakamura suggested the language be changed to "Council Members", instead of "Elected officials". The Mayor is considered a full-time employee, so is automatically qualified. Mr. Brass said that he doesn't think a benefit should be political. Mr. Shaver said that the previous language stated "all elected officials", which would have included Council Members also. Mr. Brass said that other Council Members, including the County receive insurance.

Mr. Stam asked if there was a difference between health insurance and life insurance. Mr. Zollinger said that a qualified employee receives $40,000 automatic life insurance. He believes they are two separate things. Mr. Stam asked if the Council Members receive the life insurance. Mr. Zollinger said that life insurance benefits are a question for Mr. Terry. Mr. Brass said that is something to be looked at also, and that language needs to be added to the Intent Document before the budget is adopted. Mr. Shaver said the information on life insurance is included in the benefit package they recently received.

Mr. Brass said that to include in the Intent Document language that the Council intends to look at the opt-out option for next year. Ms. Lopez stated that the decisions made tonight by the Council would be incorporated into the Intent Document; as well as some editorial changes that Mr. Nakamura suggested, and she would then send the document to everybody.

Murray Fiber

Ms. Lopez noted a change in the last sentence, adding "beyond the City's contractual obligations" where funding for these agencies is discussed.

Mr. Brass agrees that the City should be looking for alternatives.

Murray School District Funding

Mr. Zollinger commented on the agreement that the City made with the School District in the amount of $200,000 to help with the auditorium. The School District has said that more than likely an agreement would not be completed before the end of this fiscal year. He asked if the Council would like to roll that over to next year's Intent Document. Mr. Brass stated that he would roll that money into the CIP fund for that specific item. Mr. Zollinger said it was coming from the reserves of the General Fund. Mr. Shaver asked about the agreement. Mr. Nakamura said a meeting was scheduled the following day with the Superintendent. He didn't know what the issues were with the agreement. Mr. Shaver clarified that the School District is hesitant with the agreement. Mr. Nakamura said the agreement was prepared with the desired changes but the School District has yet to sign the agreement. Mr. Brass said if an agreement isn't reached, then the money should be taken out of the budget; if there is the potential of reaching an

agreement, then it could be rolled over to next year. Mr. Zollinger stated that it could be put in the budget this year, and used in the following year. Mr. Brass clarified that it is currently a line item in this year's budget. Mr. Zollinger stated that was correct for the 2012-2013 budget, but not for 2013-2014. Mr. Shaver commented that the money doesn't have to be spent if there is not an agreement. Mr. Stam asked if there could be a budget opening and move it to the next year. Mr. Zollinger said if the City knows before June 19th it could be put in the budget for the next year. Mr. Nakamura said the problem is if it has to go back before the Board again. Mr. Shaver said that if the money is in the budget, it doesn't have to be spent. If an agreement isn't reached, then the money could always be rolled over to the next year. Mr. Brass commented that if the School District doesn't want to live by the agreement, then the City is free to spend the money somewhere else. He suggested leaving the money in the budget for now. Mr. Shaver doesn't believe it needs to be part of the Intent Document, since it is already in the budget.

Department Budget Savings

Mr. Stam asked about the Department budget savings and if the Legislature approved raising the General Fund Reserves to 25%. He commented that it states that next year it is listed as the City giving back 75% after the City gets the 18%. Should the City increase reserves to 19% this year, slowly increasing until reaching 25%, he asked. He commented that the Legislature just increased the reserve amount to 25%. It was discussed that the City should graduate that number to 25%, and the Intent Document states it as 18%. He suggested picking a level to increase to at this time, slowing building the reserves up to 25%. Ms. Lopez asked Mr. Zollinger what 1% would amount to. He answered that it depends on the revenue. Mr. Stam commented that the revenue may increase 1% to 2%, and the City would still have an increase in the General Fund. Mr. Zollinger stated that total revenue is $38.8 million, and 1% of that would be about $388,000. It was discussed that it is a lot of money to take out of the CIP budget, for example. Mr. Hales asked Mr. Zollinger if he felt comfortable with the 18% reserve amount. Mr. Zollinger said reserves are important and feels that a good level is essential. Mr. Brass commented that if the City had started putting in 1% every year for the last ten years, there would be a New City Hall. It needs to be initiated at some point. Mr. Shaver agrees, even though it would be hard to take it from the CIP Fund. Mr. Brass noted that the downside of that is there are $30 million of roads that need repair, and that money keeps decreasing. There needs to be a balance. Mr. Shaver asked if the City should put it in the Intent Document that the City increases the reserves by a certain percentage every year, that way a future Council would be held to that obligation also.

Mr. Shaver believes that a lot of the money for projects in the CIP would disappear, once the project is completed and the money goes elsewhere. He suggests raising the reserves to 19%, even though it would make a difference to the departments. If the revenue increases to $39 million or $40 million, then there would be extra money that could be used for the CIP projects. Mr. Stam noted that the other part of this discussion, is whether or not to phase down the 75% over the next few years. Mr. Shaver commented that he would not be in favor of that. He believes that if the departments are saving money, it would be best to give some back to them, as best as they can.

Mr. Nicponski commented that the money would still be in reserves, and wouldn't be

gone. Mr. Shaver said it creates a mindset for the Department heads as an incentive to be wise with their budget. Mr. Brass suggested giving it a shot and building up the reserve to 19%. Mr. Zollinger stated that if the language said to build the reserve up to 19% with positive revenue variances, and not from the departments, then they wouldn't see anything. There could be two victories; with the departments still receiving 75% of their budget savings, and the other would be coming from higher revenue than was budgeted.

Mr. Brass said it could be in the Intent Document as being the intent to raise the reserves to 19%, using various sources. Mr. Nakamura said that paragraph isn't telling him that the City is going to have a 19% reserve, but that is the line of which the savings would be taken. He said that to set a reserve of 19% is a whole different animal, which causes a predicament. Mr. Stam said that it states that their allocation is after the General Fund reaches 19%, and if that level is not reached then the departments don't receive the full 75%. Mr. Nakamura said that it is tricky if it states that the 19% level of reserves must be maintained. Mr. Stam asked if there should be any other intent included as to the increasing of it over the years. Mr. Shaver said that Mr. Nakamura has pointed out that the City can establish a 19% reserve forecast for the year, and it shouldn't affect the 75%. He doesn't want to discourage the departments from saving money. The goal of the City to increase the reserve to 19% should be a separate issue. Mr. Brass reiterated that the Council would like to see an increase in the reserves from 18% to 19%, using whatever sources possible. It could be stated that this Council would like future Councils to reach the 25% level. Mr. Brass said at some point higher reserves won't make sense if roads needs repair, or if taxes are increasing. Mr. Shaver said that it wouldn't be locking the Council into a higher percentage for reserves, only if the opportunity to increase it is there. Mr. Zollinger said it would be a subject up for debate, whether or not to increase taxes if there is a healthy reserve. Mr. Brass said the difference between an 18% reserve and a 25% reserve is substantial. Mr. Zollinger said that a City should not be in a bad financial position before taxes are raised. Mr. Brass commented that a positive trend is starting to be seen. There will come a time when taxes need to be raised; it is unavoidable. Mr. Nicponski said that with the visible growth, the City doesn't need to think about raising taxes at this point.

Public Infrastructure Funding

Mr. Brass asked if there were any questions on the paragraph. This was essentially Mr. Tingey's suggested $50,000 allocation to help business enhancement. Mr. Nakamura asked if the involved committee was identified. Mr. Nicponski replied that it was identified as the Business Enhancement Committee. Mr. Brass said that the committee is in the process of being created.

Capital Improvement Program

Mr. Brass said that the CIP program had been previously discussed.

Radar Speed Signs

Mr. Brass commented that the City had found an additional $10,000 for increased Radar Speed Signs. The intent is to have the Council and the Traffic Safety Committee to determine the locations. Mr. Shaver asked Ms. Lopez if she had a copy of that. Mr. Nicponski said it could

be subject to Council review. Mr. Stam suggested having the Traffic Safety Committee come to a Committee of the Whole for discussion. That could be done after the budget is approved. Mr. Shaver suggested getting a list from them and comparing it to the Council list. Mr. Stam said theoretically every Council Member would have two signs for their District, unless decided otherwise. Mr. Nicponski said it should be reviewed in a Council Initiative Workshop.

Lobbyist

Mr. Nakamura asked if the Council would like any reference made to the Lobbyist or Grant Writer position. Ms. Lopez had some suggested language that reads, "The Council wants to retain a lobbyist to represent the City in the State Legislature Process. It is the intent of the Council to do a Request for Proposals, with established criteria, for a lobbyist. Funding for a lobbyist shall not exceed $40,000." Mr. Shaver commented that he would like the paragraph to start off with the second sentence.

Mr. Shaver said his concern was the RFP (Request for Proposals). Mr. Nicponski asked about the mechanics of an RFP and if a sub-committee was appointed to select the winner. Mr. Shaver said that you could have a committee, but typically it is the Council Chair and Vice-Chair. They would do the interviews and bring it to the Council for a recommendation. Mr. Stam said his concern is that something similar would happen as it did with Ace Disposal. An RFP could come back and raise the amount to $45,000, and currently the City has someone locked in at $40,000. Ms. Lopez commented that it is a year to year contract so the lobbyist isn't locked in either way. Mr. Shaver said that is what an RFP is. Mr. Brass said if the numbers come back higher than the City wants to pay, then the City doesn't pay. Mr. Stam said the last couple of years, the lobbyist has been okay with the $40,000. Once you go to an RFP, the door is opened for higher salaries. A salary of $45,000 could still be lower than the other bids, but an increase in the existing salary. Mr. Shaver said that part of the challenge is that this position is so varied during different times of the year regarding the amount of work involved.

Mr. Shaver asked why the lobbyist isn't given a two year contract at $40,000 per year, similar to the contracts with the audit companies. He likes the idea of a two year contract, and at the end of the two years, it is the City's option to move forward or not. Mr. Nicponski said that could be the reasoning used with the lobbyist to go to an RFP if the number of years is increased. Mr. Hales said he still feels like the idea of an RFP is the City's obligation to look around for the most qualified applicant. Mr. Hales also feels like the City position of Legislative Assistant, if that position is filled, should be more involved with the lobbyist. Mr. Shaver clarified that this person was not the Council's hire, the Council is simply providing the funds. It seems to be a better fit to him, if that relationship was developed over a couple of years. Mr. Brass stated that it could be put in the Intent Document that it was the City's intent to put out an RFP for a lobbyist position at $40,000 per year. The language of the RFP could be decided in a Committee of the Whole meeting.

Mr. Stam said that the lobbyist was originally hired to work for the Council. Mr. Hales said that the Council pays his salary and he should be reporting back to the Council. Mr. Stam said that it was hoped that the lobbyist had some connection with the Council and the Administration both. There may have been some disconnect there. Mr. Brass said there needs

to be communication, even though at times the vision may be different. Currently the position is being paid for out of the Council budget. Mr. Shaver said that comes down to the instruction given to the lobbyist from the Council Chair.

Ms. Lopez stated that the Council appropriates $15,000 to Non-Departmental for a Grant Writer. The Finance Department, with input from other departments, shall establish criteria for City-wide use of the Grant Writer. Mr. Stam asked if the title should be changed from Grant Writer to Grant Writing Assistant. It doesn't necessarily mean that it is a person hired, but possibly money to go to a specific person designated to write a specific grant, possibly even an existing employee or a consultant. Mr. Shaver said it is similar to the Legal department, hiring different attorneys for different projects at times. This gives the City the ability to hire the right person for that criteria. This would allow expertise to be given from specific individuals in specific departments. Mr. Nicponski said he liked the title of Grant Writing Assistance. That would allow the funds to be used for specific grants, not just the hiring of a person.

Passport Services

Mr. Brass asked if there were any questions on that paragraph. He liked the idea of the City providing the passport service.

Preliminary Design for a New City Hall Building

There has been $50,000 allocated to fund this project. Mr. Nicponski thanked Mr. Stam for his support in that meeting.

Mr. Brass stated that there should be a Budget Addendum in the packets. This is a lump-sum item that allows allocation of the budget without a budget opening every time.

Mr. Zollinger commented that he had a small change on the very bottom item regarding schools and music specialists. He is unsure of where that revenue is and that it hasn't been budgeted for. Ms. Lopez stated that it was an expected grant from other agencies. Mr. Brass said that is probably a grant that Mary Ann Kirk has arranged. Mr. Zollinger said he broke out every single grant in the budget, but wasn't aware of that one.

Mr. Nicponski asked about the standing of the Taylorsville Pedestrian Bridge on 4500 South. Mr. Brass said he believed the Council wanted to do a little more research on the bridge. Mr. Shaver said they would like to see how revenue and expenses are coming in. Mr. Nicponski asked if it could be put in the Intent Document. Mr. Brass said it could be looked at mid-year without it being on the Intent Document, because it is on the record.

Mr. Brass asked if there were any more questions. The meeting was adjourned.

Kellie Challburg
Council Office Administrator II

MURRAY
CITY COUNCIL

Committee of the Whole

MURRAY
CITY COUNCIL

Discussion Item #1

Murray City Municipal Council
Request for Council Action

INSTRUCTIONS: The City Council considers new business items in Council meeting. All new business items for the Council must be submitted to the Council office, Room, 112, no later than 5:00 p.m. on the Wednesday two weeks before the Council meeting in which they are to be considered. This form must accompany all such business items. If you need additional space for any item below, attach additional pages with corresponding number and label.

1. TITLE: (Similar wording will be used on the Council meeting agenda.)
SALT LAKE COUNTY HEALTH DEPARTMENT UPDATE

2. KEY PERFORMANCE AREA: (Please explain how request relates to Strategic Plan Key Performance Areas.)
SAFE AND HEALTHY NEIGHBORHOODS

3. MEETING, DATE & ACTION: (Check all that apply)
____Council Meeting OR _X__ Committee of the Whole
__X__Date requested July 16, 2013
__X__Discussion Only
____Ordinance (attach copy)
Has the Attorney reviewed the attached copy? ____
____Resolution (attach copy)
Has the Attorney reviewed the attached copy? ____
____Public Hearing (attach copy of legal notice)
Has the Attorney reviewed the attached copy? ____
____Appeal (explain) _____
____Other (explain) _____

4. FUNDING: (Explain budget impact of proposal, including amount and source of funds.)
N/A

5. RELATED DOCUMENTS: (Attach and describe all accompanying exhibits, minutes, maps, plats, etc.)
Statistical information; 2013 Health Department Report; and 2013 Health Department Report

6. REQUESTOR:
Name: Linda Bogdanow Title: Epidemiology Supervisor
Presenter: Linda Bogdanow Title: Epidemiology Supervisor
Agency: Salt Lake County Health Department Phone: 385-468-4172
Date: July 5, 2013 Time:

7. APPROVALS: (If submitted by City personnel, the following signatures indicate, the proposal has been reviewed and approved by Department Director, all preparatory steps have been completed, and the item is ready for Council action)

Department Director: Janet M. Lopez Date: July 5, 2013

Mayor: N/A Date:

8. COUNCIL STAFF: (For Council use only)
Number of pages: _____ Received by: _____ Date: _____ Time:_____
Recommendation: _____

9. NOTES:
Linda Bogdanow and Tom Trevino are Salt Lake County Health liaisons to Murray City.

Salt Lake County Health June 28, 2013

Please find attached the health department 2012 annual report; it describes our various programs and activities, as well as provides you with basic information about our finances and organizational structure.

Because the annual report's statistical information is countywide, we have selected four health department programs (out of 25) and gathered information specific to **Murray.**

In 2012:

- the department immunization program administered **326** Tdap vaccinations to your residents; these immunizations are collectively valued at **$15,974**
- **42** of your residents participated in our BeWise women's health program; the free and low-cost cancer screening services and individual coaching and activities offered in BeWise represent a value of **$7,602** to your city
- food protection staff conducted **394** food-service inspections in your city (both routine and complaint-driven, but not including any temporary events or mass gatherings); these inspections are equivalent to **$72,890**, and:
- sanitation and safety staff fielded **45** housing complaints in your city (housing complaints can include anything from mold and meth contamination, to vermin and bedbugs, to inadequate utility service or substandard weather protection); staff response time to your housing complaints is valued at approximately **$4,883**

In addition, the table below lists 2012 WIC participation by ZIP codes included within your city boundaries (as a federal program, WIC participation numbers are broken down by ZIP code and are not available by local municipality), each ZIP's share of Salt Lake County WIC participation, and the associated dollar value for each. The attached map graphically displays the "share of county WIC participation" for all ZIP codes in Salt Lake County.

WIC Participation, 2012			
ZIP	**Number of Clients**	**Share of County WIC**	**Food $ Value**
84047	1,192	4.59%	$ 56,727
84107	843	3.25%	$ 40,118
84117	298	1.15%	$ 14,182
84121	331	1.28%	$ 15,752
84123	1,191	4.59%	$ 56,680

Please let me know if you have any questions or comments about our 2012 annual report or about your city-specific information.
You may also contact either of your health department liaisons at any time, about any health-related topic with which you need assistance; your liaisons are:

- Linda Bogdanow, 385-468-4172, lbogdanow@slco.org
- Tom Trevino, 385-468-3821, ttrevino@slco.org

ANNUAL REPORT 2012

SLVHD

Salt Lake Valley Health Department

In 2012:

84,500
vaccines given

3,784
routine food service inspections

1,949,534
pounds of hazardous waste collected

30,000
disease investigations

About SLVHD

As a division of the Salt Lake County Human Services Department, the Salt Lake Valley Health Department (SLVHD) works to protect and improve the well-being of all county residents by preventing disease, illness, and injury and by impacting social, economic, and environmental factors fundamental to excellent health. While some county divisions provide services only to residents living within unincorporated areas, the SLVHD is charged with the responsibility of providing public health services to residents in both incorporated and unincorporated areas.

The structure of governmental public health agencies at the state and local levels varies considerably across the country. Utah has established a decentralized organizational model for public health in which local public health agencies are organizationally independent of the Utah Department of Health and are primarily governed by local boards of health. The Utah Legislature established these "local health departments" under Title 26A of the Utah Code.

The Salt Lake Valley Board of Health meets the first Thursday of each month at 7:30 a.m. in room N2003 (No meeting in July)

State law requires local health departments to have a policy-making Board of Health (BOH); the SLVHD has a 15-member board appointed by the Salt Lake County Mayor, and county ordinance outlines the qualifications for board members. The BOH is responsible for setting public health policy for the department and may adopt and enforce public health rules, regulations, and standards necessary to implement the public health policies. Standards and regulations adopted by the BOH supersede existing local standards, regulations, and ordinances.

The Board also approves the budget, which the health department submits to Salt Lake County. The county is responsible for setting administrative (personnel and fiscal) policies for SLVHD. Our budget is comprised of federal and state funds, county general funds, and fees collected for department services. Approximately one-third of the budget comes from each of those sources. (See page 8 for details.)

From the Director

The mission of the Salt Lake Valley Health Department is simple: "To promote and protect community and environmental health." It may sound similar to the goals of other health and medical agencies, but while the medical care system focuses on treatment after an illness occurrs, public health instead focuses on methods aimed at preventing health problems before illness strikes.

Our public health programs work for residents on a daily basis to immunize children, inspect restaurants, keep tobacco out of the hands of minors, prevent cancer in women, teach proper nutrition, protect our water and air, provide culturally appropriate services to a multitude of disparate populations, and to collaborate with our community partners to insure that public health works for all Salt Lake County citizens.

As director, I'm proud to be affiliated with the talented, dedicated staff of the Salt Lake Valley Health Department; despite tight budgets, they continue to provide exceptional service to Salt Lake County residents, recently receiving a 96% customer service satisfaction rating.

This 2012 annual report will provide you with an overview of the many SLVHD programs that keep our residents happy and healthy, as well as tell you a little about our structure and finances.

Gary Edwards
Executive Director

Programs

Air Pollution Control (APC)

The APC Bureau regulates the county's motor vehicle emissions inspection and maintenance (I/M) program, as well as enforces regulations regarding stationary sources of air pollution. The I/M program has been in effect in Salt Lake County since 1984. As of 2012, the I/M program oversees 462 decentralized stations and 1,883 technicians—all trained by SLVHD staff. Salt Lake County's I/M stations conducted 632,539 I/M tests this year.

During 2012, APC staff conducted 472 covert audits of I/M stations and discovered 93 tests improperly done. This resulted in the suspension of 26 techs in 18 stations and warning notices issued to 62 techs in 75 stations. SLVHD staff estimates that the I/M program prevented over 13,000 tons of air pollution from being released into the valley this year.

Child Health Evaluation and Care (CHEC)

CHEC works to ensure children getting Medicaid receive their well-child medical and dental visits. Each month, Medicaid identifies and alerts SLVHD of children who will be due for a well-child visit or dental exam; SLVHD staff contact the families of these children and encourage them to make an appointment for preventive care with the child's provider. Staff also offers assistance in finding providers and making appointments. The service is available to children aged 0–21 years who are enrolled in Medicaid.

Chronic Disease Prevention

SLVHD's Chronic Disease Prevention program works to reduce the incidence of chronic diseases—such as heart disease, stroke, diabetes, and cancer—by addressing preventable risk factors such as cancer screenings, physical activity, nutrition, and obesity.

In September 2012, the program concluded its year-long Commit to be Fit, an initiative designed to help county residents make a pledge to do something, small or large, to lead a healthy and fit life. The initiative reached approximately 31,000 residents in Salt Lake County, as well as built partnerships with schools, businesses, cities, townships, and the community. Reaching out within the community has also provided excellent feedback to help us mold and improve future initiatives.

Chronic Disease Prevention also administers Salt Lake County's employee wellness program, Healthy Lifestyles. In place since 1989, Healthy Lifestyles served 1,865 county workers in 2012, including 191 new participants this year.

Clinical Services

The Clinical Services program is a collaborative effort between the department and various community partners to provide comprehensive pediatric and women's health services to women, teens, and children in Salt Lake County. The University of Utah's College of Nursing and departments of Pediatrics, Obstetrics, and Gynecology have partnered with SLVHD to address the health disparities encountered by uninsured and/or low-income women, adolescents, and children in the county. In 2012, 5,904 individuals utilized nearly 17,229 appointments at the South Main Clinic; at the Ellis Shipp Clinic, 624 women attended approximately 2,475 appointments.

Communications Office

The SLVHD Communications Office responds to media inquiries about any and every topic under the department's purview. Inquiries include daily interview requests as well as proactive outreach and story

generation for community education purposes. The office also produces custom professional video products and handles internal employee communication.

In addition to traditional media outlets, SLVHD communications staff oversee the department's social media program, including Facebook, Twitter, Pinterest, YouTube, and Flickr accounts. SLVHD was among the first local health departments in the nation to embrace and effectively use social media to interact with the public, and our social media program remains one of the most respected government social media programs in the country, as well as a social media leader among the Salt Lake County family, regularly advising other departments and divisions on social media best practices.

Emergency Management

SLVHD receives grant funding from the Centers for Disease Control and Prevention that is tied directly to our ability to receive and distribute medication and other supplies from the Strategic National Stockpile (SNS). SNS supplies are reserved for a major biological terrorism threat or disease pandemic. The established SNS standard is to accomplish distribution to an affected population—no matter the population size—within 48 hours.

Emergency Response

The Emergency Response program is an on-call program that responds to any discharge into the air, soil, or water in the Salt Lake Valley. Whether the discharge was intentional or accidental, the Salt Lake Valley Health Department will respond to assess and analyze the situation.

In 2012, there was a total of 367 emergency responses and consultations, and the number of Notices of Violation issued to businesses under the Utah Clean Water Act nearly doubled to 25 from just 13 in 2010. In addition, the total amount of penalties levied from these Notices reached a total of $87,871.48, more than double the 2010 total of $33,438.00.

Epidemiology and Infectious Disease

The SLVHD Epidemiology and Infectious Disease Bureaus monitor the health of the community in Salt Lake County by providing education and information relating to communicable disease outbreaks. To protect county residents from foodborne illnesses, emerging infectious diseases, and other communicable diseases, the bureau investigates reportable diseases, conducts surveillance activities, and analyzes and interprets data to aid in disease prevention.

From 2011 to 2012, Salt Lake County saw 40% more cases of campylobacter and 600% more cryptosporidum. This year, epi/ID staff also participated in 9 multi-state outbreak investigations, 4 statewide outbreak investigations, 21 Salt Lake County investigations, and conducted over 30,000 disease investigations.

Food Protection

In 2012, SLVHD's Food Protection staff received the Crumbine Award, a prestigious national award given annually to a local health jurisdiction that demonstrates excellence and continual improvement in a comprehensive food protection program. Since the award's creation in 1955, SLVHD has been honored three times (1959, 1967, and 2012)—one of only two health districts in the nation (along with San Diego County, California) to be a triple winner.

This year, the Food Protection Bureau completed 3,784 routine inspections of Salt Lake County food service establishments and 1,449 inspections of temporary food events. Staff also investigated 698 citizen complaints and, with the Epidemiology Bureau, completed 60 foodborne illness investigations.

Healthy Communities

SLVHD provides infrastructural support, health expertise, and assistance in the execution of community projects to several Healthy Community groups throughout Salt Lake County. These groups work to identify and address local issues that affect health

and quality of life. Each group determines their health priorities then implement programs to improve the lives of people who live and work within their community. As of 2012, there are active Healthy Community groups in the communities of Draper, Herriman, Magna, Riverton, Sandy, South Jordan, Taylorsville, and West Jordan.

Household Hazardous Waste (HHW)

The HHW program runs two full-service, permanent facilities that accept household hazardous waste from Salt Lake County residents. The program also operates two ABOP (antifreeze, battery, oil, paint) centers, three electronic waste collection sites, 14 CFU light collection locations, and 14 pharmaceutical disposal sites.

The program collected 1,949,534 pounds of hazardous waste in 2012, including 80,264 pounds collected at 13 community collection events. The National Association of Counties and Cities (NACCO) also recognized HHW for our ongoing electronic scrap recylcing partnership with Samsung that saved SLVHD $124,081 in recycling costs this year.

Immunizations

The SLVHD Immunization program provides childhood vaccines to babies and toddlers, booster doses to children entering kindergarten, and vaccines for preteens and adolescents. The program serves adults with vaccines that are required or recommended, and staff members administer the various seasonal flu vaccines available for all ages—flu vaccines are available approximately nine months each year.

The immunization nurses in the five SLVHD immunization clinics administered 84,500 vaccines to Salt Lake County residents in 2012.

Injury Prevention

The Injury Prevention Program actively promotes child passenger, teen driver, and senior citizen safety initiatives, as well as the Salt Lake County branch of the national Safe Kids program. Injury Prevention staff conduct car seat installation classes, senior fall and fire safety classes, and teen driver safety outreach activities, as well as host car seat recycling opportunities countywide.

International Travel Clinic

The Internationational Travel Clinic provides pretravel education, immunizations, and prescriptions for individuals planning to travel internationally. Highly trained travel nurses also offer food and water safety tips, personal protection advice, and medical and evacuation insurance information—all customized to whatever countries a client is visiting.

Public Health Nursing

Public Health Nursing (PHN) provides home visitation services to at-risk families in Salt Lake County. PHN services are provided primarily through the Targeted Case Management (TCM) and Nurse-Family Partnership (NFP) programs.

The TCM program provides annual home visits to Medicaid clients from birth to four years of age. TCM links clients to the community resources they need; children identified as high risk can be seen up to three times. In 2012, TCM nurses conducted 4,475 home visits to clients.

The NFP program is an evidence-based nurse home visitation program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. Each mother served is partnered with a registered nurse early in her pregnancy and receives ongoing home visits that continue through the child's second birthday. This year, NFP nurses provided 2,675 home visits to an average of 122 clients.

STD/HIV Clinic and Outreach Program

The STD/HIV Prevention Program provides one-on-one risk reduction counseling and HIV testing to at-risk individuals in an outreach setting. The program partners with several drug treatment facilities, jails, and nonprofit organizations to promote safer behaviors among at-risk individuals, to provide education about STDs and HIV, and to identify infected individuals. In 2012, the program counseled 1,131 people and facilitrated 118 educational presentations in the community, reaching 1,488 individuals.

The STD/HIV Clinic offers low-cost STD and HIV tests to the residents of the Salt Lake Valley, including walk-in appointments and rapid HIV testing with same-day results. In 2012, the clinic saw 4,905 clients and performed 17,834 STD (chlamydia, gonnorhea, HIV, or syphilis) tests. The table below shows the total number of STD cases reported in all of Salt Lake County in 2012.

Positive STD Tests, 2012				
Test	**Chlamydia**	**Gonorrhea**	**HIV**	**Syphilis**
Total SL County	3,859	330	65	74

Sanitation and Safety

The Sanitation and Safety Bureau addresses complaints and deficiencies regarding housing, solid and infectious waste, transient encampments, noise pollution, indoor air quality, mold, lead, radon, and vermin infestation. The Bureau also regulates cosmetologists, body art facilities, chemically contaminated properties (meth labs), correctional facilities, massage establishments, hotels/motels, schools, tanning salons, and solid waste haulers.

In 2012, the Bureau conducted 1,409 inspections of permitted facilities in Salt Lake County and investigated 2,987 housing and solid waste complaints. The Bureau closed 150 properties to occupancy and conducted over 150 community cleanups. Community cleanups included several transient camps as well as the cleanup of Banks Ct. *(pictured above, before cleanup)*, which required 9 days of work, 75 dump trucks of refuse and resulted in 15 junked vehicles, 2 trailers of hazardous materials, and 2 trucks of waste tires.

Tobacco Prevention and Control

The Tobacco Prevention and Control program implements evidence-based strategies to prevent and reduce tobacco use among Salt Lake County residents. Tobacco program staff conduct undercover compliance checks of tobacco retailers, facilitate youth and community anti-tobacco groups, offer tobacco cessation resources, and investigate secondhand smoke complaints in multiunit residential dwellings.

Vital Records

SLVHD maintains three vital records offices within Salt Lake County. The offices offer birth and death certificates as well as marriage and divorce abstracts. In 2012, Salt Lake County saw 21,794 births and 6,713 deaths (plus 126 fetal deaths). Below shows the number of certificates ordered at each office.

SLVHD Vital Records Requested, 2012

Location	Birth		Death	
	Certificates Ordered	Additional Copies	Certificates Ordered	Additional Copies
Ellis R. Shipp	8,425	1,115	262	772
Salt Lake City	7,717	1,594	4,705	23,003
Southeast	7,850	1,463	2,939	14,075
Total	**23,992**	**4,172**	**7,906**	**37,850**

Water Quality

The Water Quality Bureau regulates and inspects solid waste and processing facilities, drinking water systems (including fluoridation levels and processes), individual waste water systems, and the 1,040 public swimming pools in the county (85% of which received a routine inspection in 2012). 12% of inspected pools were closed due to an imminent health hazard.

This year, the bureau conducted 18 sanitary surveys on public drinking water systems and processed 541 routine and 466 fluoride samples. Staff also investigated a cryptosporidium outbreak with 77 confirmed cases, 39 of which identified a permitted pool facility (the baseline of cases normally seen is 11 in one year).

WIC

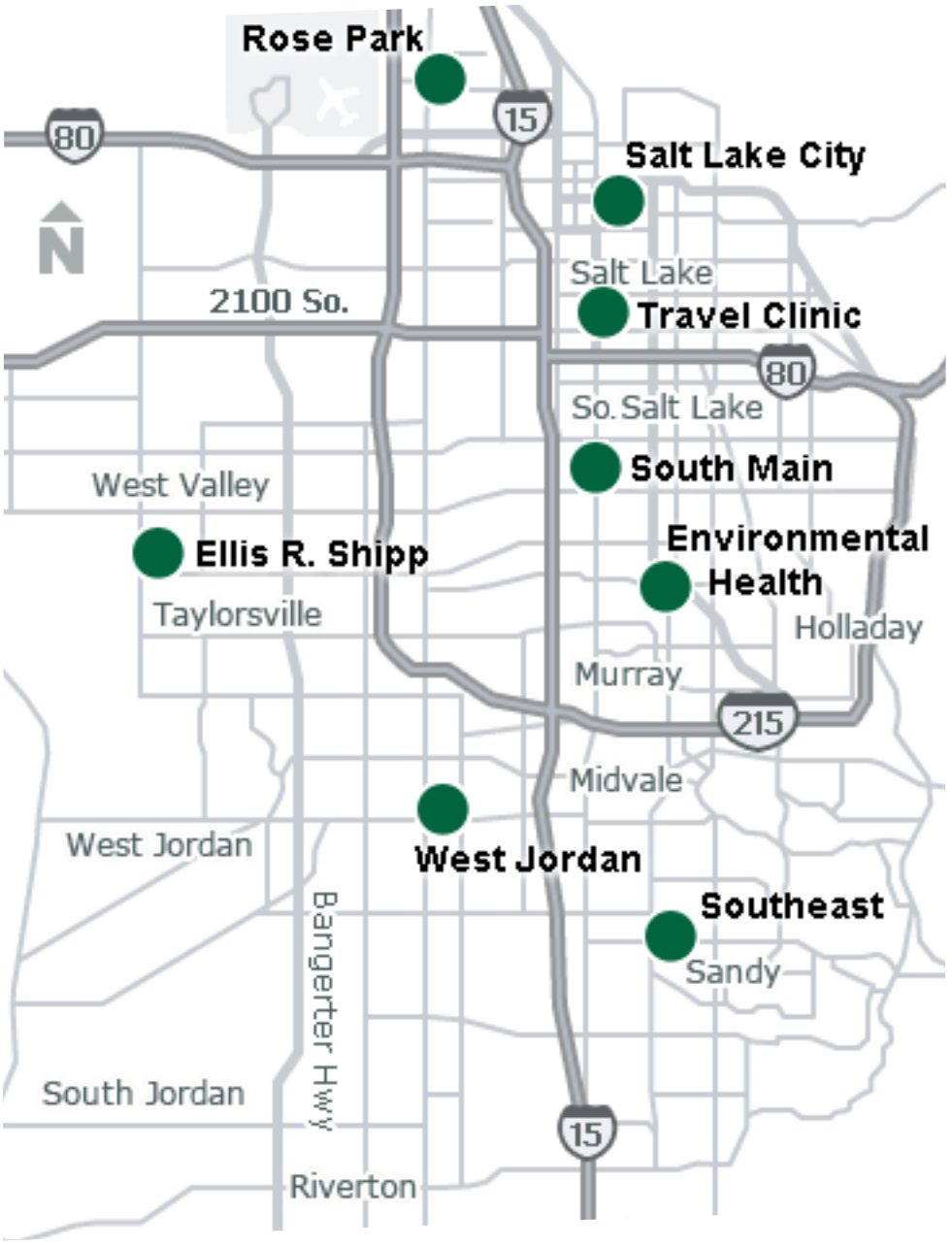
Through federal support, the SLVHD WIC program provides low-income women, infants, and children under 5 with nutrition education, breastfeeding support, supplemental food, and access to health care. In 2012, our WIC staff served an average of 25,201 clients each month (6,388 women, 5,827 infants, and 12,986 children) totaling 313,948 client contacts, and had nearly $15 million in actual food expenditures.

Women's Cancer Screening/BeWise

The Women's Cancer Screening program works to assist women in detecting breast and cervical cancer at its earliest stages. Traditional services—including breast exams, pap tests, mammogram vouchers, and some diagnostic services—are available for women aged 40-64. Expanded services, part of the affiliated "BeWise" program, are available to women aged 50–64, and include cholesterol, blood pressure, and glucose testing, as well as BMI and personal health coaching.

In 2012, 2,700 Salt Lake County women received breast and cervical cancer screening services through the Women's Cancer Screening program, and 1,500 women participated in BeWise. SLVHD staff held 1,244 face-to-face coaching sessions and 1,625 phone coaching sessions this year.

Facilities



Ellis R. Shipp Clinic
4535 South 5600 West
West Valley City
385-468-3700

Rose Park Clinic
799 North Redwood Road
Suite A
Salt Lake City
385-468-3660

Salt Lake City Clinic
610 South 200 East
Salt Lake City
385-468-4225

Southeast Clinic
9340 South 700 East
Sandy
385-468-4330

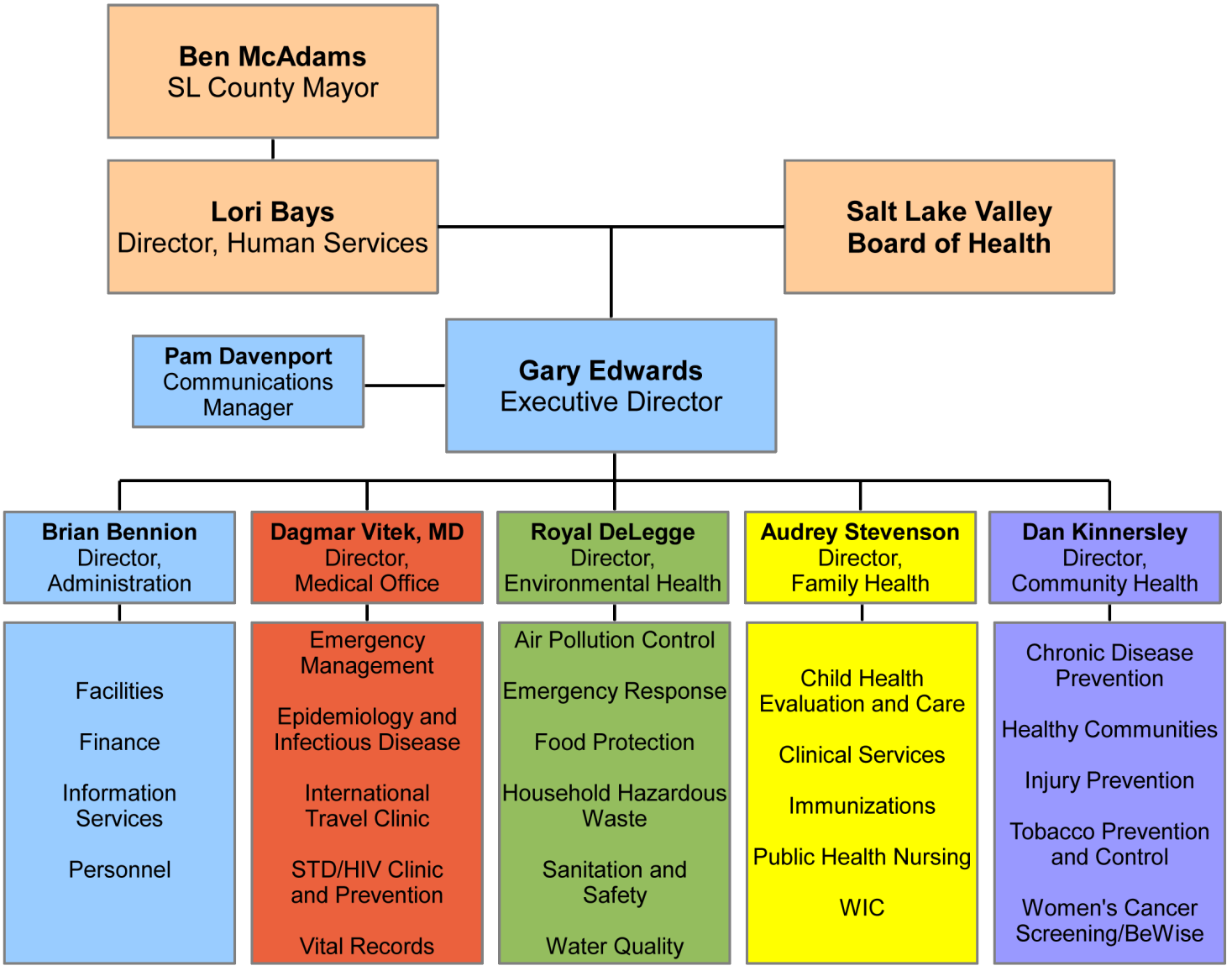
South Main Clinic
3690 South Main Street
South Salt Lake
385-468-4000

Environmental Health
788 East Woodoak Lane
Murray
385-468-3860

Travel Clinic
2001 South State Street
Suite S2400
Salt Lake City
385-468-4111

West Jordan Clinic
1740 West 7800 South
West Jordan
385-468-4365

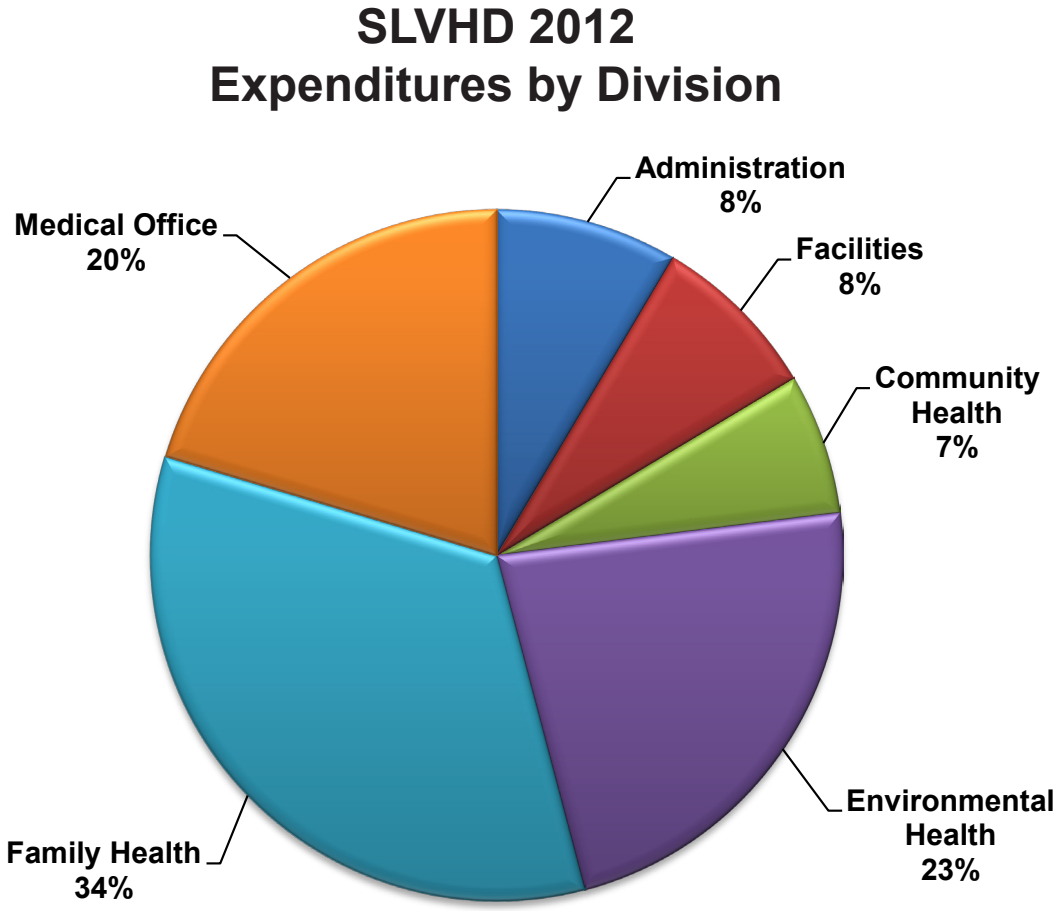
Organization



Board of Health

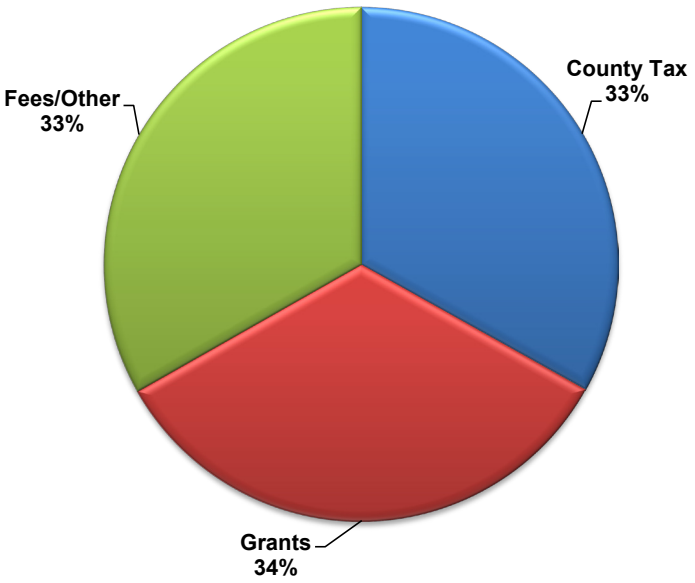
Scott Brown, *Chair*
Dr. George Delavan, *1st Vice Chair*
Mike Huber, *2nd Vice Chair*
Paula Julander, *Immediate Past Chair*
Dr. Stephen Alder
Tom Anderson
Councilman Arlyn Bradshaw
Starr Campbell
Jerry Carter
Joe Garcia
Tom Godfrey
Dr. Harry Rosado
Mayor Derk Timothy
Dr. Jeffrey Ward

Finances



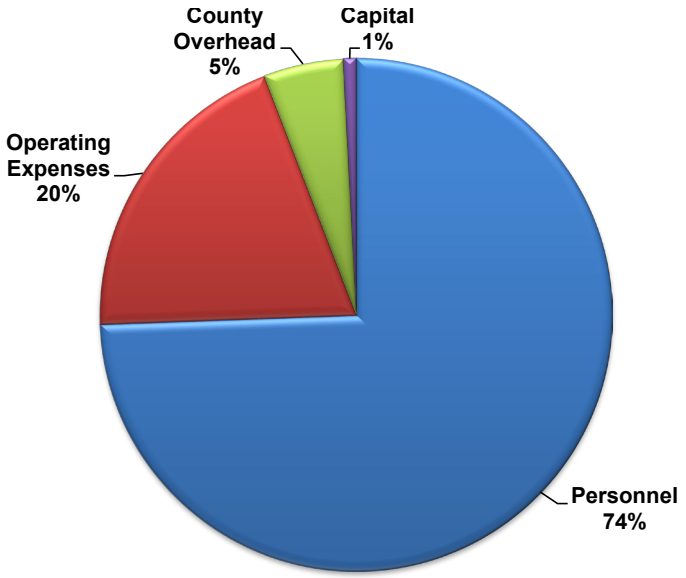
Expenditures by Division	2012 Totals
Administration	$2,611,113
Facilities	$2,434,835
Community Health	$2,012,976
Environmental Health	$7,012,727
Family Health	$10,339,620
Medical Office	$6,243,635
TOTAL	$30,654,906

SLVHD 2012
Revenue by Type



Revenue by Type	2012 Totals
County Tax	$10,146,865
Grants	$10,326,323
Fees/Other	$10,181,718
TOTAL	$30,654,906

SLVHD 2012
Expenditures by Appropriation Unit



Appropriation Unit	2012 Totals
Personnel	$22,816,336
Operating Expenses	$6,044,816
County Overhead	$1,546,240
Capital	$247,514
TOTAL	$30,654,906

SLVHD
Salt Lake Valley Health Department

2001 South State Street, S2500
PO Box 144575
Salt Lake City, UT 84104-4575
385-468-4100
www.slvhealth.org

History

1849— Brigham Young creates the Society of Health, precursor to the Salt Lake City Health Department.
1898— Utah Legislature establishes the Utah state Board of Health.
1899— Salt Lake County Commissioners create the County Health Board.
1943— Salt Lake City Planning and Zoning Commissions recommend that the SLC and SLCo Health Departments be merged into one organization as part of the city's "50-year plan."
1965— City Health Department opens its new building at 610 East 200 South.
1966— County Health Department moves into the old county hospital at 2100 South State Street.
1969— Salt Lake City and Salt Lake County Health Departments are merged into the Salt Lake City-County Health Department—26 years after consolidation was first recommended.
1974— City-County Board of Health adopts a uniform health code for the county's 10 municipalities.
1979— Health department closes Magna and Midvale clinics.
1994— Health department adds three immunization clinics in West Valley, Sandy, and Rose Park.
1995— Ellis Shipp Public Health Center opens in West Valley City.
1998— Environmental Health Division moves its four bureaus to a new building in Murray.
2000— Salt Lake City-County Health Department becomes the Salt Lake Valley Health Department and unveils its current logo.
2007— South Main Public Health Center opens in South Salt Lake.
2012— SL County Council approves SLVHD request to purchase land for a new public health center.

SALT LAKE COUNTY HEALTH DEPARTMENT

COMMUNITY HEALTH ASSESSMENT

2013

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SALT LAKE COUNTY HEALTH DEPARTMENT

Gary L. Edwards, MS • Executive Director

To: Interested Individuals and Agencies

The Salt Lake County Health Department (SLCoHD) is pleased to announce the release of the 2013 Salt Lake County Community Health Assessment. Many dedicated individuals spent numerous hours collecting data, providing input, analyzing results, and compiling information in hopes it will be useful to all those interested in the health of Salt Lake County. We are especially grateful to the many individuals and agencies that provided their time sharing experiences and knowledge to help prepare a more accurate assessment.

The purpose of this assessment is to better define the health challenges we all face in Salt Lake County. Where possible, data has been analyzed by small area (ZIP code). This has helped us see that while overall Salt Lake County is a fairly healthy county in a very healthy state, there are defined pockets of need within various health indicators. This will help all of us focus our efforts as we strive to achieve the greatest impact with limited resources.

We see this as a working document that will be updated periodically, with the assessment process repeated every five years. SLCoHD will use this document to help shape a community health improvement plan, as well as our department strategic plan.

We hope you find it valuable in helping Salt Lake County residents achieve their highest level of health status. We appreciate any comments you might have and look forward to working collectively as we all strive to make Salt Lake County the healthiest county.

Sincerely,

Gary L. Edwards, MS
Executive Director

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"There's a movement afoot. Cities and towns big and small, counties from coast to coast and groups of passionate individuals from all over are coming together across sectors to build healthier communities."

Robert Wood Johnson Foundation
New Public Health
Monthly Archives
April 2012

EXECUTIVE SUMMARY

According to a group of Salt Lake County community leaders and county residents, the most important public health issues facing the county are air pollution, communicable diseases, water quality, obesity, and substance abuse/mental health. Further, participants identified a number of individual, system, and environmental process issues that impact health and health practices.

This Community Health Assessment (CHA) is the first of three interrelated activities designed to increase the efficiency and effectiveness of the Salt Lake County Health Department (SLCoHD). As the first comprehensive Community Health Assessment conducted by the SLCoHD it identifies community health needs and strengths. Through the input of residents, leaders, and partners who serve the community, combined with review of hard data, the SLCoHD will be better positioned to form partnerships with organizations, agencies, and community leaders; as well as more strategically invest resources to seek and implement solutions.

Once the assessment is complete, findings will be used to enter into a Community Health Improvement Planning (CHIP) venture with community partners. The plan reflects the results of a participatory planning process that includes significant involvement by key community sectors: residents, illness care consumers and providers, organizations and agencies that serve the community, and the public health system.

The CHIP will help direct the development of the SLCoHD Strategic Plan that will guide SLCoHD activities through the next five years. A project plan was developed to summarize this process.

WHAT WE DID

Organized

The Accreditation Committee, a standing committee of four, was formed to guide the assessment process and write the CHA. Membership consists of the Deputy Director (executive in charge), Management Analyst (project lead), Planner/Special Projects (research/analysis and writing), and Community Development Director. This standing committee will continue to guide the Community Health Improvement Plan and Strategic Planning processes.

An Advisory Committee, consisting of department managers from each division and the past Chair of the Board of Health, provides input into process decisions and offers guidance through the remaining two tasks. Extensive utilization of interns from local university public health programs provided data collection and analysis (**Appendix 1**).

The Community Health Assessment consisted of three central interrelated activities: Collection and analysis of existing data, generation of new data, and identification of community issues.

Generated Data from Focus Groups

A large, formal assessment should be grounded in the problems and processes identified by the residents and professionals serving the communities through their lived experiences. With this philosophy guiding the SLCoHD assessment, the Advisory Committee chose to use focus groups to solicit information about community problems from the residents and those who serve them.

Since public health impacts all aspects of society, a wide variety of perspectives were sought as the community groups were planned. Representation was sought from the community at large that included neighborhood leadership, residents of various ages and ethnicities and partners who provide services to the community. Partner groups included health care providers, government, employers/business, religious organizations, charitable foundations, community organizations, ethnic organizations, nursing schools, emergency response and environmental health.

In total, 22 focus groups were conducted with over 200 community leaders and area representatives from all six sections of the county. Refugees and representatives of Spanish Speaking and Native American ethnic groups also participated.

Focus groups were audio-recorded and transcribed. ETHNOGRAPH version 6.0 was used as a data management program. Concepts were coded and grouped into themes. In addition to identifying health concerns, the focus groups provided insight into process issues that would not have come to light if demographic data and existing process data had been considered alone.

Gathered Existing Data

Existing data and reports gathered focused on:

- Performance Reports: *Community Health Status Indicator Project* and *County Health Roadmaps Project*
- *Healthy People 2020* Objectives and Targets
- Demographic data: CDC, Census Bureau, IBIS-PH
- Previous studies and reports: University of Utah's Bureau of Economic and Business Research (BEBR), Governor's Office of Planning and Budget (GOPB), and the Wasatch Front Regional Council
- Environmental data: Environmental Protection Agency standards and reports, SLCoHD data and reports

These data provide perspective into how well the county is doing on select health indicators compared to other counties, Utah, the nation, and targeted objectives for the future. Comparisons may point to additional problem areas or confirm findings from other sources.

Community Health Status Indicator Project

In 2009, the Department of Health and Human Services (DHHS) published health rankings as part of the *Community Health Status Indicator (CHSI) Project*. The CHSI report measures over 200 health indicators for each of the 3,141 United States counties and compares peer counties (counties similar in selected demographic).

County Health Roadmaps Project

The Robert Wood Johnson Foundation's *County Health Roadmaps Project (CHRP)* compared counties within a state to each other based on health indicators. In addition, Salt Lake County's (SLCo) rate is compared to the average rate (called the National Benchmark) of the top ten percent of all counties in the nation.

Healthy People 2020

As a result of the 1979 publication *Healthy People: the Surgeon General's Report of Health Promotion and Disease Prevention,* the U.S. Public Health Service (USPHS) published *Healthy People 2000* in 1990. The USPHS identified, summarized the current status, and established

year 2000 targets for various diseases, behavior, and environmental measures determined to be essential for improving the public's health. Since then *Healthy People 2010* and *Healthy People 2020* (*HP2020*) have been published.

Demographic Data and Published Reports

The 2010 Census data provided the most current information on population characteristics. Reports analyzing demographic data and morbidity and mortality data identified trends and difficulties. From this data, actual and potential problems could be identified and used to support other findings.

Analyzed Data and Reported Findings

Data from the aforementioned sources were considered in the analysis. Health measures of concern were identified from the findings of the health indicator reports, progress on *Healthy People 2020* objectives, factors identified through collection of demographic data, and the responses of community member and professional participants in the focus groups.

Reviewed Issues by Geographic Area

To identify geographical areas at issue, data were analyzed according to Small Area data sets or by Local Public Health District. Geographic Information System (GIS) mapping allowed Small Area data to be presented in visual form that allows for macro-comparison of data within Small Areas of the county and easy analysis of overlying risk factors. In addition, interventions can be focused on the areas showing the most need.

Reviewed Demographic Shifts and Trends

Utilizing 2010 Census reports, studies conducted by the University of Utah's Bureau of Business and Economic Research (BEBR), the Governor's Office of Planning and Budget, and the Wasatch Front Regional Council, we reviewed demographic trends that will impact the need for and delivery of services.

WHAT WE LEARNED

Based on input from the focus groups, air pollution appears to be the greatest community health problem facing Salt Lake County. An abbreviated discussion on air pollution in Salt Lake County is included in this report.

Salt Lake County is Not the Highest or Lowest Ranked County

According to the county Health Roadmaps Project (county rankings), Salt Lake County is the 12th healthiest county in Utah when comparing health outcomes such as premature death or low birth weight; and 16th when ranked on health factors such as obesity, smoking or sexually transmitted infections.

In general, the rankings show that SLCo has obstacles to overcome if it is to become one of the healthiest counties in the country. For example, SLCo was ranked 26th out of the 26 counties in Utah on its Physical Environment, which consist of indicators such as air pollution, recreational facilities, and access to healthy food. Further, when the topic is social and economic factors (consisting of education, children in poverty, social supports and violent crime), SLCo ranked 19th. However, there are some bright spots. SLCo ranks 5th in of clinical care (# physicians per 100,000, preventive screenings for diabetes and mammography) and 7th in mortality (premature death).

Despite its "middle of the pack" rankings when compared to other Utah counties, Salt Lake County is a fairly healthy county. It is important to note that Utah consistently ranks among the

top 10 healthiest states in the nation by *America's Health Ranking*. From 1993-1998 and again in 2002, Utah ranked as the nation's healthiest state. In 2009, Utah placed second behind Vermont for the title of healthiest state. Utah has never ranked below 7th during the 20 years that states have been ranked. As Salt Lake County accounts for about 38 percent of the state's population, Utah's ranking is significantly affected by Salt Lake County's performance.

Where You Live Can Impact Your Health

Although Salt Lake County may not meet the *HP2020* target for the county as a whole, there will usually be "Small Areas" of the county that do meet the target. Conversely, the county may have met the *HP2020* target for an objective, there will usually be Small Areas within the county that do not. Small Areas within Salt Lake County that are in greatest need for assistance to meet *HP2020* targets are Glendale, South Salt Lake, West Valley City and Magna.

Individual, System, and Environmental Factors Impact Change

While health conditions and environmental health concerns were mentioned during focus groups, the majority of time was spent on individual, system, and environmental factors that will impact many proposed interventions. These factors will either promote or impede actions taken to improve the community's health. The relationship of these process issues is delineated in the model **Factors Impacting a Community's Health**.

The County's Population is Growing and Shifting to South and West

The population of Salt Lake County grew dramatically from 2000 to 2010. In addition to overall growth, the population has shifted, and that shift is expected to accelerate. According to the 2000 census, Salt Lake County had 879,325 residents; by 2010 this number had increased to 1,029,655. During the last decade the county's population, which had been centered in Salt Lake City and the county's southeast quadrant, began shifting to the southwest quadrant. The Wasatch Front Regional Council estimates that by 2030 the southwest area will contain about 30% of the county's population. Currently, the area contains 10% of the county's population. This shift will require the relocation and extension of resources that, at the current time, are less available in that area.

The County's Population is Aging

While the population of Utah will continue to be younger than the general US population, the ratio of the aging to the young will increase. With the first of the Baby Boomers turning 65 years old in 2010, the 65 and older age group became the fastest growing age demographic. Beginning in the next few years, and continuing through the year 2040, the 85+ age group will be predominant. Services supporting the needs of elderly on fixed incomes will increase which might impact both the types and locations of services offered by health departments and other providers.

The County's Population is Becoming More Ethnically Diverse

The county's minority population is growing quickly. In 2000, ethnic and cultural minorities accounted for 19.1% of Salt Lake County's population. By 2010, the county's minority population rose to 26.3%. For nearly 20% of the ethnic minority families, English is not the primary language spoken at home. The burgeoning ethnic diversity will impact the way services are provided. As the county's ethnic and cultural minority population will continue to grow, the services provided will need to reflect this. Increasing diversity requires adjusting programs to work within the framework of a person's cultural heritage and belief system.

Data Collection Must be Uniform and More Useable

MISMATCH BETWEEN TYPE OF STATE DATA GATHERED AND *HP2020* OBJECTIVES

One of the State of Utah's key data repositories for health data is called the Indicator-Based Information System for Public Health (IBIS-PH). It features a wealth of data and is highly interactive and user friendly. However, throughout this assessment we experienced a few frustrations in the availability and usability of data.

A Community Health Assessment relies heavily on data. However if data is not reflective of the same indicators, is gathered in a different way, or refers to areas that are not clearly delineated, its value is not as great. Some of the IBIS-PH data have the following problems:

- Data collected for a significant number of *HP2020* objectives are inconsistent with the data collected by the federal government.
    - For example, fruit and vegetables in the diet are collected as servings/day by IBIS-PH while federal data are collected as cups/day
    - Additionally, one source may gather prevalence data while another uses incidence data for the same indicator
- Some geographic data (Small Area data) do not necessarily reflect the municipality they are named after.
- Data are not collected on some *HP2020* objectives that are clearly public health.

Data by geographic area are helpful to local officials and other policy makers who are charged with impacting public health. By focusing in on one or two lagging areas, interventions can become more strategic and appropriate for the citizenry of the area. However, not all of the Small Area data for Salt Lake County represents the area it is named for. For example, the Small Area named "Taylorsville" does not correlate with the City of the same name. Instead it includes parts of four other communities that are not within the city. Other neighborhoods within Taylorsville City are not part of the geographic Small Area called Taylorsville. This problem is due to the incorporation of a city after the small area boundaries were established. In addition to the problem with Taylorsville, other sources of imprecise data are due to municipalities annexing previously unincorporated areas.

When necessary, we have disclosed the limits of the data and have made adjustments to help preserve the integrity of this review.

EARLY SUCCESSES RESULTING FROM THE CHA PROCESS

As a direct result of this Community Health Assessment, collaborations with local community leaders and the professional community have expanded. In addition, opportunities to partner with area universities and hospitals have developed.

Partnerships with Area Universities

One of the critical goals of a university is to prepare students for the workforce. A key component of this preparation is experience. We have successfully partnered with three of the major universities in the Salt Lake area in an effort to help them meet their mission and benefit our agency. Interns from the University of Utah's Division of Public Health, Westminster Public Health Program, and from the Brigham Young University's College of Health have participated in the project. All of the interns have been extraordinary. Without the intellect and energy of this group of future administrators this project would not have achieved the level of excellence that it has. In addition to providing experience for interns, we have collaborated with the University of Utah on their community health assessment and have added the Director of the University of Utah's Division of Public Health program to the Salt Lake County Board of Health.

Partnership with Intermountain Healthcare Hospitals

We have partnered on several projects with Intermountain Healthcare, the largest hospital system in the Intermountain West. Through this effort we have identified several opportunities to share resources. For example, Intermountain Healthcare officials expressed difficulty in providing health education and support to their patients who suffer from chronic, potentially controllable, conditions such as hypertension, obesity, and COPD due to smoking. They noted that although their physicians were qualified to make a diagnosis and issue prescriptions, they had neither the time nor skills to provide guidance in making lifestyle changes. The SLCoHD, as the public health authority for SLCo, employs health educators who can provide the education and support. Discussions are planned to facilitate this collaboration. This is only one partnership example; other collaborations with Intermountain Healthcare and with other hospitals will be considered in the future.

Partnership with Area Cities

In an effort to better leverage dwindling resources, SLCoHD has sought to partner with Salt Lake County's cities and municipalities. These efforts include the pre-placement of Emergency supplies with Taylorsville City and working with Cottonwood Heights residents to strengthen their emergency preparations. In addition, the SLCoHD has initiated a Healthy Communities initiative and has assigned staff members to coordinate efforts with area municipalities and cities.

Community Liaisons

One of the SLCoHD goals is that "*The Salt Lake County Health Department is the first agency called by local municipalities when they need public and environmental health information and direction*." The message from focus groups was loud and clear that the community residents want to be included in planning and decision-making. Based on CHA preliminary findings, the SLCoHD has assigned two-member teams to serve as liaisons for every city and municipality in the county. Every mayor will have SLCoHD staff that can be contacted about public health related issues.

WHERE DO WE GO FROM HERE?

Promote Collaborations

Continuing to build relationships with our community partners is necessary to continue coordinating services, collaborating on projects, and maximize the use of limited resources. Planning and implementing a joint effort to deliver health education related to hypertension control, obesity management or prevention, and smoking cessation is one example. In addition, we will continue to work with area universities to provide excellent experiences for interns.

Community Health Improvement Plan

The next phase of this effort will be for SLCoHD to spearhead the development of a Community Health Improvement Plan in collaboration with our community partners. Once the CHIP is complete, a SLCoHD Strategic Plan will be developed that reflects how the agency will function to improve the priority areas identified in the CHIP.

To develop the CHIP, original partner focus group participants, those who were originally unable to participate, and new partners were invited to a meeting October 18, 2012 to review the findings of the CHA and participate in work groups based on the priority problems identified in the CHA. The CHA includes information from the first set of focus groups, performance reports, demographic data (Census, Bureau, IBIS-PH), previous studies and reports (University of

Utah's Bureau of Economic and Business Research [BEBR], Governor's Office of Planning and Budget [GOPB], Wasatch Front Regional Plan), and environmental data (Environmental Protection Agency standards and reports, SLCoHD data and reports). The work groups were: Air Quality, Water Quality, Chronic Disease, Infectious Disease, Maternal Child Health, and Mental Health/Substance Abuse.

During the work group, participants were asked to identify issues on their topic that fall within their scope of practice, and activities or projects they or their organizations have done, are doing, or plan to do to impact the issue. The work groups will then brainstorm to create projects that require collaboration. These projects will then be prioritized according to importance, cost, and likelihood of success and will form the basis of the Community Health Intervention Plan. As the lead agency, we hope to encourage our community partners to coordinate with each other as they seek to positively impact their common problems.

SLCoHD Strategic Plan

The final piece of the project is preparation of the SLCoHD Strategic Plan. This plan will be built upon the findings of the CHA, the prioritized issues identified in the CHIP, and the direction given by SLCoHD leadership.

Dissemination

The CHA will be published on the SLCoHD website. Limited hard copies will be printed for select individuals and organizations in the community.

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ACRONYMS

Acronym	Definition
ACIP	Advisory Committee on Immunization Practices
ACOG	American Congress of Obstetricians and Gynecologists
ADHD	Attention Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
BEBR	Bureau of Economic and Business Research
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
BRHD	Bear River Health Department
CBC	Midvale Community Building Community
CDC	Centers for Disease Control and Prevention
CDP	Census Designated Places
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CHRP	Community Health Roadmaps Project
CHSI	Community Health Status Indicator Project
CO	Carbon Monoxide
CO2	Carbon Dioxide
CoCASA	Comprehensive Clinic Assessment Software Application
COPD	Chronic Obstructive Pulmonary Disease
CUPPHD	Central Utah Public Health Department
DCHD	Davis County Health Department
DDW	Division of Drinking Water
DHHS	Department of Health and Human Services
DTaP	Diphtheria, Tetanus, and acellular Pertussis Vaccine (for teenagers)
DTP	Diphtheria, Tetanus, and Pertussis Vaccine
ED	Emergency Department
EPA	Environmental Protection Agency
ESF	Essential Support Function
FQHC	Federally Qualified Health Center
GIS	Geographic Information System
GOPB	Governor's Office of Planning and Budget
HbA1C	Hemoglobin A1C / Glycated Hemoglobin
HFFI	Healthy Food Financing Initiative
HHS	United States Department of Health and Human Services
Hib	Haemophilus Influenza Type b
HP2020	*Healthy People 2020*
HPV	Human Papilloma Virus
I/M	Vehicle Inspection and Maintenance
IBIS-PH	Indicator-Based Information System for Public Health Data resource
IUGR	Intrauterine Growth Restriction
LBW	Low Birth Weight
LEHS	Licensed Environmental Health Scientist
LHD	Local Health District
MAPP	Mobilizing for Action through Planning and Partnerships
MHA	Master of Healthcare Administration
MMR	Measles-Mumps-Rubella Vaccine
MPA	Master of Public Administration

MPH	Master of Public Health
NAAQS	National Ambient Air Quality Standards
NOV	Notice of Violations
NOx	Oxides of Nitrogen
PANO	Utah Department of Health Physical Activity Nutrition and Obesity Program
PHASE	Public Health Air Surveillance Evaluation
PM (10/2.5)	Particulate Matter
PPB	Parts Per Billion
PWS	Public Water System
RN	Registered Nurse
RWJF	Robert Wood Johnson Foundation
SA	Small Area
SCHD	Summit County Health Department
SDWA	Safe Drinking Water Act
SEUDHD	Southeastern Utah District Health Department
SGA	Small-for-Gestational Age
SLC	Salt Lake City
SLCo	Salt Lake County
SLCoHD	Salt Lake County Health Department
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
SWUPHD	Southwest Utah Public Health Department
TB	Tuberculosis
TCHD	Tooele County Health Department
TDaP	Tetanus, Diphtheria, and Acellular Pertussis Vaccine Booster (for adults)
TRCHD	Tri-County Health Department
U of U	University of Utah
UCHD	Utah County Health Department
UDOH	Utah Department of Health
UDOT	Utah Department of Transportation
USDA	U.S. Department of Agriculture
USEPA	U.S. Environmental Protection Agency
USPHS	United States Public Health Service
VOCs	Volatile Organic Carbon Compounds
WCHD	Wasatch County Health Department
WHO	World Health Organization
WIC	Women, Infants, and Children program
WMHD	Weber-Morgan Health Department
WQ/HHW	Bureau of Water Quality and Household Hazardous Waste

PREFACE

Like a truly healthy human body, a truly healthy community is one in which all systems function as they should and work together to make the community function well. In an individual, health is, to a large extent, a result of all the body's billions of cells getting what they need. For a community, health is, to a large extent, the result of all citizens getting what they need, not only to survive, but to flourish.

A healthy community is a whole that's larger than the sum of its parts. It's one where people take care of one another, where people from diverse backgrounds mix comfortably and work together for the good of the community. In short, a healthy community is one in which all citizens can be assured of a decent quality of life – economically, physically, environmentally, socially, and politically. It is a community in which all systems work well (and work together). This means that the health of the community is affected by the social determinants of health and development – the factors that influence individual and community health and development.[1]

"Human development, community development and health are inseparable. There is a growing body of knowledge that makes it clear that the communities we live in can help us or hurt us in every conceivable way. The effects of living in poverty can be life-long and can affect one's ability to be physically, mentally and emotionally healthy. Just in the last six months there have been new data from a 10-year study by the Department of Housing and Urban Development that demonstrates that living in quality housing in a good community reduces obesity and diabetes by as much as 20 percent – which is an impact as great as a medical intervention! We also know medical interventions can solve only about 10 percent of our health issues. Much, much more of a person's health outcomes are a result of our environment, our upbringing and our habits. It is almost impossible to overstate how important the environment is on our ability to lead healthy, quality lives." [2]

[1] Abridged from the *Community Tool Box: http://ctb.ku.edu/en/tablecontents/sub_section_main_1009.aspx*
[2] Nancy Andrews, President and CEO of the Low Income Investment Fund, comments made at the National Interagency Community Reinvestment Conference

INTRODUCTION

The mission of the Salt Lake County Health Department (SLCoHD) is to promote and protect community and environmental health. In order to accomplish this, programs and processes must be developed to improve and protect human and environmental conditions. The SLCoHD is only one rib in the umbrella of community health. Community residents, leadership, and the organizations, agencies, and businesses that serve them comprise the other ribs and must be included in the process.

The purpose of this document is to examine factors that affect the public's health and provide a framework for developing a Community Health Improvement Plan (CHIP) and five-year Strategic Plan for the SLCoHD.

The 2013 goals of the SLCoHD are:

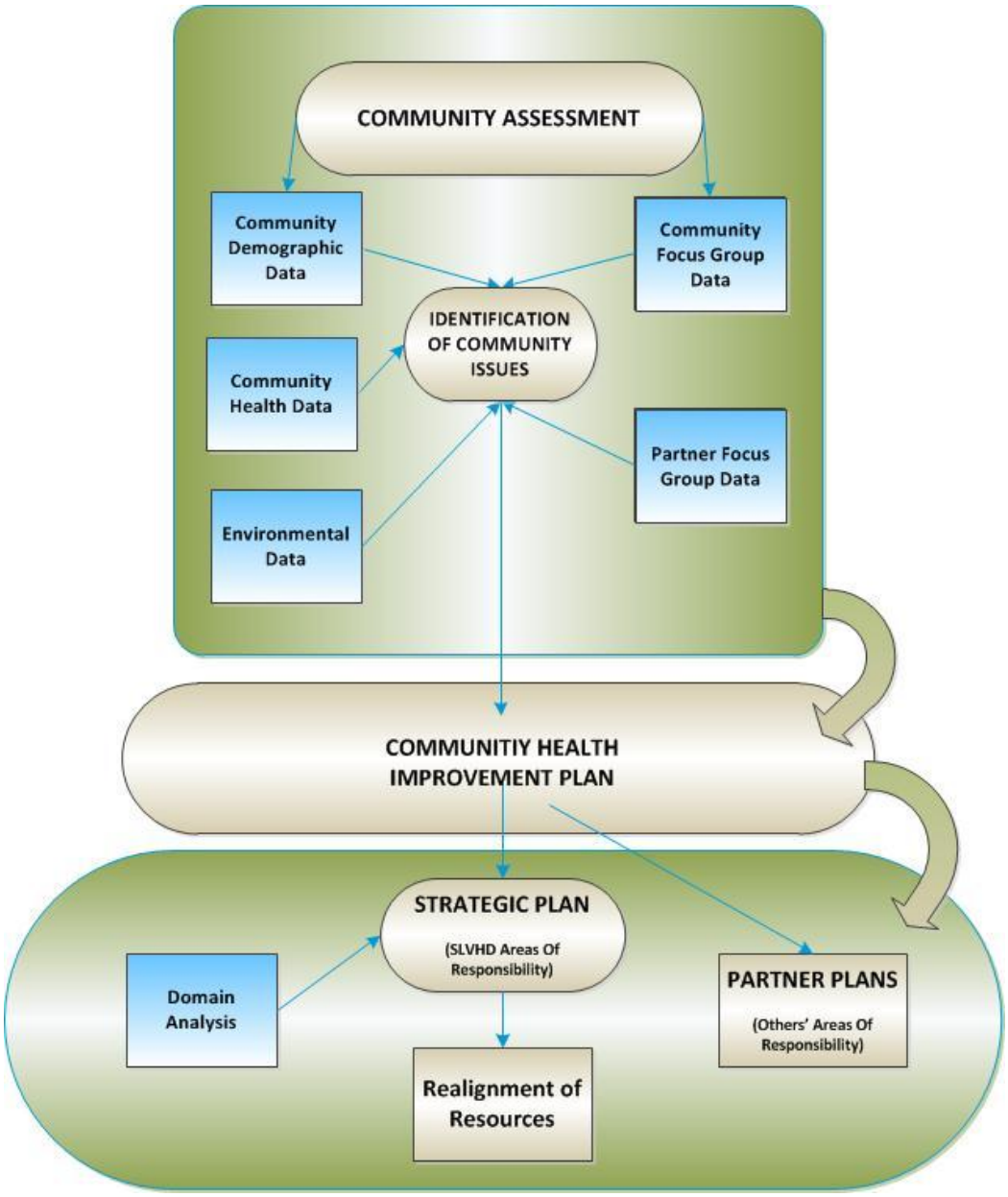
1. Develop a strategy to become the "healthiest county" in Utah by December 31, 2013
2. Apply for Public Health Accreditation and be fully accredited by December 31, 2013
3. Quality Improvement Processes will be followed to improve services 100% of the time when working on process improvement issues by December 31, 2013
4. All SLCO municipalities say they see us as the 1st partner they turn to for public and environmental health by December 31, 2013

PROJECT PLAN

The SLCoHD conducted a community health assessment to identify community health issues; the findings are discussed in this report. The SLCoHD will use the report to create, in collaboration with community partners, a Community Health Improvement Plan which will outline potential solutions to the identified health issues and delineate lead organizations. The SLCoHD will develop a Strategic Plan that will delineate agency plans and activities geared to mitigating specific public health problems identified in the Community Health Improvement Plan. This Strategic Plan will promote the mission and goals of SLCoHD and guide our activities for the next five years.

The Project Plan (Figure 1) outlines the methods data was collected, analyzed, and used to inform decision-making and planning. This model will serve as the outline for discussion of the Community Health Assessment findings.

Figure 1. Project Plan



The goal of this community health assessment is to:

- identify community strengths,
- detect unmet health needs,
- identify how well the SLCoHD has met program goals,
- uncover additional resource needs,
- mobilize community partners, and
- prioritize community needs.

Five sources of data were used to discover issues. The first three were collection approaches; the last two were data generation approaches. The analysis of the findings resulted in identification of community issues.

Assessing the community is an ongoing activity. Therefore, this document provides a solid foundation to build upon. As new information is obtained, updates will occur.

HOW DID WE CHOOSE THE ISSUES?

Determining which factors and concerns to consider in depth was a difficult endeavor. The SLCoHD acknowledges that this assessment does not cover all potential risk factors and health problems that exist in the community. Determining which health issues to review was based upon the findings of the focus groups, the *Community Health Status Indicator*[3] study, the *Community Health Roadmap Project*[4], available health data (IBIS-PH), and *Healthy People 2020*[5] objectives.

A table (**Appendix 2**) was developed to track the information sources that identified each factor/concern as a problem. Criteria for choosing the health factors/conditions to analyze in this assessment included:

- Fit with Public Health core functions and Essential Public Health Services that frame the public health sphere of responsibility.
- Salt Lake County "Small Area" rates that were significantly different from county, state and national rates.
- Condition is somewhat preventable given adoption of healthy behaviors and/or screening.
- Improvement in the problem area will impact other problem areas.
- Cause and effect relationships were considered, e.g. lack of recreational facilities is related to physical activity and obesity.
- Identification by 3 or 4 of the afore-mentioned sources as issues for Salt Lake County.

WHAT DO WE DO?

DEFINITION OF PUBLIC HEALTH

"Public health is what we do collectively to fulfill society's interest in assuring the conditions in which people can be healthy."[6]

CORE FUNCTIONS OF PUBLIC HEALTH

What is the role of public health in community health-related problems? In 1988, the Institute of Medicine described three core functions of public health in a document entitled *The Cycle of Public Health Practice: the Bellagio Report.*[7] The three core functions are assessment, policy development, and assurance.

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[3]Department of Health and Human Services (2009). *Community Health Status Indicators* (CHSI), (2009). Obtained 3 June 2012 from http://www.communityhealth.hhs.gov/homepage.aspx?j=1

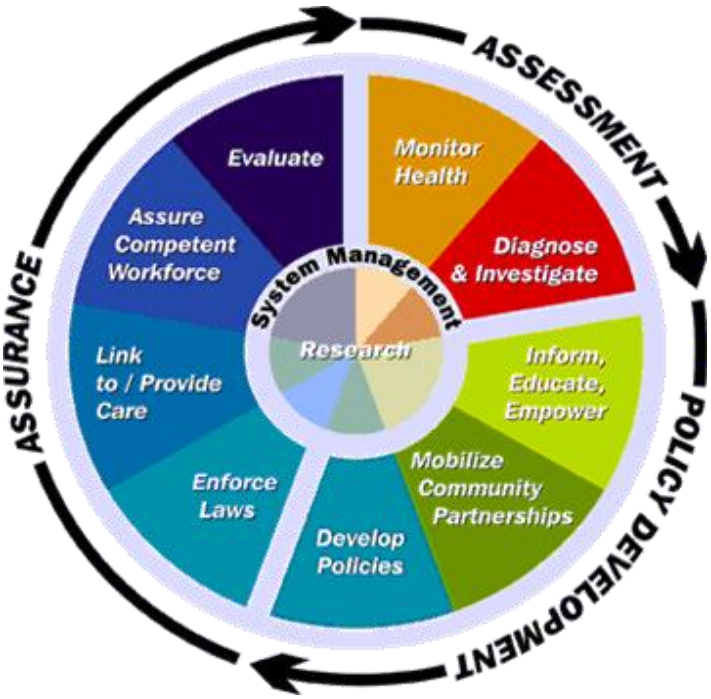
[4] *Community Health Roadmap Project.* Obtained 15 June 2012 from: http://www.countyhealthrankings.org/#app/

[5] *Healthy People.gov* obtained 15 June 2012 from: http://www.healthypeople.gov/2020/default.aspx

[6] Institute of Medicine, 1988. *The Future of Public Health.* Obtained 29 October 2012 from: http://iom.edu/Reports/1988/The-Future-of-Public-Health.aspx

[7] *The Cycle of Public Health Practice: The Bellagio Report. Obtained 29 October 2012 from: http://www.cdc.gov/genomics/events/file/print/NCI2007-Sept20.pdf*

Figure 2. Core Functions and Essential Services



ASSESSMENT

Assessment is the regular systematic collection, assembly, analysis, and dissemination of information on the health of the community. Rooted in the community, local health departments are in a unique position to be familiar with and assess a community's collective resources, assets, gaps, and challenges. Local public health departments not only bring the community's perspective, but they are legally mandated to represent the interests of all residents in a jurisdiction.

POLICY DEVELOPMENT

Policy development is the formulation of standards and guidelines, in collaboration with stakeholders. Local public health departments are in a unique position to analyze and draw conclusions about local data gathered through assessment. Local public health departments can then make relevant recommendations to elected officials. Effective policy requires local identification, familiarity with and responsibility for priorities based on needs and community resources.

ASSURANCE

Public health agencies assure the availability of services that meet public health needs of communities. Local public health does not provide all elements directly, but works to assure resources are available. At a minimum, the local health department informs the public about gaps and disparities. The local health department allocates its resources in areas of highest priority in the community. It provides the safety net for individuals in need of clinical, health promotion, health protection and/or environmental services.

ESSENTIAL PUBLIC HEALTH SERVICES

In 1994 the Core Public Health Functions Steering Committee identified ten Essential Public Health Services that are required to succeed in performing the core functions. The "Essential Services" provide a working definition of public health and a guiding framework for the responsibilities of the local public health system.[8]

These essential services provide the guiding framework for local public health responsibilities. Essential services guiding this community assessment project include:

- Monitor health status to identify community health problems
- Mobilize community partnerships and action to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services

HOW ARE WE DOING? – TWO REPORT CARDS

A number of organizations and agencies monitor and evaluate the performance of state and local health departments related to set standards or criteria. National standards were initially developed by the Centers for Disease Control and Prevention (CDC) in 1980, hoping to achieve them by 1990. Every ten years new sets of standards to be achieved during the decade are published. Today, this process continues as *Healthy People 2020*. This assessment compares selected health, socio-economic, and environmental issues against *HP2020* objectives.

Two other organizations provide "report cards" to gauge the status of counties on various health indicators. The first compares county rankings to peer counties around the country; the second compares counties within a state and ranks them on various measures that impact health.

SALT LAKE COUNTY'S HEALTH STATUS - COMPARED WITH PEER COUNTIES ACROSS THE UNITED STATES

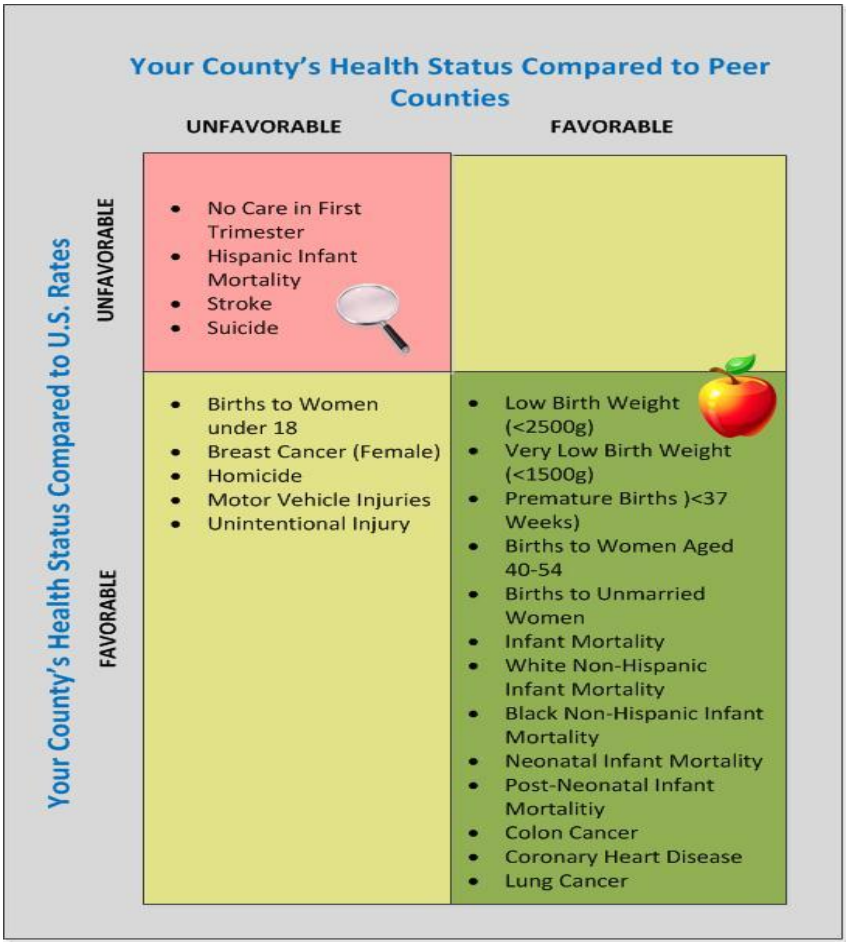
This section provides:

- A snapshot of a county's health status including leading causes of mortality, environmental health, vulnerable populations, preventive service use, and access to care.
- National rates and peer county comparisons
- *Healthy People 2020*

In 2009, the Department of Health and Human Services (DHHS) published health rankings as part of the *Community Health Status Indicator (CHSI) Project*. The CHSI report measures over 200 health indicators for each of the 3,141 United States counties and compares SLCo to peer counties. Peer counties are counties similar in population composition and selected demographics. Comparison of a county to its peers takes into account some of the factors (population size, poverty level, age distribution, and population density) that impact a community's health. All data presented are age-adjusted to 2000 standards to account for differences in age distributions.

[8] CDC (ND). *10 Essential Public Health Services.* Obtained 29 May 2012 from http://www.cdc.gov/nphpsp/essentialservices.html

The CHSI can serve as a starting point to assess community health needs, identify vulnerable populations, and measure preventable diseases, disabilities, and deaths.[9] The report is intended to facilitate collaboration among community agencies and organizations to create a healthy community.[2]



Salt Lake County did well in most areas measured by the CHSI reports. The following is the CHSI matrix that indicates areas of excellence as well as areas for improvement. Specific term definitions can be found in **Appendix 3**.

Figure 3a. Comparison of Salt Lake County's Health Status to Peer Counties and National Rates

The measures in the red box reflect where SLCo compares unfavorably to both its peer counties and the national rates. The county's performance on these indicators should be evaluated and actions taken to improve them. The indicators in the yellow boxes have favorable comparisons to either peer counties or the nation, but not both. Measures listed in the green box indicate favorable comparisons to both peer counties and the national rates.

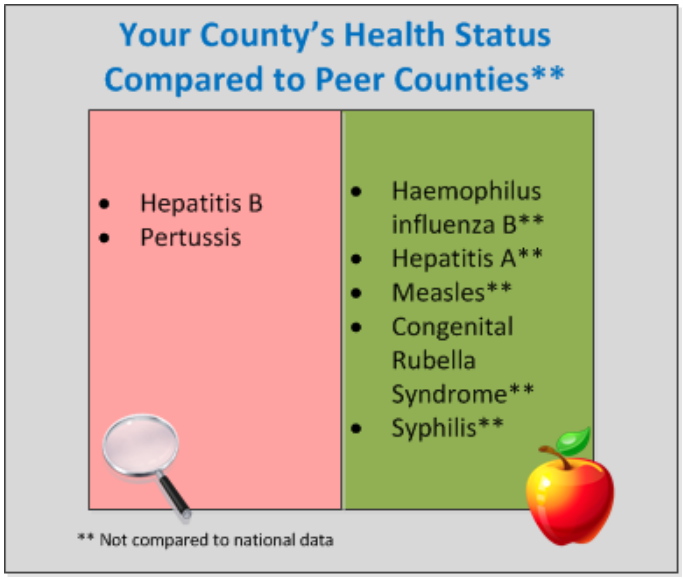


Figure 3b. Comparison of Salt Lake County's Health Status to Peer Counties – Infectious Diseases

SLCo compares favorably to peer counties for all diseases except two: Hepatitis B and Pertussis. For clarification of the incidence rates of Pertussis please see the Pertussis section of this document. For clarification of Hepatitis B please see the Hepatitis B discussion.

[9] US Department of Health and Human Services (2009). Community Health Status Indicators (CHSI), (2009). Obtained 3 June 2012 from http://www.communityhealth.hhs.gov/homepage.aspx?j=1

SALT LAKE COUNTY'S HEALTH STATUS - COMPARED TO NATIONAL DATA

The *County Health Rankings and Roadmaps Project*, conducted by the Robert Wood Johnson Foundation (RWJF), ranked each county within a state to the other counties in the state. Of the 26 counties in Utah that were rated, Salt Lake County ranked as the 12th healthiest county in terms of **Health Outcomes** and 16th in **Health Factors.**

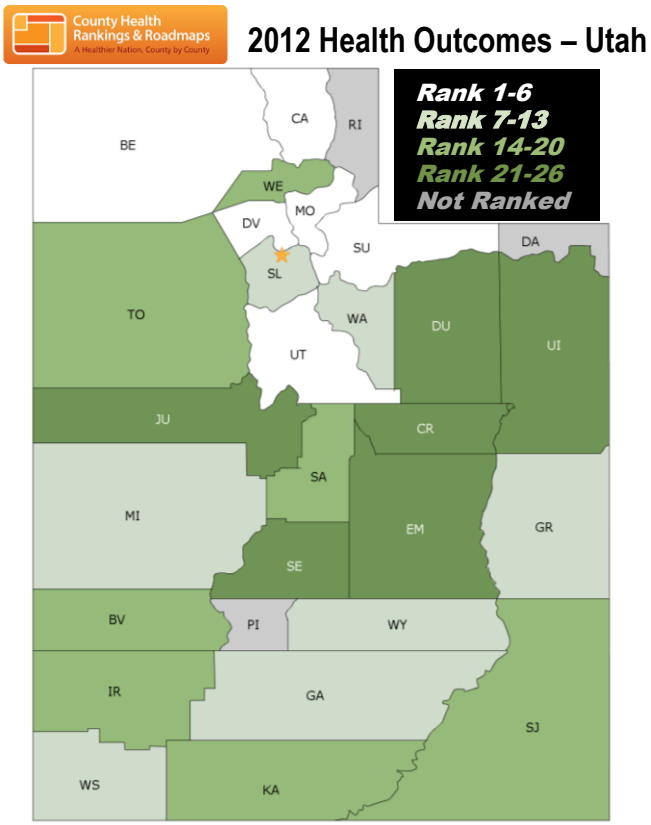
For comparison purposes, RWJF created a national benchmark using the average rates of the top ten percent of all counties within the U.S. This national benchmark should not be confused with *Healthy People 2020* Targets.

Detailed tables showing county, state, and national rates are located in **Appendix 4**.

HEALTH OUTCOMES

RWJF ranks health outcome based on mortality and morbidity rates. In terms of mortality, Salt Lake County ranks 7th in the state. This ranking is due to a premature death rate that is about 2% higher than the state rate and 12% higher than the national benchmark.

Morbidity is a way to measure the quality of life. RWJF measures it using birth outcomes and self-reported health status. SLCo's morbidity rankings are less favorable. The county ranks 15th in the state; the ranking is due in part to a higher rate of low birth weight.



Map 1. County Rankings on Health Outcomes

HEALTH FACTORS

The second major category used to develop the rankings is health factors. Salt Lake County ranked 17th among 26 Utah counties evaluated. This ranking of subcategories ranges from a high as 5th for "clinical care" to a low of 26th for "physical environment."

Health Behaviors

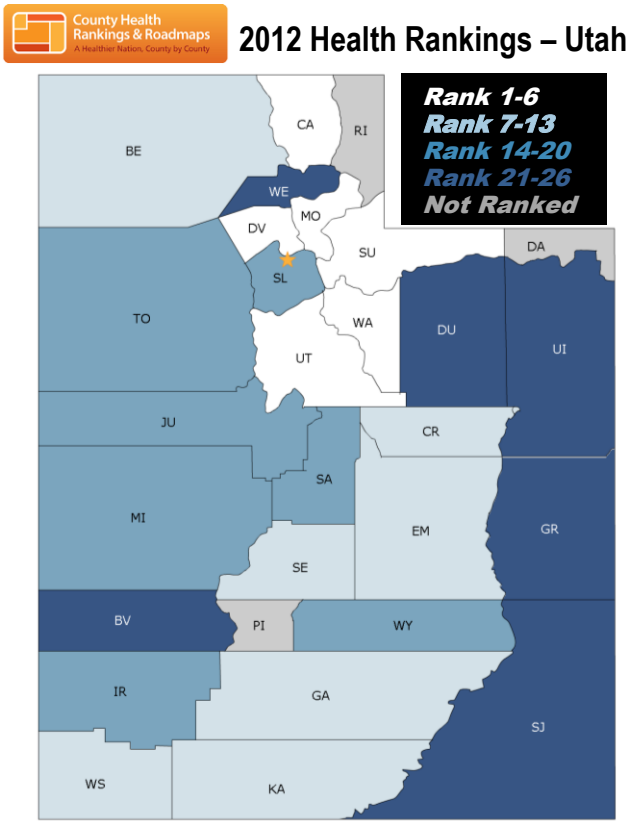
The health behaviors category is composed of seven indicators: adult smoking, adult obesity, physical activity, excessive drinking, motor vehicle accidents, sexually transmitted infections (STI), and teen birth rate. In general, Salt Lake County ranks worse than the other counties on all but three measures: motor vehicle crash death rate, adult obesity, and physical activity.

According to the RWJF study, the county STI (Chlamydia) rate is substantially higher than the state rate and national benchmark. For more information see the section on Chlamydia. In addition, Salt Lake County compare poorly on the teen birth rate (SLCo 40; Utah 35; US 22 per 1,000 females age 15-19). The least favorable health behavior was excessive drinking (SLCo 12%; Utah 9%; US 8% of population reporting binge drinking in the last 30 days).

Clinical Care

Clinical care is comprised of five categories: percent uninsured, percent who report having a primary care physician, rate of preventable hospital stays, percent of diabetic patients screened for HbA1C during the past year, and percent of 67- to 69–year-old women who received a mammogram during the past two years.

Map 2. County Rankings on Health Factors



Salt Lake County ranks fifth in the state on Clinical Care. Three out of five indicators are equal to or more favorable than the state rate. The most noteworthy clinical care indicator is the ratio of primary care physicians to residents. At 808:1, the ratio is better than the state ratio of 1072:1, but is less than the national benchmark of 631:1. Although the ratio is much worse than the national benchmark, it is the third most favorable in Utah.

Social and Economic Factors

The factors evaluated were children in poverty, inadequate social support, children in single parent households, and violent crime rate. Salt Lake County ranks 19th out of the county's in the state.

Physical Environment

The factors evaluated were air pollution (particulate matter and ozone), access to recreational facilities, limited access to healthy foods, and the number of fast food restaurants.

Salt Lake County ranks 17th in this category and has a worse rating than the state in all but one area: percentage of the population with limited access to healthy food. Statewide, 7% of the population has limited access to healthy foods, while only 4% of Salt Lake County residents have the same limitation. Salt Lake County matches the state rate of people with access to recreational facilities. However, both the state and county lag far behind the national benchmarks for all five measures.

Air pollution is the major contributing factor for Salt Lake County's poor ranking on the physical environment. The *County Health Rankings and Roadmaps Project* used the Public Health Air Surveillance Evaluation (PHASE) estimates to calculate the number of days that air is unhealthy for sensitive populations. The national benchmark for the number of excessive high ozone and particulate matter days is zero. During the year measured, 2007, Salt Lake County had 20 days of excessive ozone (the highest county in the state) and 11 days of excessive particulate matter (also the highest in the state).

HEALTHY PEOPLE 2020

Since 1979, *Healthy People* publications have sought to improve public health programs by providing national objectives for improvement. *Healthy People 2020* sets national targets for nearly 600 objectives and more than 1,300 measures of disease, behavior, and environmental indicators. *Healthy People* does not evaluate progress, but provides the objectives against which status or progress can be compared.

County data reflecting progress on *HP2020* objectives that are primarily impacted by public health programs are included within each topic section of this assessment as appropriate.

COMMUNITY DEMOGRAPHICS

HISTORY

The Fremont Indians first inhabited the area known as Salt Lake County. By the arrival of the first trappers to the area the Ute, Piute, Goshute and Shoshone had replaced the Freemont.

The Mormon pioneers, under the direction of Brigham Young, entered the valley in 1847 and established the territory known as the Deseret. "Great Salt Lake County" was established in 1850. The territory was linked to the rest of the nation through the railroad, when the golden spike was driven at Promontory Point on May 10, 1869. Utah was granted statehood January 4, 1896.

The precursor to the SLCoHD, Deseret Public Health, was founded in 1857. The Salt Lake County Board of Health was created in 1899. Deseret Public Health became the Salt Lake City Health Department. Salt Lake City and Salt Lake County operated separate health departments until 1969, when they combined to form the Salt Lake City-County Health Department. The department's name was changed to Salt Lake County Health Department in 2000.

GEOGRAPHY

Salt Lake County is in a basin bordered by the Wasatch Mountains to the east, the Oquirrh Mountains to West, Traverse Range to the south and the Great Salt Lake to the northwest. The county extends up the Wasatch Mountains encompassing City Creek, Emigration, Parleys, Big Cottonwood, and Little Cottonwood Canyons. The elevation of Salt Lake County ranges from 4200 feet by the Great Salt Lake to 11,330 feet atop Twin Peaks.

The main waterways are City Creek, Big Cottonwood Creek, and Little Cottonwood Creek, which all flow into the Jordan River and empties into the Great Salt Lake. Ten major rivers and streams come into the valley from the Wasatch Range and ten from the Oquirrh Mountains. Approximately 60% of the drinking water supply comes from four canyon watersheds: City Creek, Parleys, Big Cottonwood and Little Cottonwood. Emigration, Red Butte and Millcreek are part of the watershed but not fully protected. The remaining 40% of the drinking water comes from ground water, springs, or Provo Canyon through the Jordan Aqueduct.

Salt Lake County encompasses 737.38 square miles and has a population density of 1396.4 people per square mile. According to the US Census Bureau (2010) the population density of the cities within Salt Lake County ranges from 5,407 persons per square mile in Taylorsville to 93 in Alta.

GEOGRAPHIC INFORMATION SYSTEM (GIS) MAPPING

GIS mapping was used to present demographic, environmental, and resource data. Layered GIS maps can indicate areas of need, gaps in service, over-served areas and/or resources. GIS maps can be found throughout the text as appropriate.

SMALL AREA DATA

Health status information at the community level is reported as small area (SA) data, which is used to find pockets of need within the community. SA analysis is used throughout this report to find areas that do not meet recognized standards when the county as a whole does.

Maps showing the Small Areas for Salt Lake County can be found in **Appendix 5.** Cities are colored; SAs are outlined. The second map has SAs separated for easier identification.

Criteria used to identify SAs[10] were zip codes, population size, political boundaries, socio-economic status, and input from local authorities. Populations of 40,000-60,000 were determined to be adequate to produce stable estimates while protecting anonymity of individuals. SAs do not always represent defined city boundaries. For example, Taylorsville City is split between four SAs; three contain pieces of Taylorsville and the fourth bears its name. There are discrepancies between small area and city populations, which is shown by the table below. Though it is difficult to use the Small Area data in planning for specific cities, SA data is usually the only data available.

Table 1. Percentage of Population by Age Groups for SLCo Small Areas, and SLCo Cities or Census Designated Places (CDP)

Cities*	Small Areas	0-4 YEARS		5-19 YEARS		20-64 YEARS		65+ YEARS	
		Small Area %	City or CDP %	Small Area %	City or CDP %	Small Area %	City or CDP %	Small Area %	City or CDP %
Salt Lake City	Avenues	5	7.8	13	14.7	68	68.1	14	9.4
	Rose Park	10		24		57		9	
	Downtown	6		14		70		10	
	Foothill/ U of U	8		20		59		13.8	
	Glendale	10		24		61		8	
Cotton-wood Heights	Cottonwood	6	6.1	19	16.9	61	63.6	15	13.4
Holladay City	Holladay	6	6.8	18	18.3	57	57.6	19	17.3
Kearns CDP	Kearns	10	10.6	27	24.3	57	64.8	6	10.1
Magna CDP	Magna	11	10.6	28	23.8	55	60	6	5.6
Midvale City	Midvale	9	9.2	21	15.9	60	64.8	10	10.1
Millcreek CDP	Millcreek	7	7.2	19	15.9	58	61.1	16	15.8
Murray City	Murray	8	7.3	19	16.4	60	62.4	13	13.9

[10] Haggard, LF, Shah, G., Stat, M., & Rolfs, R.T. (1998) Assessing Community Health Status: Establishing Geographic Areas for Small Area Analysis in Utah. *Utah's Health: An Annual Review, Vol. V, 1997-1998.* Salt Lake City, UT, University of Utah. The Governor Scott M. Matheson Center for Health Care Studies. Online at http://health.utah.gov/opha/IBIShelp/sarea/SmallAreaAnalysis.htm

Cities*	Small Areas	0-4 YEARS		5-19 YEARS		20-64 YEARS		65+ YEARS	
		Small Area %	City or CDP %	Small Area %	City or CDP %	Small Area %	City or CDP %	Small Area %	City or CDP %
Riverton City	Riverton/ Draper	11	10.6	27	27.2	57	57.1	5	5.1
Draper City			8.6		24.4		61.6		5.4
Bluffdale City			10		28.2		56.5		5.3
Herriman			14.2		29.9		53.3		2.6
South Salt Lake City	South Salt Lake	9	8.3	19	13.9	61	71	10	6.8
Sandy City	NE Sandy	6	7.3	24	21.2	61	62.3	9	9.2
	SE Center	6		28		59		6	
White City CDP	Sandy Center	9	8.4	25	20.2	58	49.7	8	13.3
South Jordan City	South Jordan	9	9.2	29	25.6	56	58.1	6	7.1
Taylorsville City	Taylorsville	8	9	22	18.8	60	63.5	9	9.1
West Jordan City	W. Jordan NE	9	10.2	28	25	58	60.2	5	4.6
	W. Jordan SE	12		28		56		4	
	W. Jordan W. Copperton	14		28		54		3	
West Valley City	West Valley East	9	10.2	27	22.8	59	60.1	9	6.9
	West Valley West	11		22		56		6	

*There are six unincorporated townships within Salt Lake County: Magna, Millcreek, Emigration, White City, Kearns and Copperton. As of 2010 these townships are also considered Census Designated Places (CDP). Granite is not an unincorporated township, but is considered a Census Designated Place (CDP). The population of unincorporated Salt Lake County is 146,209.

POPULATION DEMOGRAPHICS

Population characteristics can often impact health. These characteristics are referred to as social determinants of health. *Healthy People 2020* defines these as "the social and physical environments that promote good health for all."[11] The conditions in which we live, including the opportunities and limitations placed upon us by these conditions, impact the quality of our lives. Sometimes choices are dictated by what is available in the community, not what is best for the person. Social determinants of health bear the major responsibility for inequities that affect health. The information found in this section describes some of the major inequities that are found in Salt Lake County which influence health.

POPULATION TRENDS

[11] *Healthy People 2020.* 2020 Topics and Objectives. Social Determinants of Health. Obtained 4 Sept 2012 from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

Population growth has shifted over the past decade to the south and southwest portions of the county. Table 2 shows the population growth in Salt Lake County by city and municipality between 2000 and 2010, and the projected population growth for 2050. The largest city in Salt Lake County is Salt Lake City. Sandy City was the only city with a negative population growth. The population of Herriman is fastest growing city in Salt Lake County and second fastest in Utah. The growth in the county has been, and will continue to be, primarily in the south and southwest communities of Herriman, Bluffdale, Draper, Riverton, West Jordan, and South Jordan. Although Holladay and Murray showed substantial growth during the last decade, the growth was primarily related to annexation of part of unincorporated Salt Lake County, which also accounts for the negative growth in the unincorporated county population.

Table 2. Population Growth and Projections for Salt Lake County and its Cities[12]

Cities*	2000 Population	2010 Population	Percent Change	Projected 2050 Population	Percent Increase
Salt Lake County	898,387	1,029,655	14.6%	1,663,994	61.6%
Alta Town	370	383	3.5%	798	108.4%
Bluffdale City	4,700	7,598	61.7%	56,535	644.0%
Herriman City	1,523	21,785	1330.4%	61,510	191.0%
Draper City	25,220	40,532	60.7%	60,676	48.8%
Salt Lake City	181,743	186,440	2.6%	225,066	20.7%
South Jordan City	29,437	50,418	71.3%	112,482	123.0%
West Jordan City	68,336	103,712	51.8%	182,080	75.6%
Riverton City	25,011	38,753	54.9%	63,081	62.8%
West Valley City	108,896	129,480	18.9%	167,413	29.3%
Holladay City	14,561	26,472	81.8%	30,306	10.5%
South Salt Lake City	22,038	23,617	7.2%	27,983	18.5%
Unincorporated County	209,642	146,209	-30.3%	323,382	121.0%
Cottonwood Heights	n/a	33,433	n/a	49,476	48.0%
Murray City	34,024	46,746	37.4%	47,899	2.5%
Sandy City	88,418	87,461	-1.1%	123,157	40.8%
Midvale City	27,029	27,964	3.5%	52,748	88.6%
Taylorsville City	57,439	58,652	2.1%	79,402	35.4%

*There are six unincorporated townships within Salt Lake County: Magna, Millcreek, Emigration, White City, Kearns and Copperton. As of 2010 these townships are also considered Census Designated Places (CDP). Granite is not an unincorporated township, but is also considered a CDP.

[12] UpGrade Business on the Next Level. Obtained 12 June 2012 from: http://aging.slco.org/pdf/studySummary.pdf

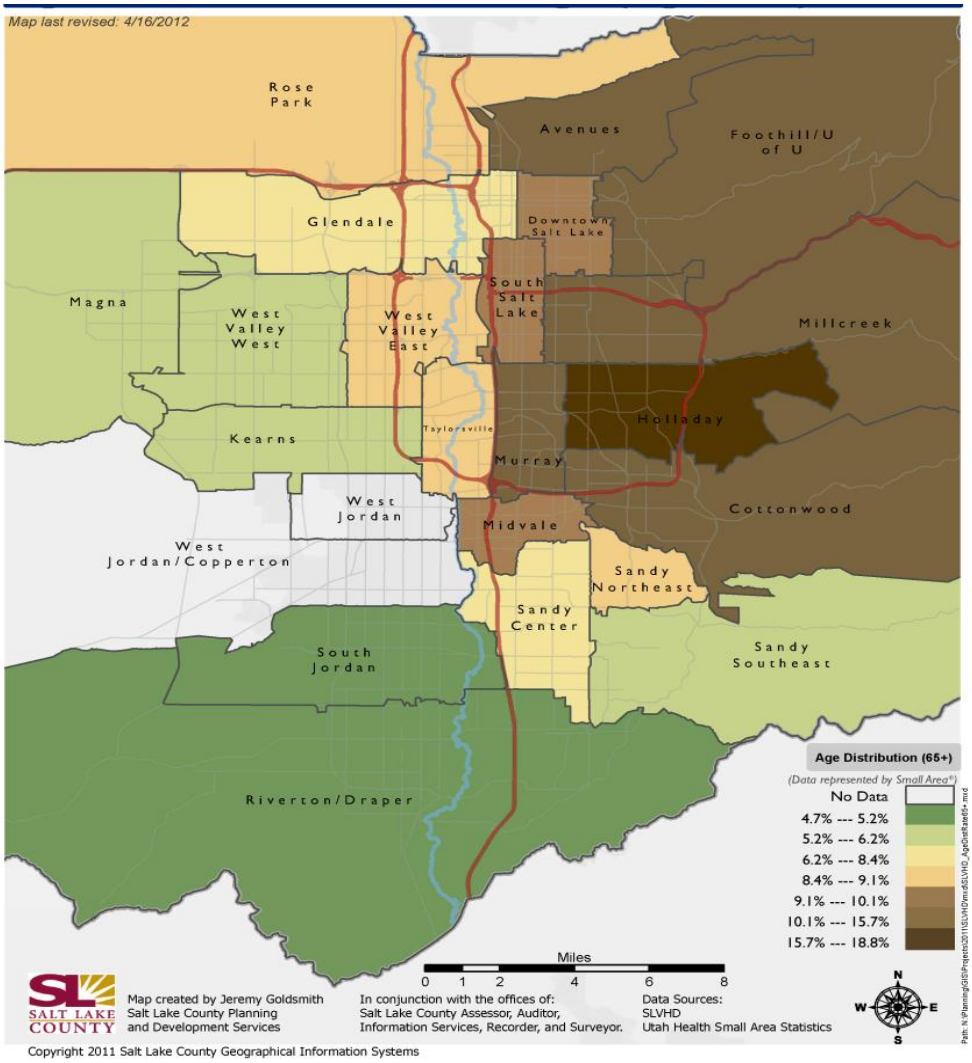
AGE[13]

Salt Lake County's population is older than the population of the state, but is relatively young when compared to the U.S. Currently, more of the aging population is in located in the east side of Salt Lake County. The south and west areas of the county attract a younger population. The small areas with the highest percentage of elderly are Holladay (19%), Millcreek (16%), Cottonwood (15%), the Avenues area of Salt Lake City (14%), the Foothill/University of Utah area of Salt Lake City (13%), Murray (13%), and Downtown Salt Lake City, South Salt Lake City, and Midvale (10%).

Table 3. Percent of Population by Age Group

AGE GROUP	PERCENT OF POPULATION		
	Salt Lake County	Utah	US
Under 5 years	8.8%	9.5%	6.5%
5-18 years	20.3%	22.0%	17.5%
18-64 years	62.2%	59.5%	63.0%
Over 65	8.7%	9.0%	13.0%

Map 3. Age Distribution Percent (Age 65+)



[13] U.S Census Quickfacts 2010: http://quickfacts.census.gov/qfd/states/49/49035.html

ETHNICITY AND CULTURE[14]

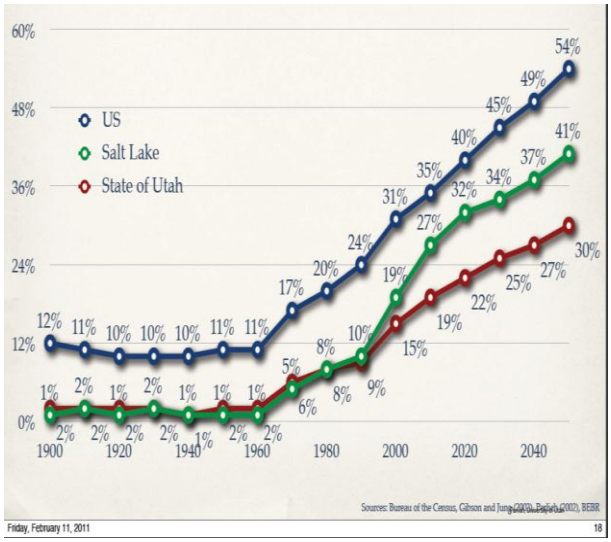


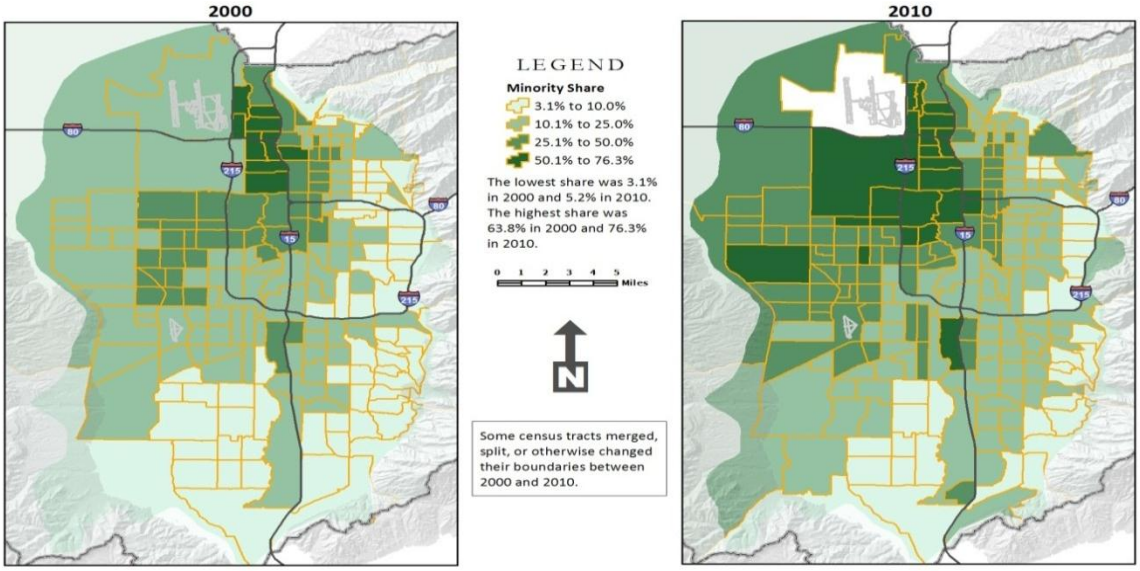
Figure 4. Ethnic and Cultural Minority Share of Population

The Salt Lake County population has a higher percentage of minorities than the state average. 1980 was the last year that the county and state had the same percentage.

In 2000, Salt Lake County's minority population accounted for approximately 33% of Utah's minority population. By 2010, the county's minority population represented 47.9% of the state's total minority population.

Although SLCo has a greater concentration of ethnic and cultural minorities than the state, the county's minorities tend to group into selected sections of the county. Map 4 shows the growth of the ethnic and cultural minority population over the previous decade.[15]

Map 4. Minority Share. Salt Lake County Population by Census Tract, 2000 and 2010



Source: U.S. Census Bureau, 2000 and 2010 Censuses; Utah Automated Geographic Reference Center.
Cartography: John Downen, BEBR | June 2012

The Hispanic and Latino population comprised of 11.9% of the county population in 2000, in 2010 it increased to 17.1%. West Valley City and South Salt Lake have some of the highest percentages of Hispanic residents in the state. 129 languages are spoken in Salt Lake County; for almost 19.3% of the ethnic families in the county, English is not the primary language spoken at home.

[14] Perlich, P.S. (2010). *Population Estimates by Race and Ethnicity for Utah Counties, 2009.* BEBR. Obtained 11 June 2012 from: http://www.bebr.utah.edu/Documents/2009_County_Race_Ethnicity_Estimates.pdf
[15] Downen, J. (2012). Comparison of Minority Populations in Salt Lake County 2000 and 2010. Obtained 12 Jun 2012 from John Downen.

Table 4. County Population by Race and Ethnicity (2010)

Race / Ethnicity	Percent of Population		
	County	Utah	US
White	81.2%	86.1%	72.4%
Black	1.6%	1.1%	12.6%
American Indian / Native Alaskan	0.9%	1.2%	0.9%
Asian	3.3%	2.0%	4.8%
Native Hawaiian / Pacific Islander	1.5%	0.9%	0.2%
Two or More races	3.1%	2.7%	2.9%
Ethnicity			
Hispanic Origin	17.1%	13%	16.3%
Non-Hispanic / White	74.0%	80.4%	63.7%
Language other than English spoken at home	19.3%	14.2%	20.1%

DEATH RATE

The death rate in Utah for 2010 was 674 per 100,000 persons (age adjusted)[17] while the U.S. rate was 746.2 per 100,000 persons (age adjusted rate).[18] Salt Lake County has lower rates than the U.S. for all leading causes of death, except diabetes mellitus, suicide, pneumonitis, and Parkinson's. The county has higher death rates than Utah for all conditions except Influenza/pneumonia, Alzheimer's, and kidney disease.

Table 5. Leading Causes of Death

Condition	SALT LAKE COUNTY (2005-2010)		UTAH	U.S.
	Rank	Rate[16]	Rate	Rate
Diseases of heart	1	144.3	135.9	178.5
Malignant neoplasms	2	128.5	128.5	172.5
Cerebrovascular diseases	3	37.1	35.2	39.0
Chronic lower respiratory diseases (asthma, COPD)	4	34.8	21.7	42.1
Accidents (unintentional injuries)	5	31.9	34.8	38.2
Diabetes mellitus	6	23.9	12.6	15.3
Influenza and pneumonia	7	16.7	21.8	20.8
Intentional self-harm (suicide)	8	16.6	17.0	11.9
Alzheimer's disease	9	16.4	16.5	15.1
Nephritis, nephrotic syndrome, & nephrosis	10	10.8	18.7	25.0
Parkinson's disease	11	9.6	8.5	6.8
Pneumonitis due to solids and liquids	12	6.5	5.5	5.1
Essential hypertension and hypertensive renal disease	13	6.5	7.0	9.4
Chronic liver disease and cirrhosis	14	6.5	6.2	10.6
Septicemia	15	5.6	5.9	7.9

[16] Age adjusted to 2000 U.S. population
[17] IBIS-PH – Important Facts for General Mortality Rates. Obtained 16 May 2012 from: http://ibis.health.utah.gov/indicator/view/DthRat.UT_US.html
[18] January 2012. CDC. National Vital Statistics System. Obtained 16 May 2012 from: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

FERTILITY RATE[19]

The general fertility rate is a more precise measure of tracking birth rate patterns than the crude birth rate. While the crude birth rate and the general fertility rate both look at the total number of live births among the population, the crude birth rate is calculated using the total population including the young, old, male, and female.

The general fertility rate is calculated using only females of reproductive age, defined as ages 15 through 44 years, residing in Utah during a specified time period. During the ten-year period from 2001 through 2010, Utah's general fertility rate has ranged from a high of 90.8 in 2007 to a low of 82.9 per 100,000 in 2010.

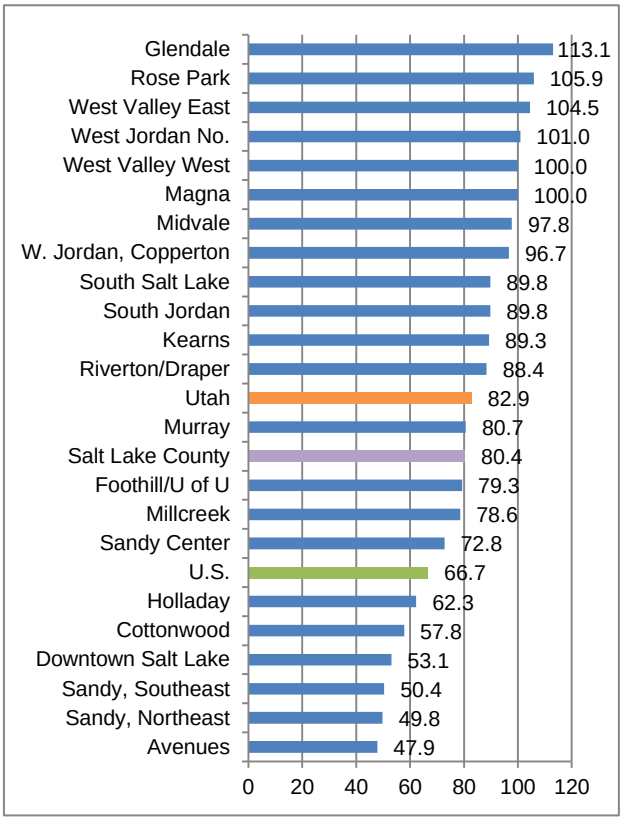
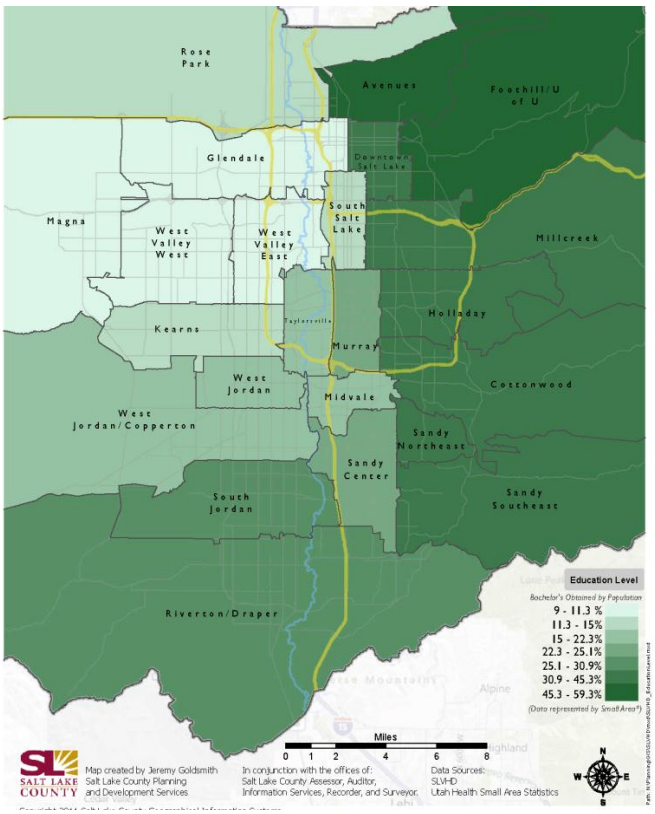


Figure 5. Fertility Rates (per 100,000 females age 15-44), by Small Areas

Nationally, the general fertility rate in 2009 was 66.7, which was a decrease from 68.6 in 2008. In 2009, Utah's general fertility rate was 82.9. Salt Lake County's rate was 80.2.

EDUCATION LEVEL[20]

Education level is generally correlated to income and poverty. 89.9% of SLCo residents have a high school diploma compared to 90.6% for the state and 84.6% nationally. 30.1% of the county's residents have a bachelor's degree or higher, compared to 29.4% for the state and 27.5% nationally. Map 7 shows the percentage of the county's population that has a Bachelor's degree or higher.



Map 5. Persons with Baccalaureate Degree

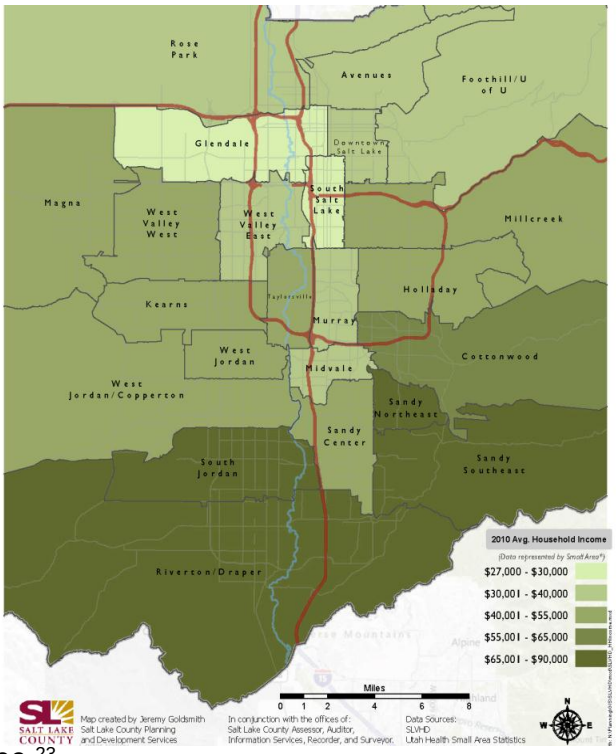
Map 5 shows that the northeast quadrant and southern end of the valley have the highest concentration of degreed persons, while the Magna, West Valley and Glendale areas have the fewest. Education tends to be correlated with socioeconomic status.

[19] IBIS-PH – Important Facts for General Fertility Rates. Obtained 16 May 2012 from: http://ibis.health.utah.gov/indicator/important_facts/FertRat.html

[20] U.S. Census Bureau. 2010 Quick Facts. Obtained 16 May 2012 from: http://quickfacts.census.gov/qfd/states/00000.html

SOCIOECONOMIC STATUS

The median household income in Salt Lake County is $58,004, which is slightly higher than the state median of $56,330 and significantly higher than the U.S. median income $51,914.[21]

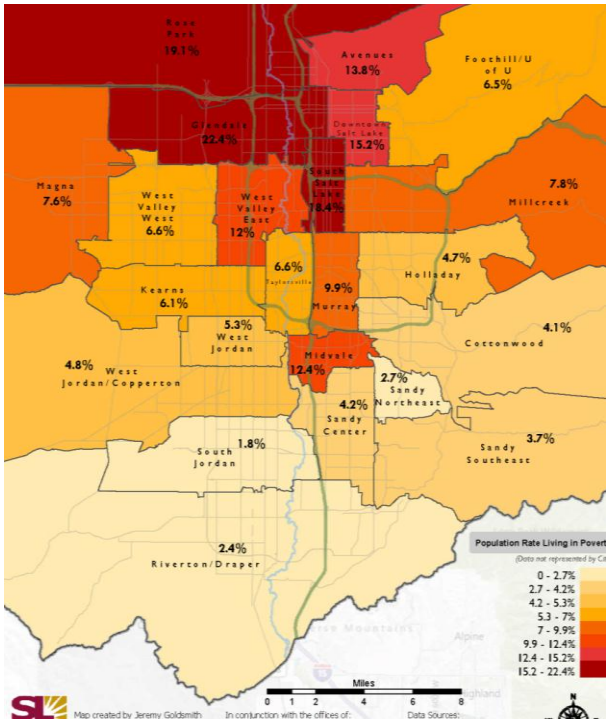


Map 6. Average Household Income

Map 6 shows that the lowest income areas are the Glendale and South Salt Lake SAs. The income levels are highest in the south end of the county.

POVERTY

Federal data indicate that 13.7% of the residents in Salt Lake County live below the poverty level[22], which is greater than the state's rate. In 2010 approximately 360,400 Utahns lived in poverty, 135,400 of whom were children age 17 or under. The Kids Count Data Center reports that 13% of children in Salt Lake County lived in poverty in 2009.[23]



Map 7. Percent of Population Living in Poverty (All Ages)[24]

Examining Small Areas within the county demonstrates some poverty disparities. Areas of high poverty, such as Glendale and Rose Park, face different issues than areas with lower poverty rates, like South Jordan or the Riverton/Draper. High areas of poverty coincide with medically underserved areas/populations and some food deserts.

Similar to the pattern for education and household income, Map 7 shows population rate living in poverty in Salt Lake County.

Poverty impacts all areas of life as it limits choices on residence, food, health care and transportation to name a few. For children, poverty can lead to lifelong impacts on development, both physical and intellectual, educational attainment, and behavioral health issues.

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[21] U.S. Census Bureau. 2010 Quick Facts. Obtained 16 May 2012 from: http://quickfacts.census.gov/qfd/states/49/49035.html

[22] USDA Economic Research Division. 2010 County Level Poverty Rates for Utah. Obtained 16 May 2012 from: http://www.ers.usda.gov/data/povertyrates/PovListpct.asp?st=UT&view=Percent&longname=Utah

[23] Anna E. Casey Foundation. Kids Count Data Center. Obtained 16 May 2012 from: http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=UT&loc=6786

[24] Poverty data is adjusted for income and family size.

CHALLENGES TO THE COMMUNITY'S HEALTH FROM DEMOGRAPHIC SHIFTS AND TRENDS

The two major population trends in Utah will drive future demographic changes[25]. The first is the continued arrival of young, working aged immigrants. The second is aging of the population.

Other demographic changes that impact service needs include population size, changing population center, and the location of jobs. Since Salt Lake County will continue to be the population center for the foreseeable future, these changes will result in a more diverse community.

CHANGE: POPULATION SIZE[26]

With a 23.8% increase in population, Utah was the third fastest growing state during the 2000-2010 decade, surpassed only by Nevada with 35.1% and New Mexico at 24.6%. The natural increase (births minus deaths) accounted for 72% of the increase while the other 28% was contributed by in-migration.[27]

According to the 2010 US Census, the population of Salt Lake County is 1,029,655. The county population grew by 14.6% since 2000. While this is a healthy growth, it was slower than the state rate.

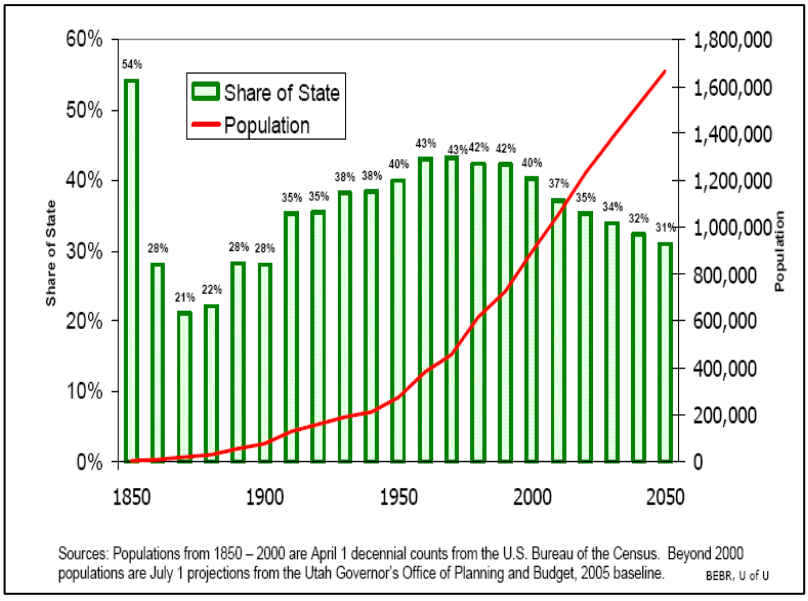


Figure 6. Salt Lake County Population: Total and Share of State 1850-2050

According to the Bureau of Economic and Business Research (BEBR) at the University of Utah, Salt Lake County's population is projected to increase to 1.7 million by 2050.

The number of households in Salt Lake County is projected to increase more rapidly than the population. It will more than double between 2000 (297,064) and 2050 (608,614). The result is a decline in persons per household from 2.99 in 2000 to a projected 2.67 in 2050. The state's projected persons per household will decline from 3.22 to 2.78 during the same period. Nationally, the average household size is expected to fall from 2.59 to 2.42. Much of this decline in household size is attributable to the aging of the population.

CHALLENGE: INCREASED AIR POLLUTION DUE TO FREEWAY TRAFFIC

Increased population will result in increased traffic on already congested freeways. This in turn causes increased air pollution.

[25] Perlich, P.S. (2009). Utah's demographic transformation: A view into the future. *Essential Educator.* Posted 9 Sept 2009 at: http://essentialeducator.org/?p=2334
[26] Perlich, P.S. (2007). Salt Lake County's Distinctive Demographics: Implications for the Aging Population. Bureau of Economic and Business Research. University of Utah.
[27] Perlich, P.S. and Downen, J.C. (2011). Census 2010 – A First Look at Utah Results. *Utah Economic and Business Review.* Obtained June 4, 2012 from http://www.bebr.utah.edu/Documents/uebr/UEBR2011/UEBR2011no2.pdf

Change: Population Movement[28]

Growth in Salt Lake County is occurring mostly in the south and west, and this trend is expected to continue. According to BEBR, in the 1990s over 80% of the county's population growth occurred in the west-central section of the county, which are West Valley, Taylorsville and West Jordan.

The Governor's Office of Planning and Budget (GOPB) projects most of the growth to occur in the south and west areas of the county. Herriman, Bluffdale, South Jordan, Riverton, Draper, West Jordan, and unincorporated Salt Lake County are expected to grow the most in the decades to come.

Table 6. Salt Lake County Population Growth by Area

GROWTH QUADRANT	2000 to 2010	2011 to 2030
North of 2100 South		
• West of 5600 W.	**4.5%**	**15.4%**
• Between 5600 W & I-15	**3.6%**	**(-1.3%)**
• East of I-15	**7.4%**	**(-2.5%)**
Between 2100S & 9000 S		
• West of 5600 W.	**11.3%**	**24.3%**
• Between 5600 W & I-15	**22.4%**	**4.3%**
• East of I-15	**19.4%**	**4.3%**
South of 9000 South		
• West of 5600 W.	**9.2%**	**29%**
• Between 5600 W & !-15	**13.5%**	**22.1%**
• East of I-15	**8.8%**	**3.8%**

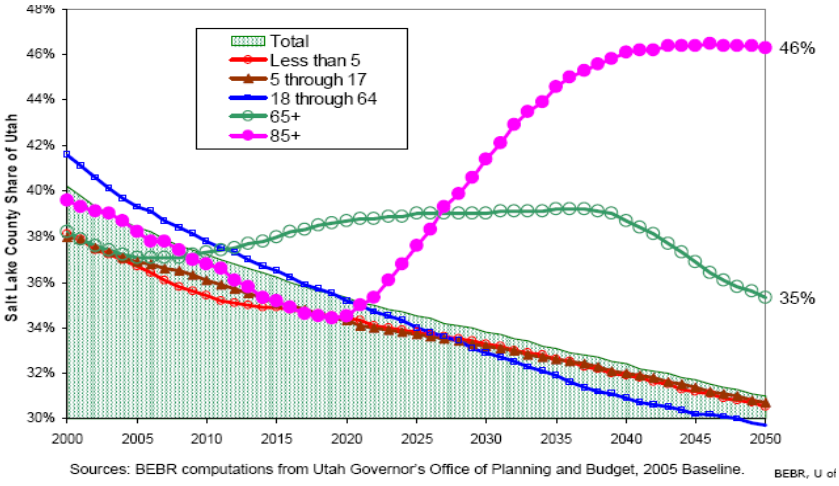
To illustrate the shift in population over the next 20 years, BEBR divided the county into 9 sectors to conduct an analysis of county growth. Table 6 shows the 2010 population distribution in those nine geographic areas within the county and expected growth or decline by 2030.

Challenge: Increasing Demands for Services in the South and West

Availability of affordable health care was identified by focus groups as a health issue. Although the poorest populations reside in the north and west sides of the Salt Lake Valley, the younger demographic is moving south and west. As it does, service needs will expand. However, as the SA map in Appendix 5 indicates, the concentration of affordable health care services is north and centrally located around I-15. Service expansion by acute care corporations is already occurring. Public and other programs must follow.

CHANGE: AGING POPULATION

Figure 7. Working Age Populations



The older demographic will soon comprise a larger share of Utah's population. In approximately 2020, the share of the population aged 85+ will increase to about 35% in 2020, and then 46% in 2040. The population aged 85+ will surpass those 65+ in about 2027 as the Baby Boom surge ends. Complicating matters, the

[28] Bureau of Business and Economic Research (2009). Obtained June 3, 2012 from http://www.bebr.utah.edu/Documents/uebr/UEBR2011/UEBR2011no2.pdf

percentage of the working age population is expected to decline dramatically between 2000 and 2050. The number of children under age 18 should remain stable.

The GOPB estimates that over a third of the population will be age 65 or older by 2020. The population of children age 5 or under will remain relatively stable. The number of adults age 65+ will surpass the number of children age 5-17 by 2030, as will the number of adults age 85+ by 2050.

CHALLENGE: INCREASING DEMANDS FOR SERVICES FOR THE ELDERLY

While the population of Utah will continue to be younger than the general US population, the ratio of the elderly to the young will increase. Services supporting elderly on fixed incomes will increase, which might impact both the types and locations of services offered by the health department and community organizations.

With an expanding number of elderly, the burden of funding health care services will increase for the working age groups since funding streams depend on tax dollars. As the population ages, health services will need to meet the increased demands of an older population while continuing to meet the needs of the youth. There will be a greater need for programs that support the elderly in the northeast and central east parts of the county.

CHANGE: INCREASING ETHNIC/CULTURAL DIVERSITY

The 2010 Census shows that more than 33% of the nation's population is classified as minority, whereas in Utah it is 20%. By 2050, these proportions are expected to increase to 30% in Utah, 41% in Salt Lake County and 54% in the U.S.

The ethnic and cultural minority share of the Salt Lake County population is unevenly distributed across the age spectrum. It is weighted toward the young. From 2000 through 2007, minorities accounted for one-third of the increase in the total population, yet accounted for two-thirds of the school enrollment increase in the state. Nearly one-third of preschool children in Salt Lake County are estimated to be ethnic/cultural minorities. In contrast, less than one-tenth of the age 65+ demographic is estimated to be members of ethnic/cultural minority groups.

CHALLENGE: SERVICES MEET ETHNIC/CULTURAL NEEDS

Increasing diversity requires adjusting programs to work within the framework of a person's cultural heritage and belief system. Agencies, including the health department, will need to recruit and mentor youth from predominant minority cultures to assist with provision of services and develop written material that fits within various cultural norms. In addition, employing people from these cultures in positions that directly influence department mission and services will validate the agency for ethnic/cultural groups.

COMMUNITY HEALTH STATUS

INTRODUCTION

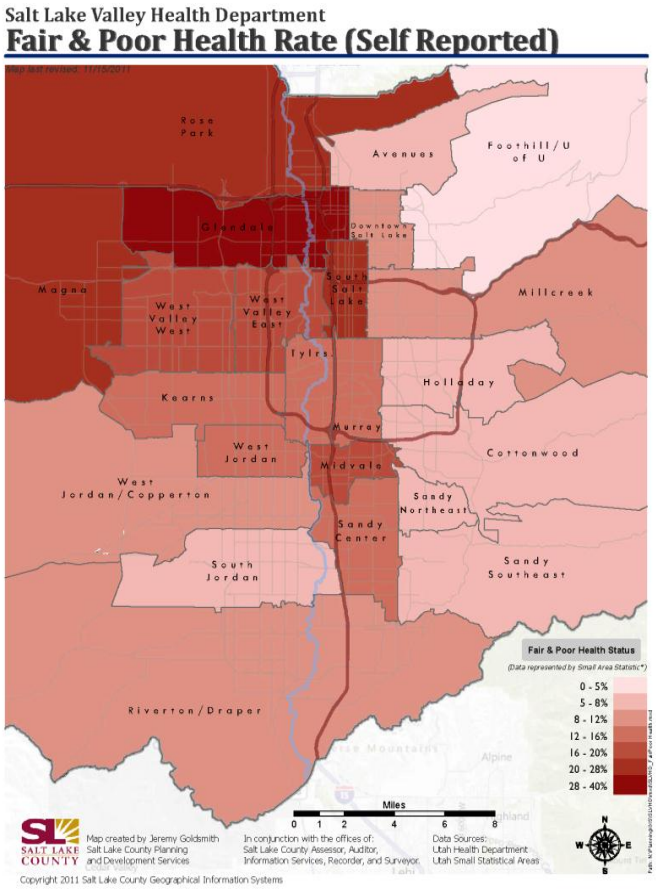
Data in this section consist primarily of figures which are graphs and maps. The maps have keys that provide the parameters for each color category. The graphs are consistent in their color codes which are:

COLOR	REFERENCE
	Represents the U.S. rate used as the baseline for determining the *HP2020* Target
	Represents the most current Utah rate available on IBIS-PH
	Represents the most current Salt Lake County rate available on IBIS-PH or through the program at the SLCoHD
	Represents the population of measure (LHDs, SAs) that have met the *HP2020* Target
	Represents the population of measure (LHDs, SAs) that have **NOT** met the *HP2020* Target

Note: Information for the maps, figures, and tables comes from the U.S. Census Bureau, IBIS-PH, *Healthy People 2020,* and/or the CDC unless otherwise footnoted. All data is adjusted to the 2000 population standard and is age adjusted.

QUALITY OF HEALTH

Map 8. Self-Reported Health Quality



Utahns consider their health as generally good. Only 14.5% of adults in the state reported seven or more days of poor physical health in the last 30 days in 2009 compared with 15.1% for the U.S. In Salt Lake County, an average of 13.5% reported poor physical health. Map 8 shows there are areas with very low reporting of poor physical health. Poor physical health can have many contributing factors, such as distance to services, cost, and lack of health insurance.

Quality of life is a multi-dimensional concept that includes domains related to physical health, mental and emotional health, and social functioning. An emerging concept of health-related quality of life is well-being, which assesses the positive aspects of a person's life, such as positive emotions and life satisfaction.

Self-reported health status is considered to be a predictor of health outcomes including mortality, morbidity, and functional health status.

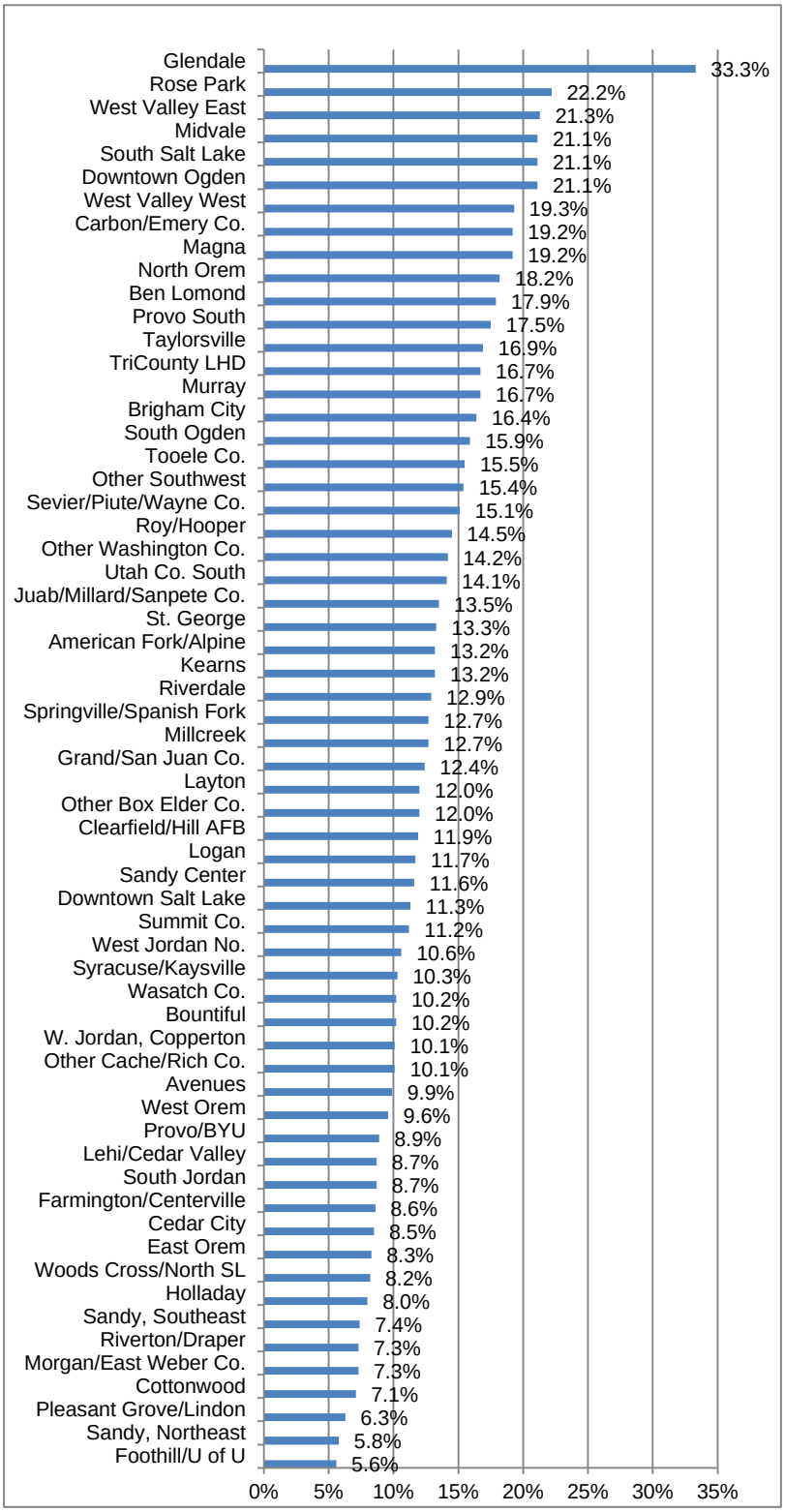


Figure 8. Percentage of Adults Aged 18 and Older Who Reported Seven or More Days When Their Physical Health Was Not Good in the Past 30 Days by Utah Small Area, 2009-2010

There are no *HP2020* objectives or targets for perceived quality of health. This topic is considered a foundational health measure along with determinants of health and health disparities. Perceived health quality is under study and will be included in future *Healthy People* documents.

Of the ten SAs reporting the fewest poor health days, six are in Salt Lake County. Conversely, eight of ten SAs reporting the most poor health days are also in Salt Lake County. Note that Glendale reports significantly poorer health than the next closest SA, Rose Park.

SLCo Small Areas that report the most poor health days also appear frequently throughout this document as the SAs not yet achieving many of the *Healthy People 2020* Objectives. They are Glendale, Rose Park, West Valley East, West Valley West, Midvale, South Salt Lake, and Magna,

SELECTED HEALTH CONCERNS

DIABETES

Diabetes was one of the health concerns brought up in both the community and partner focus groups. There are two types of diabetes. Type 1 diabetes is generally thought to be an autoimmune disease. This type can occur at any age and is insulin dependent. Type 2 diabetes is lifestyle dependent. References to diabetes in this document are related to Type 2 diabetes.

Diabetes has reached epidemic proportions in the United States. About 8.3% of the U.S. population (18.8 million Americans) has been diagnosed with diabetes. 7.3%[29] of Salt Lake County residents are diabetic compared with a state rate of 7.2% and a national rate of 8.5%.[30]

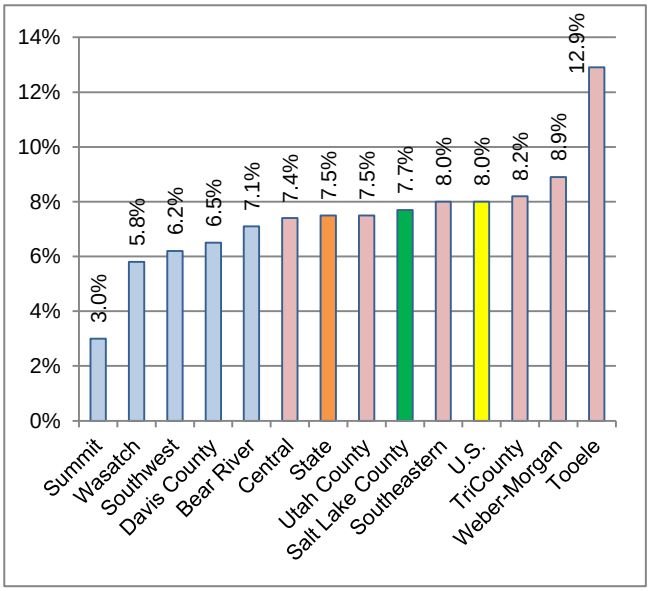
In addition to the 18.8 million currently diagnosed, CDC estimates that about one-fourth of people with diabetes (over 7 million Americans) are undiagnosed.[31] In Utah, this would mean approximately 45,000 people are not yet diagnosed. The demographics with the highest rate of diabetes are adults aged 65+ (21.27%), Hispanics (7.63%), individuals with a below high school education level (10.01%), American Indian and Pacific Islander (9.8% and 9.3% respectively), and individuals who earn less than $24,999 per year (11.27%). Salt Lake County's rate of diabetes may increase as the elderly and ethnic and cultural minority populations increase

Diabetes is a disease that can have devastating consequences. Diabetes decreases life expectancy by 15 years.[32] It is the leading cause of non-traumatic lower-extremity amputation and renal failure. It is also the leading cause of blindness among adults younger than 75. It increases the risk for heart disease two to four times. Diabetes places an enormous burden on health care resources, approximately $174 billion annually ($116 billion in direct medical costs and $58 billion in indirect costs such as disability, work loss, and premature mortality).[33]

PREVALENCE OF DIABETES

The diabetes prevalence rate in Salt Lake County is 7.7%, which is the 5th highest in diabetes prevalence rate reported among the 12 LHDs in Utah.

Figure 9. Prevalence of Diabetes by Local Health District, 2009-2011, Behavioral Risk Factor Surveillance System (BRFSS) Developmental Database



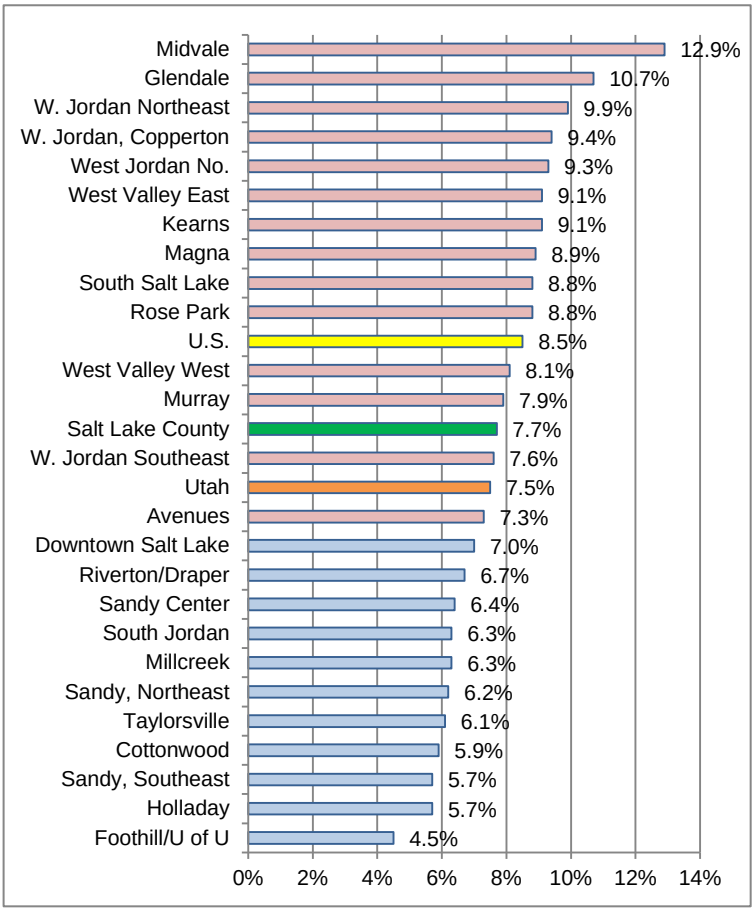
While both Utah and SLCo rates met the *HP2020* Target of 7.2 in 2008, neither met it in 2011. The state rate increased from 6.8 to 7.5 while SLCo's rate increased from 7.2 to 7.7. This trend may continue.

[29] IBIS-PH. Obtained 26 June 2012 from: http://IBIS-PH.health.utah.gov/indicator/view/DiabPrev.LHD.html
[30] IBIS-PH. Obtained 26 June 2012 from: http://IBIS-PH.health.utah.gov/indicator/view_numbers/DiabPrev.UT_US.html
[31] CDC. Diabetes Public Health Resource. Obtained 26 June 2012 from: http://www.cdc.gov/diabetes/pubs/estimates11.htm#1
[32] *Healthy People 2020*. Diabetes. Obtained 26 June 2012 from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8
[33] See American Diabetes Association, http://care.diabetesjournals.org/content/31/3/596.abstract

Healthy People 2020 Objective			
D–1: Reduce the annual number of new cases of diagnosed diabetes in the population			
Salt Lake County Rate/1000 2009-2011	Utah Rate/1000 2009-2011	U.S. Rate/1000 2007	*Healthy People 2020* Target
7.7* [34]	7.5*	8.0**	7.2**

***Prevalence **Incidence

Figure 10. Percentage of Utah Adults with Diabetes, by Small Areas, 2006-2008



Note: Small Area data reflects 2008 data while the Utah and LHD rates reflect the 2011 data. Utah and Salt Lake County rates increased from 6.8 and 7.2 to 7.5 and 7.7 respectively between 2010 and 2011. It is expected that most small areas will also see an increase in incidence.

Although Salt Lake County does not meet the *HP2020* target as a whole, 11 of 25 Small Areas meet or surpass the target.

While the diabetes death rate is not generally considered a factor modifiable by public health, it is one measure for which data is collected by the state. At 23.87 deaths/100,000, Salt Lake County easily meets the *HP2020* Objective D-3 for diabetes deaths (65.8/100,000) by a significant amount. Reducing the death rate will take a collaborative effort of public health, ambulatory care, and acute care agencies; public health to prevent or delay occurrence; outpatient care to manage diabetes and prevent occurrences of hypo or hyperglycemia requiring ED visits/or hospitalizations; and acute care to prevent and treat complications of diabetes.

[34] Although the rates presented by the IBIS-PH data are diabetes prevalence rather than incidence, it is the only data available for comparison. Salt Lake County's prevalence rate of 7.2% is above the Utah rate, but the same as the *HP2020* target

OBESITY AND OVERWEIGHT

Obesity is now considered a national epidemic. Obesity is recognized when a person has a Body Mass Index (BMI) of ≥30, and a BMI of ≥25 but <30 is recognized as overweight. The 2010 BRFSS data indicates that 23.8% of adults in Salt Lake County are obese compared with 23% for the state. Nationally approximately 17% of children and adolescents aged 2-19 years are obese (CDC). If overweight and obesity categories are combined, 6 out of 10 (59.7%) adults are affected.

The percentage of obese adults in Utah has more than doubled (a 128% increase) since 1989. In a 2008 survey, significantly more men (67.5%) were overweight or obese in Utah than women (52.4%).[35] About 40% of Magna's residents are classified as obese, while only about 12% of the Avenue's residents are obese.

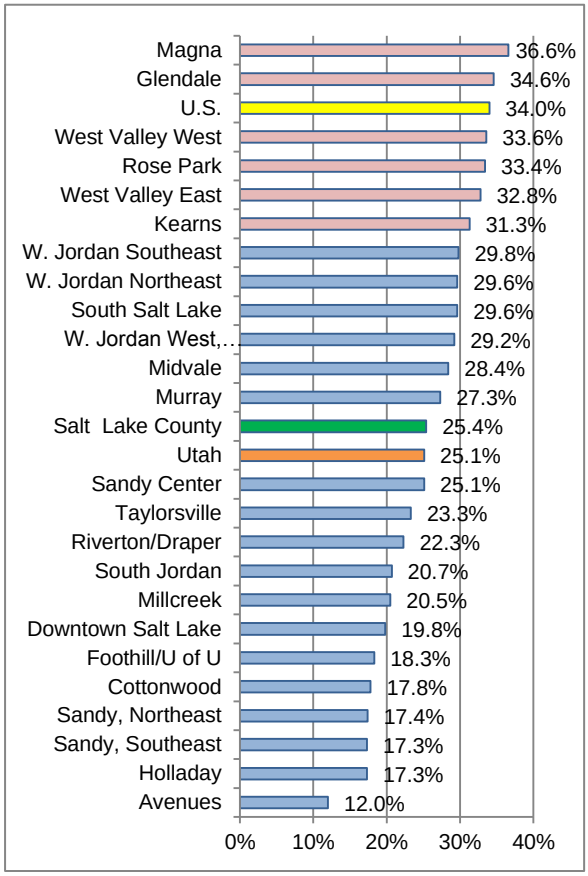


Figure 11. Distribution of Obesity in Ages 18+, by Small Area, 2009-2011

Obesity can be a precipitating factor or the direct cause of many individual health problems. It is a factor in diabetes, heart disease, and orthopedic injuries. It affects breathing, the physical ability to exercise, and endurance as well as making existing health problems such as arthritis more severe.

***Healthy People 2020* Objective**				
NWS–9: Reduce the percentage of adults who are obese to 30.6%.				
Salt Lake County 2011	Peer County Range 2009	Utah 2011	U.S. 2007	*Healthy People 2020* Target
25.4	23-26	25.1	34	30.6

***Healthy People 2020* Objective**				
NWS–8: Increase the proportion of adults who are at a healthy weight				
Salt Lake County 2011	Peer County Range	Utah 2010	U.S. 2007	Healthy People 2020 Target
39.4	NA	38.9	30.8	33.9

Both Salt Lake County and the state have met the *HP2020* Target for obesity. Both the county and state are doing better than the U.S. However, there are six Small Areas in SLCo that do not meet the target. *HP2020* has an objective for healthy weight, but Utah IBIS-PH collects data for overweight and obesity instead.

While a part of the overweight and obesity issue is personal choice for foods that may be high in calories and low in important nutrients, another factor is food availability and affordability

[35] Behavioral Risk Factor Surveillance Survey (2008). http://health.utah.gov/obesity/pages/Obesity/The_Facts.php

causing people to opt for lower quality of foods in a limited framework of choices (see Food Desert discussion).

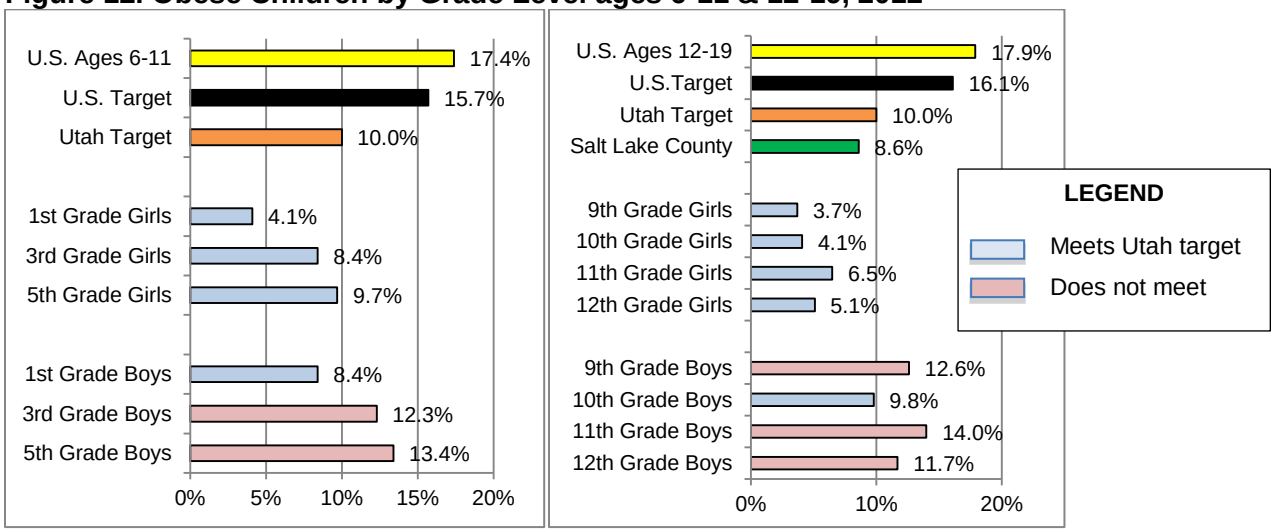
***Healthy People 2020* Objective**				
NWS–10: Reduce the percentage of children and adolescents who are considered obese				
	Salt Lake County 2011	Utah 2011	U.S. 2005-2008	*Healthy People 2020* Target
Ages 6-11	No data*	9.7	17.4	15.7
Ages 12-19	8.6	8.4	17.9	16.1

*County-level data is not reported for this age group

Appropriate nutrition and exercise in childhood set the stage for a healthy adulthood. Children and adolescents who eat a nutritious diet are more likely to reach and maintain a healthy weight, achieve normal growth and development, show improved muscle development and bone health, and have strong immune systems.

The number of overweight or obese children and adolescents is increasing and as a consequence, risk factors such as high blood pressure and high cholesterol, once considered to be adult diseases, are now being diagnosed in children and adolescents. The number of children with positive screening for Acanthosis Nigricans, an early indicator of Type 2 diabetes, continues to increase.[36] These risk factors can lead to diabetes, cardiovascular diseases, and stroke.[37] The social and psychological impacts of childhood obesity include social isolation, increased rate of suicidal thoughts, low self-esteem, increase rate of anxiety disorders and depression, and increased likelihood of being bullied.[38]

Figure 12. Obese Children by Grade Level ages 6-11 & 12-19, 2012



[36] Acanthosis Nigricans screening has been legislated as part of routine childhood screening program in public schools. The Texas Risk Assessment for Type 2 Diabetes in Children is a legislatively mandated program developed, coordinated, and administrated by The University of Texas Pan-American Border Health Office (BHO). During vision/hearing and scoliosis screenings of 1st, 3rd, 5th, and 7th graders in public and private schools, certified individuals assess children for the acanthosis nigricans marker, a skin condition that signals high insulin levels. Children who are positively identified with the marker undergo additional assessments of body mass index (BMI), BMI percentile, and blood pressure. Referrals are issued to the parents of these children, alerting each parent of their child's risk factors and encouraging further evaluation from a health professional. Additional information on Acanthosis Nigricans can be found at: https://rfes.utpa.edu/ and http://www.cdc.gov/diabetes/news/docs/an.htm.

[37] HP2020. Nutrition, Physical Activity, and Obesity. Found at: http://www.healthypeople.gov/2020/LHI/nutrition.aspx?lhiItem=144171&tab=overview

[38] IBIS-PH-P. Diabetes Prevalence among Utah Youth. Obtained 19 Jun 2012 from: http://IBIS-PH.health.utah.gov/indicator/view/DiabYou.None.html

Utah school-aged children fall well below the *HP2020* Target rate of 15.7% for 6-11 year olds and 16.1% for 12-19 year olds. Therefore, Utah has set lower targets than established by *HP2020* for weight (orange lines). Boys in Utah have a greater problem with obesity than girls. No data from SLCo is available for 6 to 11 year olds. For adolescents, SLCo falls well below the target set by UDOH.

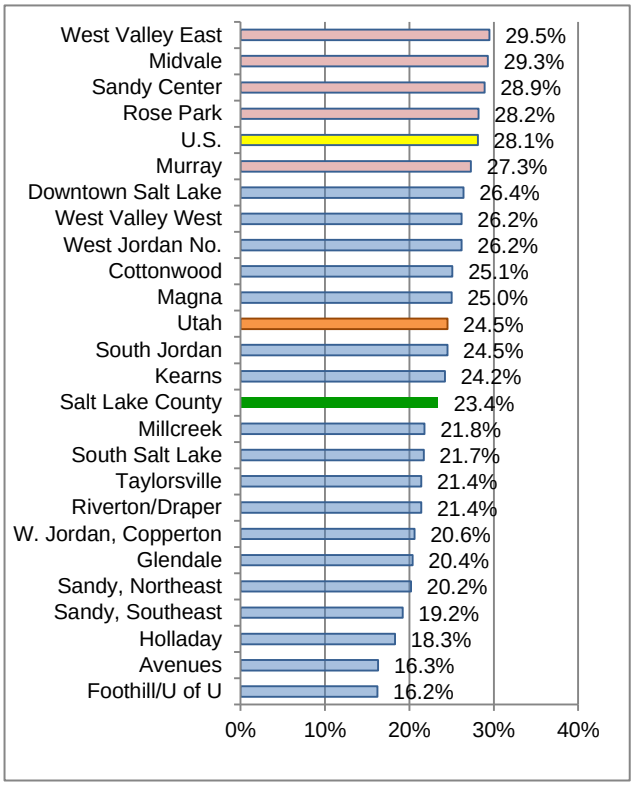
HYPERTENSION

High blood pressure (hypertension) is an important risk factor for heart disease and stroke. Although hypertension does have a genetic component which can predispose a person for hypertension, the chance of it actually occurring is impacted significantly by individual behavior and stress.

***Healthy People 2020* Objective**			
HDS–5.1: Reduce the proportion (percentage) of adults with hypertension			
Salt Lake County 2010	Utah 2010	U.S. 2005-08	*Healthy People 2020* Target
25	26.8	29.9	26.9

Hypertension is preventable given a healthy lifestyle. In most cases, it can be treated with medication and lifestyle changes, such as diet, exercise, and tobacco cessation.

Figure 13. Percent of Provider Diagnosed Hypertension, by Small Area, 2009



Compared to state and national rates, Salt Lake County has a lower rate of hypertension overall. However, there are 5 Small Areas of the valley that exceed the Healthy People goal of 26.9%.

Hypertension in children and adolescents is a growing concern. IBIS-PH does not provide hypertension data for children or adolescents.

CANCER

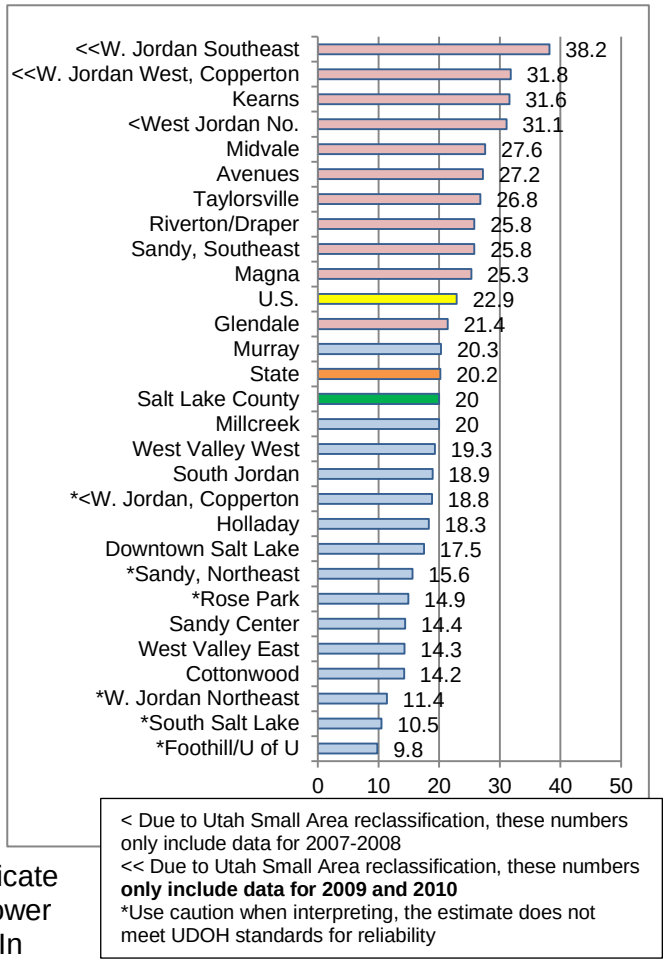
BREAST CANCER

Breast cancer is one of the most commonly occurring cancers in U.S. women and the leading cause of female cancer death in Utah.

***Healthy People 2020* Objective**				
C–3: Reduce female breast cancer death rate per 100,000				
Salt Lake County 2008-2010	Peer County Range 2009	Utah 2008-2010	U.S. 2007	*Healthy People 2020* Target
20	20.9 – 27.7	20.2	22.9	20.6

It is not known exactly what causes breast cancer, but certain risk factors are linked to the disease. Some of these risk factors include age, socio-economic status, exposure to ionizing radiation, family history, alcohol, and hormonal influence.

Figure 14. Breast Cancer Death Rates per 100,000 Women by Small Areas 2008-2010

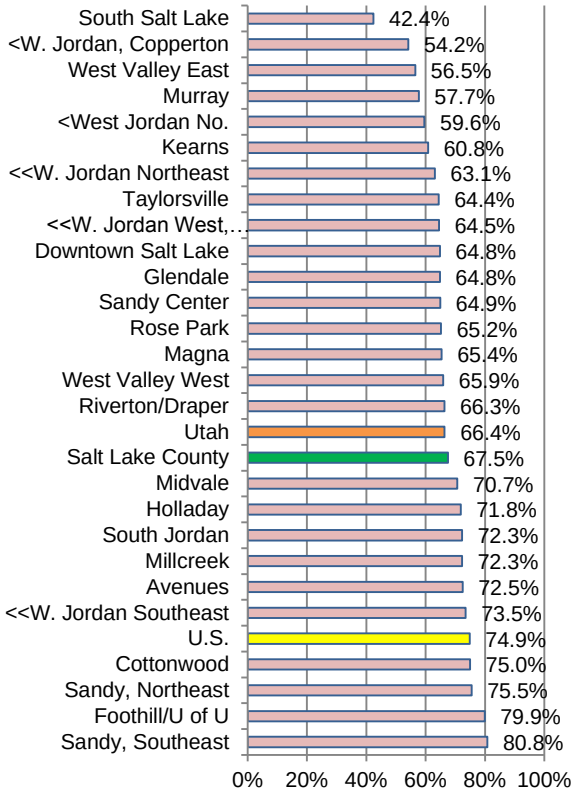


Compared to the state and national rates, the Salt Lake County breast cancer death rate is slightly lower than the state rate and lower than the national. The SLCo rate meets the *HP2020* target. However, when Small Area data for breast cancer deaths are reviewed, eleven Small Areas within the County exceed the *HP2020* Target. Fourteen met or exceeded the *HP2020* target.

For breast cancer incidence, the Salt Lake County rate (109.2/100,000) is higher than the state rate (103.8/100,000) but lower than the national rate (125/100,000). 2010 data indicate that only 4 local health districts in Utah have lower incidence of breast cancer than the SLCoHD. In addition SLCo has a lower rate than our peer counties. Incidence has not been analyzed according to Small Area data and there is no *HP2020* objective for incidence.

Screening Programs for Breast Cancer

***Healthy People 2020* Objective**			
C–17: Increase the proportion (percentage) of women who receive a breast cancer screening based on the most recent guidelines			
Salt Lake County 2007-2010	Utah 2007-2010	U.S. 2010	*Healthy People 2020* Target
67.5	66.4	74.9	81.1



< Due to Utah Small Area reclassification, these numbers only include data for 2007-2008
<< Due to Utah Small Area reclassification, these numbers only include data for 2009 and 2010

Figure 15. Percentage of Women over 40 Who Have Received a Mammogram within the Past Two Years, 2007, 2008, & 2010

Mammography is considered the most effective screening tool for early breast cancer detection. Deaths from breast cancer can be substantially reduced if the cancer is discovered at an early stage. Clinical trials have demonstrated that routine screening with mammography can reduce breast cancer deaths by 20% to 30% in women aged 50 to 69 years, and by about 17% in women 40-49 years.[39] Women aged 50-74 should be screened for breast cancer by mammography every 2 years. In 2010, 73.7% of women nationally followed this recommendation which is significantly lower than the national target of 81.1% in *HP2020.* Overall 66.4% of women over 40 in Salt Lake County had mammograms.

Neither the State nor SLCo meets the *HP2020* Target of 81.1%. No Small Areas in SLCo meet the target. The Small Areas that surpass the county, state, and national rates are Sandy Southeast, Foothill/U of U, Sandy Northeast, and Cottonwood.

[39] National Cancer Institute. Breast Cancer Screening (PDQ). Obtained 3 July 2010 from: http://www.cancer.gov/cancertopics/pdq/screening/breast/healthprofessional/page4

COLORECTAL CANCER

Healthy People 2020 Objective			
C–5: Reduce invasive colorectal cancer per 100,000			
Salt Lake County 2010	Utah 2009	U.S. 2007	*Healthy People 2020* Target
33.1	35	45.4	38.6

Figure 16. Invasive Colorectal Cancer Rate per 100,000, by LHDs, 2007-2009

No Utah Small Area data are available from IBIS-PH on colorectal cancer. The *HP2020* target for incidence of colorectal cancer is 38.6 persons per 100,000. Both Salt Lake County and the state of Utah are better than the target with 33.1 and 35 per 100,000 persons respectively. Salt Lake County has the fifth lowest incidence rate of colorectal cancer among the twelve public health districts

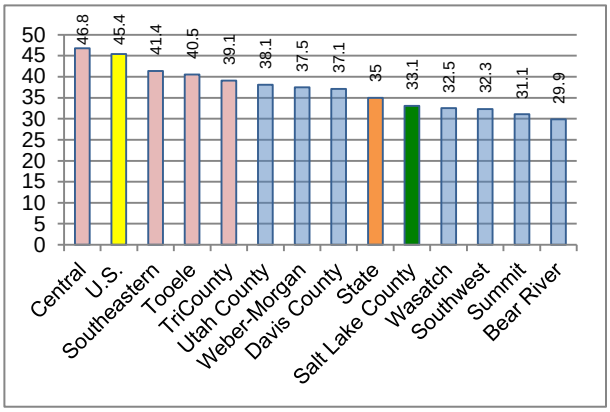
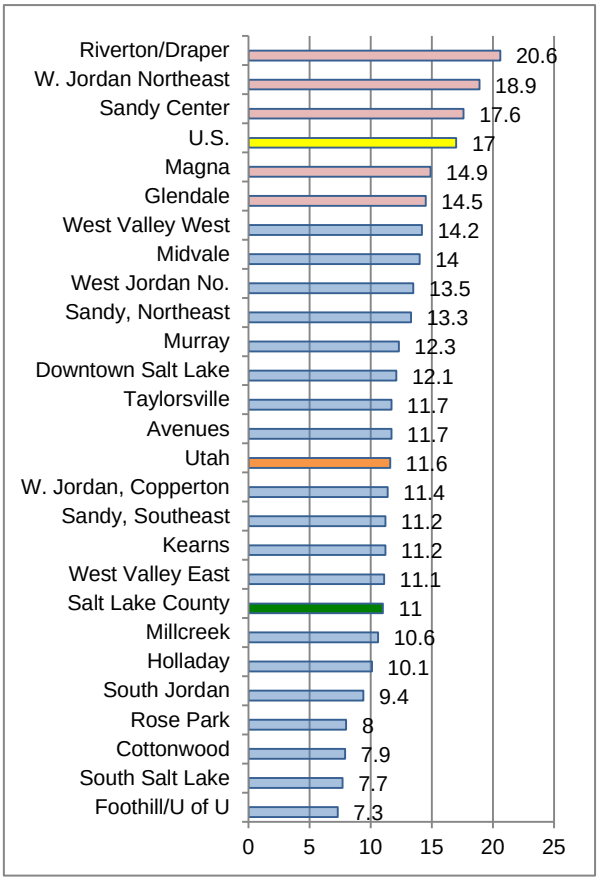


Figure 17. Colorectal Cancer Death Rates per 100,000, by Small Area, 2007-2009



Not counting skin cancers, colorectal cancer is the third most common cancer when males and females are considered together.[40] Each year more than 140,000 Americans are diagnosed with colorectal cancer (often referred to simply as "colon" cancer). In the U.S., over 50,000 people die from it annually.

Colorectal morbidity and mortality are higher among ethnic/racial minorities. This has been attributed to barriers such as lower screening rates, less use of diagnostic testing, decreased access to healthcare, cultural beliefs, and lack of education regarding healthcare practices and preventable disease.

Although Salt Lake County is well below the *HP2020* target of 14.5 deaths per 100,000 population, there are 5 Small Areas in Utah that are above the target.

[40] IBIS-PH. Obtained 5 July 2912 from: http://IBIS-PH.health.utah.gov/indicator/view/ColCAInc.LHD.html

Healthy People 2020 Objective			
C–9: Reduce the colorectal cancer death rate per 100,000			
Salt Lake County 2010	Utah 2009	U.S. 2007	*Healthy People 2020* Target
11	11.6	17	14.5

Screening Programs for Colorectal Cancer

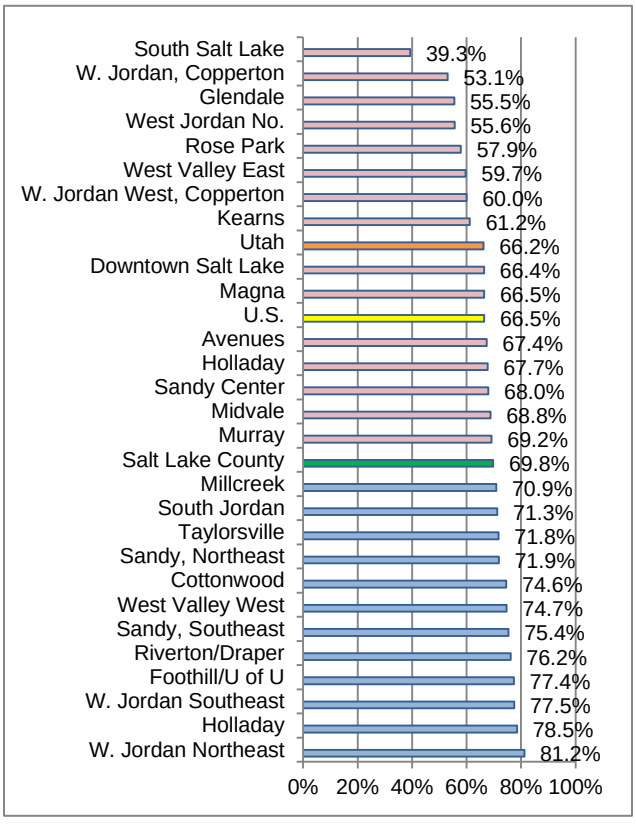
Healthy People 2020 Objective			
C–4: Reduce the death rate per 100,000 from cancer of the uterine cervix			
Salt Lake County 2010	Utah 2007-2009	U.S. 2007	*Healthy People 2020* Target
1.2	1	2.4	2.2

Colorectal cancer is largely preventable with regular screening and is treatable with early detection. When colorectal cancer is diagnosed early, 90% of the patients survive at least 5 years.[41]

Healthy People 2020 Objective			
C–16: Increase the proportion (percentage) of adults who receive a colorectal cancer screening based on the most recent guidelines			
Salt Lake County 2006, 2008, 2010	Utah 2010	U.S. 2010	*Healthy People 2020* Target
69.8*	66.2*	66.5*	70.5

*Percentage from BRFSS Developmental Database

Figure 18. Percentage of Utah Adults Age 50+ Who Reported Having a Sigmoidoscopy or Colonoscopy in the Past 10 Years (2006-2010)



Early detection is possible using fecal occult blood tests annually and a colonoscopy or sigmoidoscopy on a recommended schedule beginning usually at age 50 (or earlier depending on family history and previous findings).

Nationally, 66.5% of persons report being up-to-date on screenings which is lower than the *HP2020* Target of 70.5%. Utah falls below the nation at 66.2%. The residents Salt Lake County do better than Utah, but are still lagging behind the *HP2020* target. However, 12 Small Areas of the county have reached the *HP2020* Target of 70.5%

[41] IBIS-PH. Obtained 5 July 2012 from: http://IBIS-PH.health.utah.gov/indicator/view/ColCADth.Ut_US.html

CERVICAL CANCER

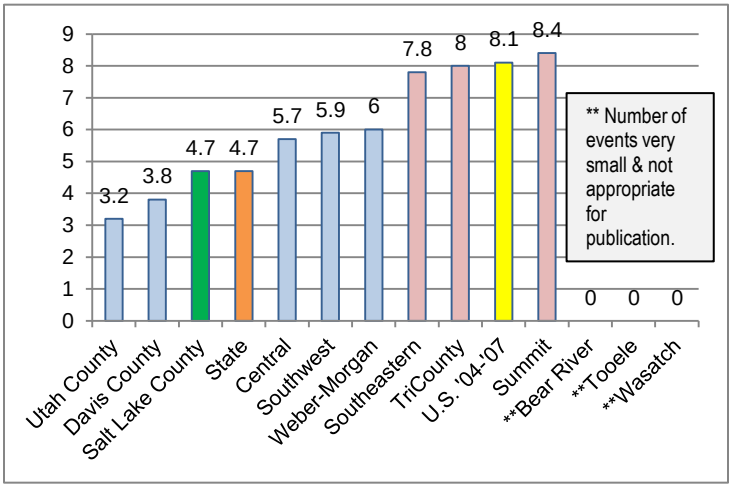
Cervical cancer is one of the most curable cancers if detected early. Almost all cases are caused by infection with the high-risk types of the human papilloma virus (HPV). Other risk factors include smoking, chlamydia infection, many sexual partners, oral contraceptives, young age at first term pregnancy and multiple full term pregnancies. There will be an estimated 12,000 new cases of cervical cancer and 4200 deaths in the U.S. from cervical cancer.

The human papillomavirus (HPV) is the most common sexually transmitted infection in the United States, with approximately 6.2 million cases diagnosed annually.[42] There are more than 100 strains of HPV, over 40 of which can cause cervical cancer and/or genital warts.[43]

The incidence and death rates vary significantly for various ethnic groups. As the demographics of the county change to include more ethnic diversity, Utah's rates may change.

***Healthy People 2020* Objective**			
C–10: Reduce the incidence of uterine cervical cancer per 100,000			
Salt Lake County 2007-2009	Utah 2007-2009	U.S. 2007	Healthy People 2020 Target
4.7	4.7	7.9	7.1

Figure 19. Cervical Cancer Incidence per 100,000, by LHD, 2007-2010



Most cervical cancer can be prevented by HPV vaccination. The federal Advisory Committee on Immunization Practices (ACIP) now recommends routine vaccination against HPV for girls and boys ages 11 and 12.

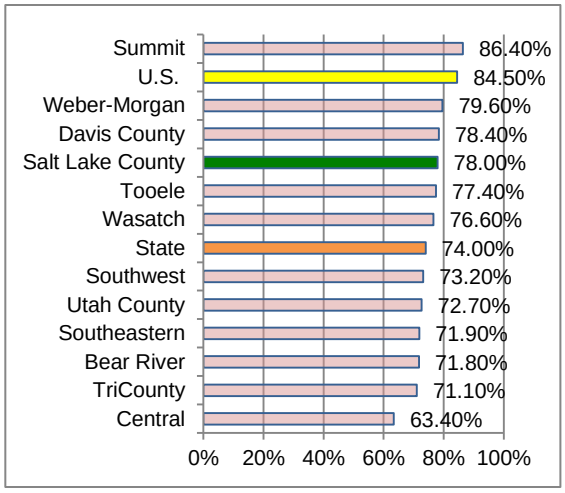
All but three local health districts for which there are adequate data meet the *HP2020* target for incidence rate. No Small Area data are available.

Screening Programs for Cervical Cancer

***Healthy People 2020* Objective**			
C–15: Increase the proportion (percentage) of women who receive a cervical cancer screening based on the most recent guidelines			
Salt Lake County 2010	Utah 2010	U.S. 2008	*Healthy People 2020* Target
78	74	84.5	93

[42] Centers for Disease Control and Prevention. (2011). HPV Vaccine Monitoring.
[43] Ibid

Figure 20. Percent of Women in Utah who have had a Pap Smear within the Last 3 Years, by LHD, 2010



The recommendation is for women aged 21-65 with a cervix to be screened by Pap test every 3 years. In the U.S., 84.5% of women reported having a Pap test within the last 3 years.

As Figure 20 shows, 78% of women in Salt Lake County and 74% of women in Utah report being tested during the last three years. These rates are significantly lower than the *HP2020* target of 93%.

At 83.3% blacks have the highest rate for screening in Utah; at 60.3% American Indians/Alaskan Native have the lowest rate of screening. Women without a usual source of healthcare or who were uninsured were less likely to have had a Pap test every 3 years.

Salt Lake County is third of 12 LHDs in the percentage of women who have received a Pap smear according to current recommendations (see Figure 20), third lowest in incidence of cervical cancer, and tied for second lowest in cervical cancer deaths. Small Area Data are not available.

LOW, VERY LOW, AND EXTREMELY LOW BIRTH WEIGHT INFANTS

Low birth weight is categorized into three levels:

- Low (<2500 grams or 5.5 pounds)
- Very low (<1500 grams or 3.3 pounds)
- Extremely low (>1000 grams or 2.2 pounds)

As birth weight decreases, the chance for increased morbidity and mortality increases. Infants who survive low birth weight often have chronic conditions and may suffer some loss of physical or intellectual ability. 2010 hospital discharge data indicates that the cost for a low birth weight baby was $44,472 compared with a normal delivery of $2,218. The costs for extremely low birth weight deliveries can be much more.

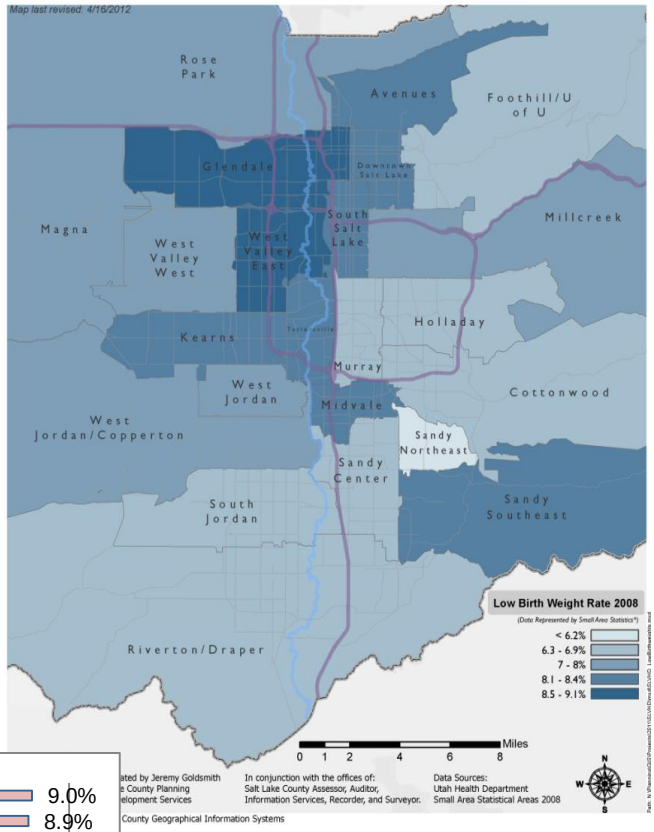
***Healthy People 2020* Objective**				
MICH–8.1: Reduce percentage of low birth weight (LBW) births				
Salt Lake County 2009	Peer County Range 2009	Utah 2009	U.S. 2007	*Healthy People 2020* Target
7.4	6.7-8.4	7.1	8.2	7.8

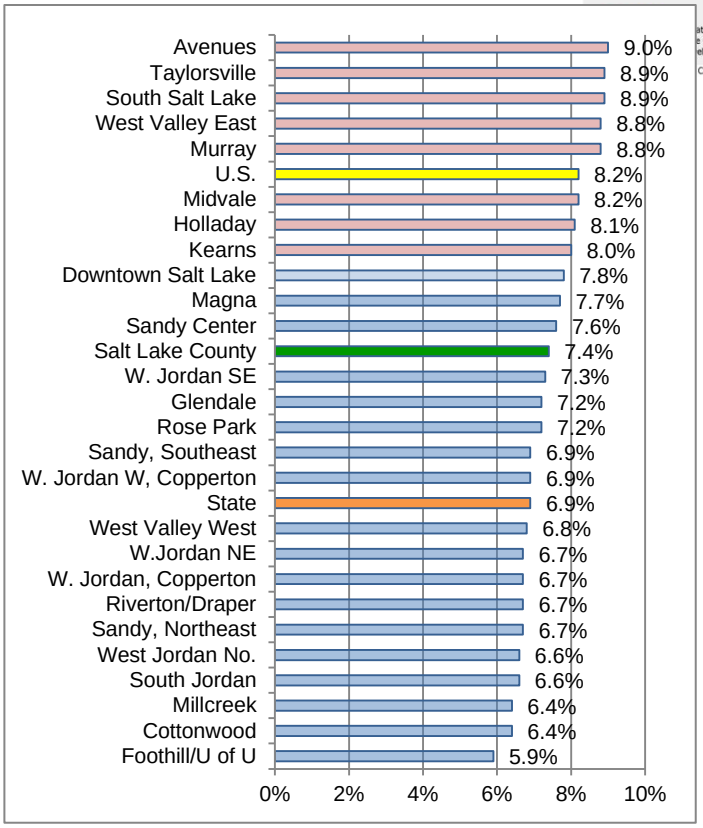
Healthy People 2020			
MICH–8.2: Reduce the incidence (percentage) of very low birth weight (LBW) births			
Salt Lake County 2009	Utah 2009	U.S. 2007	*Healthy People 2020* Target
0.8	0.84	1.5	1.4

Women at higher risk for LBW infants include those who are younger than 25 or older than 38; have chronic health problems; smoke or use substances; have infections; have inadequate maternal weight gain; and have certain socio-economic factors such as being Black, Hispanic, Asian, or Pacific Islander, low income, of low educational attainment, and unmarried.[44]

Map 9. Percent of Low Birth Weight Infants in Salt Lake County, by Small Areas

Salt Lake County's rate for low birth weight babies is a little higher than the rate for Utah as a whole. However, it compares favorably with the range for Peer Counties, U.S. as a whole, and exceeds the *HP2020* Target.





The incidence of low, very low, and extremely low birth weight births has been increasing recently due primarily to the increase in prematurely born multiple gestations – in part due to reproductive technology.[45]

Figure 21. Percent of Low Birth Weight, by Small Areas, 2008-2010

Small-for-Gestational Age may be due to genetics, growth problems that occur during pregnancy, or intrauterine growth restriction (IUGR). IUGR may be caused by lack of nutrients or oxygen required for proper growth and development, placental insufficiency, or chromosomal defects[46].

Although Salt Lake County as a whole exceeds the *HP2020* Objective for low birth weight infants, there are nine Small

[44] March of dimes. Working together for stronger, healthier babies. Obtained 5 July 2012 from: http://www.marchofdimes.com/professionals/medicalresources_lowbirthweight.html
[45] University of San Francisco Medical Center. Very low and extremely low birth weight infants. Obtained 4 July 2012 from: http://www.ucsfbenioffchildrens.org/pdf/manuals/20_VLBW_ELBW.pdf
[46] Lucile Packard Children's Hospital at Stanford. Small for Gestational Age. Obtained 17 Aug 2012 from http://www.lpch.org/diseasehealthinfo/healthlibrary/hrnewborn/sga.html

Areas of the county that are below the Peer County Median and do not meet the *HP2020* target. Low, very low, and extremely low birth weight in the case of a single gestation baby can also be an indicator of the quality and availability of prenatal health care. Many of the causes can be identified if prenatal care is begun early. Cases caused by poor lifestyle decisions can be averted through counseling and education.

Both Salt Lake and the State as a whole met the *HP 2020* target for very low birth weight births in 2006. Only one county, Daggett, did not meet the *HP2020* target. Salt Lake County fell about in the middle with 15 counties having fewer very low birth weight births and 13 having more than Salt Lake County. Because data is available only at the county level, Small Areas of the county which may have scored above the target cannot be identified.

PRENATAL CARE IN THE FIRST TRIMESTER

Women who receive early and consistent prenatal care enhance their likelihood of giving birth to a healthy child of normal birth weight. Health care providers recommend that women begin prenatal care in the first trimester of their pregnancy.

***Healthy People 2020* Objective**				
MCH–10.1: Percentage of women who received prenatal care in the first trimester[47]				
Salt Lake County 2009	Peer County Range 2009	Utah 2009	U.S. 2007	*Healthy People 2020* Target
70.1	81.4-91.5	72.6	70.8	77.9

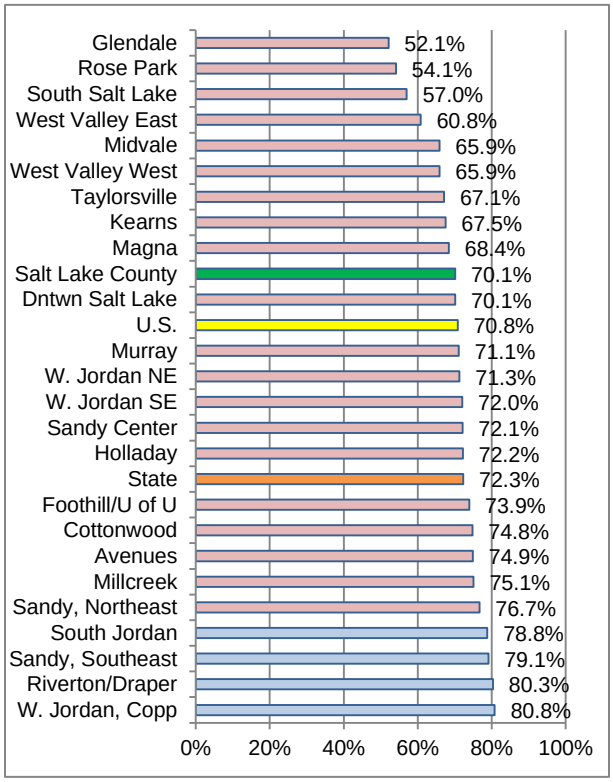


Figure 22. Percent of Women Receiving Prenatal Care in the First Trimester, by Small Area, 2009

Mothers who obtain adequate prenatal care appear to establish positive care-seeking behavior that makes them more likely to obtain preventive care for their infants.[48] SLCo does not compare favorably with Peer Counties on percentage of women who receive prenatal care in the first trimester. SLCo falls below the state by 2.5 percentage points, the *HP2020* target by 7.8 percentage points and the U.S average by 0.7 percentage points.

The Small Area data demonstrate where there are challenges. The Area with the highest percent of pregnancy care starting in the first trimester is West Jordan West/Copperton. All but four Small Areas of Salt Lake County fall below the *HP2020* target.

[47] Include 37 states, New York City and DC
[48] The Commonwealth Fund. Prenatal Care in the First Trimester. Obtained 28 June 2012 from: http://www.commonwealthfund.org/Performance-Snapshots/Preventive-Health-and-Dental-Care-Visits/Prenatal-Care-in-the-First-Trimester.aspx

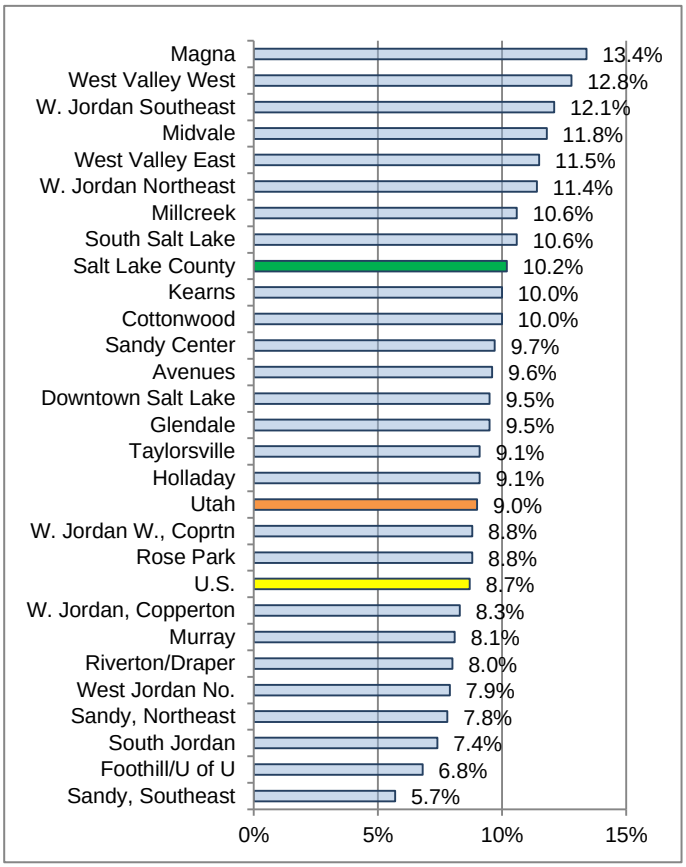
RESPIRATORY DISEASE

Asthma and Chronic Obstructive Pulmonary Disease are serious personal and public health issues that have medical, economic, and psychosocial implications. The burden of asthma can be seen in the number of asthma related medical events, including emergency department (ED) visits, hospitalizations, and deaths.

ASTHMA

There are no *HP2020* objectives for asthma incidence or prevalence for children or adults. The number of deaths is tracked for adults 35 years and older. *HP2020* objectives focus on reduction of hospital ED visits and hospitalizations. IBIS-PH data are provided for asthma prevalence at the LHD level for children and for adults at the Small Area Level. IBIS-PH reports hospital ED visits but not hospitalizations.

Figure 23. Current doctor diagnosed asthma in adults by Utah Small Areas, 2006-2010



Currently more than 23 million people have asthma in the U.S.[49] The prevalence of asthma has increased since 1980, but deaths have decreased since the mid-1990s.[50] Adult asthma rates show no sign of declining in Utah or in the U.S.

Risk factors for asthma include having a parent with asthma, sensitization to irritants and allergens, respiratory infections in childhood, and being overweight. Asthma is believed to be closely linked to air pollution especially ozone and particulate matter (PM). Additional triggers are smoke, tobacco smoke, dust mites, cockroach allergen, mold, pets, and strenuous physical exercise.

Adult asthma prevalence is higher for women than men at every age group. Figure 31 shows that in 2010 Utah had a slightly higher prevalence of adult asthma than the U.S. as a whole. SLCo had a significantly higher prevalence than Utah. Eight Small Areas have a higher rate than the County.

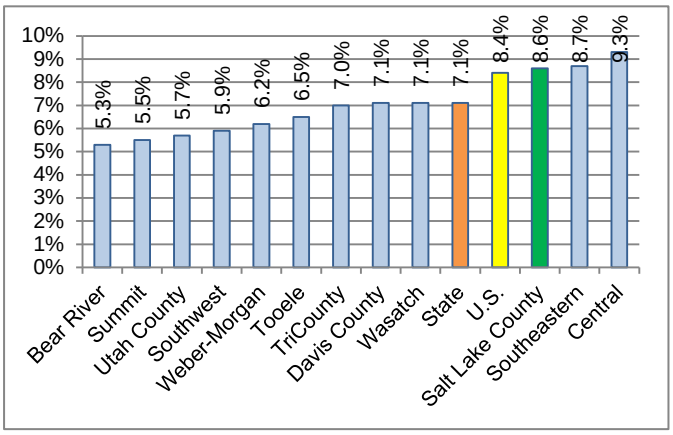
[49] Pleis JR, Lucas JW, Ward BW. Summary health statistics for US adults: National Health Interview Survey, 2008. National Center for Health Statistics. Vital Health Stat. 2009;10(242):1-157

[50] Healthy People.gov. *Healthy People 2020* Objectives - Respiratory Diseases. Obtained from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=36

Figure 24. Asthma Prevalence in Children by Health District, 2007-2010

Asthma prevalence in children is only available on IBIS-PH by LHD. There are only two LHDs with higher rates in children than Salt Lake County.

One asthma *HP2020* objective that may respond to public health intervention relates to reduction in hospital emergency department visits. The only Small Area data available are ED visits for 5-64 year olds. Data for 0-4 and 65+ age groups are available at the state and national levels only.



***Healthy People 2020* Objective**			
RD–2.3: Reduce hospital emergency department visit rate per 100,000 for asthma			
Salt Lake County 2006-2010	Utah 2006-2010	U.S. 2007	*Healthy People 2020* Target
30.2	24.4	56.4	49.1

Figure 25. Emergency Department visits for Asthma, Age Adjusted, Adults 18-64 years (UT 2010 data; U.S. 2007)

Utah as a whole ranks better than the U.S. and is well below the *HP2020* target for the 0-4 and 5-64 year age groups. However, Utah does not meet the *HP2020* standard for the 65 and older age group.

Although Salt Lake County is well under the *HP2020* target, two Small Areas are above it: Glendale and South Salt Lake.

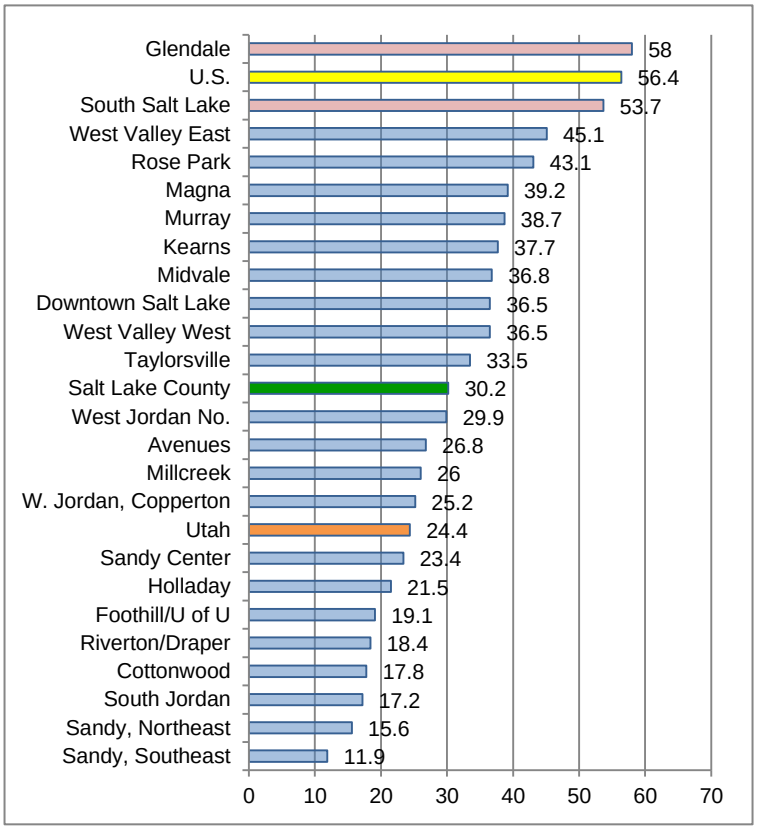
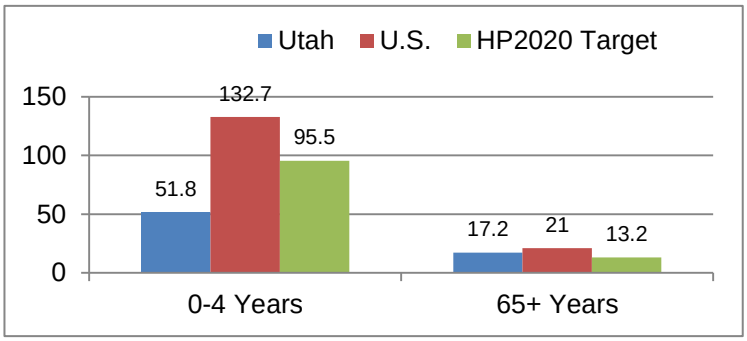


Figure 26. Emergency Department visits for Asthma by Age Group and *HP2020 Target* (UT 2010 data; U.S. 2007)



Data are not available at the Small Area level or county level for age groups 0-4 and 65+. Only state level data are available. Utah compares well with the U.S. with regard to 0-4 year old ED visits and is well under the *HP2020* target. While Utah has fewer ED visits than the U.S. for the 65+ group, it does not meet the *HP2020* target.

***Healthy People 2020* Objective**			
RD–2.2: Reduce hospitalization rate per 100,000 for asthma in children and adults ages 5 to 64			
Salt Lake County 2006-2010	Utah 2006-2010	U.S. 2007	*Healthy People 2020* Target
6.6	5.2	11.1	8.6

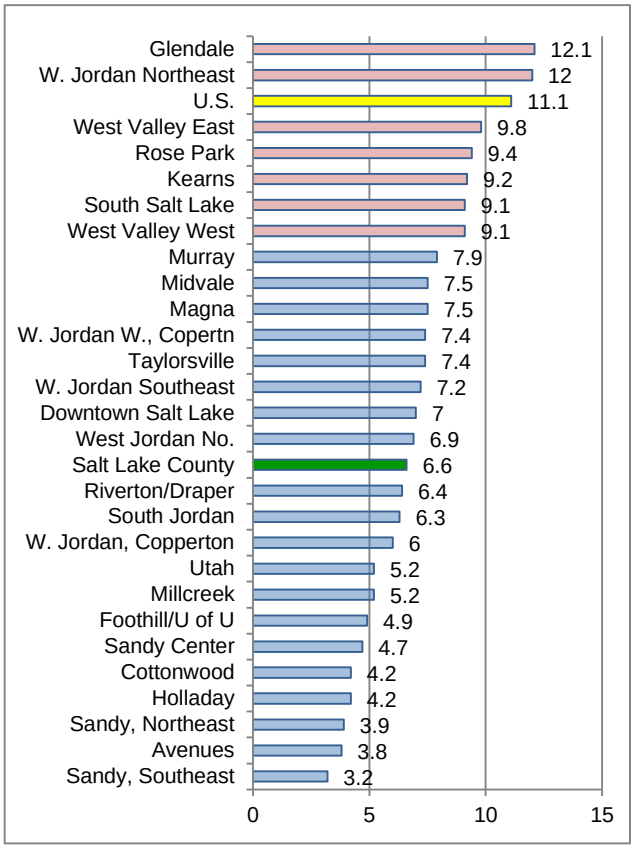


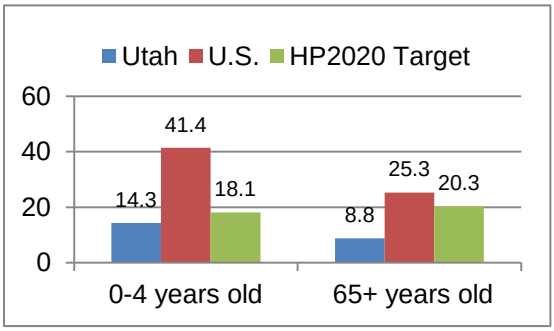
Figure 27. Hospitalizations for Asthma Ages 5-64 Age Adjusted by Small Areas, 2006-2010

Asthma can usually be managed in outpatient care settings. Hospitalizations can be prevented by reducing exposure to pollutants and allergens and following appropriate pharmaceutical routines. The number of hospitalizations in a given area may indicate that there is a problem for those with asthma accessing routine primary care early enough or at all in the community.

No data for 0-4 or 65+ year olds are available at the Small Area of LHD levels. Utah compares favorably for 0-4 year olds and 65+ falling well below the U.S. rates and within the *HP2020* targets for hospitalizations for asthma.

Since young children and elderly are populations at risk for more severe responses to pollution or allergens, Small Area data would be helpful.

Figure 28. Hospitalizations for Asthma by Age Group and *HP2020* target (UT 2010 data; U.S. 2007)



CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease (COPD) describes airflow obstruction that is associated mainly with emphysema and chronic bronchitis. It affects 13-24 million people in the U.S.[51,52]

***Healthy People 2020* Objective**			
RD–12: Reduce hospital emergency department visits for chronic obstructive pulmonary disease per 10,000 adults 45 years and older			
Salt Lake County 2009	Utah 2009	U.S. 2007	*Healthy People 2020* Target
21.78	23.37	79.7	55.2

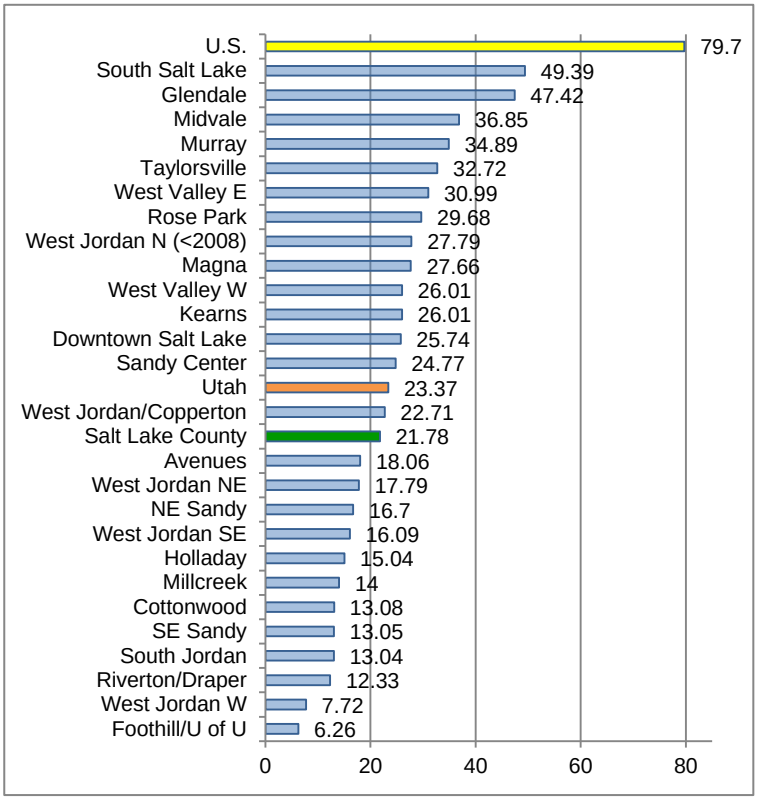


Figure 29. Emergency Department Visits for COPD for Adults 45+, 2008-2010

COPD accounts for 1.5 million emergency visits; 726,000 hospitalizations; and 8 million physician office and hospital outpatient visits. A study of Medicare beneficiary claims data from 2003-2004 showed readmission rates of COPD to be 22.6%, third highest behind heart failure and pneumonia.[53] All of this costs the nation an estimated $42.6 billion in direct and indirect costs.

The 2007 U.S. rate for emergency department visits for COPD was 79.7/10,000 which is significantly higher than the Salt Lake County rate of 21.78 or the state rate of 23.37.

***Healthy People 2020* Objective**			
RD–11: Reduce hospitalizations among adults with chronic obstructive pulmonary disease per 10,000 adults 45 years and older			
Salt Lake County 2010	Utah 2009	U.S. 2007	*Healthy People 2020* Target
18.45	16.25	56	50.1

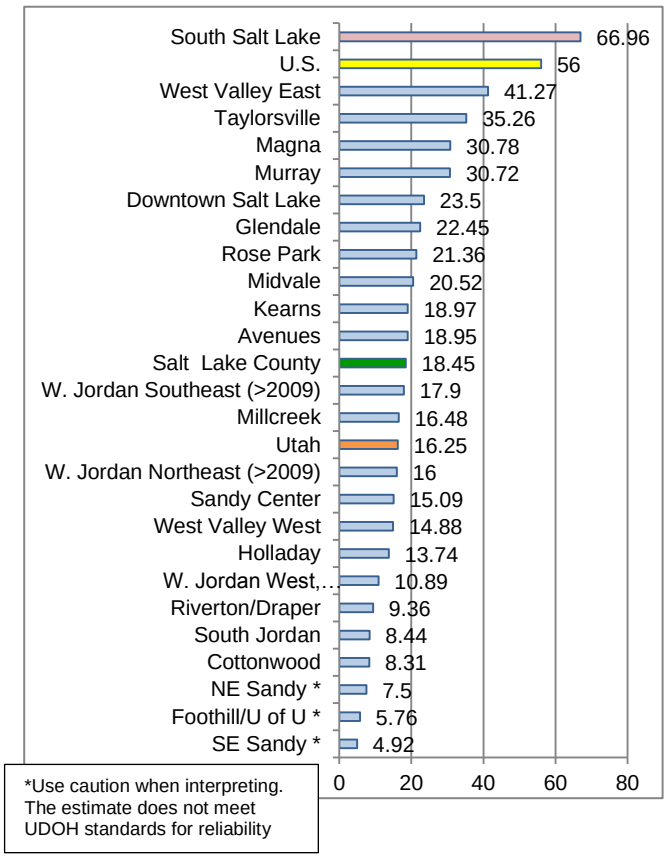
Both Salt Lake County and the State have met the *HP2020* target of 55.2 Emergency Department visits per 10,000 population. No Small Areas are above the target.

[51] Utah Department of Health. ND, COPD. Obtained 2 June 2012 from: http://health.utah.gov/asthma/pdf_files/Respiratory_Packets/COPD.pdf

[52] University of Utah Health Care. ND. Health Information: Chronic Obstructive Pulmonary Disease. Obtained 2 June 2012 from: http://healthcare.utah.edu/healthlibrary/library/diseases/adult/doc.php?type=85&id=P01155

[53] Stone, J, & Hoffman GJ (2010). Medicare hospital readmissions: Issues, policy options and PPACA. *Congressional Research Service.* Obtained 10 July 2012 from: http://www.hospitalmedicine.org/AM/pdf/advocacy/CRS_Readmissions_Report.pdf

Figure 30. Hospitalizations for COPD for Adults 45+, 2008-2010



Salt Lake County and the state both meet the *HP2020* target of 50.1/10,000 rate for hospitalization of adult COPD patients. However, one Small Area of Salt Lake County, South Salt Lake, exceeds the target by almost 17 points.

Given the air quality in the Salt Lake Valley and the aging population, COPD is a cause for concern.

The 2012 General Session of the state of Utah Legislature adopted the "House Concurrent Resolution Regarding, and Prevention of, Chronic Obstructive Pulmonary Disease [sic]" (HCR014) emphasizing the importance of this category of diseases.

INFECTIOUS DISEASES

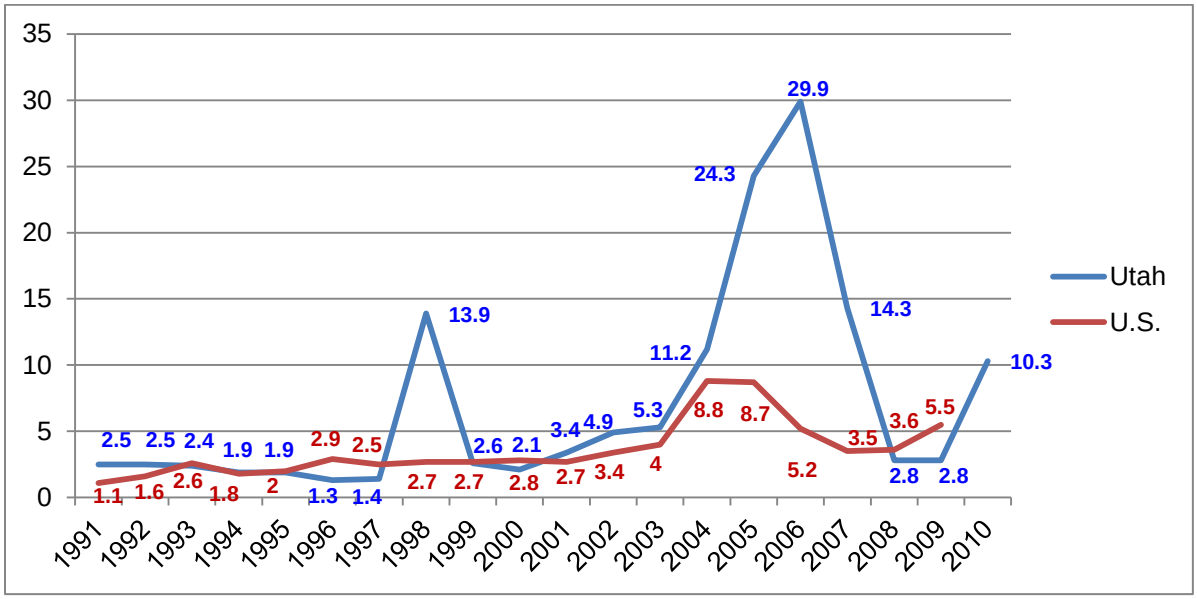
PERTUSSIS

The *Community Health Status Indicator (CHSI) Project* gave Salt Lake County a poor rating on Pertussis. However, the data presented are not reflective of the usual rates for pertussis. The data used to rate the County were taken during outbreak years. Extrapolating from the HP2020 targets, Utah and SLCo's target for Pertussis cases (proportionally) are included in the tables.

Pertussis is a vaccine-preventable disease that has cyclical peaks occurring every three to five years in the United States. Pertussis is usually a mild disease in children over 7 and adults but is often severe among infants and moderately severe among children under 7 years of age who are unimmunized or incompletely immunized. Infants under one year of age are at the highest risk for acquiring pertussis and pertussis-associated complications such as pneumonia and inflammation of the brain.

Most children up to the age of 10 years are protected against pertussis by vaccination during infancy and early childhood. The Diphtheria, Tetanus, and Pertussis (DTP) vaccine, introduced in the 1940s, was the vaccine given to infants and children to age 7. This vaccine was not recommended for people 7 years of age or older due to side effects that increased with age. Therefore, because immunity waned over time, adolescents and adults were left unprotected. In 1991, the DTaP vaccine replaced the DTP vaccine. This vaccine, containing pieces of cells, rather than whole cells was developed to reduce the local, systemic and more severe adverse reactions that could occur with the DTP vaccine. DTaP is not approved for people 7 years of age or older.

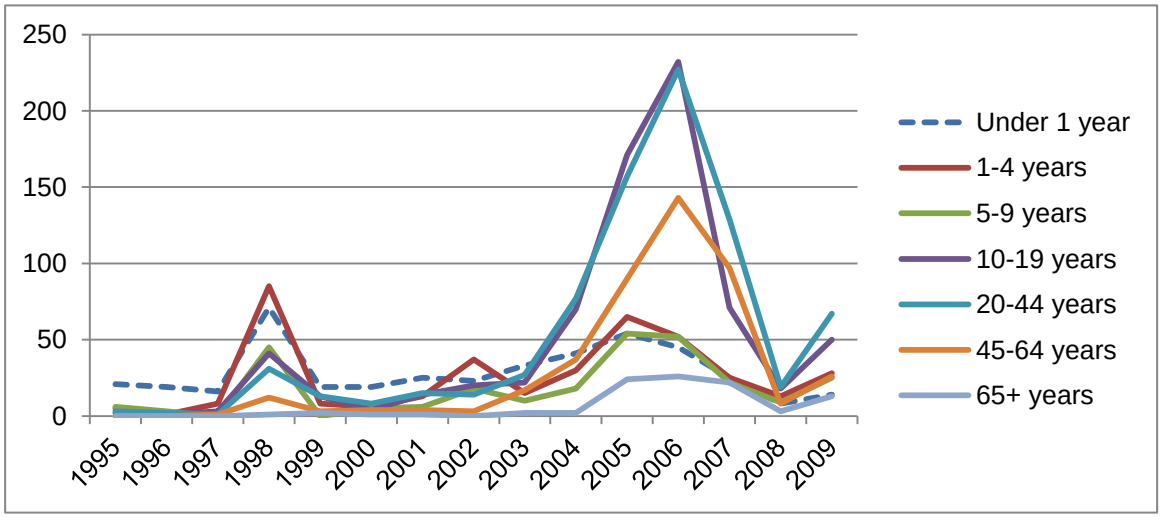
Figure 31. Reported Pertussis Cases per 100,000 persons, Utah and U.S., 1991-2010



Although peaks of infection still occur every 3-5 years, they are not as dramatic. Rates of disease dropped with less than 5000 cases occurring per year. As shown in Figure 25, beginning in 2004, rates nationally and in Utah began to increase. The increase was comprised of adolescents and adults (see Figure 26). By 2006 in Utah, nearly 78% of cases had occurred in these age groups.

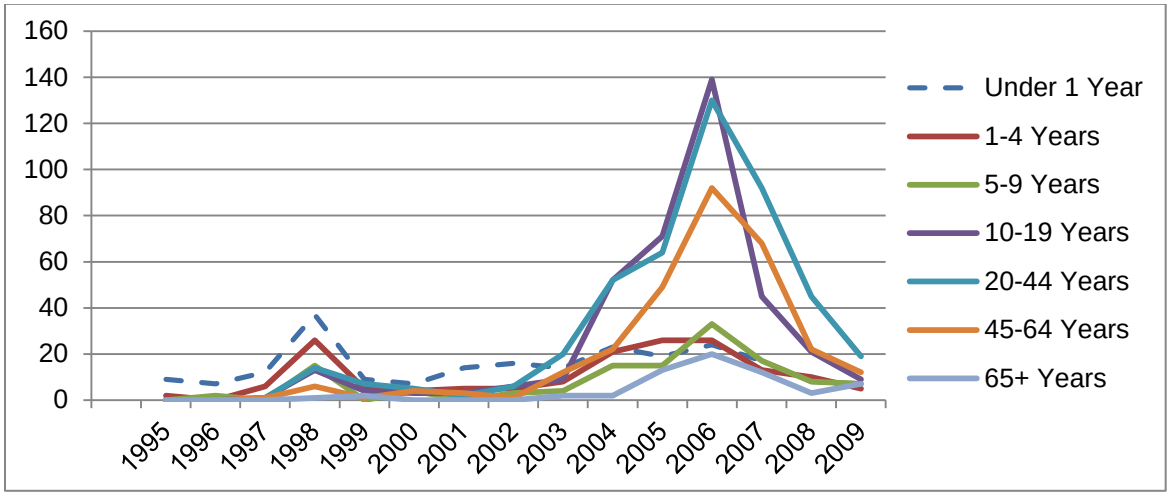
In 2005, TDaP, a new pertussis vaccine licensed for people aged 11-64 years, was approved by the FDA. Widespread use is thought to have contributed to the decrease in pertussis seen in Utah in 2007. However, since 2008 the pertussis rate in Utah has increased. While the majority of cases are in the age 15 and older population (21/100,000), the incidence in infants is highest at 33/100,000.

Figure 32. Number of Reported Pertussis Cases by Age and Year, Utah, 1995-2009[54,55]



[54] Data tables for Figures 26 and 27 can be found in Appendix 6
[55] IBIS-PH. Pertussis Complete Indicator Report. Obtained 25 August 2012 from: http://ibis.health.utah.gov/indicator/view_numbers/PerCas.AgeYr.html

Figure 33. Number of Reported Pertussis Cases by Age and Year, Salt Lake County, 1995-2009[56]



Most pertussis cases are seen in adolescents and adults who generally have milder symptoms than children. It is likely under-diagnosed and under-reported because the symptoms frequently do not include the characteristic whooping cough. Unlike adolescents and adults, infants and young children are more likely to be diagnosed because they tend to show the characteristic symptoms which are usually severe and suffer complications including death, especially those one year of age or less. A major source of disease in young children is older siblings and adults.

As of August 11, 2012, the current rate of pertussis in the U.S. is 7.36/100,000. Of the 21 states with pertussis rates above the national average, Utah, at 22.7/100,000, has the 8th highest rate (see Table 7).

Table 7. States with incidence of pertussis higher than the national incidence rate (7.36/100,000), as of 20 September 2012[57]

Wisconsin	78.6	Utah	29.3	Illinois	11.4
Minnesota*	63.5	New Mexico	22.9	New Hampshire	11.4
Washington	58.1	Alaska	18.9	Arizona	11.2
Montana	43.7	Oregon	18.3	Colorado	11.0
Vermont	42.0	Kansas	14.6	Pennsylvania	11.0
Maine	37.5	New York State	12.4	Idaho	11.0
Iowa	37.0	North Dakota	11.5	Missouri	10.6

*Only a small subset of Minnesota pertussis cases have been reported through NNDSS for 2012. This data was accessed from the Minnesota Department of Health web site.

HP2020 has objectives only for the less than 1 year and 11 to 18 year-old age groups. Both targets are national ones in numbers of cases rather than percentages. The target is not easily translated into a number useful for state and local health departments. Both Utah and SLCoHD have their own targets based on a 10% improvement from a multi-year average.

[56] Data provided by Mary Hill, SLCoHD Epidemiologist; 29 August 2012
[57] CDC Pertussis (Whooping Cough). Pertussis home page. Obtained 28 Aug. 2012 from: http://www.cdc.gov/pertussis/outbreaks.html

Healthy People 2020 Objective			
IID–1.6: Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases: Pertussis (children under age 1)			
Salt Lake County Cases 1999-2010 (yearly avg)	Utah Cases 2000-2005 (yearly avg)	U.S. Cases 2004-2008 (avg)	*Healthy People 2020* Target
14	33	2,777	2,500
SLCoHD Target*	Utah State Target*	*Target based on proportion of HP2020 target by population	
8	23		

Healthy People 2020 Objective			
IID–1.7: Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases: Pertussis (among adolescents aged 11 to 18 years)			
Salt Lake County Cases 1999-2010 (yearly avg)	Utah Cases 2000-2005 (yearly avg)	U.S. Cases 2000-2004 (avg)	*Healthy People 2020* Target
26	108	3,995	2,000
SLCoHD Target*	Utah State Target*	*Target based on proportion of HP2020 target by population	
7	18		

HEPATITIS B

SLCo reported 51 cases of Hepatitis B, 21 more than the number of expected cases. Rarely does Salt Lake County have an acute case of Hepatitis B that is contracted in the county. During the 2007, all of the Hepatitis B cases in Salt Lake County were imported. The majority of Hepatitis B cases reported are foreign born and usually diagnosed through pregnancy (Perinatal Hepatitis B cases). As a refugee county, Salt Lake County does not have control over how many refugees are entering in a given year; therefore the County has no impact on reducing the number of Hepatitis B cases in the County. Very rarely will Salt Lake County have an acute case of Hepatitis B because our vaccination rates are high.[58] The five year average for Hepatitis B (2007-2011) was 13, well within the expected number of cases (30).

TUBERCULOSIS

Healthy People 2020 Objective			
IID–29: Reduce tuberculosis rate per 100,000			
Salt Lake County 2010	Utah 2009	U.S. 2005	*Healthy People 2020* Target
1.7	1.2	4.9	1

Tuberculosis (TB) is spread when a person with active disease expels airborne particles, usually through coughing or sneezing but can also be spread to another person when organisms are put into the air through speaking or singing. People who become infected with TB usually have no symptoms and are not aware they have been infected; their bodies are able to fight the bacteria to keep it from growing. The organism remains inactive, or latent, during this time and infected people cannot spread the disease. Infected individuals may not experience symptoms following exposure for weeks, months, years, or may never.

[58] Personal communication. Email 9 September 2012. Debby Dean, Infectious Disease Bureau Manager

Figure 34. Tuberculosis Rates per 100,000 by Utah Local Health District, 5-year average 2007-2011

The bacteria may become active in the future if the immune system cannot fight them. This happens for various reasons including age or the development of chronic disease. People with HIV are at high risk for developing active TB if infected. TB usually attacks the lungs, but can also attack other parts of the body such as the kidneys, spine, and brain.

Utah's rate of active tuberculosis, while mirroring the epidemiologic curve of the nation, has consistently been 10 to 12 people fewer per year than the nation (per 100,000).

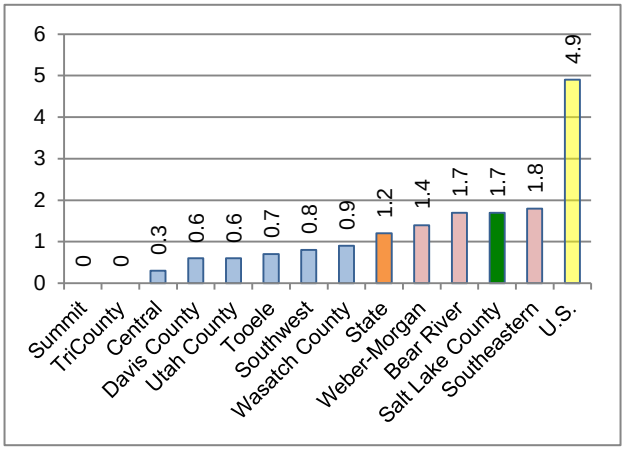
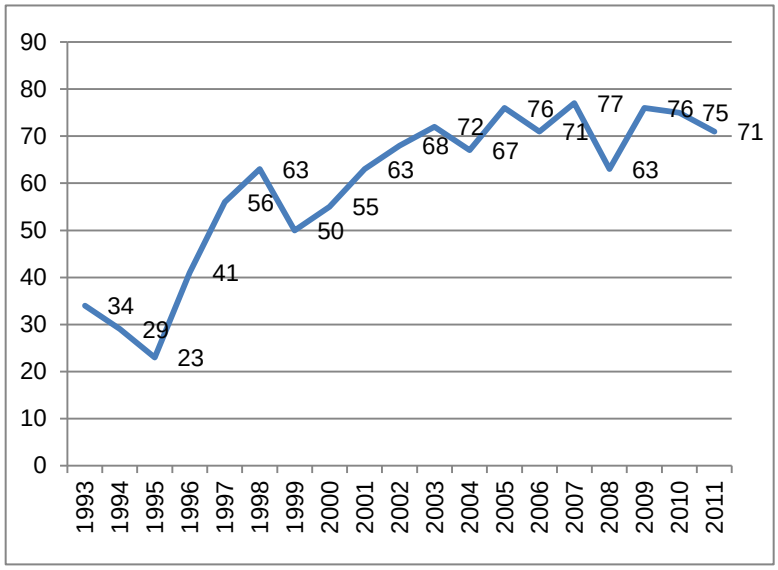


Figure 35. Percentage of TB Cases among Foreign Born Persons, Utah, 1993-2011

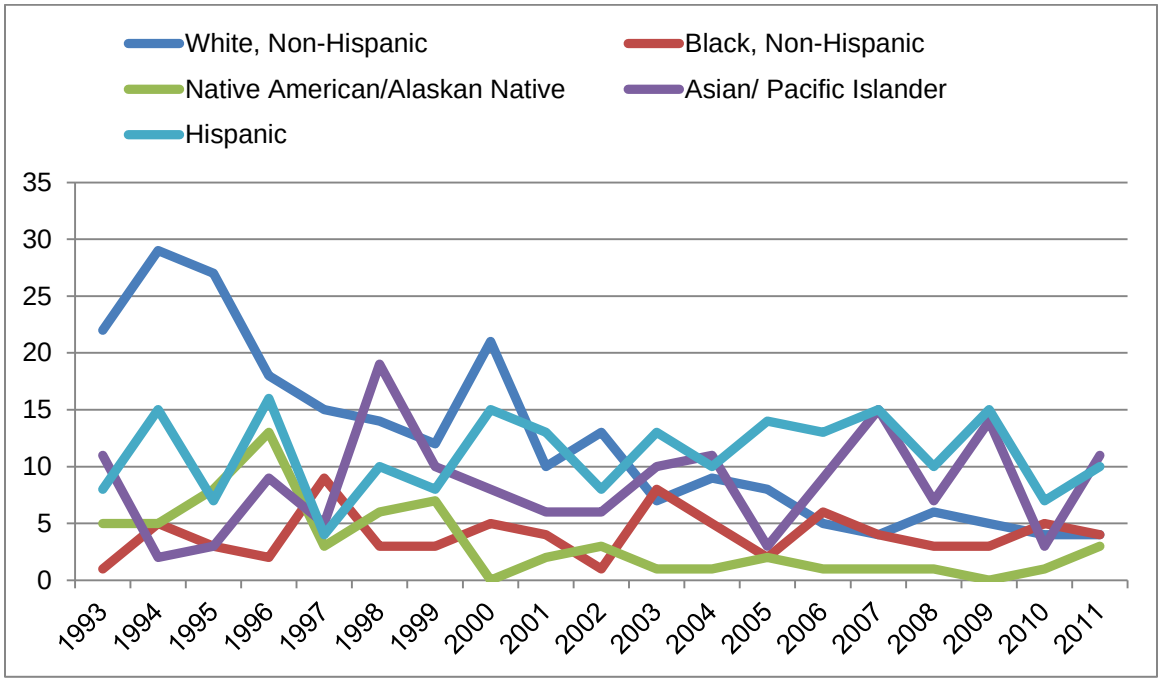


Utah is close to the *HP2020* target for this objective. Eight of the twelve local health districts have met the *HP2020* target, but Salt Lake County is one of four that does not.

In 2011, the state had 34 active TB cases. For the five previous years the number ranged from 20-34 cases and averaged 31. Since 1993, Utah has averaged 29% of the nation's rate.

Similar to Hepatitis B, TB among the long-term residents of Salt Lake County has largely been eliminated. However, the TB rate among new arrivals to the valley (especially highly mobile individuals and refugees) continues to rise while the rate in persons born in the U.S. falls.

Figure 36. Number of Tuberculosis Cases by Race/Ethnicity, Utah, 1993-2011



Persons immigrating to the U.S. from Asia, Mexico, Central America, and South America have had the highest rates of TB since the year 2000. Since the County takes a large number of refugees and our citizens engage in extended travel to foreign countries, Salt Lake County will always have a large number of persons with tuberculosis.

During 2012, the number of TB cases has increased from the previous year and this is expected to continue. Each case has at least twenty-five contacts, and these contacts will require follow-up including interview, skin testing, and (if skin test is positive) a chest x-ray. If the x-ray is positive, if appropriate, and if they agree, treatment for *latent* TB will be administered. If a person is discovered to have *active* TB, the cycle continues.

Professional and community education is necessary. Physicians who are seeing foreign-born patients on a regular basis who present with a cough and that cough does not respond to treatment (especially if there is a chronic disease co-morbidity), should consider doing a skin test and follow-up x-ray to rule out TB. Hospital and emergency department staff should consider the same if a patient with an underlying chronic condition presents with a fever of undetermined origin.

Sexually Transmitted Infections

Chlamydia

Over 19 million cases of chlamydia occur annually. CDC maintains that although sexually transmitted infection (STI) remains a significant public health problem, it is largely unrecognized by the public, policymakers, and healthcare professionals. Almost half of STIs occur in the 15 to 24 year old population, and the financial burden is upwards of $15.9 billion annually. Chlamydia is currently the most frequently reported notifiable disease in the United States. 1,307,893 cases occurred in the U.S. during 2010. Of these, 71% were among those aged 15 to 24.

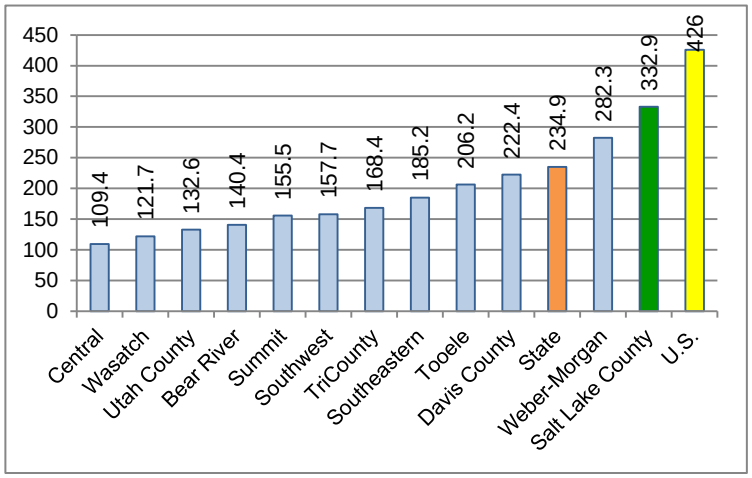
Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.

Susceptibility to more serious infections such as HIV also increases when an individual is infected with chlamydia. In addition, pregnant women with chlamydia can pass the infection to their infant during delivery, potentially resulting in pneumonia or neonatal ophthalmia.

HP2020 objectives focus only on the 15-24 year old age group in general and specifically those who are treated in family planning clinics and the National Job Training Program. A more general *HP2020* objective and target are under development; it will be "STD-2: Reduce Chlamydia rates among females aged 15-44." Since local, state, and national rates are available for the total number of people with Chlamydia infections and since all but a few *HP2020* targets are based on a 10% decrease in the base rate (which is the national rate for 2007), a target can be inferred. The table below compares the known rates with the expected HP2020 target. Based on current data, both Salt Lake County and Utah fall within the target for 2020.

(Inferred) *Healthy People 2020* Objective			
No number – Reduce Chlamydia infection rate per 100,000			
Salt Lake County 2010	Utah 2010	U.S. 2010	*Healthy People 2020* Target
332.9	234.9	426	383

Figure 37. Chlamydia Rates for All Ages, by LHD, 2010

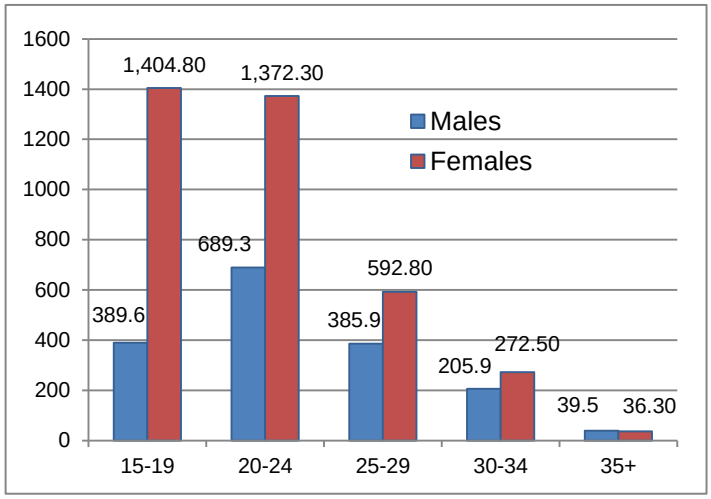


Utah ranked 46th in the nation for chlamydia rate per 100,000, however, Salt Lake County has the highest Chlamydia rate in the State.

Small Area data are not available.

Figure 38. Chlamydia Rates by Age and Gender, Utah, 2010

The age group of highest interest is the 15 to 19 year old group. The U.S. rate for females was 3,270 per 100,000 while Utah's rate was 1,405 per 100,000 – 43% lower than the national rate. Compared to the U.S. rate for males (735.5), the Utah rate of 389.6 was 47% lower.



IMMUNIZATIONS

Immunizations are the most cost effective disease prevention measure. Vaccine development has been cited by the U.S. Public Health Service as one of the Ten Great Public Health Achievements of the 20th Century. Immunization rates are a good indicator of an area's ability to prevent certain diseases. Two key immunization rates for children are tracked: Immunization rate of children at 24-months and rate at kindergarten entrance.

Immunization rates for Salt Lake County reflect vaccine administered by Vaccine For Children (VFC) program providers (physicians, hospitals, clinics, Federally Qualified Community Health Centers) as well as vaccine given by the SLCoHD.

TWO YEAR OLDS

By age two, children are recommended to have 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP), 3 doses of polio,1 dose of measles-mumps-rubella (MMR), 3 doses of hepatitis B, 3 doses of haemophilus influenza, type b (Hib), and 1 dose of varicella vaccines. This is referred to as 4:3:1:3:3:1. *HP2020* Objective IID-7 is to "Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children." The first six sub-objectives cover the 4:3:1:3:3:1 and provide a window for completion between 19- and 35-months.

***Healthy People 2020* Objective**				
IID–7: Achieve and maintain effective vaccination coverage levels (percentage) for universally recommended vaccines among young children (by 19-35 mos)				
Sub-Objective	Salt Lake County 2009	Utah 2011	U.S. 2010	*Healthy People* 2020 Target
IID-7.1 4 doses DTaP	67.9	79.5	85	90
IID-7.2 3 doses Hib	88.0	90.1	57	90
IID-7.3 3 doses Hep B	83.9	85.5	94	90
IID-7.4 1 dose MMR	83.0	86.3	92	90
IID-7.5 3 doses Polio	87.5	91.1	94	90
IID-7.6 1 dose Varicella	81.8	87.8	91	90

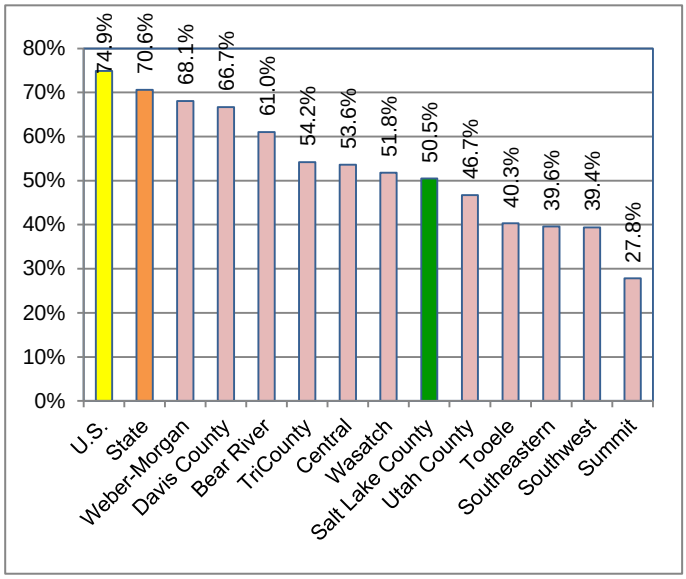
The percentages for each vaccine indicate the number of children who had had the total recommended number of dose of that particular vaccine.

***Healthy People 2020* Objective**			
IID–8: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine (PCV).[59]			
Salt Lake County 2009	Utah 2010	U.S. 2008	*Healthy People* 2020 Target
59.8	70.6	74.9	80

[59] This number is not the average of the number who are up to date on each antigen. The rate reflects the number of children who are up to date on all vaccines. For example, a child may be compete on five vaccines, but not on Varicella. That child would bring the averages up for the other five antigens, and down for the varicella (100%, 100%, 100%, 100%, 100%, 0%). This child would not be considered "complete".

Figure 39. 4:3:1:3:3:1 Coverage, by Local Health District, 2010

Salt Lake County falls in the middle of the state for percentage of up-to-date vaccinations for two year olds. None of the local health districts meet the *HP2020* target of 80%.



KINDERGARTEN

***Healthy People 2020* Objective**				
IID–10: Maintain adequate vaccination coverage levels (percentage) for children in kindergarten				
Sub-Objective	Salt Lake County 2011*	Utah 2010*	U.S. 2008	*Healthy People 2020* Target
IID-10.1 4 or more doses DTaP	Composite percentage is the average of the school district reports on up-to-date kindergarteners at school entry	79.5	95	95
IID-10.2 2 or more dose MMR		85.5	95	95
IID-10.3 3 or more doses polio		90.1	96	95
IID-10.4 3 or more doses (hepB)		91.1	96	95
IID-10.5 2 or more dose varicella		87.7	94	95
Composite	88.6*	90.2*	95.2	95

*Per Rich Lakin, Sr. Research Analyst, UDOH Immunization Program. Average percentage in Salt Lake County is determined by the average of 5 school districts.

By kindergarten, SLCo's vaccination rate increased to 88.6%. While this is a remarkable increase, only Central Utah and Utah County Health Districts have lower rates. The county still has a way to go to meet the *HP2020* objective of 95%.

County immunization data is collected by school district. There are five school districts in Salt Lake County. Kindergarten vaccination rates for each school district are Granite, 93.3%; Canyons, 91%; Jordan, 88.4%; Murray, 86%; and Salt Lake, 84.1%. Although the school district reports are submitted per antigen, UDOH reports by totals only.

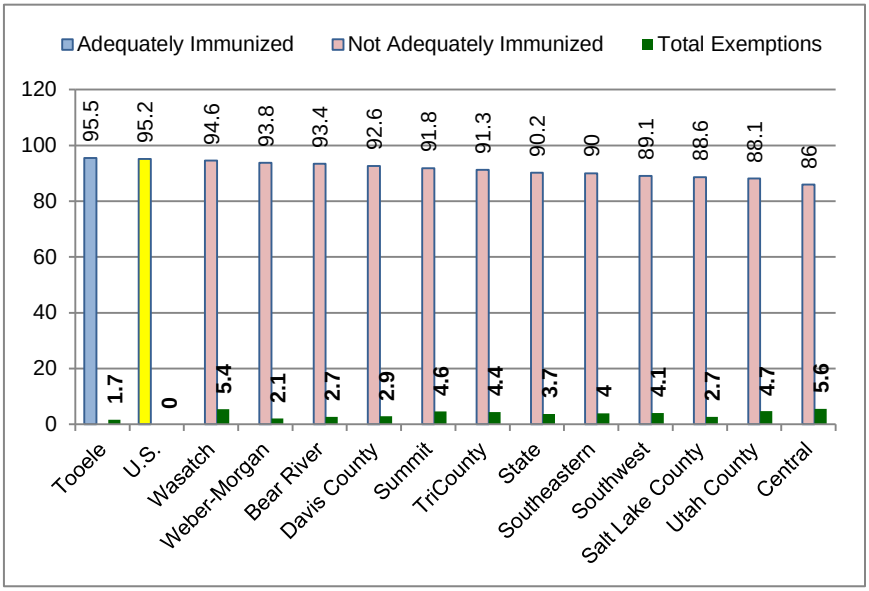
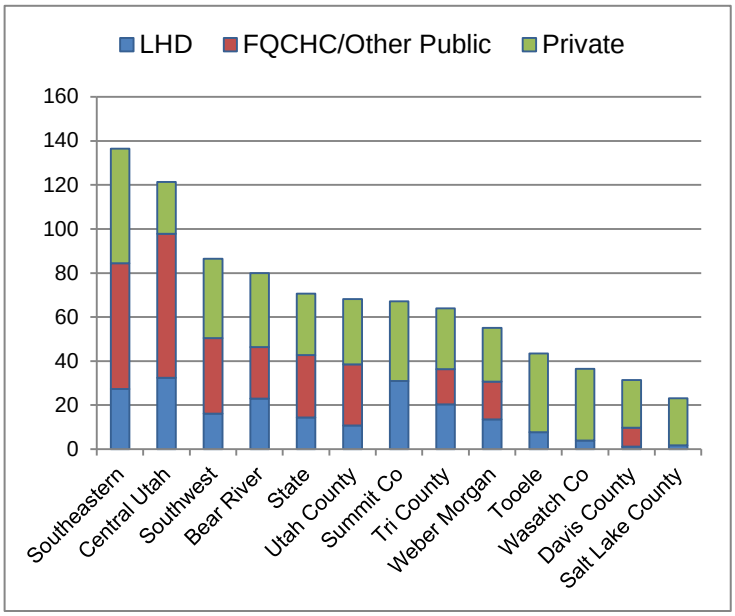


Figure 40. Children Adequately Immunized and Number of Exemptions at Kindergarten Entry, by LHD, 2011[60]

Tooele County Health Department has the highest rate of vaccination coverage for children entering kindergarten and is the only health department in Utah that has reached the *HP2020* target of 95%.

Figure 41. Missed Immunization Opportunities per 100 Patients, by LHD, 2009

Immunization data also examine missed opportunities for vaccinations according to provider type. The SLCoHD ranks very well, apparently taking almost full advantage of opportunities to vaccinate. Private providers make up the largest percentage of missed opportunities in Salt Lake County, but still have fewer missed opportunities when compared with other counties. The reason for the Federally Qualified Health Center (FQHC) scoring 0 is unknown.

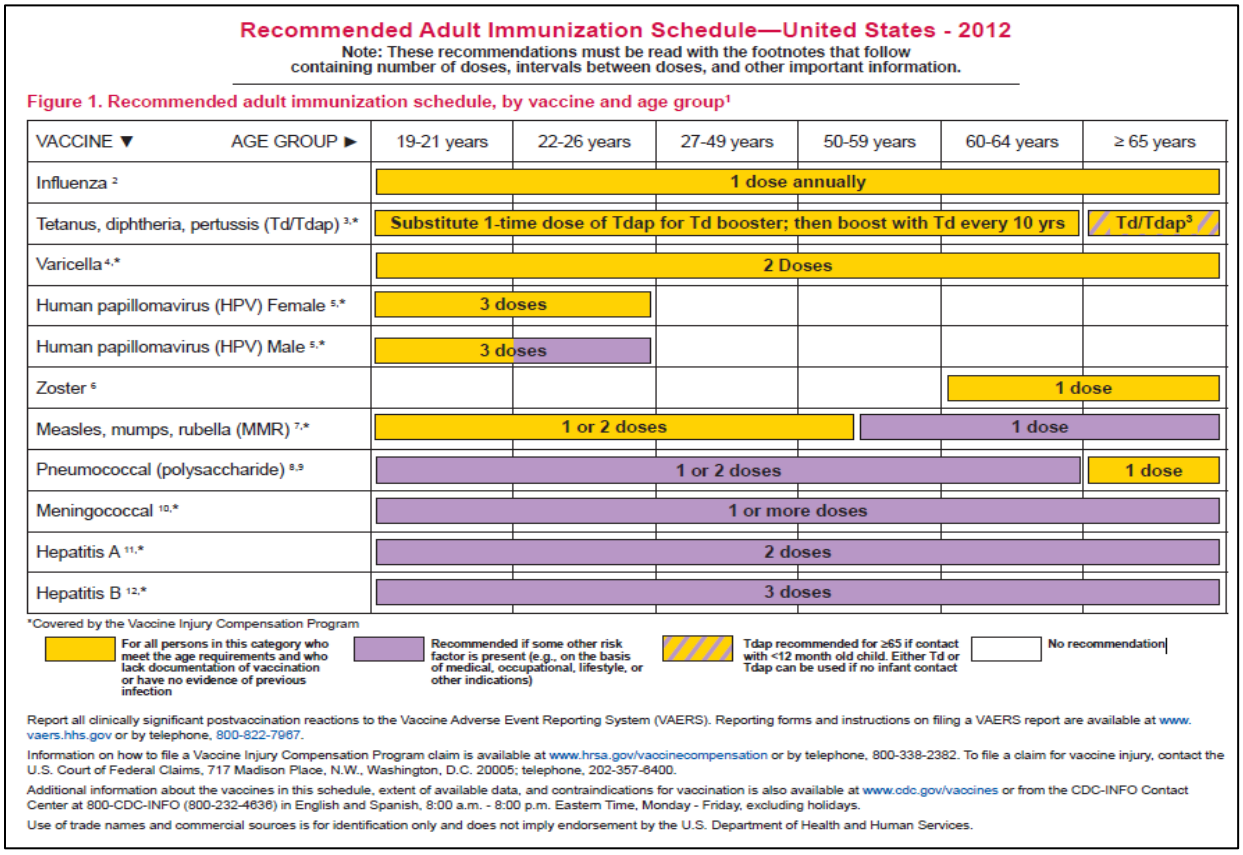


ADULTS

In the past, recommended adult immunizations were rather limited consisting of influenza, pneumococcal, and tetanus-diphtheria vaccines. During the past few years, others have been recommended and a schedule was developed to guide decisions.

At present, employers and schools may require certain vaccines as a condition of employment; otherwise vaccines are voluntary. While parents are conscientious about vaccinations for their children, most are not aware of recommendations for themselves.

[60] Personal communication with Rich Lakin, Sr. Research Analyst, UDOH Immunization Program, 16 July 2012.



Recommended Adult Immunization Schedule—United States - 2012

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group[1]

VACCINE ▼ AGE GROUP ►	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza [2]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					Td/Tdap[3]
Varicella [4,*]	2 Doses					
Human papillomavirus (HPV) Female [5,*]	3 doses					
Human papillomavirus (HPV) Male [5,*]	3 doses					
Zoster [6]					1 dose	
Measles, mumps, rubella (MMR) [7,*]	1 or 2 doses			1 dose		
Pneumococcal (polysaccharide) [8,9]	1 or 2 doses					1 dose
Meningococcal [10,*]	1 or more doses					
Hepatitis A [11,*]	2 doses					
Hepatitis B [12,*]	3 doses					

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

Tdap recommended for ≥65 if contact with <12 month old child. Either Td or Tdap can be used if no infant contact

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

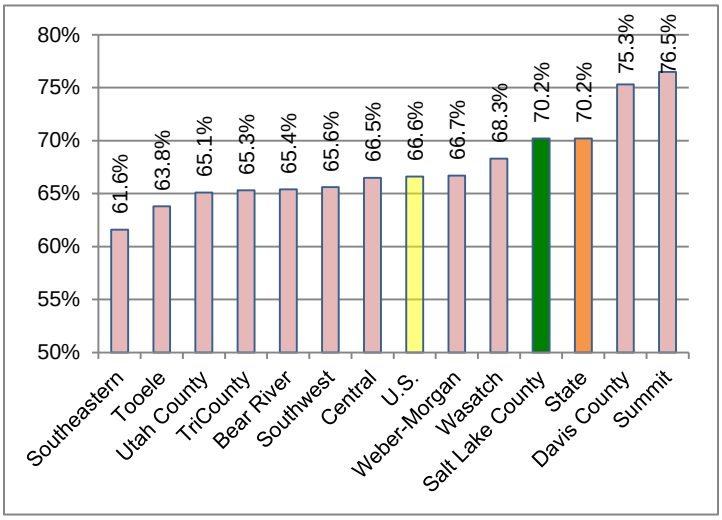
To date, data are collected for influenza and pneumococcal vaccines by local, state, and national health authorities. The federal government has begun tracking Zoster (Shingles) vaccine. Other adult vaccines are not tracked.

Healthy People 2020 Objective			
IID–12.7: Increase the percentage of adults aged 65 and older who are vaccinated annually against seasonal influenza			
Salt Lake County 2010	Utah 2010	U.S. 2010	*Healthy People 2020* Target
70.2	62.6	66.6	90

Influenza Vaccine

Older people, infants, and young children are more susceptible to seasonal influenza – the elderly because of chronic disease and weakened immune systems and the young from immature immune systems. Most of the deaths occur in the elderly population when illness with influenza causes greater susceptibility to pneumonia.

Figure 42. Percent of Adults 65+ Vaccinated Against Seasonal Flu, by LHD, 2010



Nationally, an average of 114,000 people are hospitalized for influenza at a cost of over $4.6 billion dollars a year in medical costs and $12 billion a year in associated costs lost wages, etc. This vaccine is completely covered under Medicare B.

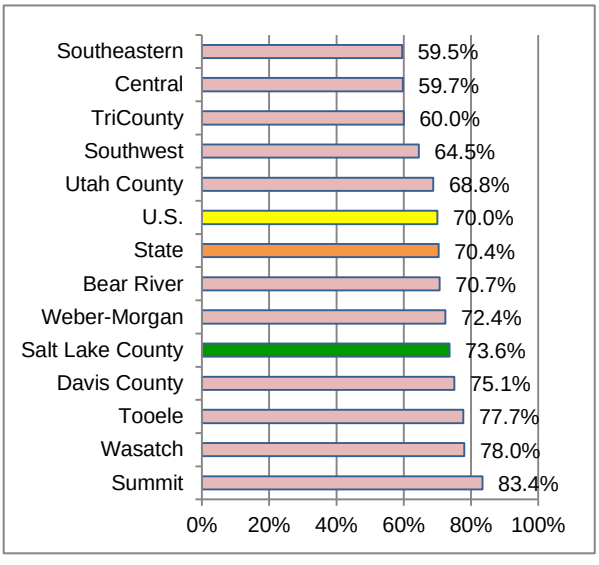
Even though Salt Lake County's vaccination rate is above the national rate, and equal to the state rate, the County has a long way to go to reach the *HP2020* target of 90%.

Pneumococcal Vaccine

Healthy People 2020 Objective			
Increase the percentage of adults who are vaccinated against pneumococcal disease ***IID–13.1: Non-institutionalized adults aged 65 and older*** ***IID–13.2: Non-institutionalized high risk adults 18-64*** ***IID–12.3: Institutionalized adults aged 18 and older in LTC or nursing homes***			
Salt Lake County 2011*	Utah 2011	U.S. 2010	*Healthy People 2020* Target
73.6*	70.4*	70	90

*Data are available only for influenza vaccination of 65+ adults by health district

Figure 43. Percent of Adults 65+ Vaccinated Against Pneumoccal Disease, by LHD, 2011



Influenza and pneumonia are grouped together as the 9th leading cause of death in Utah because the symptoms are often indistinguishable. These are preventable diseases and causes of death for the elderly and infants under one year of age. The hospitalization rate (per 10,000) for infants was 49.4 and 117.2 for those 65+. The rate for all other ages was only 12.7.

The vaccine is recommended for all adults ages 65 and older, people with chronic illnesses (e.g. diabetes, heart, lung or kidney disease), and people with compromised immune systems including HIV. Boosters are recommended for people aged 65+ who received the vaccine before age 65, people who received a transplant, people with chronic kidney disease, and people with compromised immune systems.

As with influenza vaccine, Salt Lake County is doing better than the state and nation. Four of Utah's LHDs are doing better than Salt Lake County, but none are close to the *HP2020* target.

Herpes Zoster (Shingles) Vaccine

***Healthy People 2020* Objective**			
IID–14: Increase the percentage of adults who are vaccinated against zoster			
Salt Lake County	Utah	U.S. 2008	*Healthy People 2020* Target
No data	No data	7	30

Shingles (herpes zoster) is a painful, blistering skin rash caused by the varicella-zoster virus, the virus that causes chickenpox. After the chicken pox disease resolves, the virus remains inactive in certain nerves in the body. Years later, the virus may become active causing a disease called "shingles." While the exact reason for this reactivation of the virus is unclear, there are some common characteristics among patients: older than age 60, chicken pox before age one, and immune system weakened by disease or medications. Shingles does not occur if there has never been a chicken pox infection. One in three people in the U.S. who have had chicken pox may develop the disease.[61]

Shingles can be quite debilitating. In addition to the initial symptoms of tingling and/or burning, painful rash, and then blisters, other symptoms may include abdominal pain, fever and chills, general ill feeling, genital sores, headache, joint pain, swollen glands, muscle weakness, difficulty in moving facial muscles, drooping eyelids, hearing loss, loss of eye motion, taste problems, and vision problems.[62]

While the disease subsides within two to three weeks, there can be temporary or permanent weakness or paralysis of the nerves that cause movement in the area affected. The pain may persist. More severe outcomes include blindness, deafness, encephalitis, and sepsis.

Special Projects in Immunization

The SLCoHD has three special project vaccines in progress:

- "Americares US Projects". The SLCoHD received 2000 doses of TDaP in 2011 for use of WIC clients and their family members who have no insurance. The program has been extended to include women in the "Be Wise Program" – uninsured clients who are visited by the SLCoHD Public Health Nurses.
- Another special project vaccine program is provision of Twinrix® (Hepatitis A and B) for clients who use the City Clinic's STI program. These clients are considered to be at high risk for contracting and transmitting hepatitis. This vaccine comes from UDOH.
- Free Hepatitis B vaccine provided from the UDOH through the Infectious Disease Bureau as part of Utah's Perinatal Hepatitis B program is available for pregnant and postpartum women, their partners, and children, when the woman is diagnosed with Hepatitis B.

In the past, the SLCoHD has participated with UDOH to make Hepatitis B and Twinrix® vaccines available at all of the Family Health Services clinics for uninsured adults. Four years ago SLCoHD participated in a special project providing Gardasil® HPV vaccine at the South Main Clinic to uninsured women.

[61] CDC, Shingles (Herpes Zoster) Home Page. Obtained 12 Oct 2012 from: http://www.cdc.gov/shingles/index.html
[62] Ibid.

ORAL HEALTH

Oral diseases ranging from dental caries (cavities) to oral cancers cause pain and disability for millions of Americans. Five times more common than asthma and seven times more common than hay fever, tooth decay is the single most common chronic disease of U.S. children.[63] The impact of oral disease does not stop at the mouth and teeth. Increasing evidence has linked oral health, particularly periodontal (gum) disease, to several chronic diseases including diabetes, heart disease, and stroke. In pregnant women, poor oral health has also been associated with premature births and low birth weight.[64,65] These conditions may be prevented in part with regular visits to the dentist. In 2007, only 44.5% (age adjusted) of people age 2 and older had a dental visit in the past 12 months – a rate that has remained essentially unchanged over the past decade.

Forty-five percent of school-aged children have decayed teeth; 94% of adults have had or do have dental caries.[66] Twenty-two percent of children in Utah are not covered by dental insurance which resulted in 13% of children not getting dental care when they needed it. However, one quarter of children of ethnic and racial minorities were unable to obtain needed care.

***Healthy People 2020* Objective**			
OH–7: Increase the proportion (percentage) of children, adolescents, and adults who used the oral health care system in the past 12 months			
Salt Lake County 2010	Utah 2010	U.S. 2007	*Healthy People 2020* Target
71.3	72.7	44.5	49

In the attempt to reduce dental carries, Salt Lake County began fluoridating potable water which was not naturally fluoridated in October 2003. To date there have been no in-depth studies that show the impact of fluoridation on prevention of dental carries. The 2010 Oral Health Status of Utah's Children Survey found that children who met the criteria of long-term optimal levels of fluoride either from fluoridated water or fluoride supplements had substantially fewer decayed, missing, or filled teeth compared to children without optimal fluoride levels.

Table 8. Oral Health Problems in Children 2000, 2005, 2010

Health Problem	2000	2005	2010
Prevalence of Caries	58.4%	55.3%	50.5%
Untreated Decay	22.1%	21.4%	16.7%
Sealant Rate	49.9%	45.1%	36.1%

Comparing data from the current and previous (2000, 2005) state Oral Health Status Surveys, the oral health of Utah's children has improved.

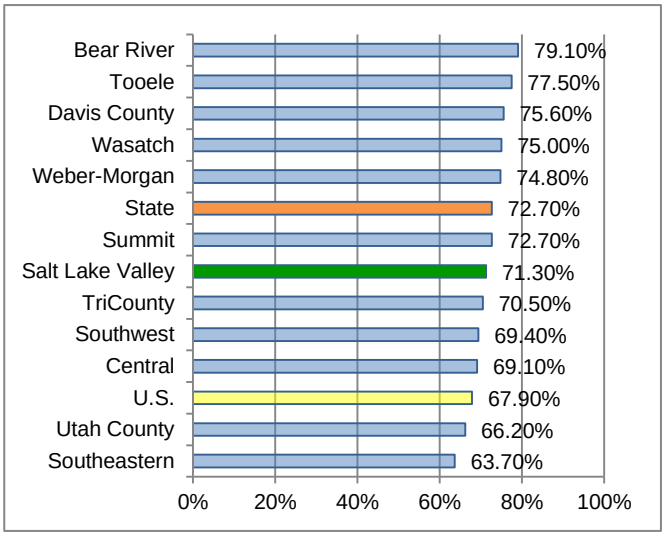
While there are no data for Small Areas or counties available regarding dental health in IBIS-PH and only limited data for Utah as a whole, Utah's status on *Healthy People 2020* objectives has been assessed through the oral health survey. The findings are:

[63] UDOH, DFH&P, OHP, DRP (2012). The Oral Health Status of Utah's Children, Results from the 2010 Oral Health Survey. January 12, 2012. Obtained from: http://health.utah.gov/oralhealth/pdf/oralHealthReport_2011.pdf
[64] Bensley L, VanEenwyk J, Ossiander EM. Associations of self-reported periodontal disease with metabolic syndrome and number of self-reported chronic conditions. Prev. Chronic Dis. 2011;8(3):A50. Available from http://www.cdc.gov/pcd/issues/2011/may/10_0087.htm
[65] *J Am Dent Assoc*. 2006;137(suppl.2). Available from http://jada.ada.org/content/137/suppl_2.toc
[66] IBIS-PH: http://ibis.health.utah.gov/indicator/view/UntDenDecChi6_8.NoChart.html

HP2020 Objective	Utah 2010	HP2010 Target	*HP2020* Target
OH–1.2: Reduce the percentage of children aged 6-9 years with dental caries in their primary and permanent teeth	51.7	42 Unmet	49.0 Unmet
OH–2.2: Reduce the percentage of children aged 6-9 years with untreated dental decay in their primary and permanent teeth	17.0	21 Met	25.9 Met
OH–12.2: Increase the percentage of children aged 6 to 9 years who have received dental sealants on one or more of their primary and permanent teeth	26.1	50 Unmet	28.1 Unmet
OH–7*: Increase the percentage of children aged 2 and older that had a dental visit in the past 12 months	57.8	NA	49.0 Met*

*Although not reported since sample of children was 6-9 years of age only and *HP2020* objective includes all children. However, for the population of 6-9 year olds, the 57.8% who had visited a dentist within the previous 6months meets the target for that age group

Figure 44. Percent of Adults who Reported a Dental Visit in the Past Year, by LHD, 2010



Although the *HP2020* objective includes children and adolescents as well as adults, only the Salt Lake County population of adults has met the *HP2020* objective.

Salt Lake County has a fair number of free and low cost clinics, and a number of other providers that accept Medicaid, CHIP, Primary Care Network, and Uninsured individuals such as:

- Maliheh (Free Clinic)
- Stephen D Ratcliffe & Central City Community Health Centers
- Salt Lake Community College Dental Hygiene Program
- Utah Partners for Health (urgent care for elementary students)
- Utah Department of Health's Dental Care Clinic
- U of U Dental Clinic at Greenwood Health Center[67]

In addition, the University of Utah and the Rosemont College are adding schools of dentistry that may provide services to low income populations as clinical experience for students. On May 1, 2012, the 4th Street Clinic received a grant of almost $3 million which will allow expansion of dental services.

[67] Utah Department of Health. Dental Resource Guide, State of Utah. Obtained August 15, 2012 from: http://health.utah.gov/oralhealth/pdf/statewideOHP.pdf

MENTAL HEALTH

The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability. Recent figures suggest that in 2004 approximately 1 in 4 adults in the United States had a mental health disorder in the past year[68]—most commonly anxiety or depression—and 1 in 17 had a serious mental illness. Mental health disorders also affect children and adolescents at an increasingly alarming rate. In 2010, 1 in 5 children in the United States had a mental health disorder, most commonly attention deficit hyperactivity disorder (ADHD). It is not unusual for either adults or children to have more than one mental health disorder.

Mental health is essential to a person's well-being, healthy family and interpersonal relationships, and the ability to live a full and productive life. People including children and adolescents with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors including alcohol or drug abuse, violent or self-destructive behavior. Suicide was the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34.

Mental health disorders also have a serious impact on physical health and are associated with the prevalence, progression, and outcome of some of today's most pressing chronic diseases including diabetes, heart disease, and cancer. Mental health disorders can have harmful and long-lasting effects including high psychosocial and economic costs not only for people living with the disorder, but also for their families, schools, workplaces, and communities.[69]

On two measures of mental health (major depressive episodes and suicides) for adults, Salt Lake County does not have favorable rates when compared to either the state or *HP2020* target. Data for Small Areas are not available.

***Healthy People 2020* Objective**			
MHMD–4.2: Reduce the percentage of adults aged 18 years and older who experience major depressive episodes (MDE)			
Salt Lake County 2006	Utah 2006	US 2008	*Healthy People 2020* Target
11.06	9.95	6.8	6.1

Data source: http://www.samhsa.gov/data/substate2k8/statefiles/UT.htm

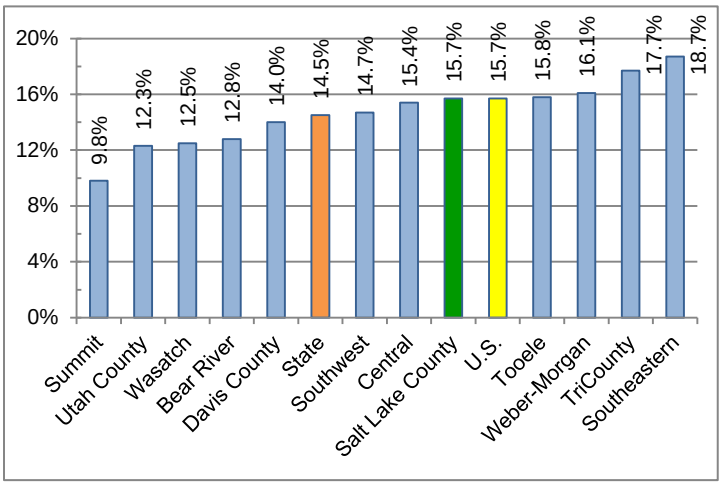
***Healthy People 2020* Objective**			
MHMD–1: Reduce the suicide rate for adults to 10.2 suicides per 100,000.			
Salt Lake County Rate 2006-2009	Utah Rate 2006-2009	US Rate 2007	*Healthy People 2020* Target
16.6	15.8	11.3	10.2

There are no *HP2020* mental health objectives directly impacted by public health. Public health can assist mental health organizations with educational/informational endeavors and advocating for services.

[68] Reeves WC, Strine TW, Pratt LA, et al. Mental illness surveillance among adults in the United States. *MMWR*. 2011;60(3):1–32. Atlanta, GA: Centers for Disease Control and Prevention. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w

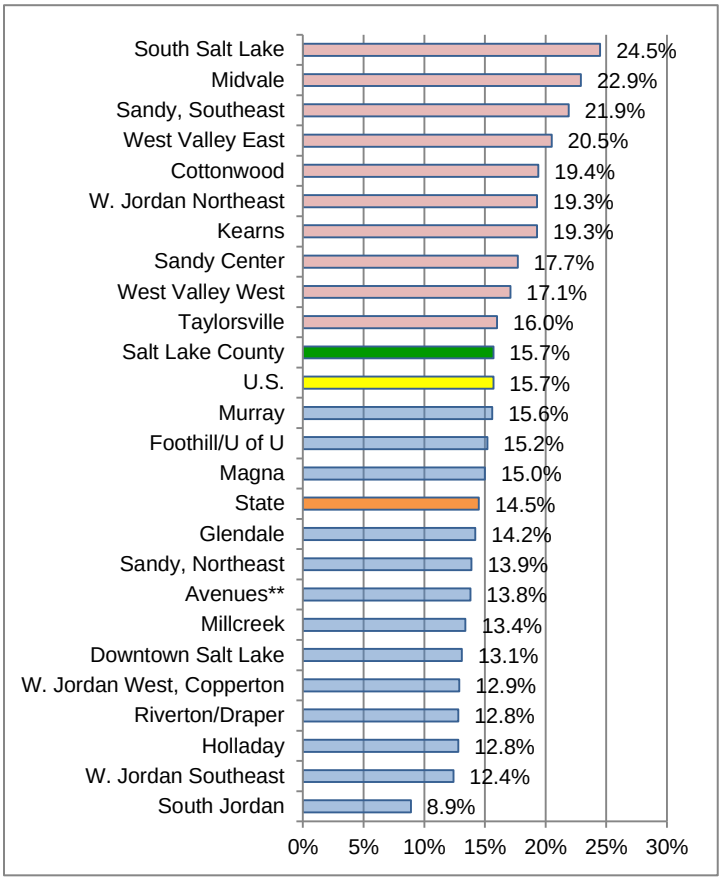
[69] *Healthy People 2020*. Leading Health Indicators. Mental Health. Available at: http://healthypeople.gov/2020/LHI/mentalHealth.aspx

Figure 45. People Who Report Seven or More Poor Mental Health Days, by LHD, 2009-2010



Health-related quality of life is a multi-dimensional concept that includes domains related to physical, mental, emotional and social functioning. It goes beyond direct measures of population health, life expectancy and causes of death, and focuses on the impact of health status on quality of life. An emerging concept of health-related quality of life is well-being, which assesses the positive aspects of a person's life, such as positive emotions and life satisfaction.

Figure 46. People Who Report Seven or More Poor Mental Health Days, by Small Area, 2009-2010



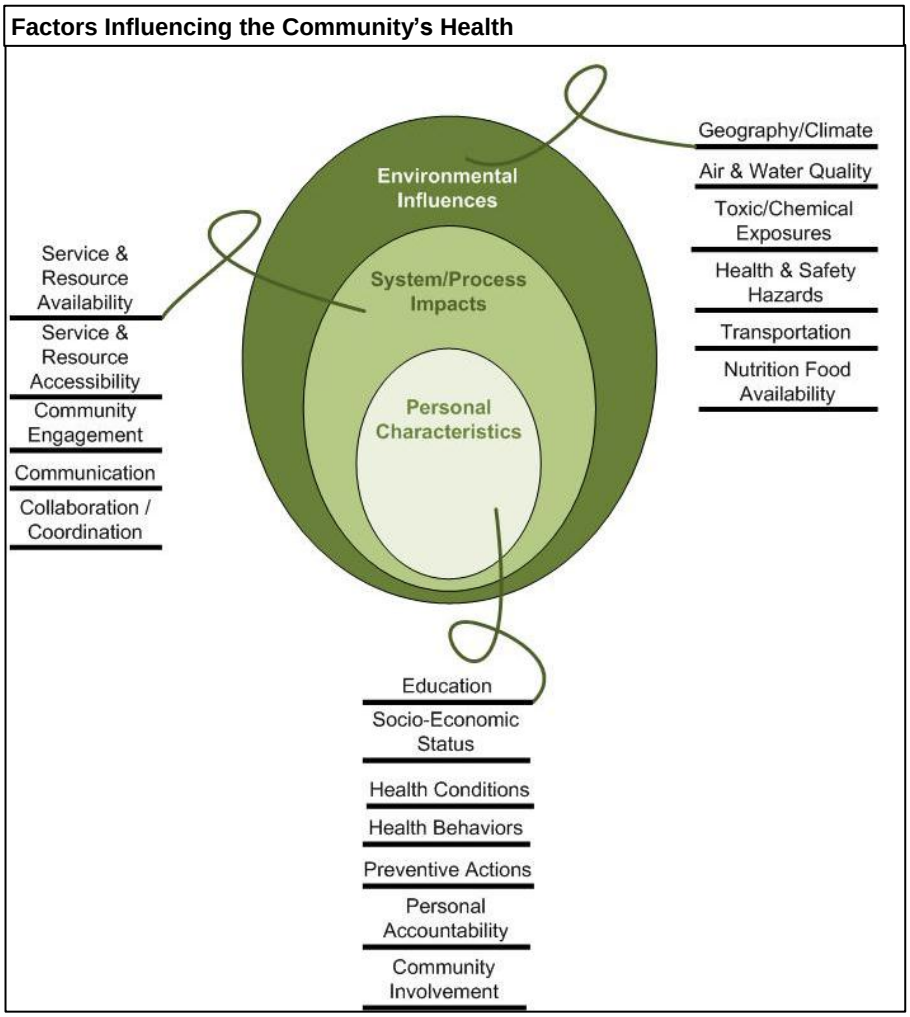
Self-report of health status is considered to be a predictor of certain health outcomes including mortality, morbidity, and functional health status. Healthy People 2020 staff is working on this measure, but currently there is no objective.

In the United States and Salt Lake County, 15.7% of adults reported having seven or more days of poor mental health in the past 30 days; in Utah this number was 14.5%.[70] SLCo residents report more poor mental health days than the state. Examining Small Area data indicates that 10 out of 23 SAs in SLCo report a higher percent of poor mental health days than does the nation. High rates were reported in South Salt Lake City (24.5%) and Midvale (22.9%), where other areas like South Jordan (8.9%) and West Jordan (12.4%) had much lower rates.[71]

The public treatment capacity for mental health and substance abuse is not adequate to meet the need. It is estimated that in Salt Lake County there are 35,237 adults and 12,548 children that need treatment. In 2010 only 10,927 adults and 4,354 children were able to be served.[72]

[70] IBIS-PH. http://IBIS-PH.health.utah.gov/indicator/view/HlthStatMent.Ut_US.html
[71] IBIS-PH. http://IBIS-PH.health.utah.gov/indicator/view/HlthStatMent.SA.html
[72] Dept. of Human Services, Division of Substance Abuse and Mental Health. December 2010. *Facing Recovery Together,* Obtained 26 Sept 2012 from http://www.dsamh.utah.gov/docs/2010_annual_report_for_web.pdf

DETERMINANTS OF HEALTH



Change to health-promoting behaviors in populations cannot be accomplished through individual knowledge and behavior change alone. Literature shows that the causes of ill health that affect populations have social and environmental elements that must be changed as well.[73] This section discusses the individual, social, and environmental determinants of health that must be addressed. This section of the Community Health Assessment follows closely the model entitled "Factors Influencing the Community's Health" which developed from the focus groups and was further defined by other data sources.

INDIVIDUAL DETERMINANTS OF HEALTH

People can choose to participate in certain health promotion programs or in certain behaviors that are not conducive to good health. While behaviors are not health conditions on their own, they can lead to major health problems in the future. Health promotion activities may not prevent diseases on their own, but they can maximize a person's ability to manage disease.

[73] (2003) Wilkinson, R.G., marmot, M.G.(eds.). World Health Organization Regional Office for Europe. *Social Determinants of Health: The Solid Facts, (2nd ed.)*. Denmark: World Health Organization.

Perceived Quality of Health

Self-assessed health status is a measure of how an individual perceives his or her health—rating it as excellent, very good, good, fair, or poor. Self-assessed health status has been validated as a useful indicator of health for a variety of populations and allows for broad comparisons across different conditions and populations.[74] In 2009, 15.1% of individuals in the United States reported their health to be fair or poor[75] compared with 14.5% of Utah's population and 13.5% of Salt Lake County's population. The number of individuals reporting fair or poor health days increases with age.

Preventive Actions

Preventive actions can identify risk factors for disease or provide a resource for early detection of disease. These actions include illness-specific screening procedures, cholesterol screening, and routine check-ups.

Illness-Specific Screening Procedures

SLCo has low rates for screening procedures that identify specific conditions early: mammograms for breast cancer screening, colonoscopies for colorectal cancer screening, and pap tests for cervical cancer screening. Two other health indicators are also low below *HP2020* targets.

Cholesterol Screening

In Salt Lake County, 70% of the population is screened for cholesterol. This rate is 1% higher than the state, but is more than 12% below the *HP2020* target.

Routine Medical Checkups

Six health districts have more adults who have seen a medical provider for a check-up in the last 12 months than does Salt Lake County (60.1%). This places SLCo only slightly above the Utah average (58.9%) and significantly below the U.S. average (66.9%). No *HP2020* objective currently exists for routine medical checkups.

Unhealthy Behaviors

In addition to social and environmental factors impacting health conditions, health is influenced by personal behaviors such as binge drinking, smoking, unhealthy diet, or failure to exercise. Of the 7 personal behaviors identified in the *County Health Roadmaps Project*, Salt Lake County compares favorably on 3 measures: Adult Obesity (SLCo 25%, national target 25%, state 25%); Physical Inactivity (18%, 21%, 18%, respectively); and Motor Vehicle Crash Death rate per 100,000 (11, 12, 13). The County also compares favorably to the national target, but is behind the State, related to Adult Smoking (12%, 14%, 10%). The County lags behind both the State and national targets related to excessive (or binge) drinking, STD/STIs, and teen birth rates.

[74] Idler E, Benyamini Y (1997). Self-rated health and mortality: A review of 28 studies. *J Health Soc. Behav. 38*(1):21-37
[75] *Healthy People 2020*. General Health Statue. Self-assessed health status. Obtained 15 Aug 2020 from: http://www.healthypeople.gov/2020/about/GenHealthAbout.aspx#one

Binge Drinking

Binge drinking can lead to negative health consequences and is an indicator of potential alcohol abuse. Nationally, the problem is focused on young adults. Alcohol is associated with injuries (especially automobile) and violence (especially among young males). Among childbearing women, binge drinking can lead to fetal alcohol syndrome. Prenatal alcohol exposure, during the first 6-8 weeks of pregnancy when a woman may not know she is pregnant can lead to birth defects.

***Healthy People 2020* Objective**			
SA–14.3: Reduce the percentage of persons binge drinking during the past 30 days			
Salt Lake County 2008-2010	Utah 2010	US 2008	*Healthy People 2020* Target
10.9	8.2	27	24.3

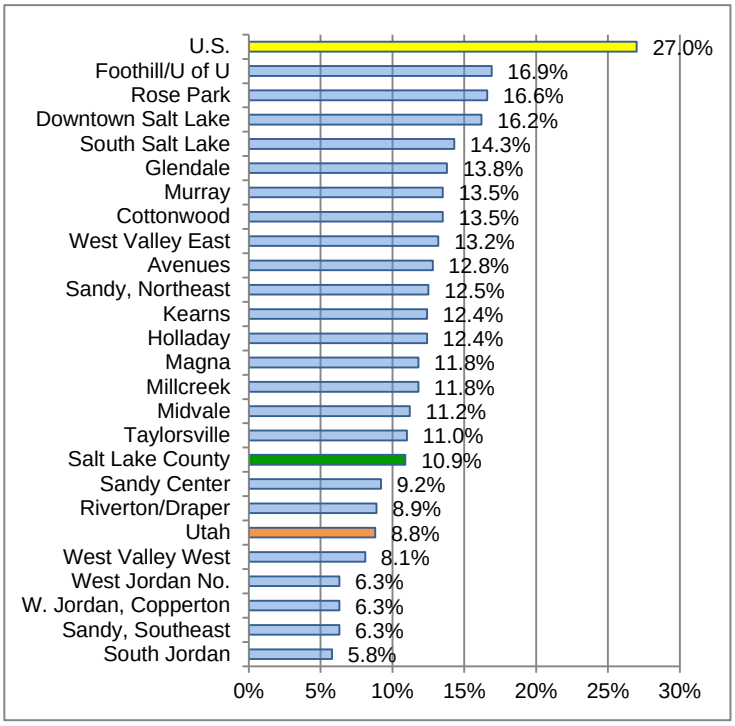


Figure 47. Percentage of Utah Adults 18+ Who Have Engaged in Binge Drinking During the Past 30 Days, by Small Area, 2008
The percentage of adults who reported binge drinking has fluctuated tremendously from a high of 12% in 1989 to a low of 7.7% in 1997.

All Small Areas of Salt Lake County are currently well below the *HP2020* objective. Even the Small Area with the highest binge drinking rate (Foothill/U of U) does not exceed the national target rate.

Smoking

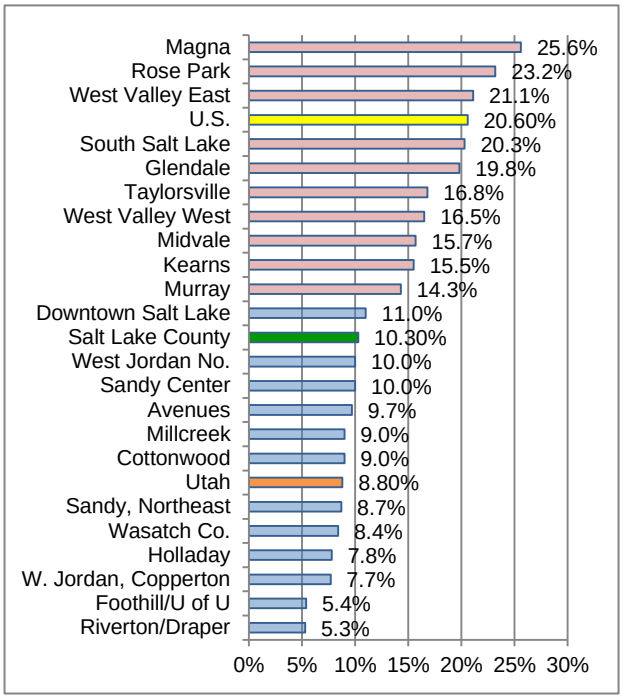
It is general knowledge that smoking is the major leading cause of disease and death in the U.S. claiming more than 1,150 lives per year. It causes or contributes to numerous diseases and exacerbates almost every chronic condition.

Increases the Risk for:	Contributes To:	Causes:
• Heart disease, • Respiratory disease • Cancer of the Lungs, Larynx, Esophagus, Mouth, Bladder	• Heart disease • Respiratory disease • Cancer of the Cervix, Pancreas, Kidneys	• Premature birth • Low birth weight • Stillbirth • Infant death

***Healthy People 2020* Objective**			
TU–2.2: Reduce percentage of adolescents aged 17 and under using tobacco who were smokers in 2009			
Salt Lake County 2005-2011	Utah 2005-2011	US 2009	*Healthy People 2020* Targets
Not available	7.4	19.5	16

***Healthy People 2020* Objective**			
TU–1.1: Reduce percentage of adults aged 18 years and older using tobacco who were smokers in 2008			
Salt Lake County 2008-2010	Utah 2010	US 2008	*Healthy People 2020* Targets
10.3	8.8	20.6	12

Figure 48. Percent of Utah Adults 18+ Who Smoke, by Small Area, 2008



Utah, as a whole, and Salt Lake County compare favorably with the *HP2020* target for adult smoking. However, 10 of the 22 Small Areas in the county have smoking rates higher than the target.

Children and adolescents who smoke are at a greater risk than adults for development of chronic disease and cancers due to additional length of exposure to toxins. One-third of these adolescents will die of tobacco-related disease.

In addition, adolescent smokers are at risk for impaired growth and weaker immune systems. Compared with non-smoking peers, they are less physically fit and less committed to education. It is harder for individuals who begin smoking as adolescents to quit smoking than individuals who begin as adults.

Utah data is collected for high school students' grades 9-12. Utah consistently ranks lower than the U.S. and both rates have been decreasing since 1995.

The highest rate since data collection began in 1991 occurred in 1993 for boys (19%) and 1995 for girls (16.9%). Since 1991, boys in Utah have consistently had higher smoking rates than girls except during the 1999-2003 time period. Rates for girls have dropped at a consistent rate since 1995 while the rate for boys spiked between 2005 and 2009 but decreased again in 2011.

Poor Nutrition

Good nutrition is an important lifestyle choice for maintaining a healthy weight[76] and maximizing response to health stressors. As stated in the obesity section, people's choices may be limited to an array of poor options. If resources are unavailable, people are limited in their ability to make healthy choices.

Though research on food environment is still in its early stages, there is strong evidence that access to fast food restaurants and residing in a food desert correlate with a high prevalence of overweight, obesity, and premature death.[77,78,79] Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores,[80] but frequently supermarkets are not located within reasonable travelling distance.

Overeating

Obesity and Overweight were discussed in an earlier section. Food Deserts are discussed in a future section.

Low Vegetable and Fruit Consumption

Fruits and vegetables contain essential nutrients that help prevent many diseases. Not having access to fresh fruits and vegetables constitutes an important barrier to consumption and is related to premature mortality.[81] Fruit and vegetable intake data are collected in two very different ways by Healthy People and IBIS-PH. This difference results in two possible scenarios for extrapolating 2020 outcomes for Utah and SLCo. The first is to set a 2020 target to match the increases in consumption per person reflected in the *HP2020* targets (80% for fruit and 35.7% for vegetables) or to seek a 10% increase which reflects the usual target for most objectives in *HP2020.*

Current dietary recommendations have discontinued using the term "servings" as a measure due to confusion about portion size. Progress on *HP2020* targets is difficult to determine with different data types.

[76] CDC. (2011, July 19). *Overweight and Obesity*. Retrieved August 2, 2011, from CDC: http://www.cdc.gov/obesity/data/adult.html
[77] Ahern M, Brown C, Dukas S. A national study of the association between food environments and county-level health outcomes. *The Journal of Rural Health*. 2011;27:367-379.
[78] Taggart K. Fast foot joints bad for the neighborhood. *Medical Post*. 2005;41.21:23.
[79] Schafft KA, Jensen EB, Hinrichs CC. Food deserts and overweight schoolchildren: evidence from Pennsylvania. *Rural Sociology*. 2009;74:153-277.
[80] Wrigley N, Warm D, Margetts B, Whelan A. Assessing the impact of improved retail access on diet in a 'food desert': a preliminary report. *Urban Studies*. 2002;39.11:2061-2082
[81] Brownson RC, Haire-Joshu D, Luke DA. Shaping the context of health: a review of environmental and policy approaches in the prevention of chronic diseases. *Annual Rev Public Health* 2006;27:341-70.

If the first scenario is chosen:

***Healthy People 2020* Objective**				
NWS–14	***Increase the contribution of fruits to the diet of the population aged 2 and older***			
NWS–15.1	***Percentage of Adults who report having 3 or more vegetable serving/day***			
SLCo 2008-2010		Utah 2010	US 2001-2004	*HP2020* Target
NWS–14	NA	No data	0.5C /1000 Cal	0.9C /1000 Cal*
NWS–15.1	NA	No data	0.8C /1000 Cal	1.1C /1000 Cal**

***(Inferred) Healthy People 2020* Objective**				
NWS–14	***Increase the contribution of fruits to the diet of the population aged 2 and older***			
NWS–15.1	***Percentage of Adults who report having 3 or more vegetable serving/day***			
SLCo 2008-2010		Utah 2010	US 2001-2004	*HP2020* Target
NWS–14	32.4	31.5	32.2	58*
NWS–15.1	24.3	24.6	26	36**
* 80% increase ** 37.5% increase				

Under scenario one, none of the Utah Small Areas meet the *HP2020* targets. The percentage of residents reporting at least two servings of fruit ranged between 40% and 47.6% for the top four Small Areas. The four highest fruit consuming Small Areas were Sandy, SE; Foothill/U of U; West Jordan, North; and Cottonwood. The scenario *HP2020* Target is 58%. The four lowest scoring Small Areas were: Glendale, Magna, West Jordan/Copperton, and West Valley East. The range for these four was 24.4 to 26.8 which is about half of the highest percent areas.

The second scenario*:*

***Healthy People 2020* Objective**				
NWS–14	***Increase the contribution of fruits to the diet of the population aged 2 and older***			
NWS–15.1	***Percentage of Adults who report having 3 or more vegetable serving/day***			
SLCo 2008-2010		Utah 2000-2009	US 2000-2009	*Possible targets*
NWS–14	32.4	31.6	32.9	36.2
NWS–15.1	30.6	26	26.5	29.2

HealthyPeople 2020 tends to look at a 10% improvement above baseline (U.S. rate) for the 2020 target. Under scenario two, the assumption is that a 10% improvement would be the target UDOH would set if data continued to be collected by IBIS-PH in the same way. The evaluation is reflected in Figures 49 and 50.

Salt Lake County as a whole and nine of its Small Areas meet the potential target for fruit consumption of 36.2% for the year 2020. The lowest reporting Small Area (Glendale) reports half as many residents eat 2 or more servings of fruit than the highest reporting Small Area (Sandy SE).

Under scenario two, Salt Lake County as a whole has met the 2020 target of 29.2% for vegetable consumption reporting that they have 3 servings of vegetables/day. Salt Lake County residents eat more vegetables than does the state or U.S. However, all but 3 Small Areas are below the 2020 target. Glendale, again the lowest reporting Small Area consumes half as many vegetable servings as the highest, Foothill/U of U.

Figure 49. Percentage of Adults Who Reported having 2 or More Servings of Fruit per Day, by Small Areas, 2000-2009

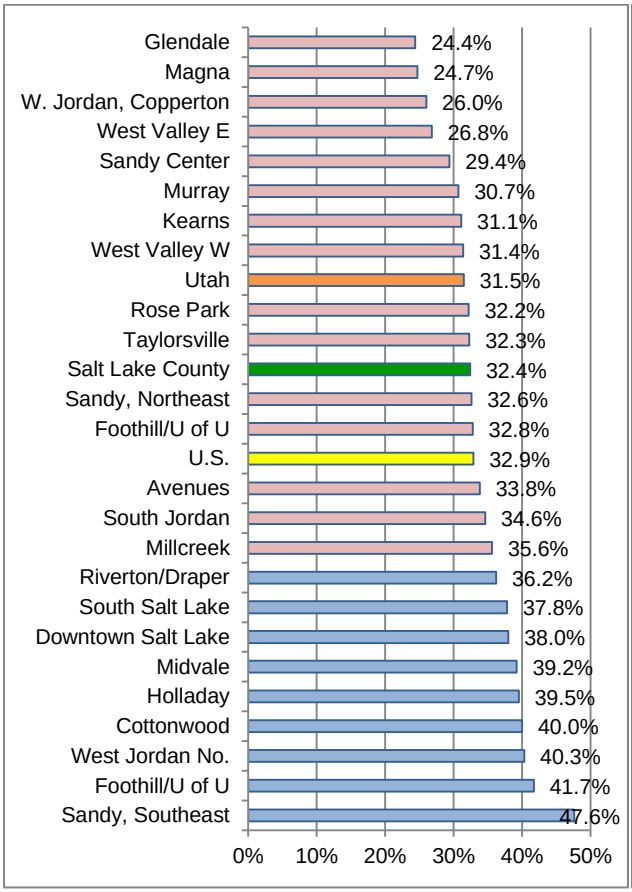
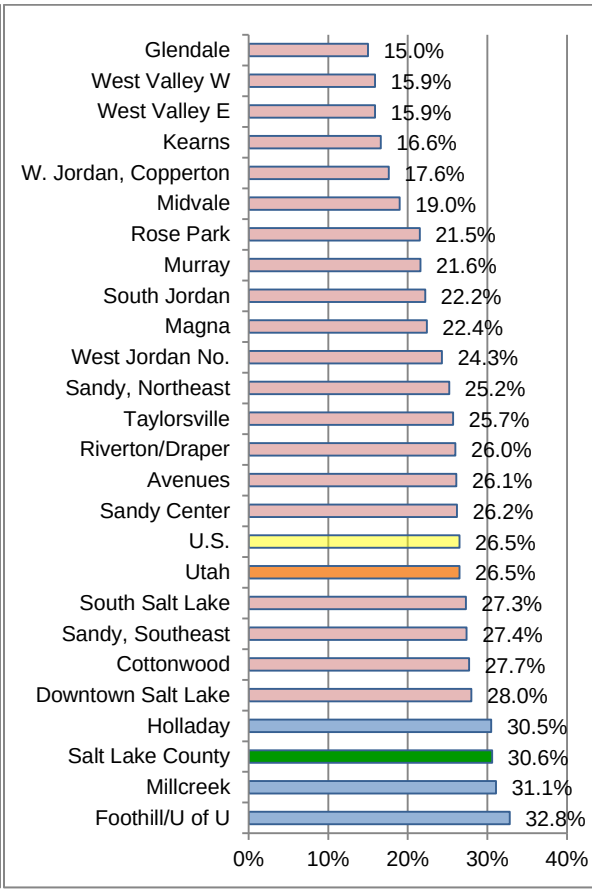


Figure 50. Percentage of Adults Who Reported having 3 or More Servings of Vegetables per Day, by Small Areas, 2000-2009



LIMITED PHYSICAL ACTIVITY

Physical activity can improve the lives of people of all ages, whether or not they suffer from chronic illness or limited physical abilities. Physical activity can reduce the risk of a number of conditions:

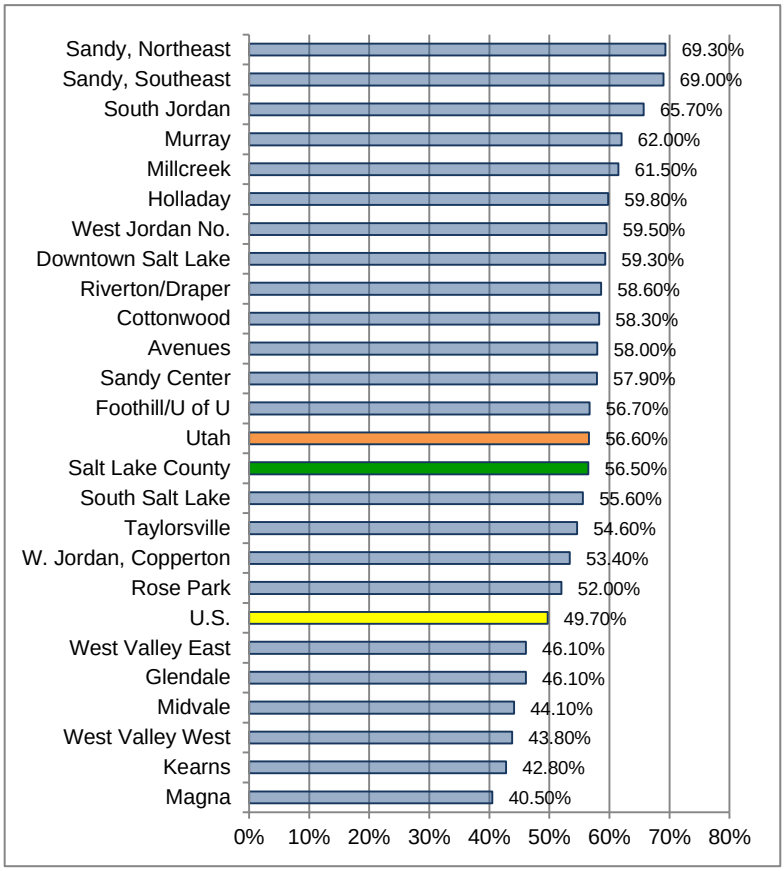
Among adults:	Among children and adolescents:
• Early death	• Improve bone health
• Coronary heart disease	• Improve cardio-respiratory health
• Stroke	• Improve muscular fitness
• High blood pressure	• Decrease levels of body fat
• Type 2 diabetes	• Reduce symptoms of depression
• Breast and colon cancer	
• Falls	
• Depression	

***Healthy People 2020* Objective**			
PA–1*: *Reduce the percentage of adults who engage in no leisure time physical activity			
Salt Lake County 2008-2010	Utah 2010	US 2001-2004	*Healthy People 2020* Target
43.5*	43.4*	36.2**	32.6**

*Derived from IBIS-PH data set (18 April 2012) (100% minus percent who engage in leisure time physical activity).
**Healthy People 2020 (2001-4 baseline) is percent who do not engage in leisure time activity.

There are no comparative data available in IBIS-PH that match *HP2020* data either for adults or adolescents. The data presented in Figures 51 and 52 represent the corollary to the HP2020 objective – those who meet the recommendations for leisure time physical activity.

Figure 51. Percentage of Adults Who Report Getting the Recommended Amount of Physical Activity, by Small Area, 2010

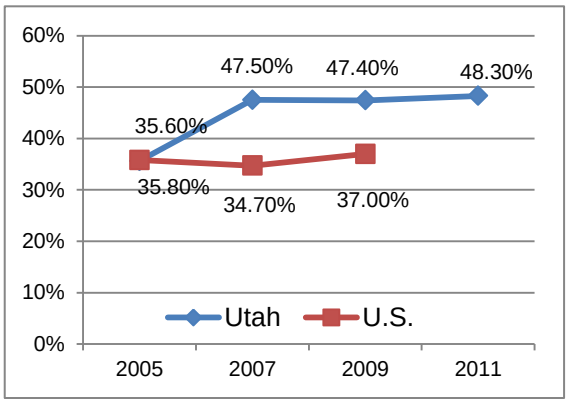


From what data are available on IBIS-PH, both Salt Lake County and Utah are doing better than the U.S. population as a whole when it comes to getting the recommended amount of exercise. However, this is somewhat contradicted by the obesity data. Accessing accurate data on exercise is important for future planning.

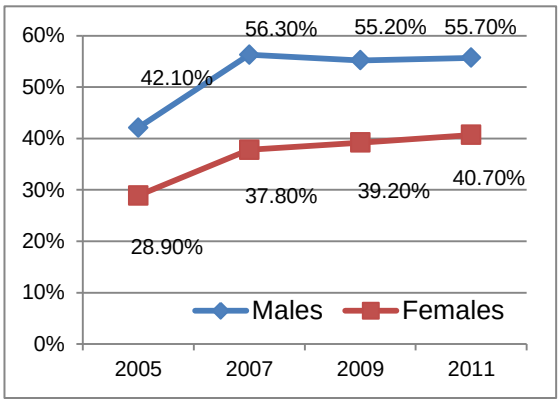
The percentage of Salt Lake County residents ages 18 and older who report light or moderate physical activity for at least 30 minutes 5 or more times per week or who report vigorous physical activity for at least 20 minutes 3 or more times per week is 56.5%. This is nearly identical to the state average and is higher than the national average of 49.7%. Utah youth who get the recommended amount of exercise are 55.7% for males in grades 9 through 12 (2011) and only 40.7% for females.

Utah State 2020 Data			
Percentage of high school students who reported participating in physical activity meet HHS physical activity guidelines for Americans, Grades 9-12			
Salt Lake County 2008-2010	Utah 2005-2011	US 2005-2009	*Healthy People 2020* Target
Data not available	44.7*	35.8	None

Figure 52. Percentage of adolescents who report getting the recommended amount of physical activity, 2005-2011



Utah & U.S.



Male & Female

Utah has consistently had higher rates of exercise in adolescents than the U.S. as a whole. Males tend to exercise more than females.

SOCIAL DETERMINANTS OF HEALTH

The World Health Organization defines “social determinants of health” as "the conditions in which people are born, grow, live, work, and age” that affect their health.[82] Conditions are influenced by the distribution of resources, power, and money which result in the differences in health status in communities. Social determinants of health address the root causes of poor health.

Access to resources that promote health is also important. County residents as well as community partners that we consulted with in focus groups mentioned that resources may be too far away or cater to only a limited demographic. Other resources may be located within a reasonable distance but cost too much. Still others are not in areas of the community that some feel are safe.

Access to comprehensive, quality healthcare services is important for the achievement of health equity and for improving the quality of life for everyone. Access to good quality, affordable health care is one problem many Utahns face. There are many problems that can hinder access to health care including geographic, linguistic, cultural, and economic barriers.

MEDICALLY UNDERSERVED AREAS

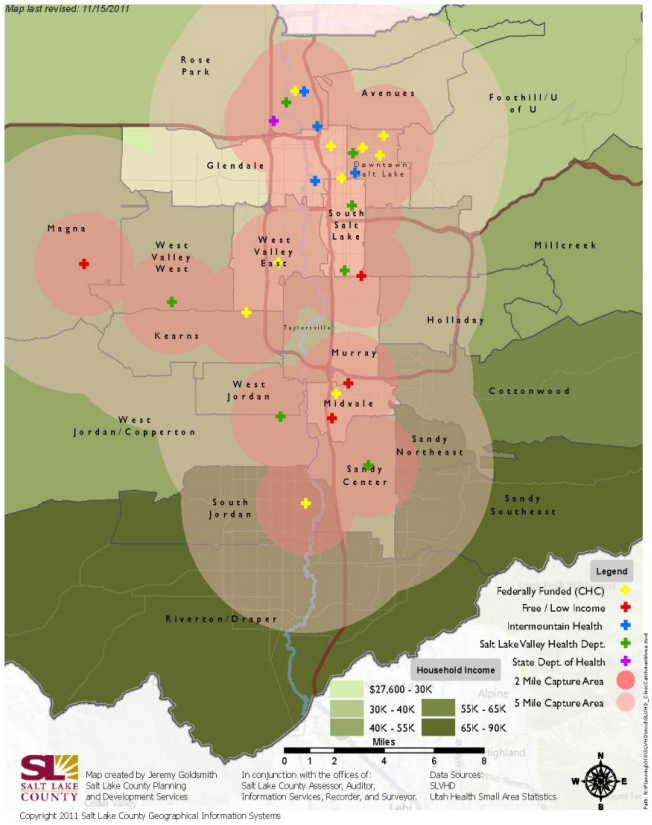
“Medically Underserved Areas and Populations” are designations given by the Health Resource Service Administration. A medically underserved area can be made up of counties, contiguous areas or a group of census tracts where residents face a shortage of primary health care, mental health, or dental providers. Medically underserved areas have a ratio less than one primary care physician per 1,000; one mental health professional per 10,000; and one dentist per 3,000 people. In Salt Lake County in 2009 there were 95 primary care physicians per 100,000 people (ratio 0.95/1000); this number is down from the 2008 estimate of 98.8 primary care physicians (ratio 0.988/1000). The major types of primary care physicians are Family and General Practice, Internal Medicine, Pediatrics and Obstetrics/Gynecology.

[82] WHO, Social determinants of health. Obtained 20 March 2012 from http://www.who.int/social_determinants/en/

Physicians tend to be more concentrated in areas with hospitals. The only hospital located on the west side of SLCo was Pioneer Valley Hospital until the opening of Jordan Valley Medical Center in West Jordan in 1983. Two new hospitals have recently opened on the southwest side of the County: Riverton Hospital (Intermountain Healthcare) in November, 2009, and South Jordan Health Center (University of Utah Healthcare) in South Jordan City in 2012. In 2013 Mountain Star is planning to open a 30-bed hospital on the Loan Peak Medical Campus in Draper, located in the southeast part of the county.[83] No new facilities are located in the northwest part of the county.

***Healthy People 2020* Objective**			
AHS–3: Increase the percent of persons with a usual primary care provider			
Salt Lake County 2010	Utah 2010	US 2007	*Healthy People 2020* Target
78.3	79.2	76.3	83.9

Map 10. Medical Clinic Catchment Areas: Two and Five Miles



Other considerations in qualifying as a medically underserved area are percent of population below the federal poverty line, percent of the population age 65 or older (both discussed previously), and infant mortality. The cutoff for being identified as a medically underserved area is a ranking below 62 on the scale of 0 to 100. The county has three areas considered "Medically Underserved."

- **Glendale Service Area:** Score 61.3. The Glendale Service area is the area between the county line to the north, 2100 South to the south, Interstate 15 to the East and Redwood Road to the West.
- **Midvale Service Area:** Score 61.3. The area of Midvale west of State Street is considered the Service Area.
- **Salt Lake Service Area**: Score 54.7. The Salt Lake Service Area consists of the area between Interstate 15 on the west, 2100 South on the south, state Road 89, Beck Street and Victory Road to the northeast and state Street to 200 East to Canyon Road on the east side.

To demonstrate the availability of medical care to low income individuals, Map 10 indicates the two and five mile catchments areas for clinics serving low income individuals.

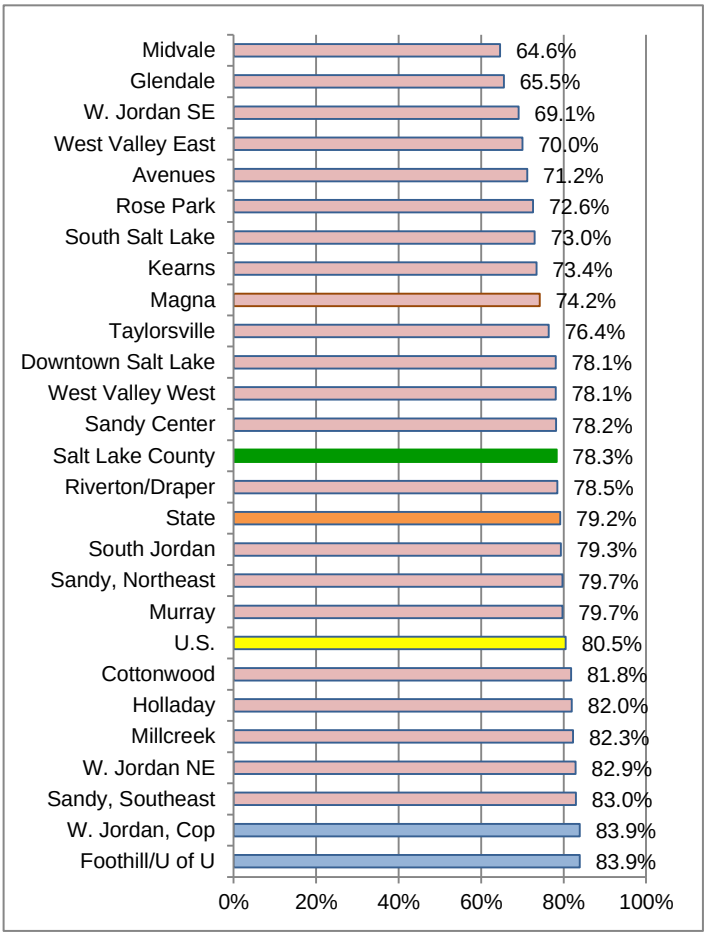
The map shows that clinics for low income persons are not necessarily located in the areas of greatest need. Glendale is considered a Medically Underserved Area. Over 22% of the

[83] Mountain Star Healthcare. Media release. http://mountainstarhealth.com/dotAsset/83cbcfcc-7870-4e1f-92ff-d078a5ac94f8.pdf&random=19123

residents of Glendale and 19% of the residents of Rose Park live in poverty. There are two federally funded community health clinics which catch the most eastern edge of Glendale within their two mile radius. The Utah Department of Health in included in this circle, but does not provide direct patient care. About a third of Rose Park (mostly to the eastside which comprises the most populated section) is within two miles of a clinic for low income persons.

Other areas with lower incomes, such as Midvale and South Salt Lake, fare better. As the population center increasingly moves south, future planning should consider more low income clinics west and south of the Interstate 215 loop.

Figure 53. At Least One Primary Care Provider, by Small Areas, 2010



The medical resources in Salt Lake County are seen as a problem to residents not living in poverty as well as to those in poverty. The topic of medical resource availability was mentioned by all focus groups conducted on the west side of SLCo and in the special population focus groups.

Only two of the Small Areas meet the *HP2020* target of 89.3% of persons with primary care providers. The two SAs with the lowest ratio of healthcare providers to population are Midvale and Glendale which are two of the three areas designed as Medically Underserved.

Cost of Health Care

To compound this problem, residents living on the west side of the County reported in their focus groups that cost was a barrier to health care at a higher rate than any other area in the valley. Nearly one quarter of Glendale, Magna, and West Valley East Small Area residents noted that cost was a barrier to health care.[84]

***Healthy People 2020* Objective**			
AHS–6: Reduce the percentage of individuals who are unable to obtain or experience delay in obtaining necessary medical care, dental care, or prescription medicines			
Salt Lake County 2010	Utah 2010	US 2007	*Healthy People 2020* Target
12.7*	12.6*	10 *HP2020*** 15 per IBIS-PH*	4.2

** Utah: Cost as a Barrier to Care in the Past Year, 2008-2010*

** HP2020* does not have a matching Objective or target for cost as a barrier; Utah does not collect data on AHS-6.

[84] IBIS-PH. Cost as a barrier to health care. Obtained 12 October 2012 from: http://ibis.health.utah.gov/indicator/view_numbers/CosBarHtlhCar.SA.html

Map 11. Cost as a Barrier to Healthcare

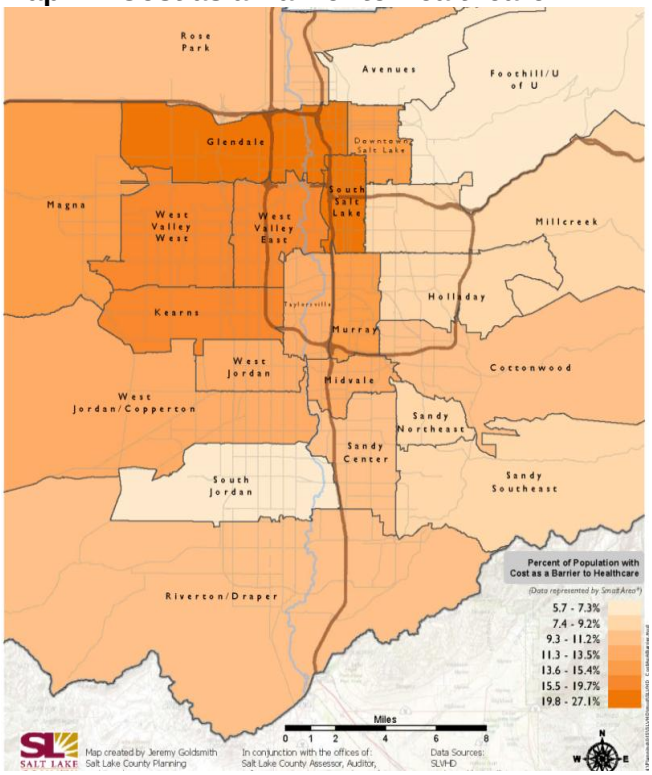
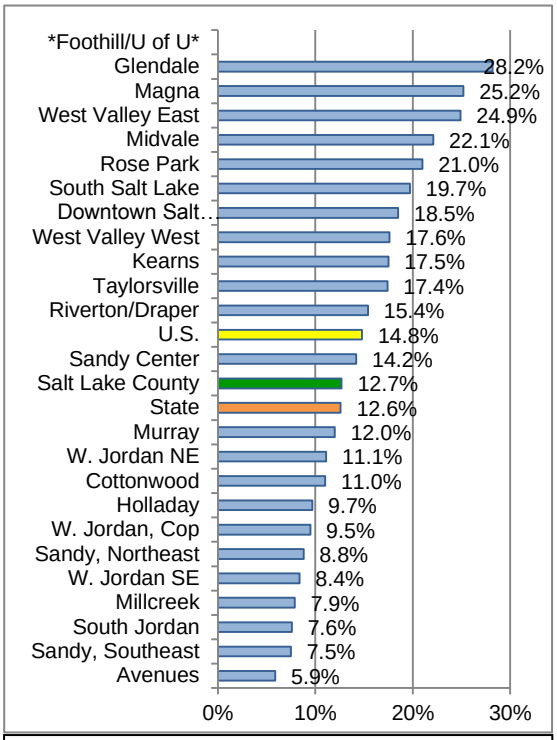


Figure 54. Percent Reporting that Cost is a Barrier to Health Care by Small Areas, 2010

The IBIS-PH indicator provides the percent of residents who identify cost as a barrier to receiving care during the previous year. This is not quite the same as the *HP2020* objective stated above.



*The Foothill/U of U Small Area data have been suppressed because the estimate does not meet UDOH standards for reliability.

HEALTH INSURANCE COVERAGE

People with health insurance are more likely to have a regular source of healthcare than those who don't and are less likely to delay obtaining needed care. Approximately 14.9% of adult residents under the age of 65 had no health insurance in 2009. In the same year 10.9% of the population was covered by Medicaid and 9.1% was covered by Medicare (including elderly and disabled).

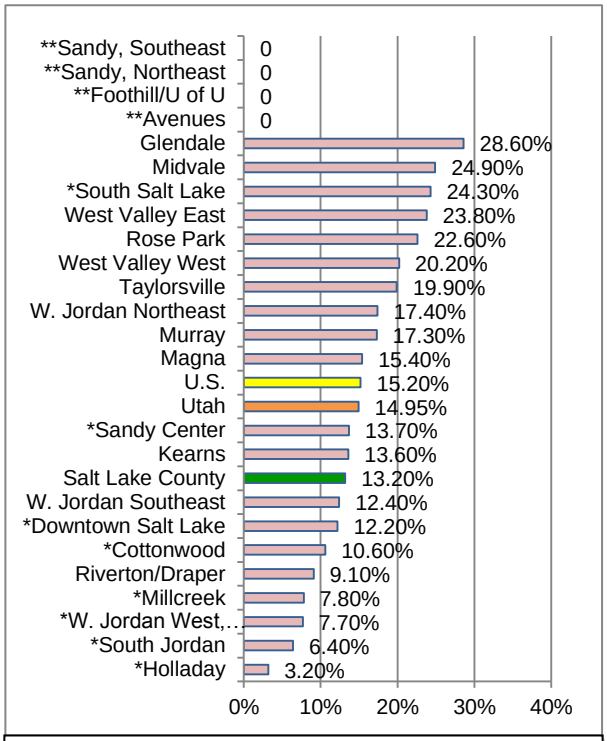
The data are soft. Various surveys are measuring in different ways and getting disparate results. A new methodology used in 2011 for the first time promises to solve some of the problems. That survey will use cell phones as well as landlines since there are an ever-increasing number of households that do not have landlines.[85]

***Healthy People 2020* Objective**			
AHS–1: Increase the percentage of persons with health insurance			
Salt Lake County 2010	Utah 2010	US 2007	*Healthy People 2020* Target
88	84.7 (ACS) 89.6 (BRFSS)	83.2	100

[85] IBIS-PH, Complete indicator report of health insurance coverage. Obtained: http://IBIS-PH.health.utah.gov/indicator/complete_profile/HlthIns.html

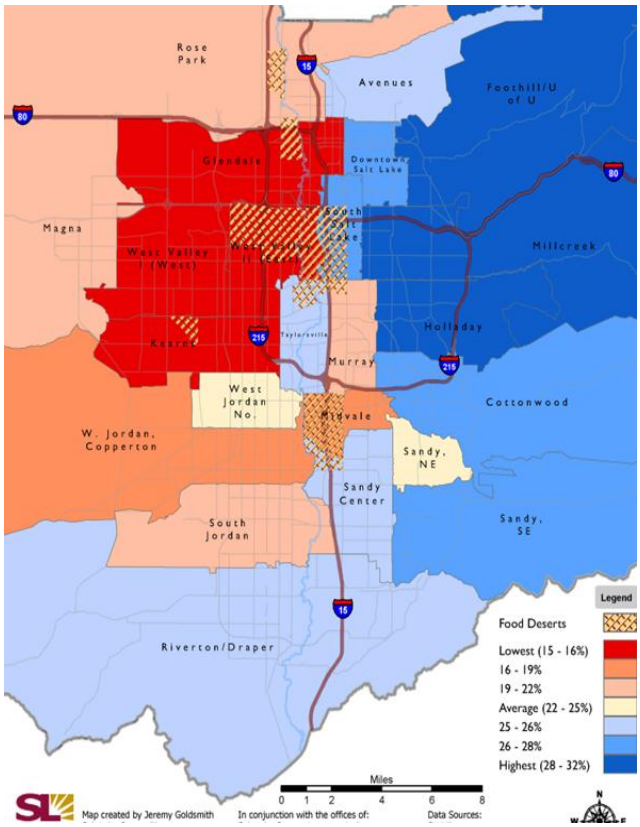
The Small Areas within the County again show a huge disparity which is skewed toward the west part of the County. In areas such as Holladay and South Jordan only 3.2% and 6.4% of residents reported having no health insurance. In areas such as Glendale and Midvale 28.6% and 24.9% respectively reported having no health insurance coverage. Figure 52 examines numbers of people per Small Area lacking health insurance in Salt Lake County.

Figure 55. Percent of people <u>without</u> health insurance, all ages, by Small Areas, Utah and U.S. ACS and BRFSS Estimates, 2010



* Estimates have a coefficient of variation between 30%-50% and may not meet UDOH standards of reliability.
**Estimates with a coefficient of variation above 50% have been suppressed because they do not meet UDOH standards for reliability.

SLCo is behind the *HP2020* target of 100% insurance coverage by 13.2%. Success in meeting this goal depends on the success of the Affordable Care Act. However, the County and all but nine Small Areas have better health insurance coverage than in Utah and the U.S.



Food Deserts

Map 12. Food Deserts and Small Area Fruit and Vegetable Consumption

According to the Healthy Food Financing Initiative (HFFI),[86] a food desert is defined as a low-income census tract where a significant number or share of residents has minimal access to a large grocery store or supermarket. In order to meet the criteria for a food desert and to qualify as a "low-income community," a census tract must have either a poverty rate of 20% or higher or a median family income at or below 80% of the area's median family income.[87] In order to meet the criteria for a food desert and to qualify as a "low-access community," at least 500 people and/or at least 33% of the census tract's population must reside more than one mile

[86] DHHS. ND. Healthy Four Financing Initiative. Obtained 2 June 2012 from: http://www.acf.hhs.gov/programs/ocs/resource/healthy-food-financing-initiative-0
[87] USDA. (2011, July 18). *Food Desert Locator*. Retrieved July 31, 2011, from ERS: http://www.ers.usda.gov/Data/FoodDesert/about.html

from a large grocery store or supermarket (for rural census tracts, the distance is more than 10 miles).[55] The USDA tract allows locating food deserts by county.[55]

There are 5 previously defined Food Desert areas as noted on the map. The USDA identified the following Small Areas as having within them census tracts that meet the criteria for classification as Food Deserts:

- Area 1 – Glendale
- Area 2 – Rose Park
- Area 3 – West Valley City
  – South Salt Lake City
  – Murray
  – Taylorsville
- Area 4 – Midvale
  – Sandy
- Area 5 – Kearns

A large retrospective meta-analysis of food deserts was conducted in 2009. Studies supported the following findings:

- Low income, high ethnic/culturally diverse areas had fewer supermarkets or chain stores and fewer mid-sized to large stores per capita than did advantaged areas.
- Supermarkets in low income areas had smaller selling space
- More convenience stores were found in low income ethnic/culturally diverse areas than middle to high income areas
- Distance to supermarkets was farther in low income areas than in middle to upper income areas.

Access to grocery stores, quality of stores in lower income areas, and quality and diversity of produce choices were issues brought up by focus group members as problems in lower income neighborhoods.

Full descriptions of the specific food deserts can be found in **Appendix 7.**

Salt Lake City Collaborative Community Food Assessment

The aforementioned Healthy Food Financing Initiative (HFFI) Food Desert assessment contained some inherent limitations which may apply to the county:

- Applying specific rules to be used nationally to define food deserts rather than considering area differences
- Inability to reflect up-to-date developments for specific areas
- Lacking local information such as the amount of industry or open land in the area

Some of the identified food desert locations, such as Area 2–Rose Park, include large sections of industrial and commercial buildings. Others, such as Area 4–Midvale/Sandy, are now served by new large grocery stores.

Responding to these limitations and needing more detailed, localized data, Mayor Ralph Becker of Salt Lake City commissioned a Community Food Assessment that began in August 2011. An initiative of the Mayor's Office of Sustainability and the SLC Food Policy Task Force, this assessment concentrated on reviewing the history and compiling current data on food production, health and nutrition. The next phase introduced in February 2012, is focused on learning how and where community members are getting their food, what guides food decisions, and what challenges residents face in feeding their families and in accessing healthy food. Assessment activities include community meetings and online surveys. The findings from this assessment will provide insight into what factors limit accessibility to food resources for residents and the locations of poor food resource availability in Salt Lake City. This assessment

can be used as a template for other communities seeking a better understanding of food availability in their communities.

A draft of the Community Food Assessment results were released at a media event in November 2012. Documents with more details about their assessment are available at http://www.slcgov.com/slcgreen/communityfoodassessment.

Food Resources

There are several issues related to the environment that limit the choices people have regarding the foods they eat. The first one is whether or not they have access to food – whether food stores are available. The second issue is whether or not the food is affordable. The third one is whether or not there are alternative food resources available.

Attempts at filling the needs for nutritious foods of the food desert communities are being made through community gardens, farmers' markets, food banks, and smaller food pantries. It is difficult to assess the impact of these attempts since the discrepancy of fresh produce use continues between higher-income communities with more grocery stores and food desert areas.

Community Gardens.

According to the CDC, community gardens are defined as collaborative projects that are shared open spaces where all participants help maintain the garden and produce healthy, affordable fresh fruit and vegetables.[88] Community gardens are run by churches, nonprofit organizations, neighborhoods, and by local agencies.[89] In addition, many existing local community gardens are coordinated through the Salt Lake County Urban Farming Office. The following link shows the locations of 38 gardens throughout the county: http://www.urbanfarming.slco.org/communityGardens/gardenMap.html

Food Banks/Pantries.

There are 32 food bank locations in Salt Lake County operated by two large food bank/pantry organizations and seven independents. The Community Action Program runs free emergency food assistance in 5 communities. The Utah Food Bank has 24 food pantries. There are 13 in Salt Lake City, 3 in West Valley City, 3 in Murray, 4 in Midvale, 2 in West Jordan, 2 in Taylorsville, 1 in Riverton, 3 in Magna, and 1 in Kearns. Sandy, South Jordan, Holladay, Herriman, Alta, Bluffdale, Cottonwood Heights, Millcreek, Emigration Canyon, White City, and Copperton do not have any food bank locations.[58]

Currently, there is no *Healthy People 2020* Objective for nutritious food availability. However, one is in the developmental phase:

> "NWS-4 (Developmental) Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by *Dietary Guidelines for Americans."*

[88] CDC. (2010, June 3). *Community Gardens*. Retrieved July 31, 2011, from CDC: http://www.cdc.gov/healthyplaces/healthtopics/healthyfood/community.htm

[89] Collins, L. M. (2011, July 24). Salt Lake County community gardens are as much for friendship as for the food. *Deseret News* .

ENVIRONMENTAL DETERMINANTS OF HEALTH

AIR QUALITY

Air pollution currently poses a severe and immediate threat to the public's health. Asthma and COPD, health maladies that can be exacerbated by polluted air, are on the rise in Salt Lake County (see Respiratory Diseases).

Air Quality and Topography

The topography of Salt Lake County is primarily a valley that is generally surrounded by high mountains and partially bordered by the Great Salt Lake. These physical features combined with periods of stagnant air, winter-time temperature inversions, and the emission of air pollutants from mobile and stationary sources typical of a metropolitan area impact the health of Salt Lake County residents and contribute to the climate change. Air quality influences participation in physical activity and affects severity of disease for people in older age groups and those with respiratory allergies or illnesses. Air pollution currently poses an immediate threat to the public's health. Asthma and COPD, health maladies that can be exacerbated by polluted air, are on the rise in Salt Lake County (see Respiratory Diseases).

Air Quality and Climate Change

In 2009 the EPA declared that carbon dioxide and other greenhouse gases were an endangerment to public health. The consequences of these emissions include increased temperature and drought, more extreme storms, a rise in sea level and political instability. This is not a new finding. Individual scientists beginning with Charles David Keeling have reported their data on global warming since the 1960s. Reputable scientific organizations (The American Academy of Sciences, American Public Health Association, National Environmental Health Association, and the United Nations Intergovernmental Panel on Climate Change) have documented this for at least 15 years. Recent extreme heat events (Europe 2003, Russia 2010, United States and Utah 2012) have brought this message home to the general public.

Salt Lake County residents will directly feel some climate changes and emissions produced by residents are partially to blame. For several years the SLCoHD has encouraged voluntary behavior changes to reduce emissions from fossil fuels including the 2009 Health Department Proclamation, The Declaration of Independence from Fossil Fuels, and the Clear the Air Challenge. These programs have encouraged individuals to make personal changes to reduce emissions, but these efforts have not produced sufficient reductions to significantly alter the course of climate change. It is worthwhile to continue these programs, but more is needed.

Criteria Pollutants

In addition to the greenhouse gasses, the EPA has identified six criteria pollutants. They are: ozone, particulate matter, carbon monoxide, nitrogen oxides, sulfur dioxides, and lead. Salt Lake County meets federal standards for most of these pollutants. Lead and nitrogen dioxide have never been significant problems. Sulfur dioxide routinely exceeded the standard in the 1970s but has not reached high levels for over 30 years – better controls by industrial sources are primarily responsible for this. Carbon monoxide was frequently above the standard during the 1970s and 1980s. This changed in the 1990s following new vehicle emissions standards and initiation of the I/M (Inspection and Maintenance) Program, and SLCo was declared a carbon monoxide attainment area in 1999. Despite successes with four of the six criteria pollutants, residents continue to be exposed to levels of particulate matter and ozone above the health standards.

At this time in Salt Lake County, only ozone and particulate matter are serious threats to public health. The concentration of both of these air pollutants is extremely dependent upon

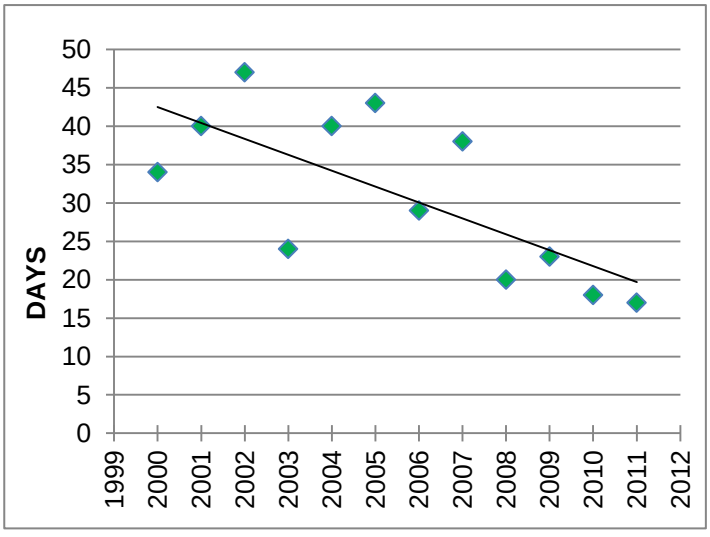
meteorology. Ozone is formed by a complex reaction involving volatile organic compounds and oxides of nitrogen in the presence of sunlight. Generally exceedances of the ozone standards require a temperature above 90 degrees Fahrenheit. The opposite is true for particulate matter. Temperature inversions during the winter trap cold air in the valley which becomes stagnant. As pollutants are generated, the concentration increases due to the smaller volume of air trapped below the inversion. When this occurs, the National Ambient Air Quality Standards (NAAQS) may be exceeded.

The Air Quality Index (AQI) is an index for reporting daily air quality.[90] It denotes how clean or unhealthy the air is, and what associated health effects might be. The AQI focuses on health effects that may be experienced within a few hours or days after breathing unhealthy air. The AQI is calculated for four major air pollutants regulated by the Clean Air Act: ground-level ozone, particle pollution, carbon monoxide, and sulfur dioxide. For each of these pollutants, EPA has established standards to protect public health. The higher the AQI value, the greater the level of air pollution and the greater the health concern. For example, an AQI value of 50 represents good air quality with little or no potential to affect public health, while an AQI value over 300 represents air quality so hazardous that everyone may experience serious effects. See Table 9 for more detail on each level.

Table 9. AQI Levels of Health Concern

Air Quality Index (AQI) Values	Levels of Health Concern	Colors
0 to 50	Good	Green
51 to 100	Moderate	Yellow
101 to 150	Unhealthy for Sensitive Groups	Orange
151 to 200	Unhealthy	Red
201 to 300	Very Unhealthy	Purple
301 to 500	Hazardous	Maroon

Figure 56. Number of Days the AQI Exceeded 100 by Year, Utah, 2000-2011



Each day concentrations of the major pollutants are monitored and recorded at more than 1,000 locations across the country. These raw measurements are converted into a separate AQI value for each pollutant (ground-level ozone, particle pollution, carbon monoxide, and sulfur dioxide) using standard formulas developed by EPA. The highest of these AQI values is reported as the AQI value for that day.

In large cities (more than 350,000 people), state and local agencies are required to report the AQI to the public daily. Many smaller communities also report the AQI as a public health service. When the AQI is above 100, agencies must also report which groups, such as children or people with asthma or heart disease may be sensitive

[90] United States Environmental Protection Agency (EPA)

to that pollutant. If two or more pollutants have AQI values above 100 on a given day, agencies must report all the groups that are sensitive to those pollutants.

Many cities also provide forecasts for the next day's AQI. These forecasts help local residents protect their health by alerting them to plan their strenuous outdoor activities for a time when air quality is better. The AQI is a national index, so the values and colors used to show local air quality and the levels of health concern are the same everywhere in the United States.

***Healthy People 2020* Objective**			
EH-1: Reduce the number of days the Air quality Index (AQI) exceeds 100			
Salt Lake County 2000-2010	Utah 2000-2010	U.S. Rate 2008	*Healthy People 2020* targets
32 (PM plus Ozone)	Not Available*	11 days	10 days

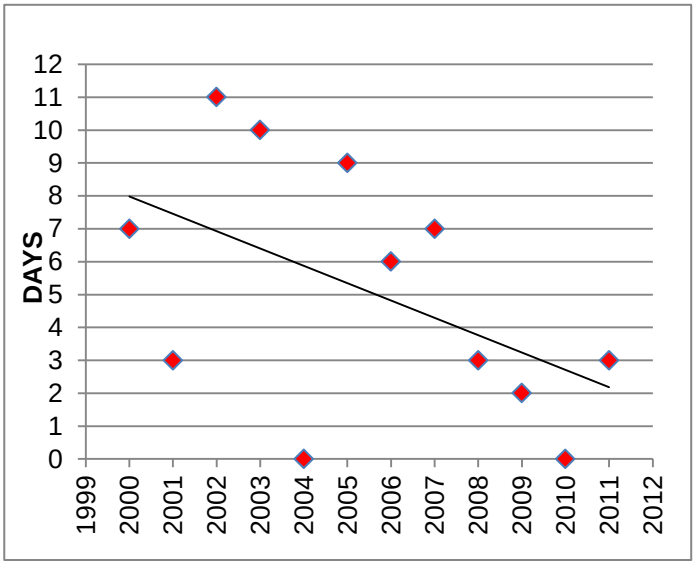
*There are no monitors for Ozone or Particulate Matter in most of the counties in state. Therefore no state rate is available.

Ozone

Salt Lake County was officially re-designated to "attainment status" for ozone by the EPA in 1997 and remains in attainment. However the levels of ozone measured are extremely close to the EPA standard of 75 parts per billion (PPB).

Figure 57 provides a historical perspective of the days that the Hawthorne Monitoring site (700 East and 1700 South) exceeded 100 on the AQI.

Figure 57. Number of Days Ozone AQI Exceeded 100 by Year, SLCo, 2000-2011



A significant portion of the measured levels of ozone is caused by background levels. The background level is approximately 50 PPB. Background levels refer to the levels of ozone that occur naturally or are transported in from downwind sources. In fact many of the national parks in the west have background levels that are close to the standards even they are located far away from industrialized communities.

Some scientists believe that the standards should be lowered. This may result in Salt Lake County moving into a "non-attainment" status even though the levels of ozone have not increased.

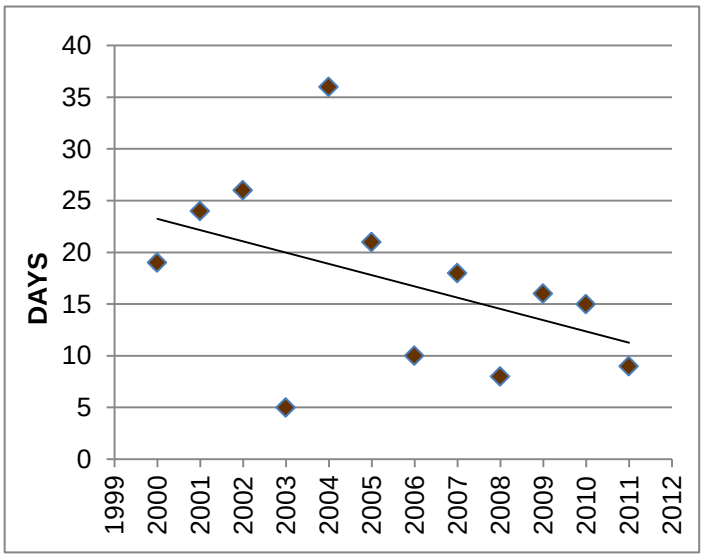
Particulate Matter (PM10/2.5)

Particulate matter is divided into two categories based on size: PM10 and PM2.5. PM10 is less than 10 micrometers in diameter, which is about one-seventh the width of a strand of human hair. PM10 is typically made up of "fugitive dust" (sand and dirt blown by winds from roadways, fields, and construction sites). PM2.5 consists of particulate 2.5 micrometers in diameter or less. Primary PM2.5 is directly emitted into the atmosphere from combustion sources and includes fly ash from power plants, carbon black from cars and trucks, and soot from fireplaces and woodstoves. Most PM 2.5 and some PM 10 are not emitted directly but are a condensation or a reaction product from gaseous emissions, primarily VOC and NOx. All of these sources of air pollution are caused by factors that are modifiable.

Particulate matter is a criteria pollutant due to its adverse health effects. Because of the small size it can become imbedded in human lung tissue, exacerbating respiratory diseases and cardiovascular problems. This is particularly problematic for sensitive groups such as children, elderly, or others with sensitive lungs. Studies show that chronic exposure can increase the odds of lung damage, bronchitis, asthma, lung cancer, and early death.

Salt Lake County is currently in the "non-attainment" category for PM10. A request to re-designate Salt Lake County to "attainment" for PM10 was submitted to EPA in 2005. The re-designation is pending.

Figure 58. Number of Days Particulate Matter M2.5 AQI Exceeded 100 by Year, SLCo, 2000-2011



Winter temperature inversions provide ideal conditions for particulates to become trapped and build up to unhealthy concentration levels. Particulate matter sometimes exceeds federal standards in the stagnant winter months. Figure 58 illustrates the trend in days exceeding 100 on the AQI in Salt Lake County at the Hawthorne site.

Current Controls

In 2011 Utah was responsible for approximately 80 million tons of CO_2 emissions, and residents of Salt Lake County were responsible for a significant portion of those emissions. The SLCoHD has operated a vehicle Inspection and Maintenance (I/M) Program for the County since 1984 to reduce air pollution. Motorists take their vehicles to authorized test stations for annual tests to ensure that their vehicles are working properly and not polluting the air. The program has been successful in reducing emissions of VOC, NOx and CO, thereby preventing many unhealthy days and hastening the attainment of the CO and Ozone standards. It continues to provide benefits for reduction of PM 2.5 and Ozone - our current criteria pollutant concerns.

Current and future levels of air pollution are dependent on several factors including improved technology, growth, personal habits, and energy costs. As a result of the improvement in vehicle technology, as the number of newer vehicles replace older ones the average emissions per vehicle decrease. However, dramatic population growth and the vehicle miles traveled by individual vehicles continue to increase. One thing that is helpful with regard to growth in reducing pollution concentration is that the area over which the pollution is emitted increases. Many organizations including SLCoHD have encouraged voluntary changes in personal habits to reduce emissions (such as choosing alternative transportation). Finally, a dramatic increase in the cost of energy also has an effect on reducing emissions in that people use less energy and decrease combustion. Increasing awareness of the seriousness of the health effects associated with air pollution—particularly climate change—will likely increase the contribution that changes in personal habits will provide to reduce air pollution.

In the past, these factors have combined to a show a reduction in air pollution inventories (tons per year):

Year	VOC	NOx	PM2.5
2005	48,500	38,100	4,860
2008	41,900	31,000	3,760

In summary, Salt Lake County is in compliance with the NAAQS for Lead, Nitrogen Oxide, Sulfur Dioxide, Carbon Monoxide and PM 10. Ozone and PM 2.5 still pose acute health issues for residents of the county.

WATER QUALITY

Water pollution can occur in the form of biological (worms, bacteria, protozoa), chemicals (oil, gasoline, paint, household chemicals, medical by-products, asbestos, pesticides, road salt, lead, mercury), and radiation (uranium, titanium). Contamination can harm humans, wildlife, fish, and/or the environment. Sources of contamination include: septic systems, leakage of underground storage tanks, broken pipelines, hazardous waste sites, industrial dumping, landfills, agricultural chemicals and fertilizers, and atmospheric deposition of airborne contaminants that form acid rain. Processes, procedures, policies, and laws are in place to control many of these threats to our culinary water and recreational water, but problems may occur despite these controls.

The SLCoHD Bureau of Water Quality and Household Hazardous Waste (WQ/HHW) regulates public swimming pools, solid waste, processing facilities, individual waste water and drinking water systems. The bureau also manages the collection of household hazardous waste and operates a pollution prevention program to assist businesses in reducing their waste streams and becoming more eco-friendly.

Public Water Systems

In 1974 The Safe Drinking Water Act (SDWA) was passed by Congress to assure that all publicly-consumed drinking water is safe. The EPA was tasked with setting the standards and overseeing a federal drinking water program. The SDWA has been amended several times to be current with scientific knowledge. The law applies to all public water systems (PWS) – defined as a piped system with at least 15 service connections or serving an average of 25 people or more daily at least 60 days per year. PWSs are divided into three categories based on the type of service, each of which is subject to different requirements. Although the EPA sets the criteria for clean water, most states have delegated authority to oversee the program in their jurisdiction. The Utah Division of Drinking Water (DDW) manages Utah's program in conjunction with the SLCoHD WQ/HHW for Salt Lake County.

The SLCoHD WQ/HHW ensures public water systems comply with and meet EPA's water standards by routinely evaluating them. Evaluations consist of conducting sanitary surveys and performing investigative bacteriological sampling of private (individual drinking water regulation #11) and public drinking water (Utah Title R309) systems. The SLCoHD WQ/HHW averages approximately 435 investigative water samples per year and quickly responds to contamination issues. In SLCo a bad water sample is usually traced to a source other than drinking water, such as a dirty tap or bad collection technique but, if necessary, disinfection/flushing occurs until no presence of an indicator remains. Dead end lines that are not flushed frequently can allow organisms to grow and should be routinely purged.

In 2012 a routine SLCoHD WQ/HHW investigative sample of a junior high returned positive for T. Coliform. Subsequent repeat samples confirmed a contamination issue existed but did not find any fecal coliform. The school and local water department were immediately notified and precautions were undertaken to keep staff and children from drinking the water until disinfection and flushing of the schools lines confirmed samples were clean. No confirmed illness resulted and the school was closed briefly with minimal disruption.

When public water systems are tested or otherwise found to be in noncompliance with the EPA's water standards, the department pursues enforcement actions as outlined in Ordinance, Rules, and Regulations. The enforcement actions include warning letters, Notices of Violations (NOV), and criminal actions. NOV Penalties vary up to $10,000 per day per violation.

Common NOVs are for storm water discharges consisting of restaurant grease, hydrocarbons, surfactants, cleaning compounds, pesticides, concrete wastewater, and hazardous materials. Sampling is done depending on the event or contamination involved. In illicit discharges, the SLCoHD involvement begins when an event occurs and lasts until mitigation is complete and may involve multiple stakeholders. Mitigation efforts include cleaning gutters, storm drain boxes, and storm drain lines, placing absorbent pads and booms in waterways, as well as removing contaminated soils.

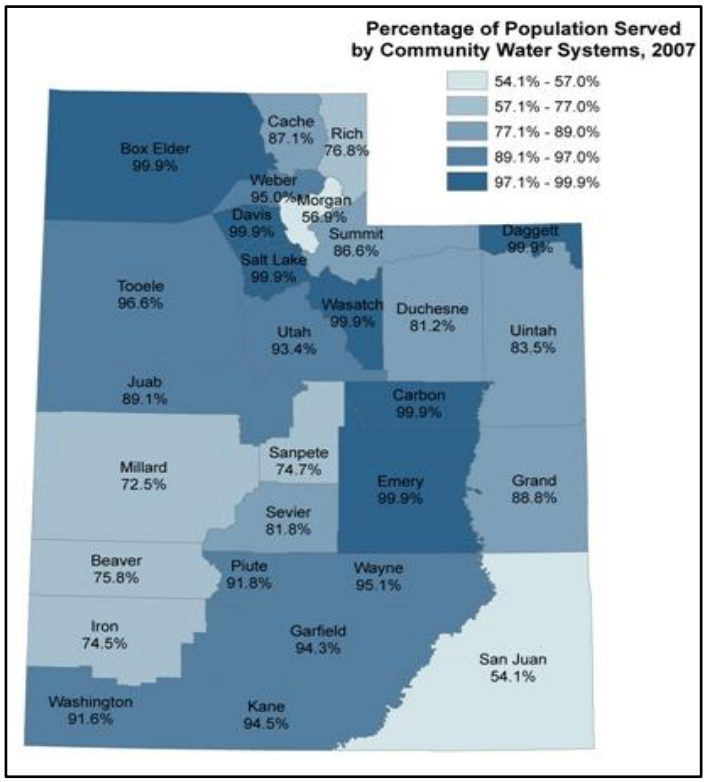
For the first two quarters of 2012, the SLCoHD WQ/HHW responded to 223 emergency response complaints and is pursuing 17 NOV for illicit discharges into the storm drain. In 2012 we are projected to have a 6% increase above the yearly average for the past 5 years which is an annual average of 425 responses. The penalties issued for 2011 totaled $122,945.35.

Environmental Health emergencies are handled though a 24/7 on-call emergency response number which is (801) 580-6681.

Private Water Systems

To maximize the number of citizens who receive high quality water meeting EPA standards, the DDW and SLCoHD regularly audit private water systems to determine if they meet the requirements to become a public water system. If a system meets the criteria, they are officially notified by the DDW and become subject to public water system requirements (Utah Title R309). In the past two years, several new systems (Cottonwood Cove and the Wasatch Mountain Club) were identified and added to a growing list of SLCo Public Water Systems (PWS). The SLCoHD currently monitors and inspects 74 PWSs. UDOH data indicate that 99.9% of Salt Lake County residents are served by water meeting the standards of the SDWA.

Map 13. Percentage of Utah Population Served by Community Water Systems, 2007



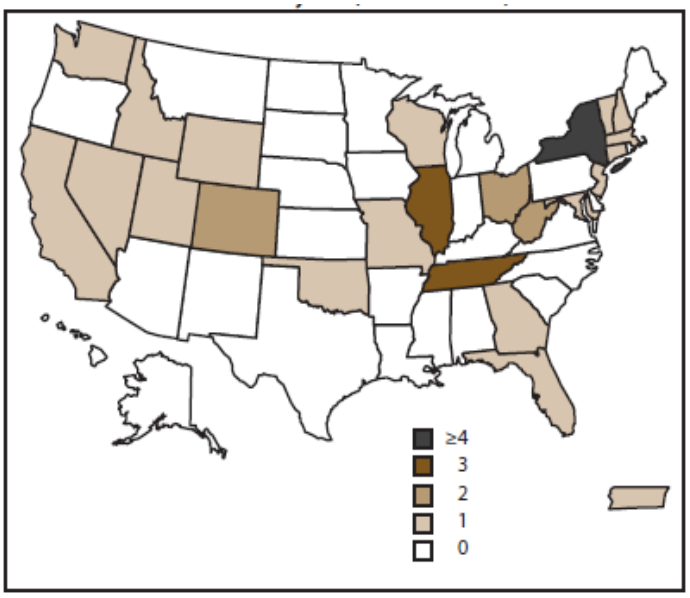
SLCoHD Water Quality and Hazardous Waste plays an active role in protecting and monitoring the watershed areas (Watershed Regulation #14 and Waste Water Disposal Regulation #13). Regulations and ordinances help protect the long-term quality of drinking water for SLCo residents. The protections provided include septic system set-backs from streams, lakes, ditches, rivers, ponds, wetlands, and drinking water wells**,** requirements for black water (toilet waste) holding tanks, preservation of wetlands, and restrictions for a variety of contamination sources such as business or homeowner activities that would contaminate these water courses: Waste water runoff, pesticides, stream alterations, or construction byproducts (paint, concrete, oil).

In addition to inspection of water systems and protection of water sources, the SLCoHD routinely conducts permitted facility inspections of food establishments, cosmetology shops, and K-12 schools for problems. Part of the inspection involves looking for and rectifying cross connection or backflow issues to prevent potential contamination of drinking water.

Water-Borne Disease

Two criteria must be met for an event to be defined as an outbreak associated with drinking water:

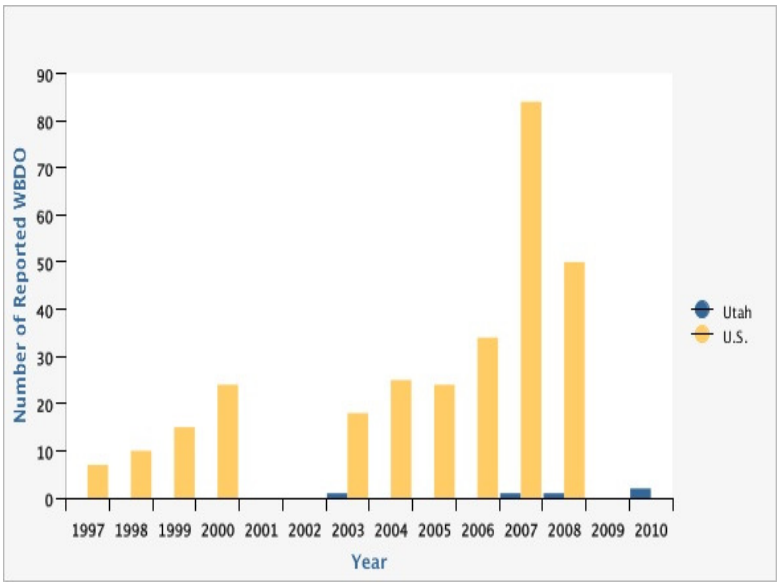
- Two or more persons must be linked epidemiologically by time, location of exposure to water, and illness characteristics
- The epidemiologic evidence must implicate water as the probable source of illness.



Map 14. CDC Waterborne Disease and Outbreak Surveillance System, Number of waterborne disease outbreaks associated with drinking water (n = 36), 2007–2008

Since 1999 there have been no verifiable water-borne disease outbreaks or illnesses in Salt Lake County attributable to Public Drinking Water. In 2007-2008, CDC documented two waterborne disease outbreaks in Utah linked to drinking water (Map 14). These occurred in other Utah counties**.**

Figure 59. Number of Reported Waterborne Disease Outbreaks by Year, Utah and U.S., 1997-2010



Looking ahead, the SLCoHD is committed to improving five environmental areas to ensure the availability of clean water in SLCo: energy efficiency, recycling, pollution prevention, overall sustainability, and water conservation. The Salt Lake County Green Business program targets these areas by encouraging local businesses to improve their environmental practices and educating them in green business tips such as low flow water devices and pre-rinse dishwasher spraying to save upwards of $1,300 and 90,000 gallons of water per year.

Legionella Contamination

The SLCoHD continues to receive sporadic reports of Legionella bacteria present in water systems. Few of the reports rise to the level of a confirmed outbreak (as defined by finding two or more unrelated cases linked by time and place). Two cases of note are described below.

October 2010-July 2011. The SLCoHD received two reports of travel-associated legionellosis resulting in deaths of the individuals. The common denominator in both cases was a hotel at the south end of the valley where both individuals stayed in late July 2010. Original sampling of the facility found significant numbers of Legionella *pneumophila* serotype 1 in the three water heaters serving the guest rooms (98000, 64000, 28000 cfu). Organisms were recovered in guest rooms but at significantly lower levels. Samples of the incoming cold water supply were negative for Legionella.

Remediation consisted of installing a thermostatic mixing valve on the common outlet of the water heaters. This allowed the temperature of the water heaters to be maintained at 160^0F+ without presenting a scalding risk to the guests. The water heaters and guest room outlets were flushed a number of times. The hot water temperature in the guest rooms was maintained at about 122^0F. Over the next several months, the water heaters were periodically heated to 170^0F or higher and drained. Sampling occurred during this period. Between February and July 2011, all samples were negative for legionella. At that time, sampling was discontinued.

September 2012-October 2012. The SLCoHD received a report of a confirmed death from legionellosis at an assisted living center in Salt Lake County. The facility also reported an unusually high number of cases of pneumonia, possibly caused by Legionella *pneumophila*. While this did not fall under the category of a confirmed outbreak, the SLCoHD Bureau of Epidemiology felt an investigation should be conducted. The facility has 12 water heaters serving the resident rooms. Samples were taken from the water heaters serving the room associated with the confirmed death occurred as well as from fixtures in the room. Additional random samples were taken from other water heaters, resident rooms, and the incoming water supply. Legionella

was isolated from the water heater serving the deceased person's room (48000 cfu) as well as the fixtures (12000 cfu). The incoming water supply was negative. Other samples were positive for Legionella but at lower levels.

Remediation consisted of installing thermostatic mixing valves on all water heaters. Water heaters were flushed and maintained at 160^0F or higher. Outlet temperatures in the resident rooms were maintained at 110^0F due to scalding possibilities with an elderly population. All showerheads and faucet aerators were removed, cleaned and disinfected. Subsequent sampling found reduced levels of Legionella in the range of 12000-7300 cfu (sampling this time was a combination of water and swab samples of the fixtures). Water heaters were again flushed as were fixtures in the resident rooms. The results of the sampling found fixtures in one room positive for Legionella. Facility management stated this room had been vacant for a number of months, which would allow for significant biofilm growth. At this time, sampling was discontinued. Follow-up sampling will be conducted in 6 months.

Public Beaches

Salt Lake County has few public recreational beaches and has not had any significant beach closures in the past five years other than a voluntary closure of a beach in a private subdivision due to an Ascariasis (intestinal worm parasite) outbreak.

Public Pools and Spas

During the latter half of 2007, SLCoHD collaborated and coordinated with health officials and many community partners (including pool operators) across the Wasatch Front to investigate and control a large community-wide outbreak of cryptosporidiosis. Statewide, over 1,900 people became infected with *Cryptosporidium* from June 1, 2007 to November 30, 2007. Health districts most affected included Salt Lake, Utah, Davis, Weber-Morgan and Bear River; cases were first reported outside of Salt Lake County.

A total of 684 lab-confirmed cases of cryptosporidiosis were reported to the SLCoHD. By comparison, only 5 cases are expected during this same time period each year. By mid-November, all restrictions were lifted and all jurisdictions reported a drastic decrease in cases, indicating the outbreak had come to an end. The CDC information warned that similar events could reoccur. However, due to enhanced surveillance, public education, and coordination with outside agencies, an increase in Crypto cases in subsequent years has not been found. Ultimately, the public is responsible for adhering to these guidelines in order to prevent the spread of disease through public water venues and to other people. This is why SLCoHD has a press conference each year to remind the public of their role in prevention.

Water Contaminants

SLCo is committed to EPA's goal of protecting human health and America's waters by protecting and restoring recreational and drinking water sources to reduce human exposure to contaminants that might be contained in them. Since 1975, SLCo government has engaged in regional water quality planning. Between 1985 and 1992, the SLCoHD assumed responsibility for the program. In 1997, the program was placed directly under the SLCo Public Works Department which currently operates the program as the SLCo Watershed Planning and Restoration Program. This program has engaged in numerous restorations, assessment, and planning activities since its inception. The primary goals of the program include assessment and restoration of streams and other water resources in the Jordan River sub-basin, stewardship planning, and environmental education outreach.

The scientific assessments and subsequent bioengineered restoration projects are carried out on a cooperative partnership basis with local municipalities, service districts and state/federal agencies. The program typically leverages local financial contributions with federal and state grants targeted at specific stream or lake restoration measures to accomplish its goals.

Chemical Spills

Red Butte Creek had significant damage to the aquatic life and vegetation in June 2010 when 33,600 gallons of crude spilled from a Chevron pipeline in the Wasatch mountain foothills and then again in December of that year when another 21,000 gallons escaped from a cracked valve but did not enter the creek. The riparian ecosystem of Red Butte Creek sustained serious damage as a result of the crude oil releases.

SLCo's Watershed Planning & Restoration Program was one of the 14 projects selected by the Division of Water Quality to receive Chevron mitigation funds. Using stream bank bioengineering techniques, this project proposes to restore vegetation with minimal impact and maximum benefit to the ecosystem. Replanting native riparian shrubs that were destroyed will help restore the many benefits that trees and shrubs provide to riparian ecosystems, including 1) a source of food and habitat for terrestrial and aquatic organisms, 2) stabilizing stream banks with their extensive root systems, 3) helping to protect water quality by preventing erosion and slowing overland flows of rain and snowmelt, and 4) reducing in-stream flows. The program will target the stretch of creek that flows through the University of Utah campus from just below Red Butte Garden to just above Foothill Blvd – approximately 4,580 feet of stream length.

A second project mitigating the Chevron pipeline oil spill was selected by the DDW and will be completed by SLCoHD. At the time of the spills, SLCoHD was not able to monitor the air quality parameters of concern. The SLCoHD was awarded $30,000 to enhance their capability to monitor air quality during similar events.

Landfill Leaching

Landfills are required in Health Regulation #1 (Solid Waste Management and Permitting) to monitor groundwater. This monitoring occurs twice a year for municipal landfills and once per year for construction and demolition landfills. These reports are submitted to SLCoHD Bureau of WQ/HHW for review. In addition, the regulation requires statistical analysis over time to look for increases in background levels of contaminants. The Health Department performs groundwater monitoring for Waste Control Management Construction and Demolition Landfill due to permit violations. These activities are funded with the bond required by the regulation at the time of permit application.

Other

Leaking underground storage tanks, cemetery washouts, and above or underground gas storage tanks are all monitored by Utah Division of Environmental Quality.

COMMUNITY CONTRIBUTION

An issue with many community assessments is that community resident input is limited to a formal questionnaire, requiring answers to specific questions that are either multiple choice or short answer. The liability with this approach is the respondents are forced into pre-determined choices. The response choices provided are usually based on the developers' assumptions and points of view.

Any large, formal assessment should be grounded in the problems and processes identified by the residents and professionals serving the communities through their lived experiences. With this as an assumption guiding the SLCoHD assessment, the Accreditation Committee chose a qualitative approach, using focus groups as a way to solicit information about community problems from its residents.

Focus groups are one method of collecting community-focused data. Because of the possibility of differing points of view, focus groups were held with community residents only, community professionals/partners only, and a combination of the two. To accomplish this, two rounds of focus groups were conducted. The first round was designed to identify health problems; the second was aimed at identifying solutions.

Public health impacts all aspects of society, a wide variety of perspectives were sought as the groups were planned. Representation was sought from two groups. The first group, referred to as "community" was the community at large, which included neighborhood leadership, and residents of various ages and ethnicities. The second group, referred to as "partners" was comprised of individuals providing service to the communities. Members of this group included representatives from health providers, government, businesses, religious organizations, charitable foundations, community organizations, ethnic organizations, nursing schools, emergency response and environmental health. In addition, three special population focus groups were conducted: refugees, Hispanic, and American Indian.

Community and special population focus groups were held during February and March, 2011. The partner focus groups were held on March 11, 2011. All but one focus group lasted 60 to 90 minutes.

DATA GENERATION

COMMUNITY FOCUS GROUPS

Salt Lake County was subdivided into six sections that reflect areas of similar demographics. Demographic aspects considered in participant selection were income, race/ethnicity, socioeconomic status, ages of residents, age of the establishment of the city/area, housing type, and city boundaries. These aspects were not formally researched, but rather considered and agreed upon by each focus group organizer through common knowledge, experience in the community, and known community dynamics. Efforts were made to recruit a representative group from each community section (see Appendix 8).

Six community focus groups were conducted. One focus group was held in each community section. Participants were solicited by email and phone calls. Community leaders were asked to recruit general community residents and refer them to the SLCoHD. In addition, walk-ins were welcomed. A total of 69 people (31 community group participants and 38 special population participants) participated in our six community resident focus groups and three special population groups.

Focus groups were audio recorded with permission. Notes were taken on large chart paper during the proceedings so participants could verify that their ideas were being interpreted correctly. The recordings from the initial community and partner/professional groups were transcribed and analyzed for themes using ETHNOGRAPH v.6, a qualitative data management computer program.

Community focus groups were held during the evenings or on Saturdays. Snacks were provided, but other types of incentives or compensation for participants' time were not provided. This decision was made because of budget constraints and the intent to recruit proactive community members. Attendance varied between groups with some having only two participants and others having up to eight. Each focus group had one facilitator and one note taker. A semi-structured questionnaire (see Appendix 9) was used to guide discussion.

Special Population Groups

Three additional groups were asked or requested to participate in this health assessment process: refugees, Spanish-speaking, and American Indians. Lutheran Social Service, Centro de la Familia, and the Urban Indian Walk-In Center (respectively) assisted us in recruitment and/or hosting these special focus groups.

Refugees

Lutheran Social Service holds English classes with various refugee groups. Eight refugees from countries such as Somalia, Burundi, and Burma participated. Most participants were familiar with English, but needed interpreters to help express complex ideas. However, only one interpreter was available. While this interpreter spoke several of their languages, she did not speak all.

Main ideas from this group were:

- Language barrier prevents real integration into society as well as communication to healthcare providers.
- Lack of education and career training (exacerbated by the language barrier) prevents finding good jobs.
- Without good jobs, refugees cannot become self-sufficient or get health insurance. This reliance on government programs and low-/no-cost healthcare leads to poor health outcomes.

Spanish-speaking

Requests were made to cultural and community leaders to help select participants as well as to advertise to their community members. Guadalupe School, Midvale Community Building Community (CBC), SLCoHD South Main Clinic, and Centro de la Familia were some of the organizations who sent participants. Five Spanish-speaking community members attended. The discussion was taped and notes were taken by the facilitators. The Centro de la Familia generously let SLCoHD use their large meeting facility.

The following are highlights from the focus group:

- Major health concerns includes childhood chronic disease, high rates of childhood obesity and lack of physical activity, lack of preventive screenings, and other conditions such as autism, diabetes, lupus, tuberculosis, and depression.
- There is a lack of health information and education in the Spanish-speaking community, and a lack of health information resources in Spanish.
- Difficulty accessing health insurance including CHIP, high cost of health care resources including emergency care, and lack of access to preventive care including contraception for women.

AMERICAN INDIAN

This group was serendipitously developed when SLCoHD learned the Urban Indian Walk-In Center was conducting a focus group with urban American Indians to find out what their health concerns were, what they needed (resources), and their problems with the current healthcare system. A SLCoHD emergency preparedness staff member of American Indian heritage facilitated the focus group, and incorporated some of the questions developed for the original CHA into focus groups. Permission to collect data for SLCoHD's assessment was obtained prior to the event from the Urban Indian Walk-in Center as well as the participants prior to the discussion. There were 25 participants from various tribes.

This focus group identified the following health concerns:

- Diabetes, alcohol, and mental health issues.
- Predisposing factors related to these health problems were lack of availability of good foods, both from the cost and availability in the communities. A lack of understanding what balanced nutrition entails was not a factor
- Lack of affordable health care, especially mental health services.
- Lack of transportation was seen as a mitigating factor in seeking services and food.

Partnerships between the Urban Indian Walk-In Center and public and private entities were seen as a method to gain better understanding and access to services. Grant application was seen as another possible method to increase understanding and access to services.

PARTNER FOCUS GROUPS

ROUND 1

All partner focus groups were conducted the same day, March 23, 2011. The partner community group was recruited through postal mail using "save-the-date" postcards, followed by a more descriptive invitation and explanation letter. Follow up emails and phone calls were made when proper contact information was gained and when participants had not yet returned an RSVP. Of the 298 partners invited, 87 participated in the first focus group.

All participants initially met together for an orientation on the purpose and the process of the focus groups. They then broke into eight groups, each with a facilitator and note taker. Groups lasted 60 to 90 minutes. The same semi-structured facilitator's guide used for the community focus groups was used (see Appendix 9) to guide the discussion.

ROUND 2

The second round combined professional/partners with the community residents and was scheduled one month later. 56 partners/professionals participated, in which 52 attended the first set of focus groups and 4 were new to the process. This group was combined with three interested community members. Analysts took the main themes derived from the first round and categorized the issues as Health Problems, Environmental Concerns, and Process Issues. The framework for the second, combined focus groups was based upon these categories (see Appendix 10).

The second round was designed to identify solutions. The format included a general session where the participants prioritized the issues identified during the first session and then broke into individual focus groups to discuss possible solutions. In prioritizing the issues the participants were asked to consider the following factors in assigning their priority:

- Number of people impacted.
- Overall impact on the community.
- Which condition, if addressed would create the greatest gains for the community.

In a group session, each partner/resident was given five votes to cast between health problems and environmental concerns (members were allowed to cast their votes in any way, i.e. casting all votes for only one issue rather than split them up between five). Totals were summed and the top six problems were assigned to six different focus group facilitators. Mental health and substance abuse issues were combined into one group. Group members were then asked to participate in the group with the issue they preferred for discussion. Participants were charged with identifying priority problems, issues, and potential solutions. They were also asked to discuss their topics in the context of the process issues listed.

DATA MANAGEMENT

Focus groups were audio recorded with permission and notes were taken on large chart paper to facilitate discussion, summarize points, and allow participants to verify that their ideas were being interpreted correctly.

The recordings from Round 1 community and partner/professional groups were professionally transcribed and analyzed for themes using ETHNOGRAPH v.6, a qualitative data management computer program. The transcripts were analyzed by three persons: one SLCoHD doctorally-prepared qualitative researcher with content analysis experience and two public health graduate students from the University of Utah. Intra-rater reliability procedures for transcription coding were established. Themes were identified and presented in written format (see Partner Focus Group Discussions in Themes section).

ESTABLISHING VALIDITY

While quantitative approaches seek to explain a phenomenon, qualitative approaches seek to generate understanding of a phenomenon. As such, evaluation of reliability and validity for each approach is different. Credibility and Triangulation are accepted as two methods of establishing reliability and validity for qualitative approach.

- **Credibility** is defined as the degree to which the findings reflect the experience or thoughts of the participants. This was established during the prioritization process at which time participants had the opportunity to review the findings.
- **Transferability** is established when findings can be transferred to other situations or populations. The fact that the partner groups identified the same problems and issues as the community groups supports transferability.
- **Confirmability** is established by checking and rechecking the data collection and analysis procedures for bias or distortions. Consensus in establishing the groups for participation and establishing inter-rater reliability in analysis and coding procedures among those analyzing the focus group data help to confirm these findings.
- **Triangulation** is the validation of data through cross verification from two or more sources and/or research methodologies in the study of the same phenomenon. Toward this end, an analysis of demographic, morbidity, and mortality data as well as a review of *Healthy People 2020* Objectives and performance targets, IBIS-PH data related to Utah performance on health indicators, and other empirical data sources support focus group findings.

FOCUS GROUP FINDINGS

Focus group discussions can be divided into two foci: 1) Health-specific issues focusing on diseases and their predisposing factors, and 2) Variables affecting health**.** The community and partner focus groups identified the following health issues as the most critical for public health in Salt Lake County:

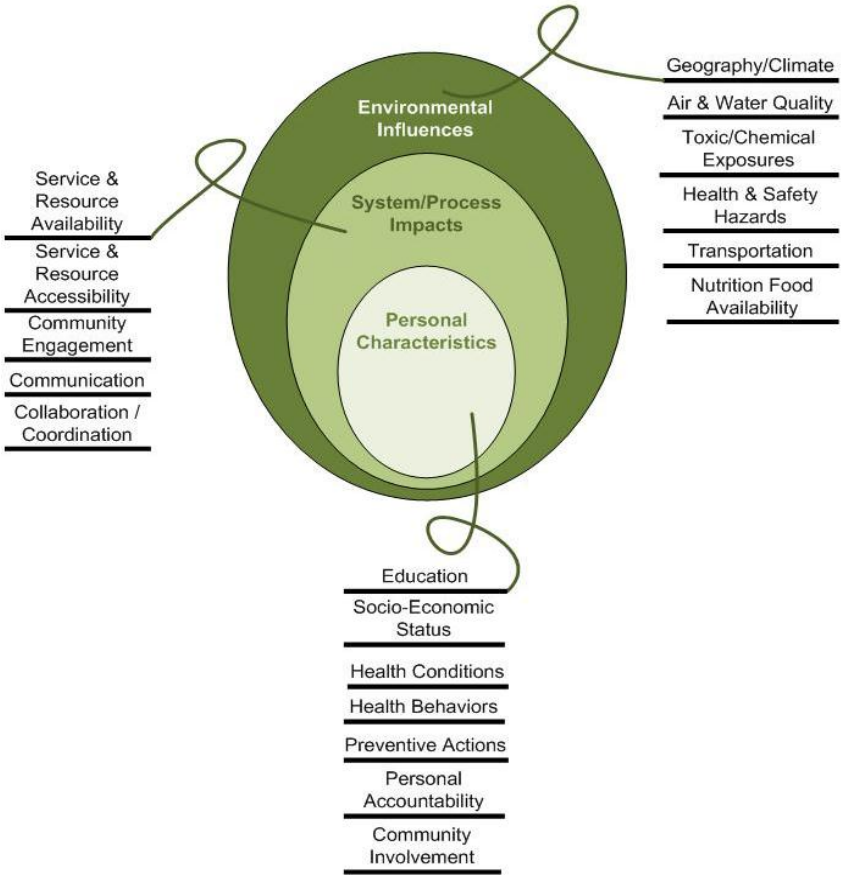
- Air Pollution
- Communicable Diseases
- Chronic Conditions or Diseases (Obesity, Heart Disease, and Diabetes)
- Water Pollution
- Mental Health & Substance Abuse

THEMES

Comparative analysis of the emerging themes between and among the focus groups indicated there is consistency among communities and community agencies regarding health problems and concerns. As the analysis progressed, it was apparent the issues fell into three categories or themes: Personal Characteristics, Environmental Influences, and Process/System Impacts.

The focus group data provides a framework delineating potential barriers and challenges for improving the identified health-specific issues. Clearly discussed at each focus group was the concern that numerous individual, system, and environmental factors have, do, and will impact any intervention proposed. Figure 60 depicts the factors at issue. The model was derived from analysis of the focus group discussions and will be used as the framework for discussing the findings from both the focus group, demographic, and community health data.

Figure 60. Factors Influencing the Community's Health



COMMUNITY FOCUS GROUP DISCUSSIONS

Personal Characteristics

Personal characteristics that influence a person's health were identified. Included in the list of personal characteristics were health conditions, health behaviors, preventive action, education, socio-economic status, personal accountability, and community involvement.

- Health conditions or illnesses included primarily chronic disease which leads functional limitations, thus limiting the types and/or venues of activities people can participate in.
- Health behaviors include decisions about whether or not to participate in healthy behaviors, such as eating healthy foods.
- Preventive action refers to residents' decisions to seek preventive services such as immunization, annual examinations or various screening procedures.
- Personal accountability is the willingness of an individual to take responsibility for one's decisions and behaviors.
- Community involvement refers to a person's willingness to be proactive and involved in programs, groups, or other activities at the community level to influence decision making.

These decisions are dependent not only on residents' choices to practice these activities, but also on the availability of personal resources, such as disposable income and time to take advantage of the available resources, as well as the knowledge about health promotion activities offered.

In general, focus group participants believed everyone has a personal responsibility to make the best choices for themselves when it comes to health. The system can provide the resources, but not the motivation. Residents have a responsibility to help guide the decisions government makes about the resources for their communities. In addition, community leaders and resources in the community need to reach out to community residents to seek their ideas and assistance in motivating other community members.

Process/System Issues

Process and system issues tended to dominate the discussions over environmental influences and personal characteristics. System issues discussed by participants focused on availability of resources in the community and residents' ability to access them. Resources necessary to maintain health included: availability of markets providing the opportunity for appropriate food choices, public education about healthy lifestyles, safe walking paths, etc.

Inequities and barriers such as socioeconomic status and age were a recurring topic. The observation that grocery stores in poorer areas do not carry the same quality of healthy foods such as fruits and vegetables as stores in more affluent areas was mentioned frequently. In addition, food choices available at grocery stores in lower income areas are limited or unhealthy. Some participants mentioned prices for healthy foods are higher.

Elderly participants voiced concern that recreation resources available in their communities are more focused on youth programs rather than providing a mix including indoor activities for the elderly who are concerned about weather and safety.

While people do have a personal responsibility for their health, the focus group members believe their tax dollars should be used to facilitate community health and well-being in the best possible way for the community. Limited funding to support health programs and resources was

acknowledged. The limited funding should be used to benefit as many as possible so community input from residents across various demographics should be solicited.

Every focus group expressed concern about government officials and program leader's infrequent engagement of the community for input. Communities in general believed they have limited opportunity for input into decisions made on their behalf. In addition, the participants identified problems between community leaders and elected or bureaucratic entities and problems within and between elected officials and bureaucratic agencies that result in poor decision making regarding resources. Interagency communications and collaborations need improvement.

Environmental Influences

Air pollution was mentioned by all focus groups as the most significant environmental issue. Other environmental hazards frequently mentioned were property management issues related to trash, insects, critters, hoarding, disrepair, and abandonment. The climate's impact on availability of year-round use of outside resources is limited which places greater emphasis on the need for indoor recreation opportunities.

Ability to access facilities providing health promoting programs and activities was consistently mentioned. Transportation was discussed as a major barrier. Not only are few transportation options available in lower income communities, there is also the belief that the newly expanding communities (in the southwest region of the county) do not need to create infrastructure for public or alternative transportation options.

The distance to health care facilities is a problem for many without transportation, yet the focus group members believe that the availability of low income healthcare resources is currently sufficient.

Partner Focus Group Discussions

Air Quality

Participants from the air quality focus group agreed that environmental influences were not as significant as the system impacts to air quality. System impacts, such as transportation issues and a lack of recreation facilities were a concern to focus group participants.

The transportation concerns focused on traffic and automobile related pollution, and a lack of alternatives to automobiles (e.g. TRAX and bike lanes). Participants mentioned that the UDOT advisories are not effective since the advisories are only seen on the road while commuting to work. Participants mentioned the TRAX system takes too long, the wait time from train to train creates an undue burden thus making the system inconvenient. Until Utah has better alternatives to driving participants do not feel that people will drive less.

Participants mentioned that greater emphasis on carpooling and idle-free campaigns could be helpful. There are current programs such as the Clear Air Challenge that have been successful, and participants feel would be well suited for an expanded purpose. However, participants believe that improving public transportation would have the most significant impact on reducing automobile traffic.

A lack of individual motivation was also mentioned. Participants mentioned that most people are unaware of their personal contribution to poor air quality and thus are not motivated to change behaviors. In addition, participants mentioned that people don't take responsibility for their behaviors. Participants specifically discussed how every school has parents who sit and idle for

10 minutes or longer while waiting for children. The lack of education or enforcement of idle-free programs makes this a poor situation.

Participants mentioned that partnering with local services would improve the public perception of their impact on air quality. They felt that SLCoHD becoming involved would be helpful since people respect the health department. Participants also mentioned that an improvement in the available programs would reduce the need to drive. A more walking-friendly environment or parents to stop idling at schools would be important. Many people don't understand that being idle-free all the time would help more than they realize.

Obesity

Participants from the obesity focus group discussed that system impacts and personal characteristics are entirely at fault for the rise in childhood obesity. Participants agreed the most significant factors affecting child obesity include a lack of health-related facilities, a lack of nutritious foods as alternatives to fast foods, and a lack of education or a sense of responsibility on an individual's part.

Participants discussed that a significant barrier to preventing obesity is that children do not have easy access to parks, recreation facilities, or gyms. When parks are far from the residence, it becomes a safety concern for children to go and play since they must travel through busy street and business districts. There are few bike and walking trails available, which also limit where children may play. Recent economic trends have also limited the number of families with memberships to gyms or recreational facilities. The cost of obtaining a gym membership, or of driving to parks on a regular basis has become cost prohibitive.

The focus group participants mentioned that creating more accessible bike and walking lanes, and easier access to parks could positively impact childhood obesity. They discussed how government support should create opportunities for easier access. Organizations such as 211 Information and Referral, Gold Medal Schools, UDOH Physical Activity Nutrition and Obesity Program (PANO), and organized sports leagues could be used to impact a greater number of people. They concluded that these programs are already in place, and being a part of an organization is more likely to cause children to participate than just going to the park independently.

Participants discussed that the greatest issues in child obesity are nutrition and diet. Fast food is easily accessible, cheap, and requires little preparation or cooking. This creates an incentive for working or busy parents to rely on unhealthy foods for meals. In addition, there are limited education resources available to teach kids to eat fruit or vegetables for snacks instead of junk food.

Participants suggested a nutrition education outreach program that partners with community and church groups. Healthy food is available, but when people go grocery shopping, they buy packaged dinners rather than fruits, vegetables, and other healthy foods. An educational approach should address these habits, and teach kids what to eat at school so they can ask for healthy foods from parents.

Water Quality

Participants from the water quality focus group discussed how environment-related issues and system impacts are the predominant issues in water quality. They discussed how natural contamination and man-made waste disposal are polluting water. Participants discussed how the lack of enforcement for cleanup laws allows people to dump waste and let their animals leave waste without cleaning up. This contamination affects both surface and ground water. The

decisions people make are impacting urban land. Participants also discussed how insect populations are contaminating waters with waste and disease. Insects that spread diseases are becoming more problematic.

Participants also discussed how system impacts can harm water quality. They talked about how people are uninformed and uneducated about the legal and environmental consequences of their behaviors. Participants agreed there is a lack of adequate water facilities, which causes people to utilize natural water sources for recreation, such as rivers and lakes. These natural water sources are then contaminated by people's careless decisions.

Participants discussed how influential organizations could partner with government agencies to better enforce and educate the public about waste dumping and conserving natural water sources.

Communicable Disease

Group members were asked to describe the perfect scenario for combating communicable disease and several ideas emerged. The perfect scenario would translate to a vaccination rate of 100 percent, as well as utilizing other types of preventive care, such as keeping sick children home from school to prevent the spread of disease. In addition, community, local and state governments need to be prepared for the spread of disease. Another element contributing to the perfect scenario is education. Education, especially spearheaded by school districts was seen as important. To position ourselves better to address the problem, education would also need to be focused on reducing the stigma around diseases such as STDs and emphasize preventative measures. Members also felt cultural competence was important and supported the idea of approaching educational information from a culturally-important perspective.

Partners in building the perfect scenario were identified as 4th Street Clinic, Planned Parenthood, the current immunization system, organizations utilizing community buildings, mayors, schools and institutions of higher education, healthcare providers, wildlife biologists, veterinarians, senior citizen volunteers, legislators, lobbyists, non-profits who serve undocumented populations, United Way, 211 Information and Referral, agriculture and food departments. Group members felt the most logical groups for leading such efforts were the local and state health departments, legislators, community leaders such as clergy and cultural representatives.

Group members expressed concerns around process issues including: transportation to clinics, proximity to clinics, and general access problems (affordability, capacity restraints, and convenience).

Exactly how to inform the public about communicable diseases involved the persistence of the message, simplicity, incentives, and the use of current news on epidemics, playing on already understood concepts such as natural disaster and emergency preparedness, and using the media and professionals to make the health department and its message more visible in the community.

Suggestions on the enhanced use of public relations and making SLCoHD more visible included:

- Educate the population about public health.
- Promote the concept that public health is public safety.
- When the spotlight is focused on SLCoHD (such as a measles outbreak), utilize the opportunity to promote public health.

- Discuss collateral damage from events, for example the tangible and intangible costs associated with a measles outbreak.
- Stress how events are linked and how one action impacts another. For example unvaccinated children are at risk and put others at risk.
- Work more closely with veterinarians. Animals can cause disease (plague, tularemia).
- Continue to work closely with mayors and local officials.
- Better utilization of social media tools, such as Twitter and Facebook.
- Improve education and access to care by creating a presence at local clinics, health fairs, and places people go.

CONCLUSIONS AND RECOMMENDATIONS

The interplay of individual, social, and environmental determinants of health makes the monitoring, maintenance, and improvement of the public's health a challenging and unrelenting but vital task. To impact and improve the public's health there must be an understanding of this interplay. This report, through the use of quantitative and qualitative data endeavors to outline the basics of these interrelated factors. The health of the public impacts and is impacted by all facets of society. Just as the community must accept some responsibility to provide the resources to support the health of the community, so must the residents acknowledge their roles and take not only personal responsibility for their own health, but also participate in community-wide health improvement programs, citizen advisory and advocacy activities. Agencies, organizations, and coalitions coordinating among themselves and with policy and decision makers can maximize the benefits of limited resources. By working together with the community, all will gain.

Overall, the health of SLCo compares favorably to the nation, but there is still a distance to go in order to reach the goal of becoming the healthiest county in the state and in the nation. While some areas of the county meet all or nearly all of the health standards, some meet very few. Efforts will be concentrated to help these failing areas improve with the understanding that there are underlying factors that play into the negative outcomes.

However there are significant challenges that must be met, both physically and sociologically. SLCo's population is expected to continue to increase, and is expected to shift in concentration from the east center of the valley to the southwest section. This shift will not only create new demands for facilities, it may increase the physical gap between those who are elderly or those with low incomes or poor education to those who are younger, have greater mobility or are more affluent. In addition, the population is aging and increasing in ethnic and cultural diversity. These factors need to be considered when the demand for new facilities or evaluation of existing facilities arises.

SLCoHD made the following observations:

- Community Members were engaged in a meaningful way. This assessment is the product of the efforts of a variety of players, not the least of which were residents and community leaders. As discussed earlier, invited community partners included a number of nontraditional partners such as wildlife biologists, chambers of commerce, unions, major employers, private nonprofits, religious organizations, and funding organizations. Through this effort, and the planned process for the Community Health Improvement Plan, SLCoHD will leverage resources, and through the combined genius of the group, better identify practical, cost-effective solutions to pressing community health problems.
- Community leaders and professionals/partners learned they had many of the same community interests, needs, and some over-lapping programs. At each group, participants exchanged information and committed to work together informally on

projects in the future. The seeds of community participation were sown at the focus groups as new and renewed partnerships emerged from the process. SLCoHD's plan is to nurture willingness to participate, provide structure and enable committed community members to work with one another on common goals. SLCoHD has learned of several efforts in the community, among them: 1) A fledging effort between SLCoHD and a hospital where physicians will prescribe healthy lifestyle training to their obese or smoking patients, and SLCoHD will provide qualified health educators; 2) An insurance company in cooperation with an area school is providing physical activity training, nutrition education, and healthy snacks in an effort to impact obesity in school age children.

- Leveraging resources is more essential than ever. As funding for programs continues to decrease, using the dollars in the most efficient and effective manner will maximize outcomes. It is the need to leverage resources that drives many of the decisions agencies make as they seek collaborations with other agencies. Long standing barriers between types of agencies will need to be confronted and worked through. SLCoHD heard this loud and clear in the focus groups.

For the purposes of this report, SLCoHD noted two general categories of issues – **Overarching** and **Specific**:

OVERARCHING ISSUES

During the course of this review, SLCoHD identified the following macro issues impacting community health. Not surprisingly many of these same issues plague other components of society. These issues include:

- System issues
- Process issues
- Usefulness of the data
- Geographic Location

SYSTEM ISSUES

COMMUNITY

- Service and resource availability to community members
- Service and resource accessibility for community members
- Coordination and communication between agencies and community leadership

AGENCY

- Continue to improve the collaborations that were initiated as a result of this effort
- Continue to utilize interns from area universities
- Continue to expand opportunities for collaboration

PROCESS ISSUES

- Communication and collaboration between agencies
- Coordination of services, e.g. to avoid such things as two low-cost clinics within a few blocks of each other
- Engagement of community members in health-related decision making for the community

DATA AVAILABILITY AND USEFULNESS

- Small area data does not correlate with municipal boundaries.
- IBIS-PH Health Indicators frequently do not match Healthy People 2020 Objectives.

- Need for data reported at the county level and small area levels. For example, some of the indicators for diabetes are only available at the national level.
- Labeling of small area data is confusing to municipalities. Many municipalities are divided and share in small area data with other municipalities yet only one small area bears its name.
- Work with IBIS-PH to ensure that indicators reflect data needs for determining progress on *Healthy People 2020* objectives.
- Need consistency in the way immunization data are collected at the state and local level. At the current time, Salt Lake, Davis and Tooele counties use a CDC approved system to track vaccinations, while the state of Utah uses another system based on a sampling methodology. As a result, the state-estimated rates tend to be lower than the rates calculated by the local health departments. At a minimum, the official state figures should be derived using the same methodology.

GEOGRAPHIC LOCATION

Where a person lives can have an impact on their health. In SLCo, as with most medium to large population centers, there are pockets of poor public health. As discussed in this report, the areas of Glendale, Rose Park, Magna and to a lesser extent, West Valley and South Salt Lake are the most troubled areas in terms of community health. The question then becomes what can be done to impact some of these areas given that income and education are generally considered to be the best predictors of a community's health. Ironically, these are the most difficult to impact, and require the most time and funding. That is not to say that nothing can be done, as many things are being done or can be done. Short- and long-term solutions can be sought only when there is an awareness of a problem and a willingness to combat it. SLCoHD's hope is that this report (along with several others) will serve as a catalyst to begin that journey.

SPECIFIC ISSUES

In addition to the overarching issues, there are a number of smaller, more discrete issues. Among those identified in this report are:

- Relative rankings compared to peer or neighboring counties
- Shifting demographics
- Selected diseases
- Social determinants of health
- Individual determinants of health
- Environmental concerns

IMPROVE COUNTY RANKINGS

Rankings of counties are a good barometer of how well a county is doing in comparison to its peer counties and its neighboring counties. According to the data described in this report, SLCo is in the middle of the pack. To improve and become the healthiest county, SLCo must strategically identify geographic areas that are lagging, and develop interventions to impact the problem issues. This effort must in collaboration with community partners.

- Work with organizations that design and conduct county ranking reports so data used to rank and report clearly reflect the county they purport to represent.
- Work with community partners to impact critical issues and use county rankings to help guide and prioritize efforts.
- In collaboration with community partners, target small areas having challenges in meeting *Healthy People 2020* targets for additional assistance.

RESPOND TO AND PREPARE FOR SHIFTING DEMOGRAPHICS

New arrivals of residents (many of whom are immigrants), ageing of existing residents, and a marked shift in population to the southwest quadrant are the central demographic issues facing SLCo. Elderly individuals will tend to be located in the suburban southeast area of the valley, and in the lower-income urban northern areas including the Avenues, Rose Park, and Glendale. At the same time, the more affluent southwest area will be bursting with young families. The new arrivals, based in large part on their incomes will tend to distribute themselves along income lines and/or in neighborhoods with fellow immigrants. The implications of this shift are significant. In terms of community health, including more services for an increasingly frail population in one area, greater linguistic and cultural resources for an increasingly diverse population in another, and increased demand for immunizations and family health services in yet another. In addition, increased pressure on infrastructure issues related to water and sanitary needs wherever the population expands.

To better prepare for these changes SLCoHD's recommend:

- Locate facilities in the southwest quadrant, an area of projected high growth.
- Work to ensure the availability of services for elderly in the southeast and for youth and young families in the southwest.
- Insure greater cultural sensitivity and multiple language availability.

DISEASES AND SELECTED HEALTH PROBLEMS

Although SLCo is generally meeting the objectives established in the *Healthy People 2020* effort, there are significant sectors of SLCo that are not reaching the targets. In general this means that while Sandy, South Jordan, Foothill/University areas and others are consistently meeting or exceeding the targets, there are a few areas such as Glendale, Rose Park and Magna that consistently have difficulty meeting the targets. One approach for assisting these areas might be to assist community leaders to collaborate with agencies and organizations to identify and develop interventions for health issues and focus resources on these communities.

OBESITY

Obesity can be a predisposing, precipitating factor, or the direct cause for many health problems including diabetes, heart disease, orthopedic problems. Obesity affects breathing, the ability to exercise, endurance, as well as making existing health problems worse. Obesity was identified in focus groups, data, and community ranking reports as one of the major community health issues facing SLCo. Of note, the percentage of obese adults in Utah more than doubled in 22 years. For example, only 12% of Avenues residents are considered obese, compared to nearly 40% of Magna's residents. Of extreme concern is the increase in obesity among children. As has been seen earlier, some small areas are healthier than others.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are recognized as key factors influencing the public's health. As part of this assessment, SLCoHD accounted for income, education, risky behaviors, access to nutritious foods, and access to care as critical factors impacting the public's health. The direct relationship between these social factors and a disproportionate share of illness and perceived poor health is evident in the findings. Greater investment by policymakers in improving the infrastructures related to the aforementioned social determinants of health is necessary to realize improvement in the health of the residents and health indicators of the aforementioned communities.

INDIVIDUAL DETERMINANTS OF HEALTH

Individual determinants of health are key factors influencing individual health. People have accountability for their own health. While expecting the system to provide accessible services to

maintain health, they must avoid unhealthy behaviors such as binge drinking, overeating, and smoking and engage in healthful ones such as exercise, proper nutrition and participation in disease-specific screenings.

ENVIRONMENTAL CONCERNS

Focus group participants identified air and water as the environmental areas of the greatest concern, proclaiming air pollution as the greatest threat to community health.

AIR POLLUTION IS THE GREATEST AREA OF NEED

Air pollution and haze has been a concern in the Salt Lake Valley for several years. The cause of the pollution has changed but the problem remains. The Salt Lake valley is surrounded by mountains; these mountains tend to retain pollutants by restricting cleansing winds. This problem was noted in Salt Lake City's 1943 City Plan. In the *Problem of Smoke in Salt Lake City* section they note that:

> *Because of peculiarities of its location, Salt Lake City, although not a tremendous smoke producer nevertheless finds smoke an exceedingly serious problem.* It goes on to state: *The location of Salt Lake City in a valley closed on three sides by mountains retards dispersal of smoke. During the winter months the wind velocities are lowest, and long periods of calm weather permit the smoke to accumulate in areas not entirely responsible for its production.*

To combat the problem Salt Lake City established the forerunner of the Bureau of Air Quality; the Smoke Control Division.

The EPA has identified six criteria pollutants. They are: ozone, particulate matter, carbon monoxide, nitrogen oxides, sulfur dioxides, and lead. SLCo currently meets federal standards for most of these pollutants. Only ozone and particulate matter are considered by EPA to be serious threats to public health in SLCo. The concentration of both of these air pollutants is extremely dependent upon meteorology. As pollutants are generated, the concentration increases due to the smaller volume of air trapped below the inversion. When this occurs, the National Ambient Air Quality Standards (NAAQS) may be exceeded.

Since 1984, the SLCoHD has operated a Vehicle Inspection and Maintenance (I/M) Program to reduce air pollution. Motorists take their vehicles to authorized test stations for annual tests to ensure that their vehicles are working properly and not polluting the air. The program has been successful in reducing emissions of NOx, CO, and VOCs. Thereby preventing many unhealthy days and hastening the attainment of the CO and Ozone standards. The Vehicle Inspection and Maintenance (I/M) Program continues to provide benefits for the reduction of PM 2.5 and Ozone - our current criteria pollutant concerns.

SLCoHD believes that current efforts must be maintained and that as additional technologies become available they be carefully reviewed and if feasible, aggressively adopted. Combatting air pollution must be done on an incremental scale. Public awareness, public policies, technological advancements, and public demand will all be needed to effectively combat air pollution.

WATER POLLUTION

In general water pollution in SLCo is not a major problem, due in large part to the efforts of the Bureau of Water Quality. That is not to say the problem is solved, as ensuring clean water is an on-going task.

The sources of water pollution are widespread. Water pollution can occur in the form of: bacteria, chemicals (oil, gasoline, paint, household chemicals, medical by-products, asbestos, pesticides, road salt, lead, mercury), and radiation (Uranium, titanium). Contamination can harm humans, wildlife, fish, and/or the environment. Sources of contamination include: septic systems, leakage of underground storage tanks, broken pipelines, hazardous waste sites, industrial dumping, landfills, agricultural chemicals and fertilizers, and atmospheric deposition of airborne contaminants that form acid rain. Processes, procedures, policies, and laws are in place to control many of these threats to our drinking water and recreational water, but problems may occur despite these measures.

END NOTE

This review considered a few of the health determinants and issues facing SLCo that hold us back from becoming the healthiest county in the nation. There are challenges and related responsibilities to go around, the burden of which must be shared by all involved stakeholders – residents, providers, advocacy groups, and informal and elected officials.

The next step is to come together to develop a Community Health Improvement Plan that reflects the unique roles of each stakeholder in the journey toward becoming the healthiest county in the nation.

APPENDICES

Appendix 1	Graduate Student Assistants
Appendix 2	Criteria for Choosing Health Factors for Review
Appendix 3	*Community Health Status Indicator Project* Definitions
Appendix 4	*County Health Roadmaps Project* Detailed Tables
Appendix 5	Small Area Map
Appendix 6	Table data for Pertussis Figures 26 and 27 and Tuberculosis Figure 41.
Appendix 7	Detailed Descriptions of Salt Lake County Food Deserts
Appendix 8	Focus Group Locations
Appendix 9	Facilitator's Guide
Appendix 10	Focus Group Activity – 2nd Focus Group

APPENDIX 1 – GRADUATE STUDENT ASSISTANTS

GRADUATE STUDENT ASSISTANTS
ACCREDITATION PROCESS

SEMESTER	SCHOOL	NAME	ACTIVITY	MENTOR
Spring – Fall 2011	University of Utah	Suzanne Millward	Data collection (focus groups) and analysis	Cynthia Morgan, PhD, RN
Spring 2011	University of Utah	Sarah Ashitey	Focus Group data analysis	Cynthia Morgan, PhD, RN
Spring 2011 – June 2012	University of Utah	Daniel Crouch	Data Analysis for Critical Indicators	Jim Thuet
Summer 2012 – Present	University of Utah	Daniel Bennion	Community Health Assessment report	Cynthia Morgan, PhD, RN

APPENDIX 2 – CRITERIA FOR CHOOSING HEALTH FACTORS FOR REVIEW

Criteria for choosing variables to analyze

# Times ID'd	Groups ranking problem → / Health and Health-Related Concerns ↓	County Health Status Indicator Project (CHSI)	Community Health Roadmaps Project (CHRP)	Focus Groups	Health Data	Healthy People 2020	Comments
4	Obesity		X	X	X	X	Obesity is a factor for numerous chronic illnesses
3	Diabetes			X	X	X	
3	Asthma			X	X	X	Both Asthma and COPD are problems with air pollution
2	COPD				X	X	
1	Stroke	X					
3	Breast Cancer	X			X	X	
3	STDs		X		X	X	
3	Pertussis	X			X	X	
3	Tuberculosis	X		X		X	
1	Hepatitis B	X					
3	Suicide	X			X	X	
2	Motor Vehicle Accidents	X	X				
4	First Trimester prenatal care	X	X		X	X	Related to low birth weight
4	Low Birth Weight babies	X	X		X	X	
1	Hispanic Infant Mortality	X					
4	Births to Women Under 18	X	X		X	X	
	Individual Behaviors						
2	Smoking		X			X	
3	Binge drinking		X	X			
3	Physical Inactivity		X	X		X	
3	Maintain healthy weight		X	X		X	
3	Cancer Screenings		X		X	X	
5	○ Mammogram	X	X	X	X	X	
4	○ Colorectal	X		X	X	X	
4	○ Cervical	X		X	X	X	

Criteria for choosing variables to analyze

# Times ID'd	Groups ranking problem → / Health and Health-Related Concerns ↓	County Health Status Indicator Project (CHSI)	Community Health Roadmaps Project (CHRP)	Focus Groups	Health Data	Healthy People 2020	Comments
	Physical Environment		X				
4	Air Quality		X	X	X	X	
3	Limited Access to Healthy Foods		X	X		X	
1	Number of Fast Food Restaurants		X				
2	Access to recreational facilities		X	X			
1	Lack of Transportation			X			
3	Water Quality			X	X	X	
	Social/Economic Factors						*Objectives are under development.
3	Poverty		X		X	X*	
3	Education		X		X	X*	
4	Uninsured / Cost		X	X	X	X	
	Clinical Care						
3	Low cost primary healthcare services		X		X	X	

Community Health problems were identified utilizing five sources:

1. County Health Status Indicator Project which compared Salt Lake County with peer (similar) counties
2. Community Health Roadmaps Project ranked Salt Lake County against other counties in the state by comparing its rank to the other counties in the state.
3. Community and partner focus groups identified problems from their unique perspectives
4. Health Data from IBIS-PH was reviewed to identify areas where Salt Lake County needs improvement.
5. Healthy People 2020 targets for each of the identified health problems were reviewed.

Criteria for choosing health problems to analyze:

- Identified by 3 or 4 of the above sources as issues for Salt Lake County
- Public Health Core Functions and Essential Public Health Services that frame the public health sphere of responsibility

- Salt Lake County Small Areas rates that were significantly different from county, state, and national rates.
- Condition is somewhat preventable given adoption of healthy behaviors and/or screening
- Improvement in the problem will impact other problems
- Items were related to others to be considered, e.g. lack of recreational facilities is related to physical activity and obesity.

APPENDIX 3 – COUNTY HEALTH RANKINGS DEFINITIONS

"Rank (of 26)": Of Utah's 29 counties, only 26 are included in the analysis. Rich, Piute, and Daggett counties are "NR: Not Ranked."
National target: 90th percentile, i.e., only 10% are better
Premature Death: Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Poor or fair health: Percentage of adults reporting fair or poor health (age-adjusted)
Poor physical health days: Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Poor mental health days: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Low birth weight: Percent of live births with low birth weight (< 2500 grams or 5.5lbs)

Adult Smoking: Percent of adults that report smoking >= 100 cigarettes and currently smoking
Adult Obesity: Percent of adults that report a BMI >= 30
Physical inactivity: Percent of adults aged 20 and over reporting no leisure time physical activity
Excessive drinking: Binge plus heavy drinking
Motor vehicle crash death rate: Motor vehicle crash deaths per 100,000 population
Sexually transmitted infections: Chlamydia rate per 100,000 population
Teen birth rate: Teen birth rate per 1,000 female population, ages 15-19

Uninsured: Percent of population under age 65 without health insurance
Primary care physicians: Ratio of population to primary care physicians
Preventable Hospital Stays: Hospitalization Rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Diabetic Screening: Percent of diabetic Medicare enrollees that receive HbA1c screening
Mammography screening: Percent of female Medicare enrollees that receive mammography screening.

High School Graduation: Percent of 9th grade cohort that graduates in 4 years.
Some College: Percent of adults aged 25-44 with some post-secondary education
Unemployment: Percent of population age 16+ unemployed but seeking work
Children in Poverty: Percent of children under age 18 in poverty
Inadequate social support: Percent of adults without social/emotional support
Children in single-parent households: Percent of children that live in household headed by single parent
Violent crime rate: Violent crime rate per 100,000 population

Air pollution-particulate matter days: Annual number of unhealthy air quality days due to fine particulate matter.
Air pollution-ozone days: Annual number of unhealthy air quality days due to ozone
Access to recreational facilities: Rate of recreational facilities per 100,000 population
Limited access to healthy foods: Percent of population who are low-income and do not live close to a grocery store
Fast food restaurants: Percent of all restaurants that are fast-food establishments

APPENDIX 4 – COUNTY HEALTH ROADMAPS PROJECT DETAILED TABLES

HEALTH OUTCOMES OVERALL HEALTH OUTCOMES RATE FOR SALT LAKE COUNTY = 12TH	SALT LAKE COUNTY RATE	UTAH RATE	AVERAGE TOP 10 COUNTIES
MORTALITY RANK	**7 – SLCo Rank**		
• Premature death (potential life lost before 75)	6,106	6,002	5,466

MORBIDITY RANK	**15 – SLCo Rank**		
• Poor or fair health (% reporting age adjusted to 2000 population)	13%	13%	10%
• Poor physical health days (# days reported adjusted to 2000 population)	3.3	3.4	2.6
• Poor mental health days (# days reported adjusted to 2000 population)	3.3	3.2	2.3
• Low birth weight babies (% live births weight <2500 gms)	7.1%	6.7%	6%

LEGEND	
	Equal to or better than national benchmark
	Equal to or better than Utah rate; worse than national benchmark
	Less than both national benchmark and state rate

HEALTH OUTCOMES OVERALL HEALTH FACTOR RATE FOR SALT LAKE COUNTY = 17TH	SALT LAKE COUNTY RATE	UTAH RATE	AVERAGE TOP 10 COUNTIES
HEALTH BEHAVIORS	**12 – SLCo Rank**		
• Adult smoking % aged 20> smoking every or most days; >100 cigarettes in lifetime)	12%	10%	14%
• Adult obesity (% of aged 20 & > BMI ≥ 30 kg/m2)	25%	25%	25%
• Physical inactivity (% of aged 20 & > reporting no leisure time physical activity)	18%	18%	21%
• Excessive drinking (binge >4 for women, 5 men on a single occasion past 30 d)	12%	9%	8%
• Motor vehicle accident (MVA) rate (all types per 100,000)	11	13	12
• STDs (measured by chlamydia rate)	319	225	84

HEALTH OUTCOMES OVERALL HEALTH FACTOR RATE FOR SALT LAKE COUNTY = 17TH	SALT LAKE COUNTY RATE	UTAH RATE	AVERAGE TOP 10 COUNTIES
• Teen birth rate (per 1000 aged 15-19)	40	35	22

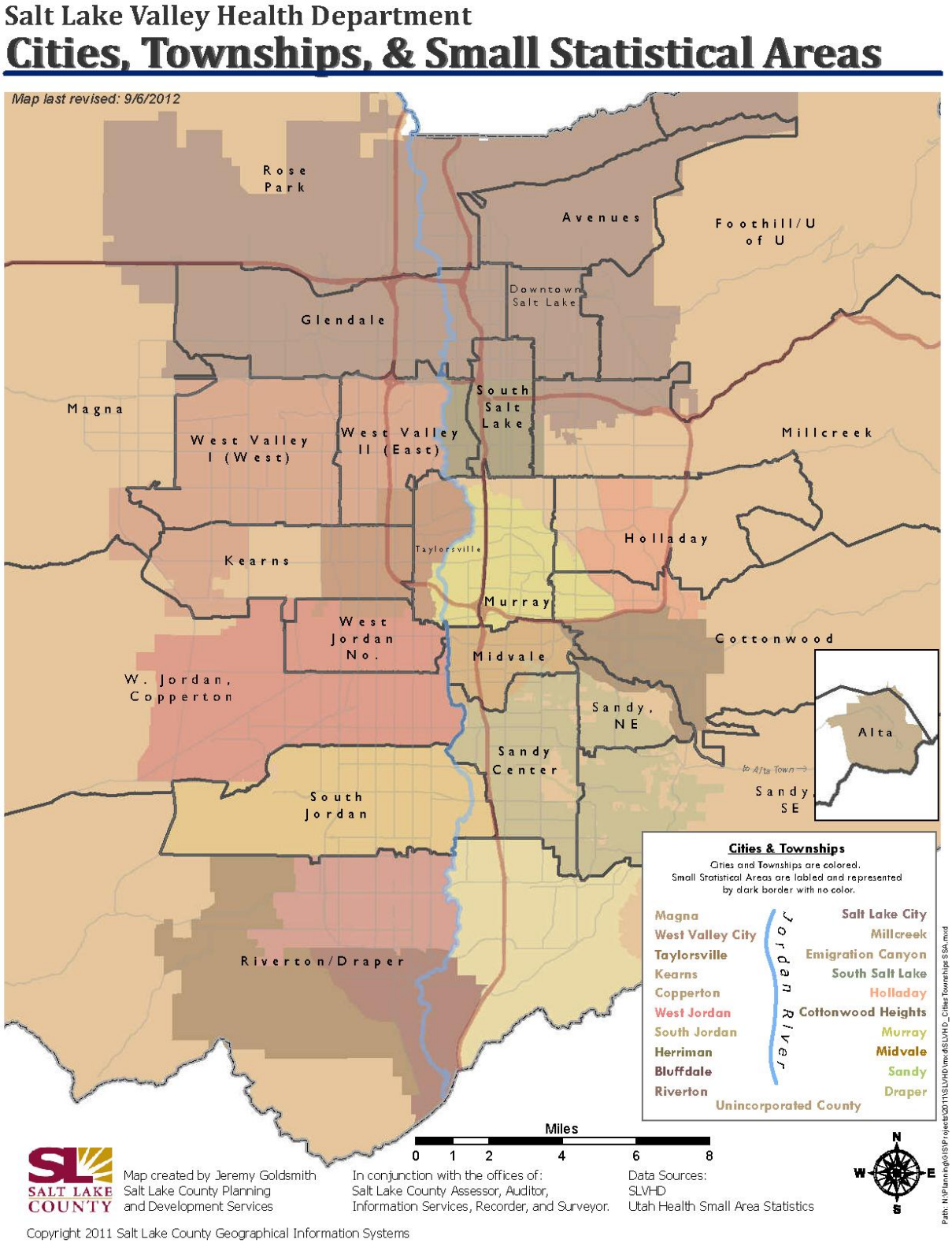
CLINICAL CARE	5 – SLCo Rank		
• Uninsured (% <65 years)	17%	16%	11%
• Primary care physicians (GP, FM, IM, Peds, OB/GYN)	808:1	1072:1	631:1
• Preventable hospital stays (hospital discharge rate for ambulatory sensitive conditions per 1,000 Medicare enrollees)	36	37	49
• Diabetic screening (% diabetic Medicare patients – HbA1c screened past year)	83%	82%	89%
• Mammography screening (Medicare patients aged 67-69 – 1 within last 2 years)	62%	72%	74%

SOCIAL AND ECONOMIC FACTORS	19 – SLCo Rank		
• Children in poverty	18%	16%	13%
• Inadequate social support	17%	15%	14%
• Children in single parent households	21%	17%	20%
• Violent crime rate	378	226	73

PHYSICAL ENVIRONMENT	26 – SLCo Rank		
• Air pollution – particulate matter	11	6	0
• Air pollution – ozone	20	12	0
• Access to recreational facilities	8	8	16
• Limited access to healthy foods	4%	7%	0%
• Fast food restaurants	59%	58%	25%

LEGEND	
	Equal to or better than national target
	Equal to or better than Utah rate; worse than national target
	Less than both national target and state Rate

APPENDIX 5 – SMALL AREA MAP



APPENDIX 6 – TABLES FOR PERTUSSIS FIGURES 26 AND 27 AND TUBERCULOSIS FIGURE 41

Table 11. Numerical Presentation of Figure 26. Number of Reported Pertussis Cases by Age and Year, Utah, 1995-2009

Year	Age in Years						
	< 1	1-4	5-9	10-19	20-44	45-64	65+
1995	21	5	6	2	3	0	0
1996	19	1	3	1	2	0	0
1997	16	8	0	3	1	1	0
1998	71	85	45	41	31	12	1
1999	19	8	0	13	13	3	2
2000	19	6	5	4	8	4	1
2001	25	13	6	14	15	4	1
2002	23	37	18	20	14	3	0
2003	33	15	10	22	27	17	2
2004	41	30	18	70	77	37	2
2005	54	65	54	171	157	90	24
2006	45	52	52	232	227	143	26
2007	25	25	22	71	129	97	22
2008	8	13	9	18	19	8	3
2009	14	28	25	50	67	26	13

Table 12. Numerical Presentation of Figure 27. Number of reported Pertussis cases by age and year, Salt Lake County, 1995-2009

Year	Age in Years						
	< 1	1-4	5-9	10-19	20-44	45-64	65+
1995	9	2	0	0	0	0	0
1996	7	0	2	0	0	0	0
1997	12	6	0	1	1	1	0
1998	37	26	15	13	14	6	1
1999	9	5	0	4	7	1	2
2000	7	4	4	3	5	4	0
2001	14	5	0	3	2	3	0
2002	16	5	3	6	6	1	0
2003	14	8	4	9	20	12	2
2004	23	21	15	52	52	22	2
2005	19	26	15	71	64	49	13
2006	24	26	33	139	130	92	20
2007	17	13	17	45	92	68	12
2008	8	10	8	21	45	22	3
2009	7	5	7	9	19	12	7

APPENDIX 7 – DETAILED DESCRIPTIONS OF SALT LAKE COUNTY FOOD DESERTS

According to the USDA, Salt Lake City has two locations that are considered food deserts. Geographically, the first location is near the Rose Park Golf Course with I-215 to the west. The second location is south of the first location in the Glendale neighborhood – east of the Jordan River with Redwood Road (Hwy 68) to the west. The first location has a population of 8,898 people. 5,456 of those people (61.3%) have low access to food and 866 (9.8%) of these people are considered low-income. The second location has a population of 8,177 people. 1,194 of these people (14.6%) have low access to food and 261 people (3.2%) are considered low-income and also have low access.

Table 10 - Food Desert Tracts

Exhibit 3. North Central Salt Lake County Combined Food Desert Tracts

FIPS Code	Community			Total People with low access		Low income people with low access	
	Name	ID	#	#	%	#	%
4903511	West Valley City	3305	6101	2322	38.1%	491	8.0%
	West Valley City	3307	5707	2250	39.4%	275	4.8%
	West Valley City/South Salt Lake City	1500	2017	527	26.1%	136	6.7%
	West Valley City/South Salt Lake/Murray	1600	6386	5202	81.5%	756	11.8%
	Taylorsville	3512	3474	2062	59.4%	178	5.1%
			23685	**123**[63]	**52.2%**	**1836**	**7.8%**

West Valley City (WVC), Taylorsville, Murray and South Salt Lake city (SSL) share five locations that are considered food deserts. Each location borders at least one other and all are generally located with Hwy 201 as the north border, state Street (Hwy 89) as the east, and 3500 South cutting through the center of this triangle shaped area. Combined, these areas contain 23,685 residents and 12,363 (52.2%) have low access to food. Of the total population, 7.8% are low income residents who also have low access to food.

Exhibit 4. Midvale/Sandy Combined Food Desert Tracts

FIPS Code	Community			Total People with low access		Low income people with low access	
	Name	ID	#	#	%	#	%
4903511	Midvale	2401	8672	3427	39.5	966	11.2
	Sandy	2402	5089	5089	100	431	8.5
			13761	**8516**	**61.9%**	**1397**	**10.2%**

Midvale has two contiguous tracts that are considered food deserts. The combined area straddles I-15 with 6500 S as its north border and 9000 S as its south. This area includes the entire west side of Midvale city with both tracts tailing into a few blocks of Sandy city at the south end. Combined, this area has 13,761 residents with 62 percent having low access to food. Of the total population, 1,397 people (10.2%) are people considered low income who also have low access to food. Exhibit 4 shows that the smaller of these two tracts has 100%of residents with low access to food.

Kearns also has only one location. Kearns is located on the west side of all of the other food desert locations. It falls between West Valley City (north of Kearns) and West Jordan (south of Kearns). Kearns has a population of 3,758 people. 943 of those people (25.1%) have low access to food and 362 people (9.6%) from the total population are low-income people who have low access. Salt Lake City, South Salt Lake, and Midvale all have the highest number of people who have low-incomes and have low access to food.

APPENDIX 8 – FOCUS GROUP LOCATIONS

Focus Groups

Area	Date & Time	Location	Facilitator	Scribe
1	17 March, 6:00-8:00PM	Sorensen Unity Center	Cindy Morgan	Suzy Millward
2	29 March, 6:30-8:30PM	Kearns Community Center	Cindy Morgan	Suzy Millward
3	11 March, 6:30-8:30PM	Taylorsville Recreation Center	Cindy Morgan	Suzy Millward
4	19 March, 10:00-12:00PM	Riverton Library	Suzy Millward	Cindy Morgan
5	09 April, 10:00-12:00PM	Sandy Library	Cindy Morgan	Suzy Millward
6	19 March, 1:00-3:00PM	Holladay Library	Cindy Morgan	Suzy Millward

APPENDIX 9 – FACILITATOR'S GUIDE

Health Department Community Focus Groups

March, 2011

Introduction:

The Salt Lake County Health Department is seeking to learn about what our communities and partners feel are the key health concerns for individuals, their communities, and the County. Our Health Department offers many services (e.g., immunizations, health classes, prevention opportunities, emergency services, and environmental health services) but we're not sure if we're meeting the needs in communities and across the County. So, we're asking you to help us. We're here today to learn from you. We have _____ minutes/hours to talk and learn. I'll be facilitating your conversation and _____ will be taking the notes. By the end of today, we'd like to know about what you know that currently exists and is working well and what we, with our partners, should be focusing on over the next few years.

1. First of all, I'd like to know what you believe are the greatest health problems in your community. What problems do you see, hear about, or maybe talk about? Why do you believe these are issues? How about for the County overall?

   Facilitator: Continue to prompt until everyone has spoken and you feel you've collected as much as you can. Quick review of what you've collected—anything missing?

2. So, what services or organizations do you know of that are doing work to address these concerns? We've always found it's better to build on existing strengths, if possible. Do you know of things that are working well right now?
   a. Are there areas of duplication in services where some things have a lot of focus and maybe are overlapping?

   Facilitator: Often, this question leads to some initial silence. People aren't used to being asked what's going well. Keep on prompting, maybe providing some initial ideas/suggestions to get them going.

3. Ok, so now, where are the gaps? What issues aren't being addressed or aren't being addressed at a sufficient level? What services/supports are missing in the community?

   Facilitator: After the list completed, define the key categories then lead group through a prioritization exercise—either to vote for top 3-5 issues with a raise of hands (get a total of 5 votes, can use all of them for one, one each, or any mix in between). Could also have people come up with markers and vote with dots. This will let us know the key things they are worried about.

4. What recommendations do you have for addressing these issues? What kinds of services do you believe would make a difference for the issues you've identified? Who would you like to see working on the issues?

5. *If time:* What would it do for your community if these were addressed? How do you think things would change? *(This will start the group in their thinking about how things could be. May help motivate their future involvement in changes)*

Closing: Thank you for your time and insights. If anything else comes to you, please feel free to contact _____ at _____.

APPENDIX 10 – PARTNER FOCUS GROUPS: SECOND ROUND ACTIVITY

FOCUS GROUP ACTIVITY

April 20, 2011

1. Rank health problems and environment concerns
2. Choose one of the top 10 health or environment problems you believe the SLCoHD should focus on during the next 5 years.
3. Go to the location instructed.
4. Focus groups will be formed
5. Discuss Process/System issues related to your health/environment problem.
6. Develop creative approaches to mitigate the process/system issue for your chosen health/environmental problem.

Health Problems	Environmental Concerns	Process/System Issues
Asthma	Air Quality	Abuse of system
Cancer	Carbon Monoxide	Accountability (mistakes, delayed care)
Cardiovascular Disease	Insects	Addressing the needs of different groups (age, ethnicity, gender, sexual orientation, etc.)
Communicable Disease (incl. vaccine-preventable disease)	Property Maintenance (incl. trash, hording, disrepair, abandonment)	Affordability
Dental Disease	Rodents & other pests	Availability
Diabetes	Second hand smoke (indoor air quality)	Collaboration (horizontal vs vertical [siloed])
Mental Illness (incl. suicide, abuse/neglect)	Toxic Exposures (incl. pesticides)	Communication
Obesity	Waste Disposal	Community engagement
Sexually Transmitted Diseases (incl. HIV/AIDS)	Water Quality (incl. fluoridation)	Competition
Substance Abuse (incl. illicit & prescription drugs, alcohol)		Funding
Teen pregnancy		Holistic approach to health
Tobacco		Incentives (for professionals & consumers)
		Inequities (poverty, homelessness)
		Language barriers
		Local government support
		Multi-sectorial approach (integrating health into all agencies)
		Responsibility (system vs individual)

The lists are in alphabetical order.

Council Meeting

6:30 p.m.
Call to Order

Opening Ceremonies:

Pledge of Allegiance

Council Minutes

Murray City Municipal Council
Chambers
Murray City, Utah

The Municipal Council of Murray City, Utah, met on Tuesday, the 21st day of May, 2013 at 6:30 p.m., for a meeting held in the Murray City Council Chambers, 5025 South State Street, Murray, Utah.

Roll Call consisted of the following:

Brett Hales	Council Chair - Conducted
Jim Brass,	Council Member
Darren Stam,	Council Member
Jared Shaver,	Council Member
Dave Nicponski,	Council Member - Excused

Others who attended:

Justin Zollinger,	Mayor Pro-Tem
Jan Wells,	Chief of Staff
Jennifer Kennedy,	City Recorder
Frank Nakamura,	City Attorney
Greg Bellon,	Assistant General Manager
Kevin Potter,	Deputy Fire Chief
Mary Ann Kirk,	Cultural Arts Director
Brady Jenkins,	Power Department
Stephanie Wright,	Chamber of Commerce
Citizens	

Mr. Hales excused Mayor Snarr and Councilmember Nicponski.

5. OPENING CEREMONIES

5.1 Pledge of Allegiance - Diane Turner, Murray resident.

5.2 Approval of Minutes

5.2.1 Approval of minutes for April 16, 2013.

Mr. Shaver made a motion to approve the minutes for April 16, 2013. Mr. Brass seconded the motion.

Voice vote taken, all 'ayes.'

5.3 Special Recognition:

5.3.1 Murray City Council Employee of the Month – Brady Jenkins, Power Generation/Substation Technician.

Staff presentation: Greg Bellon, Assistant General Manager, Power Department

Mr. Hales presented Mr. Jenkins with a certificate and gift card to Fashion Place Mall. He told Mr. Jenkins that his name will also be placed on the plaque in the Council Chambers.

Mr. Bellon presented Mrs. Jenkins and her children with roses. He stated that he and Mr. Jenkins go back quite a long time. They worked at Bountiful together. Mr. Jenkins actually transitioned over to Murray City about a year before Mr. Bellon did. Mr. Bellon said he felt very honored and privileged to be able to present the Employee of the Month award to Mr. Jenkins. Mr. Jenkins started working for Murray July 9, 2007 and he was quite an impressive hire for Murray City. Mr. Jenkins is currently working on his Engineering Degree which he should receive next spring. Currently, Mr. Jenkins is working as the Sub-tech/Compliance Officer for the Power Department. Just in the last year, he helped the Department through a major audit from WEC, which was five years in the making. He had a lot of work to do but the Department came through the audit feeling really good with where they are at and what they have accomplished with his help.

Mr. Bellon said that Mr. Jenkins is one of those guys who gets asked to do a lot and performs, never complains, and is always happy to help. He is a very good employee. He started cross-fit training about four months ago and last month was the 'cross-fitter' of the month for his box or gym. Mr. Bellon went there with Mr. Jenkins the other day and as he walked in it was like he was a movie star, with everyone recognizing him. If Mr. Jenkins does something, he does it well. He is a very good employee and Mr. Bellon couldn't ask for a better guy working for Murray City Power.

Mr. Bellon added that they got him some golf balls instead of flowers, and presented him with those.

5.3.2 History Advisory Board Report and Award Presentation to Eldene Petrovich.

Staff presentation: Peter Steele, History Advisory Board Chair

Mr. Steele gave a quick report on the state of Murray History. Currently they have 344 buildings on the local historic register. Of those, 223 are in National Registry Districts which allows the property owners to access Federal and State tax credits for the upkeep of their buildings. One hundred twenty-one of those are listed outside of National Registry Districts including a few that are also on the National Registry of Properties. In addition, this last year the Board completed an inventory of all buildings constructed in Murray before 1950. There are about 3,900 buildings on that inventory and that allows them to know what is going on in the City when projects come through. During 2012, two buildings on their local register were demolished. Those buildings were located at 760 East Vine Street and a duplex at 152 - 156 East Court Avenue. There were also eighteen buildings which were within the historic period, older than 50 years old, which were not on the local register.

Mr. Steele went over some of the projects they have completed this year. They have posted the complete local registry on-line with photographs of the buildings that is accessible through the Library website. They have completed the survey for the City and are currently in the process of updating their multiple property listings adding a new area to the National Register District, which is the Hillside area just east of the Library. This will allow homeowners in that neighborhood to also access tax credits if they desire to do so. They have also participated in the Utah Shakeout activities, sponsoring presentations for homeowners to learn how to upgrade their homes seismically. This year they are working on updating museum policies, projects, and making sure that everything is in line with national standards. They are also working on going through the surveys that have been completed and updating the registry which currently only goes up to about 1920 in most cases. They will be updating the local registry with building from the 1930's and 1940's now. The local registry will grow a little bit this year.

In addition the museum has completed an oral history project with some of the older residents of the City. They got their memories of Murray and are currently creating an exhibit for the museum to allow visitors to listen to those memories.

Mr. Steele said that they would like to present the Murray Heritage Stewardship Award to Eldene Petrovich and invited Ms. Petrovich to come forward. Ms. Petrovich is the original owner of her home in the LaSalle Acres subdivision which is just south of 5900 South and east of 700 west. It is one of the early ranch-house subdivisions of Murray, built in the 1950's, which was a period of

major expansion in Murray City. Her one-story brick ranch house has been maintained in excellent condition throughout the years and retains all of its historic features including the brick masonry walls, plaster and lath interior walls and decorative elements. Her home also represents the excellent condition of many of the homes in LaSalle Acres where the residents have obviously made an effort to maintain and preserve their homes and be an asset to the neighborhood and Murray City.

The Petrovich family moved to Murray in 1934 and originally lived at 153 West 5900 South, running a truck and garden farm. Their children attended Murray High and were active in school. Two of the children married and built homes in LaSalle Acres as well. Their children and grandchildren have been very involved in the schools and community groups such as the Murray Symphony. Both Eldene and her husband were employees of Murray City and the Murray School District. Eldene was a long-time secretary at Murray High School. Her late husband was, among other things, a ditch master with the Cahoon and Maxfield Ditch Company as well. The Petrovich brothers passed away recently but their widows have continued to maintain their beautiful homes.

The History Board would like to thank Mrs. Petrovich and her family for her commitment to our community.

6. CITIZEN COMMENTS (Comments are limited to 3 minutes unless otherwise approved by the Council.)

Jennifer Beavers, 1219 W. Saddle Bluff Drive, Murray, Utah

Ms. Beavers stated that she lives in the Murray Bluffs II subdivision and is representing her neighborhood. They wanted to thank Murray City for helping them get through the canal break and each of the neighbors signed thank you cards for the Police Department, Fire Department, and the City Council for listening to them and helping them get a task force together so that they can feel safe in their homes. Her daughter sleeps in her bedroom and their home is one away from all of the other homes that got flooded. If it had happened in the middle of the night, something could have happened. Her daughter was probably more worried about her clothes than anything else, but still. Ms. Beavers also thanked Gil Rodriguez, Fire Chief and his family for coming over that Sunday to help out by shoveling and using his muscles. She presented the Council with the cards.

Mr. Shaver asked Kevin Potter, Deputy Chief from the Fire Department, to stand and accept the card for the Fire Department. Lieutenant Doug Roberts accepted the card on behalf of the Police Department and the Council accepted the card.

Mr. Hales said it was nice to receive a thank you from the citizens. He also drove by and took a picture of the very nice "Thank You" sign that they posted in the neighborhood. Mr. Hales added that Murray City is very lucky to have such great Departments and Department Heads, they are

phenomenal. It was very nice of them to recognize that.

Mr. Shaver said that as much as the Council appreciates that the City helped, many people came to the neighborhood who are not affiliated necessary because they are a City employee, but just wanted to help. There were many stories about people who came and spend hour after hour helping clean up just because they are citizens of Murray. That is the kind of people who live here. Mr. Shaver thanked all of those people as well.

Jennifer Pecharich, 6345 South 370 East, Murray, Utah

Ms. Pecharich stated that just in the past month they have had an issue with parking. One of the businesses across Winchester has overrun their parking or has hired so many employees that they have used up all of their allotted parking spots. Now the employees are parking on the residential street. They have anywhere between 25-30 cars on their streets at 370 East and 300 East. It is really bad when you come in off of Winchester into the neighborhood. People are parking on both sides of the street and only one car can get through at a time. She has almost been hit twice as she has turned left into her neighborhood.

Mr. Hales asked for guidance on the exact area of the neighborhood.

Ms. Pecharich explained that east from the Fashion Place Mall, where Red Lobster and Red Robin are, she is the first light to go left after that. The real problem is where they turn left at the light into the neighborhood. They are parking on both sides of the street there. They have called the police a couple of times because there have been a couple cars that have parked right on a corner which is dangerous. She has emailed the Mayor and she knows that somebody had a meeting with Sutter Health. She is not sure if anything can be done. It is a safety issue. They have kids in the neighborhood and a lot of elderly in the neighborhood. There is no place for an ambulance or fire truck to park because of the parking on both sides of the road. She is not sure if any more can be done but she wanted to come and let the Council know that this is a concern. It is more than just her that are concerned. There are quite a few neighbors who have the same concerns and have called and emailed to let the City and the Mayor know. She understands that it is public parking but she does not want to live in an overflow parking lot for the businesses across the street.

Mr. Shaver asked if she is seeing a beginning and ending time each day for the parking problems.

Ms. Pecharich said that it starts around 9:00 a.m. and they are gone by 5:30 or 6:00 p.m. She thinks they are there seven days a week but feels that since at night and on weekends the other businesses are closed, there is available parking over there during those times. It is really bad between 9:00 a.m. and 5:30 p.m.

Mr. Hales asked if buses for the schools also go through that area.

Ms. Pecharich said that they do. There is a family down the street that has two handicapped girls and the bus has to come through.

Mr. Shaver said that they can look at it specifically and find out what the parking regulations are. Obviously, if they are parking on the corner, there are distances that they need to look at. He won't tell her to keep calling the police, but there are things that the City can look at.

Ms. Pecharich asked who is in charge of painting the curbs for fire hydrants and parking distances.

Mr. Stam said that he doesn't know that any department is in charge of that. He does know that a lot of it is being done by Boy Scout projects rather than anyone from the City.

Ms. Pecharich stated that she has lived there for eighteen years and doesn't think that they have ever been repainted. That might help guide some of the people to where they should or shouldn't be parking. She doesn't know if there is anything anyone can do but it is very, very frustrating to go from a nice quiet residential neighborhood to now, an overflow parking lot for the businesses across the street.

Mr. Shaver said that there are obviously always things that the City can do. They need to find out exactly what is happening on the corners and make an assessment of it before they can actually take action. There are always things that they can do.

Mr. Hales asked Ms. Pecharich to put her information on the sign in sheet. They will follow up with her on this issue.

Ms. Wells stated that they had this concern a few weeks ago and they have been working on it. Tim Tingey, Administrative and Development Serviced Director, had met with Sutter Health just before he left for the conference, so she is not sure what the outcome of that meeting was. The problem was that when that business was put in there, there was anticipation that the employees would use the TRAX station. They do provide a shuttle bus for the employees to come back and forth but obviously the employees are not taking advantage of that. The City has sent this to the Traffic Safety Committee already. There are limited things that they can do with parking in neighborhoods, but the City is working on it. She wanted to let them know that they are aware of the issue and are working on it.

Mr. Stam stated that he dealt with some parking issues on Sanford for a little bit. He asked Ms. Pecharich to stay after the meeting and he could discuss with her what he found out on that issue.

Tracy Pecharich, 6345 South 370 East, Murray, Utah

Mr. Pecharich added that last week on garbage day, some of the trash did not get picked up because the garbage trucks could not get to the cans because of the parked cars.

Citizen comment closed.

7. CONSENT AGENDA

7.1 None scheduled.

8. PUBLIC HEARINGS

8.1 None scheduled.

9. UNFINISHED BUSINESS

9.1 None scheduled.

10. NEW BUSINESS

10.1 Consider a Resolution adopting the City Council's Tentative Budget, as amended, for the Fiscal Year beginning July 1, 2013 and ending June 30, 2014 and scheduling a Public Hearing to receive public comment before the Final Budget is adopted.

Staff Presentation: Finance Director, Justin Zollinger

Mr. Zollinger stated that the budget is completely electronic. If there is any citizen who would like to access it, it is online at our website. We have created some summaries this year which haven't been available in the past. This allows the City to see changes and movement in the budget and hopefully answer more questions. There is also more detail that has been provided. As you go though, we have put notes in on different line items so that you can see that. We are trying to communicate more to the public and to the Council.

Mr. Zollinger said that for the most part, they asked the departments to keep their budgets flat as much as possible. There are expenses that come up such as increases in utility costs, Interlocal agreements, etc. Those are things that have to go up. But for the most part, for the things that are controllable, the departments kept them flat. That was very much appreciated. The overall increase in the budget this year was $300,000.00 in our General Fund.

The City has implemented target based budgeting. To do this, you start with your revenues, try to make those a little bit conservative, and that gives you your number that you have to work with on the expense side. That way you don't overspend and you maintain your reserves. In addition, that provides flexibility for the departments and adds increased oversight at the administrative and Council levels. Revenues are conservative and most of the increase in the General Fund was from Sales Tax.

In terms of operations, we have had citizens requests that the Park Center is open on Friday nights and we were able to allocate some of the budget to be able to do that. The City is also going to provide passport services at City Hall and there will also be some economic incentive programs for some businesses in Murray. In terms of personnel we

have, to some degree, addressed compression issues. We have taken a shot at that. They are trying to help out a little bit with employee compensation. The City had increased cost in our insurance of 4.9% which he is happy about because it is a better number than 8% or 10%. Lastly, our total increase in personnel costs in terms of benefits that we are required to do through URS (Utah Retirement Systems) and insurance comes to a total compensation of just over one million dollars. The interesting thing is that our General Fund Budget is only up $300,000.00 even though many of our costs were absorbed by the General Fund.

Mr. Zollinger stated that regarding some use of reserves, the City has set aside $50,000.00 for the preliminary design of City Hall. They will also pay off early on bonds for the Power Department of about one million dollars and for replacement of street lights that have been rusting out, they allocated $25,000.00.

Just to balance the City's budget this year, they have cut back on our central garage and retained risk assessment. They have reduced our non-departmental budget, reconciled personnel positions and also reduced positions. They have eliminated our other post-employment benefits. In addition, the Power Fund helped pay for street light costs. That is not a reduction but they helped pay for that instead of the money coming out of the General Fund. It has been a huge team effort to make a balanced budget.

While these changes are great and appreciated, they are done. There is no more adjusting of those numbers to be able to make any more room. Mr. Zollinger heard someone say that we have swept corners to make things really clean and tight. We provide a service and our citizens have come to expect a certain level. He believes that our budget would provide the level that our citizens have come to expect from us and he is proud and happy to say that. Overall, the Council, Mayor and staff have brought a balanced and sustainable budget for our citizens to consider. If anyone has questions, he would be more than happy to address them and refers everyone to the City website where the budget will be posted and updated.

Council consideration of the above matter.

Mr. Shaver commented that each year when the budget is presented, part of the task of the Council is to also possibly make a contingency list. He wanted to mention that it will part of the discussion that the Council will have on Thursday evening. The Budget Chair, Jim Brass, will address this and several other issues. This is a tentative budget and that is what the Council is adopting, not the completed budget.

Mr. Brass said that this has been a very easy, painless budget process so far with no 500 pound books. The electronic budget has made it so much easier. He praised Mr. Zollinger for the excellent summaries.

Mr. Hales added that it is a nice compliment to the Administration when Mr. Brass said it is easy because they are the ones who presented it. The Council appreciates the hard work that was put into this and he appreciates that.

Mr. Zollinger said that it is always a team effort to take care of the budget and bring it together.

Mr. Brass said that Utah is really good about this. By law they have to balance the budget and not go into debt. They have heard about other cities back east who don't have that law and are heavily in debt. They had a consultant advise the City on a long-term plan. So that the citizens understand, the money that comes in is the money the City spends. If the money doesn't come in they have to cut more from the budget. When the economy turned down they had to look for three or four million dollars. It has been an interesting process and it was nice to at least have revenues stabilize.

Mr. Zollinger added that right now, we are in an okay time. The challenging times are when things are not looking so good and the economy is not doing so well. That is when you face even more challenges and people have to be careful. During the good times, you may provide a little bit too much and that puts us in a really bad spot which he doesn't recommend.

Mr. Brass said that the next on-going challenge for the City is roads. Funding road repair has become difficult. It is admirable that the cars get better gas mileage you've got hybrids and electric cars. The problem with that is the car that used to get 20 miles to the gallon now gets 40 miles to the gallon and still drives the same number of miles on our road but we only collect half as much money to repair those roads. Our road fund revenue continues to drop and our need for road repair continues to increase. At some point we hope to work with all elected officials in the State to figure out a way to fix that problem.

Mr. Hales asked Mr. Zollinger to take a few moments to tell everyone where the majority of our income comes from.

Mr. Zollinger said that with a $38 million budget, not including the contingency transfer, $12.6 million comes from sales tax. Sales tax is much like the tide; there are times when there is high tide and low tide and it comes in and out. That is very much how the sales tax is and it varies with the economy both nationally and locally.

Mr. Hales said that many people have told him the same thing he thought that the revenues came mainly from property taxes.

Mr. Zollinger stated that $5.5 million comes from property tax and $12.6 million comes from sales tax.

Mr. Brass added that on the property tax bill the City gets 12% of that. Murray City is one of the lower collecting agencies. We are trying to add property to raise the overall revenue and it is working out well.

Mr. Brass said that they will be making a motion to adopt the tentative budget but they will schedule a public hearing and receive public comment on this when they make this

motion. The public will have a chance to speak on the final budget on June 4, 2013. The public will have a chance to go online and look at the budget and contact the Council if you have any questions.

Mr. Brass made a motion to adopt the Resolution.
Mr. Shaver 2nd the motion.

Call vote recorded by Jennifer Kennedy.

A Mr. Stam
A Mr. Brass
A Mr. Shaver
A Mr. Hales

Motion passed 4-0

10.2 Consider a Resolution establishing a Task Force to facilitate solutions by the North Jordan Irrigation Company to City residents' concerns.

Staff presentation: Councilmember Brett Hales

Mr. Hales stated that they had a full house a few weeks ago regarding the canal break. The Council was asked to do a task force and they agreed to present that, which is what they are doing tonight. The City has created a Resolution establishing a task force to facilitate solutions by the North Jordan Irrigation Company to city residents' concerns. Mr. Hales asked if there were any questions or statements regarding this.

Council consideration of the above matter.

Mr. Shaver said that having read through the Resolution, one of the things that it states is that the task force remains in force until its purposes are accomplished. He is wondering what those purposes are as they are not specifically outlined in the Resolution. There is a statement that says that the task force will have no municipal, legislative or executive authority and will be advisory only. If they are only advising, is the purpose of this just to advise?

Mr. Nakamura, City Attorney, stated that the task force is to facilitate discussions between the North Jordan Canal Company to address concerns from City residents. The task force determines whether or not then and to what extent those purposes are resolved. The task force and what happens in the task force will be set by those discussions that will be facilitated.

Mr. Shaver asked Mr. Nakamura if they needed to state that in the Resolution.

Mr. Nakamura answered that with a task force he doesn't think that you want to set specific strict parameters around what this task force will do. The City's role is to

facilitate discussions. We are not necessarily setting parameters of what those discussions or all the concerns those residents may have.

Mr. Shaver clarified saying that what he is asking is if we should add something into these five listings that says that the task force will determine its own purposes. The Resolution does not state that.

Mr. Nakamura said that it does discuss that this is facilitating discussions. It states in the Resolution that the issues are the future safety and integrity of the canal. The other issue has to do with the existing discussions surrounding the liability that the residents are having in regards to what happened with the canal company. Those items are stated in the Resolution. Beyond that, he feels that the security and the integrity of the canal is a purpose although it is generally stated. What that entails, he doesn't know for sure. If the Council wants something more such as what Mr. Shaver has stated for the record, it can certainly be included in the Resolution.

Mr. Shaver went to the last "whereas" in the Resolution. It states specifically "whereas the Chair of the City Council shall determine the composition of the task force as he deems necessary to accomplish the purposes of the task force." Mr. Shaver feels that this should also state that the task force shall establish its own purposes based on this Resolution.

Mr. Nakamura said that all he can say is that in the first sentences, the key issues are compensation for damages as a result of the breach of the irrigation canal on April 27, 2013, and the safety and integrity of the irrigation canal. He does not know if there will be discussions beyond that but those are the ones that he understood are the specific issues that the task force will be involved in. If there are others beyond that… you want to state it somewhat generally because in that compensation, safety and integrity of the canal you can be very specific as to what all of that means, whether it is engineering or whatever. He sees those as the purposes and does not know what other purposes there might be. If the Council wants to add others, Mr. Nakamura would suggest that it be added in that sentence.

Mr. Shaver stated that perhaps he isn't making himself understood clearly. He is not saying that they should define what those purposes are, only that the task force decides itself what the purposes are. If some issue comes up in the discussions as they are having conversations and it is an issue that is not listed here, if they wanted to address that particular issue.

Mr. Nakamura said that is true. He feels that they need to say why they are establishing the task force. He thinks that it needs to have some parameters.

Mr. Shaver said no doubt. He feels that they have done a great job of that. But, if they limit it to only what is stated, then it says that these are the only things that they get to address. Whereas if something comes up in those discussions that would be pertinent and needs to be resolved, the task force can say that yes, that is something that they will take

on in order to accomplish our purposes.

Mr. Nakamura suggested a change. Instead of saying 'regarding compensation' perhaps they should say "including" leaving room for other purposes. He sees Mr. Shavers point. On the Resolution that they are adopting the sentence would read "in creates a task force for the purpose of facilitating solutions by North Jordan Canal that concerns the City residents including compensation for damages as a result of the breach in the irrigation canal on April 27, 2013 and safety and integrity of the irrigation canal". He sees what is being said and that would leave room for additional issues.

Mr. Shaver said that otherwise it would limit the conversation to those two issues.

Mr. Nakamura stated that they would make that change.

Mr. Hales asked if they should see if this passes before discussing the committee.

Mr. Nakamura said that it is not necessary to talk about the committee in here at this point. They establish the task force and what it says is that the Chair will then decide that composition. As you have to determine representatives from the canal company and the residents, and there has to be a discussion with the administration as to who will be assigned to this, there needs to be some additional conversations.

Mr. Stam stated that the Council Handbook talks about the composition of committees and things being formed and decided on in the Committee of the Whole. He would say that on the next Committee of the Whole, at that point they determine the composition.

Mr. Shaver made a motion to adopt the Resolution as amended.
Mr. Stam 2nd the motion.

Call vote recorded by Jennifer Kennedy.

A Mr. Stam
A Mr. Brass
A Mr. Shaver
A Mr. Hales

Motion passed 4-0

11. MAYOR

11.1 Mayor's Report

None

11.2 Questions of the Mayor

None

12. ADJOURNMENT

Jennifer Kennedy, City Recorder

Special Recognition #1

Murray City Municipal Council
Request for Council Action

INSTRUCTIONS: The City Council considers new business items in Council meeting. All new business items for the Council must be submitted to the Council office, Room, 112, no later than 5:00 p.m. on the Wednesday two weeks before the Council meeting in which they are to be considered. This form must accompany all such business items. If you need additional space for any item below, attach additional pages with corresponding number and label.

1. TITLE: (Similar wording will be used on the Council meeting agenda.)

Employee of the Month

2. KEY PERFORMANCE AREA: (Please explain how request relates to Strategic Plan Key Performance Areas.)

N/A

3. MEETING, DATE & ACTION: (Check all that apply)

- [x] Council Meeting OR [ ] Committee of the Whole
- [x] Date requested **7/16/2013**
- [ ] Discussion Only
- [ ] Ordinance (attach copy)
  Has the Attorney reviewed the attached copy? ____
- [ ] Resolution (attach copy)
  Has the Attorney reviewed the attached copy? ____
- [ ] Public Hearing (attach copy of legal notice)
  Has the Attorney reviewed the attached copy? ____
- [ ] Appeal (explain) _____
- [ ] Other (explain) _____

4. FUNDING: (Explain budget impact of proposal, including amount and source of funds.)

Council Budget

5. RELATED DOCUMENTS: (Attach and describe all accompanying exhibits, minutes, maps, plats, etc.)

Employee of the Month Form

6. REQUESTOR:

Name: Brett Hales
Presenter: Justin Zollinger
Agency: Murray City
Date: 7/5/2013

Title: Council Chair
Title: Finance Director
Phone: 801-264-2669
Time: 5:00 PM

7. APPROVALS: (If submitted by City personnel, the following signatures indicate, the proposal has been reviewed and approved by Department Director, all preparatory steps have been completed, and the item is ready for Council action)

Department Director: _____ Date: 7/5/2013

Mayor: _____ Date: 7/5/2013

8. COUNCIL STAFF: (For Council use only)

Number of pages: _____ Received by: _____ Date: _____ Time: _____
Recommendation: _____

9. NOTES:

EMPLOYEE OF THE MONTH RECOGNITION

DEPARTMENT: DATE: 7/3/2013

Finance Department

NAME of person to be recognized: Submitted by: Justin Zollinger

JoAnn Miller

DIVISION AND JOB TITLE:

Payroll Coordinator

YEARS OF SERVICE:

5 Years

REASON FOR RECOGNITION:

JoAnn Miller is the type of employee all employers would want to have work for them. Some of JoAnn's traits are: she is a hard worker, willing to help, punctual, happy, and communicates well. She does not complain and enjoys learning.

I would like to give some examples of JoAnn's work ethic and willingness to help. The Finance Department has had some difficult times this last fiscal year. We lost one of our own to tragedy. JoAnn was prepared though, because she had cross trained on the Payroll Coordinator job. When this tragedy occurred JoAnn did both the Accounts Payable and Payroll Coordinator jobs as we worked out budget constraints and filled the open position. This required long work days, but JoAnn did not complain or develop a negative attitude, she just kept things rolling. Even with these longer work days JoAnn still came in 15 minutes early to work every day.

Another example is when JoAnn was first hired in the Finance Department as our Accounts Payable Clerk; she helped with duties pertaining to her previous position so Utility Billing didn't fall behind and also trained the new employee. JoAnn is concerned with helping make Murray City better.

JoAnn is a great communicator; if she makes a mistake she is quick to inform me and works hard to correct any problems the mistake may have caused. As she finds areas in our software that do not work so well, she communicates the problems to me, but she also finds ways to perform tasks more efficiently.

JoAnn was my first hire I made and I am so glad she works in the Finance Department and Murray City is lucky to have her as part of our team.

COUNCIL USE:

MONTH/YEAR HONORED July 2013

Citizen Comments

Limited to three minutes, unless otherwise approved by the Council.

Public Hearing #1

MURRAY CITY CORPORATION

NOTICE OF PUBLIC HEARING

Notice is hereby given that on July 16, 2013, beginning at 6:30 p.m. of said day in the Council Chambers of the Murray City Center, 5025 South State Street, Murray, Utah, the Murray City Municipal Council will hold and conduct a Public Hearing on and pertaining to the following proposed amendments to the City's 2012-2013 Fiscal Year Budget:

1. Appropriate $78,890 from restricted fund balance of the General Fund as revenue from the Beer Tax and appropriate same to the Police Department to purchase in-car video cameras.

2. Appropriate up to 10% of total project costs, not to exceed a maximum of $190,000 from General Fund Reserves to Public Services Department to assist with the costs of repairing the North Jordan Canal breach.

The purpose of the hearing is to receive public comment concerning the proposed amendments to the City's 2012-2013 Fiscal Year Budget.

Dated July 1, 2013.
PH 13-18

MURRAY CITY CORPORATION

Jennifer Kennedy, City Recorder

DATE OF PUBLICATION: July 4, 2013

Murray City Municipal Council
Request for Council Action

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1. **TITLE**: (Similar wording will be used on the Council meeting agenda.)

   Budget Opening

2. **KEY PERFORMANCE AREA**: (Please explain how request relates to Strategic Plan Key Performance Areas.)

   Financial Sustainability

3. **MEETING, DATE & ACTION**: (Check all that apply)
   - [✓] Council Meeting OR [ ] Committee of the Whole
   - [✓] Date requested **7/16/2013**
   - [ ] Discussion Only
   - [ ] Ordinance (attach copy)
     Has the Attorney reviewed the attached copy? ____
   - [ ] Resolution (attach copy)
     Has the Attorney reviewed the attached copy? ____
   - [ ] Public Hearing (attach copy of legal notice)
     Has the Attorney reviewed the attached copy? ____
   - [ ] Appeal (explain) _____
   - [ ] Other (explain) _____

4. **FUNDING**: (Explain budget impact of proposal, including amount and source of funds.)

   Beer Tax money, and General Fund reserves

5. **RELATED DOCUMENTS**: (Attach and describe all accompanying exhibits, minutes, maps, plats, etc.)

   Memo

6. **REQUESTOR**:

   Name: Justin Zollinger
   Presenter: Justin Zollinger
   Agency: Murray City
   Date: 6/25/2013

   Title: Finance Director
   Title: Finance Director
   Phone: 801-264-2669
   Time: 5:00 PM

7. **APPROVALS**: (If submitted by City personnel, the following signatures indicate, the proposal has been reviewed and approved by Department Director, all preparatory steps have been completed, and the item is ready for Council action)

   Department Director: _____ Date: 6/25/2013

   Mayor: Daniel C. Snarr Date: 6/25/2013

8. **COUNCIL STAFF**: (For Council use only)
   Number of pages: _____ Received by: _____ Date: _____ Time: _____
   Recommendation: _____

9. **NOTES:**

MURRAY CITY CORPORATION
FINANCE & ADMINISTRATION

Memo:

To: City Council

From: Justin Zollinger, Finance Director

Date: June 25, 2013

Subject: Budget Opening 7/16/2013

Fiscal year 2013 the City received $78,890 of Beer Tax money. In the past, this money was allowed to be used to pay for our D.A.R.E officer; this is no longer the case. The money must be utilized for alcohol-related prevention, treatment, law enforcement, prosecution and confinement programs. The Police have summited a plan to the Utah Substance Abuse Advisory Council, and they have accepted our plan, to purchase in car video cameras.

The North Jordan Canal Company requested the City pay a portion of the costs for fixing the canal. Mayor Snarr suggested City assistance of 10 percent of the total project costs with a maximum limit of $190,000. The funding source for this would come from City General Fund reserves.

Budget Opening Summary

Police:
Beer Tax $78,890

Public Works:
North Jordan Canal $190,000

ORDINANCE NO.

AN ORDINANCE AMENDING THE CITY'S FISCAL YEAR 2012 – 2013 BUDGET

On June 19, 2012, the Murray City Municipal Council adopted the City's budget for Fiscal Year 2012 - 2013. It has been proposed that the Fiscal Year 2012 - 2013 budget be amended as follows:

1. Appropriate $78,890 from restricted fund balance of the General Fund as revenue from the Beer Tax and appropriate same to the Police Department to purchase in-car video cameras.

2. Appropriate up to 10% of total project costs, not to exceed a maximum of $190,000 from General Fund Reserves to Public Services Department to assist with the costs of repairing the North Jordan Canal breach.

Section 10-6-128 of the Utah Code states that the budget for the City may be amended by the Murray City Municipal Council following a duly noticed public hearing. Pursuant to proper notice, the Murray City Municipal Council held a public hearing on July 16, 2013, to consider the proposed amendments to the Fiscal Year 2012 - 2013 budget. After considering public comment, the Murray City Municipal Council wants to amend the Fiscal Year 2012 - 2013 budget.

BE IT ENACTED by the Murray City Municipal Council as follows:

Section 1. Purpose. The purpose of this Ordinance is to amend the City's Fiscal Year 2012 - 2013 budget.

Section 2. Enactment. The City's Fiscal Year 2012 - 2013 budget shall be amended as follows:

1. Appropriate $78,890 from restricted fund balance of the General Fund as revenue from the Beer Tax and appropriate same to the Police Department to purchase in-car video cameras.

2. Appropriate up to 10% of total project costs, not to exceed a maximum of $190,000 from General Fund Reserves to Public Services Department to assist with the costs of repairing the North Jordan Canal breach.

Section 3. Effective Date. This Ordinance shall take effect on first publication.

PASSED, APPROVED AND ADOPTED by the Murray City Municipal Council on this 16th day of July, 2013.

MURRAY CITY MUNICIPAL COUNCIL

_____
Brett A. Hales, Chair

ATTEST:

_____
Jennifer Kennedy, City Recorder

MAYOR'S ACTION: Approved

DATED this ____ day of _____, 2013.

_____
Daniel C. Snarr, Mayor

ATTEST:

_____
Jennifer Kennedy, City Recorder

CERTIFICATE OF PUBLICATION

I hereby certify that this Ordinance or a summary hereof was published according to law on the ___ day of _____, 2013.

_____
Jennifer Kennedy, City Recorder

MURRAY CITY CORPORATION
OFFICE OF THE MAYOR

Daniel C. Snarr, Mayor
Jan Wells, Chief of Staff
801-264-2600 FAX 801-264-2608

MEMORANDUM

TO: Murray City Municipal Council

FROM: Jan Wells, Chief of Staff Jan Wells

CC: Doug Hill, Public Services Director
Frank M. Nakamura, City Attorney

DATE: July 9, 2013

RE: Proposed Cost Sharing Agreement with the North Jordan Irrigation Company

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On July 16, 2013, the Council will be considering a budget amendment to fund a Cost Sharing Agreement with the North Jordan Irrigation Company ("North Jordan"). Attached is the Mayor's proposed Cost Sharing Agreement with North Jordan. Please note the following essential terms of the proposed Agreement:

1. The City will reimburse North Jordan ten percent (10%) of the qualifying costs to repair and enhance the North Jordan Canal not to exceed $190,000.

2. North Jordan must agree to indemnify the City for any and all claims or obligations relating to the North Jordan Canal.

3. North Jordan will reimburse the City for all clean-up costs as the result of the breach of the North Jordan Canal on April 27, 2013.

4. North Jordan will construct and operate a quality SCADA system.

The Mayor believes the proposed Agreement is consistent with the Council's intent. Thank you.

COST SHARING AGREEMENT

Between

MURRAY CITY

and

NORTH JORDAN IRRIGATION COMPANY

* * *

THIS AGREEMENT ("Agreement") is made and entered into this ____ day of _____, 2013, by the between MURRAY CITY ("Murray"); and the NORTH JORDAN IRRIGATION COMPANY ("North Jordan"). The Murray, and North Jordan are sometimes referred to as the "Parties."

RECITALS

WHEREAS, North Jordan intends to repair a breach that occurred at 1203 West Saddle Bluff Drive and line a section of its canal (the "North Jordan Canal") between West Winchester Street and approximately 6800 South (the "Project");

WHEREAS, the location of the Project runs behind the houses on Saddle Bluff Drive in Murray;

WHEREAS, the North Jordan Canal is part of the ~~County's~~ Salt Lake County-wide flood control system;

WHEREAS, North Jordan has contracted with consultants to design, engineer and prepare plans for the Project. The plans, which are attached hereto as Exhibit "A," represent the scope of work now required to complete the Project and are incorporated into the Agreement by this reference;

WHEREAS, the plans were reviewed and approved by the State Engineer's Office;

WHEREAS, the opinion of probable costs to complete the project by North Jordan is attached hereto as Exhibit "B";

WHEREAS, the Parties desire to enter into a cost-sharing agreement to fund the work required for the Project;

WHEREAS, since Murray has no obligation to share the costs, Murray wants a full indemnification from North Jordan for any claims, causes of action, or suits of any kind arising out of or in connection with the North Jordan Canal and reimbursement of costs incurred by Murray as a result of the breach of the North Jordan Canal on April 27, 2013 and construction of a quality Supervisory Control and Data Acquisition ("SCADA") system for water;

WHEREAS, North Jordan is willing to provide such indemnification and reimbursement and a SCADA system;

NOW, THEREFORE, in consideration of the mutual promises set forth herein, the Parties agree as follows;

AGREEMENT

1. North Jordan shall select and enter into a contract with a qualified contractor (the "Contractor") to perform the work specified in Exhibit "A." North Jordan shall select the Contractor on a fair and open competition basis consistent with Murray's Procurement Ordinances. North Jordan further agrees to administer and oversee all aspects of the Contractor's contract, including making all payments to the Contractor, and inspection and acceptance of the completed work. As part of the project, North Jordan shall construct and operate a quality SCADA system.

2. Upon the selection of the Contractor, North Jordan shall provide Murray with a copy of the Contractor's final bid and copies of all documentation concerning the selection process. A copy of the Contractor's final bid shall be attached hereto as Exhibit "C."

3. ~~The County and~~ Murray shall ~~each pay~~ reimburse North Jordan ~~a portion~~ ten percent (10%) of the total costs based on itemized receipts for the project (the "Qualified Costs")~~:~~ not exceed One Hundred Ninety Thousand Dollars ($190,000) total. Qualified costs includes the cost of a quality SCADA system.

~~Murray: Ten Percent (10%) x% of the Qualified Costs, which portion shall not exceed One Hundred Ninety Thousand Dollars ($190,000) total;~~

4. Payments required under Paragraph 3 shall be made as follows:

~~(a)~~ Within thirty (~~1~~30) days after receipt by Murray of copies of invoices representing total qualified costs incurred by North Jordan, ~~the Contractor's final bid,~~ Murray shall pay to North Jordan ten percent (10%) of the qualified costs ~~deposit an amount equal to their respective~~ its not-to-exceed a totals of $190,000. ~~set forth in Paragraph 3 into an escrow account to be designated by North Jordan.~~

~~(b) North Jordan shall use the escrow account funds to pay expenses incurred during the design and construction operations.~~

~~(c) By no later than December 31, 2014, North Jordan shall provide Murray with copies of statements and invoices to account for all monies paid into the escrow account. The statements and invoices shall show respective Murray's proportionate share of the Qualified Costs, as set forth in Paragraph 3.~~

~~(d) Also by December 31, 2014, and in the event any amount paid under Paragraph 3 is not expended by North Jordan for Qualified Costs, North Jordan shall refund,~~

~~release or transfer the unexpended amount back to Murray in their~~ its ~~respective proportionate share, as set forth in Paragraph 3.~~

5. North Jordan shall keep Murray abreast of substantive communications and activities related to the Project. Following completion of the Project, Murray shall be invited to participate in the final inspection of the work

~~5.~~6. Murray does not own or operate the North Jordan Canal. Murray has no responsibility for the maintenance or operation of the North Jordan Canal. Murray is, by this Agreement, providing financial assistance to North Jordan to promote the safety and welfare of its residents. Nothing in this Agreement should be construed to impute to Murray any obligation for the maintenance and operation of the North Jordan Canal. North Jordan agrees to hold Murray harmless from any and all liability arising out of or in connection with the Project.

~~North Jordan shall keep the Murray abreast of substantive communications and activities related to the Project. Following completion of the Project, Murray shall be invited to participate in the final inspection of the work.~~

~~6.~~7. North Jordan agrees to indemnify and hold Murray harmless from any and all liability, claims, suits and causes of action of any kind arising out of or in connection with the North Jordan Canal including claims related to the breach, safety and structural integrity of the North Jordan Canal. North Jordan shall pay any and all costs including attorney's fees incurred by Murray to defend against any liability, claims, suits or causes of action arising out of or in connection with the North Jordan Canal including claims from property owners and others` harmed by the breach of the North Jordan Canal on April 27, 2013. North Jordan also agrees, within thirty (30) days of execution of this Agreement, to reimburse Murray for all costs Murray incurred as a result of the breach of the North Jordan Canal on April 27, 2013, including cleanup costs.

~~7.~~8. This Agreement shall become effective upon execution by both Parties. The term shall be for two (2) years from the effective date or six (6) months after the completion of the Project, whichever occurs first~~.~~, provided however the indemnity provision in paragraph 7 shall extend beyond the expiration date of the Agreement.

~~8.~~9. The Murray is a governmental entity under the Utah Governmental Immunity Act, UTAH CODE ANN. §§ 63G-7-101 to -904 (2011). ~~Consistent with the terms of this Act, it is mutually agreed the Murray is responsible and liable for their own wrongful or negligent acts which they commit or which are committed by their agents, officials, or employees. No Party~~ Murray does not waives any defenses otherwise available under the Governmental Immunity Act.

~~9.~~10. Alterations, extensions, supplements, or modifications of the terms of this Agreement as detailed herein shall be agreed to in writing by the Parties, incorporated as amendments to this Agreement, and made a part hereof.

~~10.~~11. All notices required or permitted to be given hereunder shall be deemed sufficient if given by a communication in writing and shall be deemed to have been received (a) upon personal delivery or actual receipt thereof, or (b) within two days after such notice is deposited in

the United States Mail postage prepaid, and certified and addressed to the Parties as set forth below:

Murray: Doug Hill, Public Services Director
4646 South 500 West
Murray, UT 84123

North Jordan: North Jordan Irrigation Company
4788 Hidden Cove
Taylorsville, UT 84123

~~11.~~12. This Agreement contains the entire agreement between the Parties, and no statements, promises, or inducements made by any Party or agents for any Party that are not contained in this written contract shall be binding or valid; and this Agreement may not be enlarged, modified, or altered except in writing, and signed by the Parties.

~~12.~~13. This Agreement shall be governed by the laws of the State of Utah both as to interpretation and performance, and if any provision of this Agreement is held invalid, the remainder shall continue in full force and effect.

IN WITNESS WHEREOF, the Parties have subscribed their names and seals the day and year first above written.

MURRAY CITY

By:_____

Title:_____

ATTEST:

_____
Jennifer Kennedy, City Recorder

Approved as to form:

By:_____
Frank M. Nakamura, Murray City Attorney

NORTH JORDAN IRRIGATION COMPANY

By:_____

Title:_____

~~Approved as to form:~~

~~By:_____~~

~~Title:_____~~

New Business Item #1

Murray City Municipal Council
Request for Council Action

INSTRUCTIONS: The City Council considers new business items in Council meeting. All new business items for the Council must be submitted to the Council office, Room, 112, no later than 5:00 p.m. on the Wednesday two weeks before the Council meeting in which they are to be considered. This form must accompany all such business items. If you need additional space for any item below, attach additional pages with corresponding number and label.

1. TITLE: (Similar wording will be used on the Council meeting agenda.)

A RESOLUTION APPROVING THE POLL WORKERS SPECIFIED BY THE SALT LAKE COUNTY CLERKS OFFICE, ELECTIONS DIVISION, FOR THE CITY 2013 ELECTIONS.

2. KEY PERFORMANCE AREA: (Please explain how request relates to Strategic Plan Key Performance Areas.)

Responsive and Efficient City Services

3. MEETING, DATE & ACTION: (Check all that apply)

_X_ Council Meeting OR ___ Committee of the Whole
____ Date requested July 16, 2013
____ Discussion Only
____ Ordinance (attach copy)
Has the Attorney reviewed the attached copy? ____
_X_ Resolution (attach copy)
Has the Attorney reviewed the attached copy? Yes
____ Public Hearing (attach copy of legal notice)
Has the Attorney reviewed the attached copy? ____
____ Appeal (explain) _____
____ Other (explain) _____

4. FUNDING: (Explain budget impact of proposal, including amount and source of funds.)

Not Applicable

5. RELATED DOCUMENTS: (Attach and describe all accompanying exhibits, minutes, maps, plats, etc.)

See attached memo, the list of the 2013 poll workers, Resolution, and copy of the executed Interlocal Agreement with Salt Lake County for election services.

6. REQUESTOR:

Name: Tim Tingey
Presenter: Jennifer Kennedy
Agency:
Date: July 3, 2012

Title: Director of Administrative and Development Services
Title: City Recorder
Phone: (801) 264-2663
Time:

7. APPROVALS: (If submitted by City personnel, the following signatures indicate, the proposal has been reviewed and approved by Department Director, all preparatory steps have been completed, and the item is ready for Council action)

Department Director: _____ Date: 7/5/13
Mayor: _____ Date: 7/5/13

8. COUNCIL STAFF: (For Council use only)

Number of pages: _____ Received by: _____ Date: _____ Time: _____
Recommendation: _____

9. NOTES:

MURRAY CITY CORPORATION
ADMINISTRATIVE &
DEVELOPMENT SERVICES

B. Tim Tingey, Director

Building Division
Community & Economic Development
Geographic Information Systems

Information Technology
Recorder Division
Treasurer Division

TO: City Council
Mayor Snarr
Jan Wells, Chief of Staff

CC: Tim Tingey, Director of Administrative and Development Services

FROM: Jennifer Kennedy, City Recorder

DATE: July 3, 2013

SUBJECT: Resolution to Approve Poll Workers

I am requesting your approval of the attached list of poll workers submitted by the Salt Lake County elections office. State election code requires that at least 15 days before the date scheduled for any local election, the municipal legislative body shall appoint or provide for the appointment of poll workers as stated in UCA 20A-5-602.

RESOLUTION NO. _____

A RESOLUTION APPOINTING POLL WORKERS FOR THE CITY'S 2013 PRIMARY AND GENERAL ELECTIONS

WHEREAS, Title 20A, Chapter 5, Section 602, Utah Code Annotated 1953, as amended, requires the governing body of a city to appoint or provide for the appointment of poll workers at least fifteen days before the date scheduled for any local election; and

WHEREAS, on April 4, 2013, the City entered into an Interlocal Cooperation Agreement with Salt Lake County ("County"), wherein the County's Election Division agreed to assist the City in conducting its 2013 Primary and General Elections; and

WHEREAS, the City Recorder, in conjunction with the County's Election Division, has compiled a list of poll workers for the City's 2013 Primary and General Elections, which is attached as Exhibit "A" and incorporated herein; and

WHEREAS, Title 20A, Chapter 5, Section 602, Utah Code Annotated 1953, as amended, requires the City to compensate poll workers for their services.

NOW, THEREFORE, BE IT RESOLVED by the Murray City Municipal Council as follows:

1. The poll workers listed in Exhibit "A" are appointed for the City's 2013 Primary and General Elections.

2. The Mayor is authorized to compensate the poll workers for their services during the City's 2013 Primary and General Elections.

PASSED AND APPROVED this 16th day of July, 2013.

MURRAY CITY MUNICIPAL COUNCIL

_____
Brett A. Hales, Council Chair

ATTEST:

_____
Jennifer Kennedy, City Recorder

City Contract No.
County Contract No. ELI3017C
DA Standard Form No. 13-8858

INTERLOCAL COOPERATION AGREEMENT BETWEEN

MURRAY CITY

-AND-

SALT LAKE COUNTY on behalf of the COUNTY CLERK ELECTION'S DIVISION

THIS AGREEMENT is made and entered into the 4 day of April, 2013, by and between Murray City ("City"), and SALT LAKE COUNTY, a political subdivision of the State of Utah ("County"), on behalf of the Salt Lake County Clerk's Office, Elections Division.

WITNESSETH:

WHEREAS, the County desires to provide the services of its Clerk's office, Elections Division, to the City for the purpose of assisting the City in conducting the City's 2013 primary and general municipal elections; and

WHEREAS, the City desires to engage the County for such services;

NOW, THEREFORE, in consideration of the promises and covenants hereinafter contained, the parties agree as follows:

1. **Term.** County shall provide election services to the City commencing on the date this Agreement is executed, and terminating on December 31, 2013. The term of this Agreement may be extended by mutual agreement in writing signed by all parties. Either party may cancel this Agreement upon thirty (30) days written notice to the other party. Upon such cancellation, each party shall retain ownership of any property it owned prior to the date of this Agreement, and the City shall own any property it created or acquired pursuant to this Agreement.

2. **Scope of Work.** The services to be provided by the Salt Lake County Clerk's Office, Elections Division shall be as set forth in the Scope of Work, attached hereto and incorporated by reference as Exhibit "A." Generally, the County Clerk shall perform all elections administration functions as set forth in Exhibit "A" and as needed to ensure implementation of the City's 2013 primary and general municipal election.

3. **Legal Requirements.** The County and the City understand and agree that the 2013 primary and general municipal election are the City's elections. The City shall be responsible for

compliance with all legal requirements for these elections and shall direct the manner in which the elections are conducted. The City agrees to translate ballot issues, if any, into Spanish. The County will provide the remaining Spanish translations for the ballot and other election materials. County agrees to work with the City in complying with all legal requirements for the conduct of these elections and conduct these elections pursuant to the direction of the City. County agrees to disclose and maintain election results through its website merely as a courtesy and convenience to the City. The City, not the County, is responsible to resolve any and all election questions, problems, and legal issues that are within the City's statutory authority.

4. **Cost.** In consideration of the services performed under this Agreement, the City shall pay the County an amount not to exceed the estimate given to the City by the County. The County shall provide a written invoice to the City at the conclusion of the elections, and the City shall pay the County from the invoice within thirty days of receiving it. The invoice shall contain a summary of the costs of the election and shall provide the formula for allocating the costs among the issues and jurisdictions participating in the elections. In the case of a vote recount, election system audit, election contest, or similar event arising out of the City's election, the City shall pay the County's cost of responding to such events, based on a written invoice provided by the County. The invoice amount for these additional services may cause the total cost to the City to exceed the estimate given to the City by the County. For such consideration, the County shall furnish all materials, labor and equipment to complete the requirements and conditions of this Agreement.

5. **Governmental Immunity.** The City and the County are governmental entities and subject to the Governmental Immunity Act of Utah, Utah Code Ann. §§ 63-30d-1, et seq. (1953, as amended) ("Act"). Subject to the provisions of the Act, the City and County agree to indemnify and hold harmless the other party, its agents, officers and employees from and against any and all actions, claims, lawsuits, proceedings, liability damages, losses and expenses (including attorney's fees and costs) arising out of or resulting from the performance of this Agreement to the extent the same are caused by any negligent or wrongful act or omission of that party, its officers, agents and employees. Nothing in this Agreement shall be deemed a waiver of any rights, statutory limitations on liability, or defenses applicable to the City or the County under the Act.

6. **Election Records.** The City shall maintain and keep control over all records created pursuant to this Agreement and to the elections relevant to this Agreement. The City shall respond to all public record requests related this Agreement and the underlying elections and shall retain all election records consistent with the Government Records Access and Management Act, Utah Code Ann. §§ 63G-2-101 – 901 (1953, as amended) and all other relevant local, state and federal laws.

7. **Service Cancellation.** If the Agreement is canceled by the City as provided herein, the City shall pay the County on the basis of the actual services performed according to the terms of this Agreement. Upon cancellation of this Agreement, the County shall submit to the City an itemized statement for services rendered under this Agreement up to the time of cancellation and based upon the dollar amounts for materials, equipment and services set forth herein.

8. **Legal Compliance.** The County, as part of the consideration herein, shall comply with all applicable federal, state and county laws governing elections.

9. **Indemnification.** To the extent permitted by law, the City agrees to indemnify and hold County harmless, including providing legal defense costs on behalf of the County, as a result of any legal or administrative claim, action or proceeding brought against the County by any person or entity claiming that the County violated any state or federal law by providing election services under this Agreement.

10. **Interlocal Agreement.** In satisfaction of the requirements of the Interlocal Cooperation Act, Title 11, Chapter 13, Utah Code Annotated 1953, as amended ("Interlocal Act"), in connection with this Agreement, the City and the County (for purposes of this section, each a "party" and collectively the "parties") agree as follows:

(a) This Agreement shall be approved by each party, pursuant to § 11-13-202.5 of the Interlocal Act;

(b) This Agreement shall be reviewed as to proper form and compliance with applicable law by a duly authorized attorney on behalf of each party, pursuant to Section 11-13-202.5 of the Interlocal Act ;

(c) A duly executed original counterpart of the Agreement shall be filed with the keeper of records of each party, pursuant to § 11-13-209 of the Interlocal Act;

(d) Each party shall be responsible for its own costs of any action done pursuant to this Agreement, and for any financing of such costs; and

(e) No separate legal entity is created by the terms of this Agreement. To the extent that this Agreement requires administration other than as set forth herein, it shall be administered by the City Recorder of the City and the County Clerk of the County, acting as a joint board. No real or personal property shall be acquired jointly by the parties as a result of this Agreement. To the extent that a party acquires, holds, and disposes of any real or personal property for use in the joint or cooperative undertaking contemplated by this Agreement, such party shall do so in the same manner that it deals with other property of such party.

EL13017C

11. **Counterparts.** This Agreement may be executed in counterparts by the City and the County.

12. **Governing Law.** This Agreement shall be governed by the laws of the State of Utah both as to interpretation and performance.

13. **Integration.** This Agreement embodies the entire agreement between the parties and shall not be altered except in writing signed by both parties.

IN WITNESS WHEREOF, the parties have executed this Agreement on the day and year first above written.

MURRAY CITY, STATE OF UTAH CORPORATE SEAL

Attest:

Jennifer Kennedy, City Recorder

By _____
Mayor Dan Snarr

Approved as to form and compliance with applicable law:

City Attorney
Date: _____

APPROVED AS TO CONTENT

SALT LAKE COUNTY

By _____
Mayor Ben McAdams or Designee

Approved as to form and compliance with applicable law:

_/s/_Melanie F. Mitchell_____
Salt Lake County Deputy District Attorney
Date: 2/14/2013

Approved as to the availability of funds
Murray City Finance Division

Budget Officer

Exhibit "A"
2013 Municipal Elections
Scope of Work

The County shall provide to the City with an Official Register as required by Utah Code Ann. § 20-5-401, U.C.A. (as amended).

The City shall perform all administrative functions related to candidate filing requirements and all other requirements of Utah Code Ann. § 20A-9-203 (as amended), including all administrative functions related to financial disclosure reporting.

The City agrees to consolidate all elections administration functions and decisions in the County Clerk to ensure the successful conduct of multiple, simultaneous municipal elections. In a consolidated election, decisions made by the County regarding resources, procedures and policies are based upon providing the same scope and level of service to all the participating jurisdictions and the City recognizes that such decisions, made for the benefit of the whole, may not be subject to review by the City.

Services the County will perform for the City include, but are not limited to:

- Ballot layout and design
- Ballot ordering and printing
- Machine programming and testing
- Polling place and poll worker selection and assignment
- Delivery of supplies and equipment
- Provision of all supplies
- Absentee Ballot administration
- Early Voting administration
- Updating state and county websites
- Tabulating, reporting and canvassing election results
- Conducting recounts as needed
- All notices and mailings required by law (except those required by Utah Code Ann. § 20A-9-203)
- Direct payment of all costs associated with the election to include poll workers, polling places, rovers.

The City will provide the County Clerk with information, decisions, and resolutions and will take appropriate actions required for the conduct of the election in a timely manner.

The County will provide a good faith estimate for budgeting purposes (Exhibit "B"). Election costs are variable and are based upon the offices scheduled for election, the number of voters, the number of primaries, the number of jurisdiction participating as well as any direct costs incurred.

The City will be invoiced for its pro-rata share of the actual costs of the elections which will not exceed the estimate in Exhibit B.

In the event of a state or county special election being held in conjunction with a municipal election, the scope of services and associated costs, and the method of calculating those costs, will remain unchanged.

Exhibit "B"
2013 Election Estimate
Murray

Below is the good faith estimate for the upcoming *2013 Municipal Election* for the city of Murray. The city will be billed for actual costs, which will not exceed this estimate.

Assumptions for providing this estimate consist of the following:

A. Active voters (as of 2/1/2013): 24,817
B. Permanent Vote by Mail voters (as of 2/1/2013): 7,408
C. Worst case primary election.
D. General election for the 2013 offices below.
E. 16 Cities participating in the consolidated 2013 elections.

2013 Offices	Estimate
Mayor	
Council #2	
Council #4	$96,786.30

Murray

Date: .July 10, 2013

***Subject to Change**

Calvary Chapel of Salt Lake 460 W Century Dr (4350 S)						
Poll Manager	Demitri	Fontenot	407 E Woodlake Ln Apt 168	Salt Lake City	(801)664-1173	demitri.fontenot@hotmail.com
Provisional Judge	Patricia	Richardson	250 E 4460 S Apt 2	Murray	(801)347-2841	patfurry60@yahoo.com
Technician	Michael	Johnson	6233 S Rodeo Ln	Murray	(385)232-0356	boeingmj@gmail.com
Cottonwood Presbyterian Church 1580 E Vine St (6100 S)						
Poll Manager	Dennis	Alexander	1584 E 6430 S	Murray	(801)948-4053	whoof@comcast.net
Provisional Judge	Nelson	Wadsworth	5968 S Village 3 Rd	Murray	(801)424-3238	n.wadsworth@comcast.net
Technician	Alicia	Cruz-Jones	6134 S Vineway Cir	Murray	(801)652-1137	omo_alicia@yahoo.com
Grant Elementary 662 W Bulldog Cir (6140 S)						
Poll Manager	Cherylann	Miller	5922 S Sanford Dr	Murray	(801)268-3387	stargazer.cherylann@gmail.com
Provisional Judge	Nolberto	Castro	1206 W Red Rose Ln	Murray	(801)263-8703	nolberto_address@msn.com
Technician	Dennis	Winslow	553 W La Salle Dr	Murray	(801)550-2730	dwmustang44@yahoo.com
Make A Wish Foundation 771 E Winchester St (6500 S)						
Poll Manager	Erlindo	Montoya	1250 E 6600 S	Murray	(801)243-3252	judy.wayman@imail.org
Provisional Judge	Dale	Brimley	6461 S Blaine Dr	Murray	(801) 590-8706	DBBRIMLEY@HOTMAIL.COM
Technician	Verla	Reid	6041 S Lasalle Cir	Murray	(801)808-4186	verlar23@hotmail.com
Murray City Hall 5025 S State St (100 E)						
Poll Manager	Frances	Brummett	548 E Julep Cir	Murray	(801)261-5495	fbrummett@slcpl.org
Provisional Judge	Nancy	Ferrin	4773 S Meadow View Rd	Murray	(801)266-6753	nancyheathferrin@gmail.com
Technician	Marshall	Smith	1536 E Village 3 Rd	Murray	(801)272-5608	mailtosmith@yahoo.com
Murray City Library 166 E 5300 S						
Poll Manager	Dustin	Rodeback	5729 S Utahna Dr	Murray	(801)635-4704	dustinebm99@aol.com
Provisional Judge	Glenda	Preece	5414 S Alpine Dr	Murray	(801)263-2823	nikkipreece84@gmail.com
Technician	Cheryl	Rodeback	5729 S Utahna Dr	Murray	(801)860-3621	csr1186352@aol.com
Murray Parkway LDS 5555 S 700 W						
Poll Manager	Anne	Sorenson	6008 S Roanoke Dr	Murray	(801)694-4634	annemsorenson@gmail.com

Provisional Judge	Peggy	Cox	5493 S Allendale Dr	Murray	(801)261-2699	cox5493@msn.com
Technician	Caroline	Costello	1172 W Bullion St	Murray	(801)268-1589	CAROLMOM50@YAHOO.COM
	Southeast Christian Church 1881 E Vine St (6085 S)					
Poll Manager	Norma	Chisholm	6018 S La Tour St	Holladay	(801)278-2172	davidjohnc@msn.com
Provisional Judge	Charles	Mason	5659 S Highland Park Ct	Holladay	801-272-1270	mason.c.l@att.net
Technician	David	Chisholm	6018 S La Tour St	Holladay	(801)278-2172	DAVIDJOHNC@MSN.COM
	Three Fountains - West 5050 S Three Fountains Cir (825 E)					
Poll Manager	Brandy	Pruett	4931 Lake Pines Dr Apt #6b	Murray	(801) 918-5975	bpruett@myriad.com
Provisional Judge	Robert	Nelson	4629 S Cresthill Cir	Holladay	(801)272-1244	chilepepper2@gmail.com
Technician	Stephen	Walker	891 W Walden Hills Dr	Murray	(801)808-3631	swalker@slco.org
	Utah Association of Counties 5397 S Vine St (730 E)					
Poll Manager	Dixie	Bryson	581 W 5900 S	Murray	(801)262-1338	brysonfamily581@q.com
Provisional Judge	Andres	Carrasquillo	829 E Three Fountains Cir Apt	Murray	(801)856-7766	shirleylopez1@hotmail.com
Technician	George	Humphries	9278 S Edenbrook Way	West Jordan	(801)569-1310	grandpa.humphries@gmail.com
	Wheeler Historic Farm 6351 S 900 E					
Poll Manager	Stacie	Peterson	5958 S 620 E	Murray	(801)694-0873	STACIEMARIE@GMAIL.COM
Provisional Judge	Maryellen	Houghton	6420 S 1680 E	Murray	(801)274-7224	maryellenhoughton@yahoo.com
Provisional Judge	Carolyn	Kilgrow	1241 E Hemingway Dr	Murray	(801)263-0448	ckilgrow@comcast.net
Technician	Charles	Christensen	6568 S Lombardy Dr	Murray	(801)272-2518	ccurtischris@hotmail.com

Mayor's Report and Questions

Adjournment