IDAHO DIVISION OF PUBLIC HEALTH

Get Healthy Idaho

2020-2024

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Idaho Foodbank

Idaho Hospital Association

Idaho Immunization Coalition

Idaho Oral Health Alliance

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Idaho Hospital Association

Idaho Oral Health Alliance

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Get Healthy IDAHO

VISION

Healthy people living and thriving in safe, healthy and resilient communities

MISSION

To create the conditions that ensure all people can achieve optimal health and resiliency

INTRODUCTION

A major shift in the way Idaho funds and addresses population-level prevention and health promotion strategies is needed in order to improve health outcomes, lower healthcare costs, reduce health disparities and improve health equity across Idaho. In State Fiscal Year (SFY) 2020, the Division of Public Health (division) is embarking on a collaborative process to identify the state's top health priorities and develop a five-year plan to address those priorities. This initiative and accompanying plan is known as *Get Healthy Idaho: Building Healthy and Resilient Communities (Get Healthy Idaho).*

The vision of *Get Healthy Idaho* is healthy people living and thriving in safe, healthy and resilient communities.

The division has a deep commitment to improving health and achieving equity for the most vulnerable individuals, families and communities. The division cannot build health, increase resilience and improve health outcomes alone; it will require integration and collaboration with the entire Idaho Department of Health and Welfare (department) and fostering partnerships across all systems and sectors that affect health. By removing the silos that exist both within and outside of the department, the division can better leverage funding and partnerships and optimize resources to support this community-driven approach.

The vision of *Get Healthy Idaho* is healthy people living and thriving in safe, healthy and resilient communities.

A movement of this breadth and magnitude calls for a shift in the department's organizational funding structure from one that has traditionally invested wide-and-shallow to one that focuses narrow-and-deep in prioritized communities, in order to catalyze community-driven, place-based health initiatives. This shift includes rethinking and changing conventional funding structures to create a system that more effectively uses data to invest in the health of specific populations.

Using the division's vision, and by combining resources and aligning goals with statewide and community partners, the department has a unique opportunity to invest in bold and innovative solutions that address the root causes of poor health affecting entire communities and, ultimately, individuals, families and children. To achieve this, the department must turn its focus towards addressing the key influencers of health, also referred to as the social determinants of health, in specific communities to improve health equity for all, regardless of age, income, race, gender, sexual orientation or ability.

Get Healthy Idaho consists of two integral parts: a statewide, comprehensive population health assessment that provides the foundation for understanding the health of Idahoans and its communities; and a population health improvement plan focused on efforts to address specific priority areas identified through the assessment. The division conducts the *Get Healthy Idaho* assessment every five years and updates the data annually. The health improvement plan is a five-year plan, monitored quarterly, with annual updates made as necessary.

Get Healthy Idaho supports the division's strategic plan and the department's larger strategic plan to "catalyze community-driven, place-based health initiatives addressing determinants of health in high priority communities."

The strategies the division will utilize to achieve this vision include identifying high-priority communities; cultivating partnerships and capacity; achieving a shared vision; empowering a community-led approach; and investing in upstream approaches that impact the social determinants of health.

The health priorities identified in *Get Healthy Idaho* are the division's focus for the next five years (2020-2024); however, before the division can impact health priorities, the division and department need to create the foundational components of the initiative. The first year of the initiative focuses on building the framework and infrastructure that does not currently exist at the department. This includes defining terminology, refining communication plans and establishing connections both within the department and with other statewide partners.

OVERVIEW OF IDAHO

Demographics

Idaho is a large western state with impressive mountain ranges, large areas of high desert and massive expanses of forested terrain. Idaho contains the second largest wilderness area in the lower 48 states, the Frank Church – River of No Return Wilderness, which covers almost 2.4 million acres.[1] Geography and distance impact both the demographic characteristics and social determinants of health within Idaho. Idaho is ranked 40th of the 50 United States for total population and 14th for geographic size.[2,3] The 2018 estimated population for Idaho was 1,754,208 and, because of its large size and relatively small population, Idaho remains one of the most rural states in the nation.[2] With approximately 20.5 people per square mile, Idaho ranks 44th of the 50 states in population density. The national average population density is 92.2 people per square mile, a four-fold greater density than Idaho.[3] Thirty-five of Idaho's 44 counties are rural, with 19 of these considered frontier, which means those counties have fewer than six people per square mile.[4]

The racial groups that comprised Idaho's population in 2018 were: (a) white, 93 percent; (b) Black, 0.9 percent; (c) American Indian/Alaska Native, 1.7 percent; and (d) Asian or Pacific Islander, 1.8 percent. Data indicate that 2.5 percent of Idahoans identify as being of two or more races. Persons of Hispanic or Latino origin comprised 12.7 percent of Idaho's total population.[5] Idaho is home to six federally recognized tribes: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes of the Fort Hall Reservation, the Northwestern Band of the Shoshone Nation and the Shoshone-Paiute Tribes of the Duck Valley Reservation.[6] Idaho also has two refugee centers located in southwest Idaho (Ada County) and south-central Idaho (Twin Falls County).

Social Determinants and other Demographics

The conditions in which people are born, live, learn, work and play have a substantial impact on health outcomes. These conditions, known as the social determinants of health, are important to consider when thinking about improving the health of a population. The social determinants of health vary at every stage of life and include factors such as age, personal behaviors, socioeconomic status, educational attainment, employment status, the physical environment and access to healthcare.[7]

While the ideology that "your zip code is a greater predictor of health than your genetic code" is widely used by public and community health professionals, a

deeper look indicates that "your neighborhood is a greater predictor of your health." The social, economic and environmental factors and their influence on health can vary greatly depending on the neighborhood one grows up in and their access to affordable housing, good jobs, healthy food, education and healthcare. In Idaho, mapping life expectancy by census tract shows a difference of as much as 20 years of life expectancy between the highest and lowest tracts.

According to the U.S. Census 2016 Current Population Survey, 12.8 percent of Idahoans were living below the poverty level and the median household income in Idaho was $50,985. Idaho's per capita income in 2016 was $25,471.[5] Idaho is an important agricultural state, producing nearly one-third of the potatoes grown in the United States. Wheat, sugar beets and alfalfa hay are also major crops. Other industries contributing to Idaho's economy include information technology, mining, lumber, tourism and manufacturing.

The most recent national data (2013 to 2017 five-year average) indicate that the percentage of Idahoans over the age of 25 who have graduated from high school is higher than the national average (90.2 percent and 87.3 percent respectively). A quarter (26.8 percent) of Idahoans over the age of 25 hold a bachelor's degree or higher, compared with the national average of 30.9 percent.

Data on Idaho's social determinants of health show 36.1 percent of children enrolled in public schools were eligible for free or reduced-price lunch; 30.8 percent of residents do not own their housing units; and, 27.6 percent of homeowners' monthly housing costs were 30 percent of household income or greater.[12]

According to the 2017 County Health Rankings, Idaho's most rural counties experience higher rates of obesity and diabetes, higher rates of food insecurity and limited access to healthy foods. These counties also have more limited access to quality healthcare services and suffer from higher rates of premature death.

According the Idaho Vital Records Annual Report 2017, Idaho's Hispanic, Black and Tribal populations experience higher rates of teen pregnancy. The Hispanic population also experiences higher rates of obesity,[13] and Hispanic youth ages 9-12 represent a high percentage of cigarette smokers.[14]

Idaho's percentage of adolescent suicide attempts exceeds the U.S. median at 9.7 percent, compared to 7.4 percent. Of those, the Idaho Hispanic population's adolescent suicide attempts are 12.9 percent.[12]

Public Health District Description

To facilitate the availability of public health services, the state aggregated contiguous counties into seven local public health districts. The boundaries that separate each of the seven areas include geographic barriers, transportation routes and population centers. Access to healthcare and other services have continued to be barriers to improving health outcomes for Idaho residents; however, Idaho's seven local public health districts represent the primary outlets for public health services. Each district responds to local needs to provide services that may vary from district-to-district, ranging from community health nursing and home health nursing to environmental health, dental hygiene and nutrition. Many services that the districts provide are through contracts with the division.

Health Professional Shortage

In 2019, 100 percent of Idaho was a federally-designated mental health professional shortage area, 95 percent of Idaho was a federally-designated shortage area in primary care and 94 percent of Idaho was designated a dental health professional shortage area. Idaho had 64.5 primary care physicians per 100,000 population in 2018. In 2019, the Idaho Hospital Association

membership directory reported 50 hospitals (including facilities in Oregon, Washington, and Wyoming). Twenty-seven of these hospitals are critical access hospitals, located in Idaho, and own a combined 55 clinics. These clinics include primary care and specialty services and may be co-located with the hospital or operate as remote clinics.[10]

In 2018, the first college of osteopathic medicine began operating in Idaho for the purpose of training and developing physicians. The Idaho College of Osteopathic Medicine (ICOM) received pre-accreditation status while it continues working towards establishing full accreditation status from the Commission on Osteopathic College Accreditation. The impact of ICOM on the health professional shortages in Idaho remains to be seen.

Idaho Medicaid

In SFY 2019, approximately 280,000 Idahoans were enrolled in Medicaid. Medicaid enrollment fluctuates depending on the state's economy: When the economy is strong, more people are working and have access to healthcare coverage through their employers; however, when the economy is not performing well, more Idahoans seek healthcare assistance through Medicaid. Overall, Medicaid's enrollment declined four percent from SFY 2018.

Medicaid serves individuals from birth to end of life, provided they meet eligibility criteria. In SFY 2019, 33 percent of Medicaid Trustee and Benefits expenditures went to children from birth to 18 years of age. Medicaid enrollment varies by county, with the highest number of participants living in counties that include some of Idaho's largest cities (e.g., Ada County has 456,849 participants). However, some of the smallest counties have the greatest density of residents receiving Medicaid benefits, with Lewis County at 31 percent, followed by Owyhee County at 24 percent and Cassia, Gooding and Jerome Counties at 23 percent.[11]

In November 2018, voters passed a ballot proposition to expand Medicaid in Idaho. The goal of Medicaid expansion is to provide Medicaid coverage to individuals with incomes up to 138 percent of the Federal Poverty Level. The state implemented Medicaid expansion January 1, 2020.

GET HEALTHY IDAHO ASSESSMENT PROCESS: OVERVIEW

The Get Healthy Idaho planning committee, consisting of division leaders and data owners, identified the Community Health Assessment Toolkit, from the Association for Community Health Improvement, as the model they would follow for the 2020-2024 Get Healthy Idaho initiative.

Community Health Assessment Toolkit[15]

The model consists of nine key steps:

1. Reflect and Strategize
2. Identify and Engage Stakeholders
3. Define the Community
4. Collect and Analyze Data
5. Prioritize Community Health Issues
6. Document and Communicate Results
7. Plan Implementation Strategies
8. Implement Strategies
9. Evaluate Progress

GET HEALTHY IDAHO ASSESSMENT STEPS

Steps 1-3: Reflect, Strategize, Identify and Engage

Between January and April 2019, a core group reviewed the process used for Get Healthy Idaho 2015-2019. Key recommendations from the review included:

- Expand the review of data to all programs in public health, regardless if they fall under accreditation guidelines
- Avoid arbitrary constraints to what health and social issues Get Healthy Idaho can address, such as public health funding restrictions
- Focus on the social determinants of health
- Engage division programs and partners more authentically
- Identify other organizations conducting health assessments and incorporate the data
- Include non-traditional partners such as transportation and housing agencies
- Define the community as the state, focus on state-level data and then work with high-risk communities to focus efforts based on locally-identified needs

Step 4: Data Collection and Analysis

Data used for the 2019 Get Healthy Idaho assessment included both primary and secondary data. Primary data included key informant interviews conducted by division staff between May and July 2019. Key informants consisted of partners representing local public health districts, the Idaho Hospital Associations and Boise State University. Additionally, the division held interviews with partners representing disparate populations such as the Idaho Foodbank, the Idaho Commission on Aging, Genesis Medical Clinic and the Center for Community Justice. Interviews engaged partners in discussions about their current involvement in community issues; their perception of key health issues related to the populations they serve; underlying issues that contribute to those health issues (such as access to care and inequities); and barriers to addressing health issues and long-term consequences of not addressing these issues. The interviews sought

the key informant's perception of the largest gaps in the state regarding health and recommendations for addressing those gaps. In all, the division conducted ten interviews. The summary of the interview results is on pages 21-24.

Idaho's Leading Health Indicators provide the framework for Get Healthy Idaho and seek to answer questions about the health of Idahoans. Data from the Idaho Behavioral Risk Factor Surveillance System (BRFSS), the Idaho Pregnancy Risk Assessment Tracking System (PRATS) and public health programs serve as primary data sources that inform the Leading Health Indicators.

Secondary data sources utilized in the assessment came from Community Health Needs Assessments (CHNA) published by hospitals and local public health districts. Major findings and local priorities helped lead the division to the state-level priorities. A listing of the CHNAs and other community health needs assessments referenced is on pages 25-27.

When the division compiled various data, the division then developed dashboards and uploaded to gethealthy.dhw.idaho.gov, a public-facing website for partners to review. The division hosted two webinars walking partners through the site and providing guidance for interpreting the data. Data include the Leading Health Indicators and social determinants of health at the local public health district level and county level, when possible.

Step 5: Prioritization of Community Health Issues

On August 6, 2019, the division hosted the Get Healthy Idaho assessment partner meeting. The purpose of the meeting was to present the Get Healthy Idaho vision, review and discuss the assessment data and identify the priority areas for Get Healthy Idaho from 2020 to 2024.

Thirty-one agencies with regional or statewide scope attended the meeting. These agencies included local public health departments, hospitals, universities, rural health clinics, medical associations, health clinics, community-based organizations, associations, coalitions, other state agencies including those focused on drug policy, education and environmental quality. From the department, representatives from the Divisions of Public Health, Behavioral Health and Medicaid also attended. A complete list of participants is on page 28.

The division provided a data presentation that considered all data variables as described in Step 4. Following the presentation, an independent facilitator led the group through a prioritization process. In order to allow the partners full engagement, division staff did not participate in the prioritization process. The facilitator utilized Poll Everywhere to lead the group through a ranking process to narrow down the group's top health issues. Knowing the vision of Get Healthy Idaho was to impact the social determinants of health, the group discussed if the priorities should be health outcomes or social determinants. Collectively, the group decided the focus would be on health outcomes.

The four priorities identified were:

1. Behavioral health
2. Diabetes
3. Overweight and Obesity
4. Unintentional Injury (specifically motor-vehicle accidents, falls and accidental poisoning/drug overdose)

Following the priority identification, the group convened in small groups to discuss state and community assets, existing programs, innovative ideas, lingering questions and additional needed partners for each health priority. The full meeting summary begins on page 29.

Step 6: Documenting and Communicating Results

Following the partner meeting on August 6, 2019, division leadership immediately communicated the results of the assessment with partners and department leadership. As this is a priority for the department, as well as the division, planning began immediately.

Steps 7 and 8: Implementation and Evaluation

These steps are addressed in the following health improvement plan.

GET HEALTHY IDAHO: HEALTH IMPROVEMENT PLAN

The four priority areas identified for *Get Healthy Idaho*: Building Healthy and Resilient Communities health needs assessment, will be the focus of the Health Improvement Plan for calendar years 2020-2024

Behavioral Health

Behavioral health conditions, which include both mental health and substance use disorder diagnoses, affect millions of adults and adolescents in the U.S. every year. In 2018, the National Survey on Drug Use and Health (NSDUH) estimated that a mental illness had affected the lives of more than 19 percent of adults nationwide, or 47.6 million people, during the past year. Less than half of them (43.3 percent) received treatment services in the past year. An estimated 21.2 million people ages 12 and over needed substance use disorder treatment in 2018, with only about 3.7 million receiving it in the past year. An estimated 9.2 million adults struggled with both a mental illness and substance use disorder in the past year, according to the NSDUH; 48.6 percent received no specialty treatment for either issue in the past year.

The rural nature of Idaho makes the delivery of treatment services for behavioral health issues more challenging as people in need are spread across large areas with limited treatment resources in all but the urban centers of Idaho. All 44 of Idaho's counties received federal designation as mental health professional shortage areas, either geographic areas or populations with a deficit in mental health services.

The stigma surrounding behavioral health issues poses an additional barrier that may cause those who need treatment most to avoid seeking it out: They can feel ashamed or embarrassed of issues that are out of their control, and the lack of treatment can cause the issues to worsen over time. Untreated behavioral health issues can lead to worsening symptoms, including physical health problems, financial struggles, job stability difficulties, law enforcement encounters, emergency hospitalization and death.

Opioid Epidemic

In efforts to combat the nationwide opioid epidemic in Idaho the Idaho Response to the Opioid Crisis (IROC) Program has provided funding for 1,309 Idahoans to access opioid use disorder treatment since May 2017. Initiatives include a law enforcement-assisted diversion program that allows people to receive treatment rather than be arrested; distribution of 2,944 doses of the overdose reversal drug Naloxone; increased access to recovery support services statewide; and collaboration with Idaho's six federally recognized tribes to address their communities' needs.

Crisis

Nationwide, as suicide rates have increased, Idaho needs comprehensive systems to address behavioral health crises. The Agency for Healthcare Research and Quality reports that one in eight visits to emergency departments involve a

behavioral health issue. With a suicide rate 50 percent higher than the national average, Idaho is developing a new, less fragmented crisis system that will reduce the over-reliance on law enforcement and emergency responders and end unnecessary emergency department admissions and jail bookings, resulting in overall state cost savings, improved quality of care and better health outcomes.

Youth Empowerment Services (YES)

Mental health is an important part of a child's overall health, having a complex interactive relationship with their physical health and ability to succeed in many areas of life. Without early diagnosis and treatment, children with mental health needs have symptoms that often interfere with their healthy development, and these problems can continue into adulthood. About one in five children in the U.S. need extra support for their mental health needs; but many families do not know how to access help. Idaho is implementing a new system of care for children's mental health called Youth Empowerment Services (YES) to support children and families in a timely way. The goals of YES include increasing understanding of mental health needs in children, providing access to quality mental health care and monitoring the effectiveness of treatment.

Diabetes

An estimated 133,000 Idaho adults, or 10.2 percent of the adult population, live with diabetes. Additionally, the CDC estimates that 466,000 Idaho adults, or 35 percent of the adult population, live with pre-diabetes that puts them at increased risk of developing diabetes. Improperly managed diabetes often leads to costly and serious complications, sometimes resulting in death (diabetes is the seventh leading cause of death in Idaho). The conditions in which Idahoans live, learn, work and age affect their health, including diabetes. Social determinants of health, such as neighborhood, education and healthcare can influence lifelong well-being. Sustainable lifestyle changes can prevent type 2 diabetes. Ensuring sustainable lifestyle changes requires addressing the social determinants of health, so that all Idahoans can lead more productive and healthier lives.

10.2%

of the adult population in Idaho, live with diabetes

The Diabetes Prevention and Control Program is working with the following partners to prevent and manage diabetes statewide:

- Diabetes Alliance of Idaho
- Seven local public health districts
- Idaho State University College of Pharmacy
- National Diabetes Prevention Program lifestyle coaches
- Diabetes Self-Management Education & Support Program coordinators
- Idaho Hunger Relief Task Force
- Idaho Physical Activity and Nutrition Program
- Lincoln County Community Health Emergency Medical Services Program
- Health Systems: Shoshone Family Medical Center, Family Health Services, Bingham Memorial Hospital, Lost Rivers Medical Center, Valor Health and Genesis Community Health
- Idaho Community Health Worker Association and Network

Overweight and Obesity

Idaho, like most states, is seeing a steady increase in the percentage of its population that is overweight or obese. According to the 2018 Idaho Behavioral Risk Factor Surveillance System (BRFSS), 28.4 percent of Idaho adults ages 18 and older are obese. Like adults, youth are experiencing increased obesity rates. In 2017, 14.7 percent of Idaho high school students were overweight, and 11.4 percent were obese (Youth Risk Behavior Survey). The health and economic burden of chronic conditions, and their associated risk factors, require public health agencies to establish obesity and associated chronic diseases as a health priority. Obesity can also lead to co-morbid chronic conditions such as heart disease, hypertension, high blood cholesterol, diabetes and some cancers.

Upstream socioeconomic and environmental determinants of health, such as poverty, housing, education, food access and healthcare access, can systematically influence individual behaviors that have an impact on weight and associated health outcomes.

The Idaho Physical Activity and Nutrition Program (IPAN) is working with the following partners to support obesity prevention efforts statewide:

- Local public health districts
- Healthy Eating, Active Living (HEAL) Idaho Network
- Idaho Hunger Relief Task Force
- SNAP-Ed Program
- Maternal and Child Health (MCH) Program

Unintentional Injury

Unintentional Injuries include motor vehicle accidents, discharge of firearms, drowning and submersion, suffocation, falls and unintentional drug overdoses, among others. Unintentional injuries represent a significant issue in Idaho. They ranked fourth in Idaho's leading causes of death in 2018, with a total of 887 deaths. Non-fatal accidental injury can result in permanent disability and significant economic impacts to individuals and families. Unintentional injuries can be preventable by studying the risks for injury and adopting proven intervention strategies. For Get Health Idaho, initiative members selected falls, motor vehicle accidents and unintentional drug overdose as the top priorities.

Falls

Falls can result in injury and death. The Centers for Disease Control and Prevention (CDC) estimates that one out of five falls causes a serious injury such as a broken bone. Other potential injuries include head injuries and hip fractures. In 2018, 235 (or 13.4 deaths out of 100,000 population) Idaho residents died as the result of a fall. Falls pose a particular risk to the older adult population. CDC estimates the economic impact of falls in Idaho to adults age 65 and older is $164 million. Falls can be prevented through lifestyle changes such as strengthening exercises and a safer home environment.

235

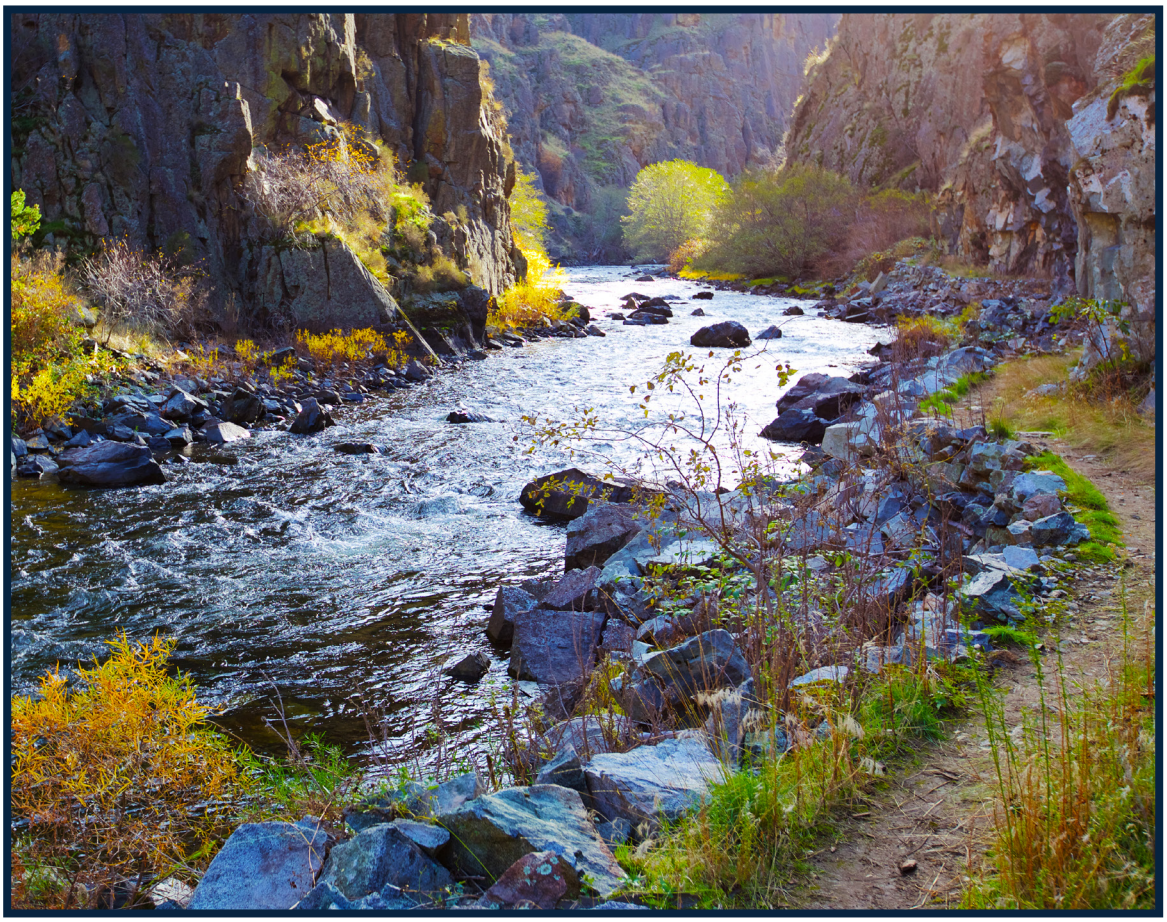
Idaho residents died as the result of a fall in 2018

Motor Vehicle Accidents

In 2018, 248 Idaho residents died in motor vehicle accidents. This represents 14.1 deaths per 100,000 population. The CDC has calculated that for every person killed in a motor vehicle accident, eight people are hospitalized and 99 are treated and released from an emergency department. The CDC also estimates the cost to Idaho resulting from motor vehicle crash deaths is $303 million. Fortunately, strategies exist that can be implemented to reduce the number of motor vehicle deaths in Idaho.

Unintentional Drug Overdose

Idaho has also experienced the national drug overdose epidemic. From 2009 to 2018, unintentional drug overdose mortality increased 97 percent (101 deaths in 2009 to 199 deaths in 2018). The opioid epidemic is a complex issue facing the nation and Idaho. It will take a comprehensive and multifaceted public health approach to reduce drug overdose deaths.



OPERATIONALIZING THE PLAN

The health priorities identified in *Get Healthy Idaho* represent the focus of the division over the next five years. With CY 2020 being the first year of the new initiative, the activities and measures included in the current plan emphasize establishing a foundation and beginning to build communication and infrastructure. Activities in CY 2020, include educating department staff and external partners about the basics of the social determinants of health and place-based initiatives; researching effective models used in other states or communities; identifying key partners for engagement; identifying opportunities for partnership; and, finally, identifying a funding model and funding sources to support this work both internally and for communities.

Because the *Get Healthy Idaho* initiative has limited designated staff or funding, the division's first step towards implementation was to establish an operational structure to begin this cross-cutting work. Those involved in the various workgroups are laying the groundwork and building the internal infrastructure needed to support this long-range initiative.

Calendar years 2021-2024 will focus on implementation activities to include deployment of the first subgrant solicitation to a minimum of one local community in year two and potentially one new solicitation to a community in years three through five.

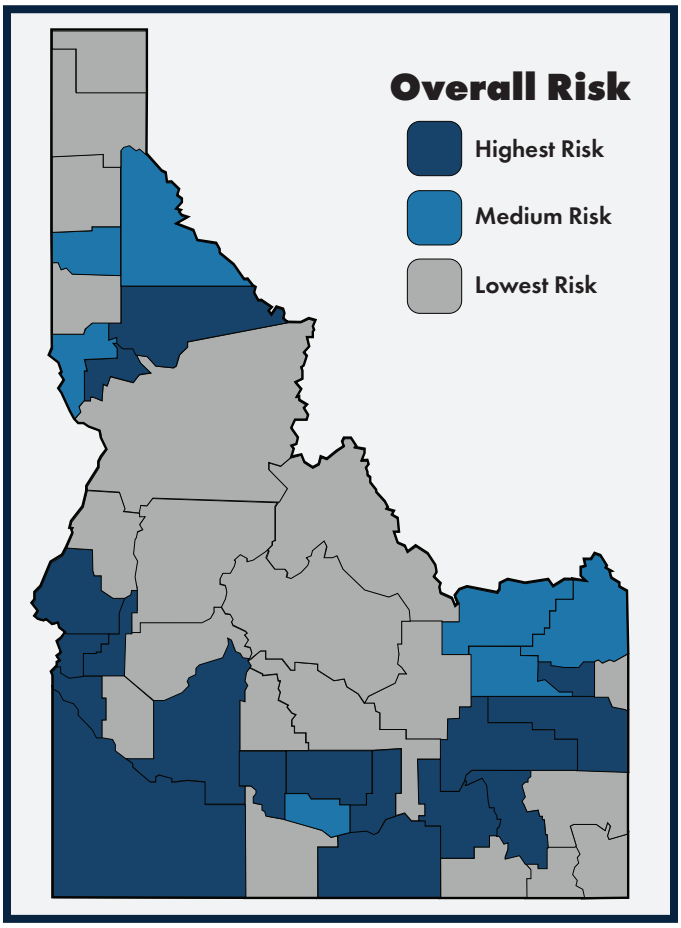
Identifying Communities

DPH will use a data-informed approach to identify communities with poorer health outcomes where investments in upstream approaches will be most effective. To identify these communities, the division developed a data dashboard showing county-level health outcome measures (incidence, prevalence, mortality, etc.) combined with the health determinant indices. Indices are composite measures that combine multiple social determinant of health factors into one "score".

Two health determinant indices (the Social Vulnerability Index (SVI) and the Concentrated Disadvantage Index (CDI)) were selected based on their ability to provide county-wide estimates, support and promotion by the Centers for Disease Control and Prevention and range of individual measures which are used to develop the index score.

The SVI has two composite groups focused on Socioeconomic Status (SES) and Housing. The SVI-SES index considers poverty levels, unemployment, income and high-school graduation. The SVI-Housing index considers multi-unit structures, mobile homes, crowding, access to vehicles and group living.

The CDI considers poverty, those receiving public assistance, female-headed households, unemployment and those younger than 18. When these indices, in combination with health outcome data, are applied to the state population, counties of highest risk are identified, as seen by the dark blue shading in the Diabetes Prevalence and SDOH Risk by County map. The division's data dashboard located at gethealthy.dhw.idaho.gov allows the counties to be ranked from 1-44 (the number of Idaho counties). As the division identifies the counties that will be funded through *Get Healthy Idaho*, social determinants and other resource data will be reviewed for the cities and towns located in those counties. This will allow for a more comprehensive, yet targeted assessment of each community's highest needs.



Community Engagement

Through *Get Healthy Idaho*, the division will sustain investments in statewide partnerships to connect resources and opportunities for authentic engagement with community members. This also reflects the department's desire to ensure place-based initiatives are led and driven by communities. A fundamental component of this work is developing a model for authentic community engagement, led by a community leadership team, which will ensure open and ongoing dialogue with partners, residents, families, youth and community leaders. Authentic engagement, following the International Association for Public Participation (IAP2) spectrum, will build a foundation of partnership and trust and empower residents to take leadership roles, build social capital and identify resources to help the community collectively work toward impactful solutions.

A local agency will serve as the hub or community lead of this effort and will ensure a diverse representation of community members is engaged in the process and empowered to make decisions. Engagement will include capturing qualitative feedback through key informant interviews to gain a better understanding of the known assets, challenges and opportunities that exist in the community. By combining population-level health outcomes and qualitative feedback from residents, the community will be tasked with selecting evidence-based interventions that will promote the conditions needed to support health, safety and resilience in their community. Through this process, the division will gain a better understanding of what matters most to the community's health and learn about their experiences and recommendations for improvement.

Community members will have opportunities to engage throughout the process and contribute to the planning and implementation of solutions. Continual engagement and feedback of residents will be vital to ensure the work meets community needs.

Indicators of Health Improvement and Priorities for Action

Calendar year 2020 indicators focus on building and mobilizing the *Get Healthy Idaho* initiative. This work has no dedicated funding and limited dedicated staffing, so time is needed to lay the groundwork for engaging partners and communities in a way that will ultimately impact health improvement outcomes. The work began in calendar year 2019 through the department's and division's strategic plans; therefore, January 2020 through June 2020 of the health improvement plan indicators align with the metrics defined in those strategic plans:

1. Develop a communication and education strategy
2. Define and share the Get Healthy Idaho framework
3. Develop a financial model framework
4. Engage stakeholders and key partners in Get Healthy Idaho

From July 2020 through June 2021, the division will identify indicators that measure continued progress with establishing the infrastructure and implementation of *Get Healthy Idaho* community subgrants.

Plans for policy and system level change

The department will provide technical assistance and knowledge to help community members and leaders advance their capacity and knowledge of practices that ensure implementation of meaningful solutions. As this work develops, plans will be specific to individual communities based on their unique challenges, needs and opportunities. Policy, system and environmental changes will be identified based on what is most critical to individual communities and will have the most impact on improving health outcomes. It is anticipated that community priorities will be just as diverse as the communities themselves, given the variation in population-level health outcomes, culture, geography, sociopolitical climate, capacity and allocated resources across the state. With the knowledge that health happens where people live, policy, system and environmental interventions that ensure healthy opportunities are accessible to everyone in a community will receive recommendations.

Publication of the Assessment and Plan

The *Get Healthy Idaho: Building Healthy and Resilient Communities plan* is located publicly at gethealthy.dhw.idaho.gov. In Calendar Year 2020, the division will expand this site from its current state to include progress reports on plan strategies and performance metrics, partner and community involvement and the most current population health data. The site will serve as the central location for all information related to this initiative.

At least annually, the division will convene the larger *Get Healthy Idaho* partner group to review the prior year implementation plan, present new data and modify the plan, as needed. Partnering agencies and the department team responsible for identified strategies will report progress. On a quarterly basis, strategy leads will meet to review progress, barriers and successes. Local agencies assigned to lead the work in their communities will also attend.

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APPENDIX 1: KEY INFORMANT INTERVIEWS, SUMMARY

Participants included:

- Boise State University
- Center for Community and Justice
- Community Health Worker Alliance
- Genesis Community Health
- Idaho Academy of Family Physicians
- Idaho Commission on Aging
- Idaho Foodbank
- Idaho Hospital Association
- Panhandle District Health
- Eastern Idaho Public Health

Questions Asked of Participants – Three Main Pillars:

- Agency or organization's role in health-related issues
- Identifying top 3-5 health issues
- Addressing top health issues

What are the most critical and pressing health issues for Idaho?

- Access to health care
- Affordable housing
- Chronic diseases
- Cost of health care
- Immunization rates
- Livable wages
- Mental health

- Obesity/diabetes
- Opioids and other substance use
- Social determinants of health
- Suicide
- Tobacco and vaping
- Workforce issues in health care/shortages

What underlying dynamics contribute to these health issues?

- Access to health care
- Disconnection across health care providers
- Economic inequality
- Education levels and health awareness
- Geography – rural vs. urban communities
- Increase in misinformation
- Independent culture of Idahoans
- Mental health incidences
- Adequate transportation
- Workforce shortages and issues

What are some of the short- and long-term impacts of these health issues?

- Decreased life expectancy
- Decrease in the quality of life for Idahoans
- Fear/personal suffering – costs and access of health care
- Health literacy not passed down through generations

- Higher rates of incarceration
- Individual isolation
- Mortality and morbidity
- Rising health care costs
- Substance abuse – and higher suicide rates

Which populations face the greatest risk for these health issues?

- Children
- Disabled
- Elderly
- LGBQT
- Low-socioeconomic status
- Minority populations
- Rural communities

APPENDIX 2: CHNA RESULTS

Health District	Health Organization	Website	Date	Sectors at the Table	Priorities/Themes	Community Health Improvement Plan?	Helpful Things
AI/AN		www.npaihb.org/images/epicenter_docs/IDEA/2014/IdReports/ID_THP_Final_FullReport.pdf	2014				
Idaho Tribes	NWPAIHB	www.npaihb.org/wpfb-file/healthprofile2014-0_idaho_introcontents-pdf/	2014	The NW TEC established a planning team for the health profile reports in December 2013.This core group of NW TEC employees held planning meetings once or twice per	The common theme noted in the identified disparities is that the causes are often preventable. Conclusions recommend focusing on programs that encourage healthy lifestyles and environments. Specifically called out was a reduction in BMI, injury prevention targeting motor vehicle safety and overdose		
PHD 1	Panhandle Health District	panhandlehealthdistrict.org/community-health-assessment-and-plan	2018	Hospitals, Health Centers, Tribes, Cities, School Districts, EMS, Office on Aging, Businesses, Higher Education, Head Start, Faith Community, RBHB, Early Child Care, EPA, United Way	Access to Care, Mental Health /Suicide, Substance Abuse	panhandlehealthdistrict.org/wp-content/uploads/2018/11/CHIP-Final.pdf	
PHD 1	Bonner General Hospital	www.bonnergeneral.org/community-health-needs-assessment/	2016	Business, religious organizations, schools, law enforcement, food bank, local media, medical professionals, substance abuse prevention coalition, chamber of commerce	In order: 1. obesity 2. child abuse/neglect 3. suicide 4. mental health	www.bonnergeneral.org/wp-content/uploads/2017/03/2016-CHNA-Implementation-Strategy.pdf	
PHD 2	Public Health - North Central Idaho	www.idahopublichealth.com/district2/dataresources/2016%20CHNA%20Final%205.31.17.pdf	2016	Aging, housing, business, healthcare, hospitals, law enforcement, food assistance, school districts, child care, United Way, EMS, behavioral health	Three Areas: HEALTH - Obesity and Chronic Disease, Health Insurance, Mental Health and substance abuse. EDUCATION - Opportunities for post secondary Education and training, Tutoring at risk, Child Care. INCOME - Housing, food assistance, Managing finances and employment assistance.	www.idahopublichealth.com/district2/dataresources/chip/2017%20CHIP%207.6.17%20FINAL.pdf	
PHD 2	Clearwater Valley Hospital & Clinics St. Mary's Hospital and Clinics	www.smh-cvhc.org/getpage.php?name=community_health	2016	Public health, hospitals/clinics, tribal health, human needs council;	Access to care, obesity and other contributors to chronic disease, mental health	Includes progress to date on 2013 CHNA	BMI screenings for elementary school children in Orofino; medically underserved and low-income represented by county Human Needs Councils (included Nimiipuu Tribal Health); created benefits counseling program;
PHD 2	Gritman Medical Center	gritman.org/wp-content/uploads/CHNA_Gritman_2016.pdf	2016	Various agencies and individuals responded to survey and some provided "local expert advisor" opinions but didn't appear involved in the planning process	Mental health/suicide, substance abuse, physicians, affordability/accessibility, obesity/overweight	Same website includes implementation strategy	Implementation strategy lists the organization and contact name to help address need

APPENDIX 2: CHNA RESULTS

Health District	Health Organization	Website	Date	Sectors at the Table	Priorities/Themes	Community Health Improvement Plan?	Helpful Things
PHD 3	Valor Health	www.valorhealth.org/community-health-needs-assessment-2017/	2017	Link to the 2017 United Way of Treasure Valley Community Assessment	Top identified health risk behavior: overweight/ obesity Key findings/areas of concern: child poverty, access to social/emotional support, low college graduation rates, physical inactivity		
PHD 3	Weiser Memorial	www.weisermemorialhospital.org/ assets/chna-2016-final.pdf	2016	N/A (compiled data and conducted surveys/interviews to prioritize)	Top identified health risk behavior: overweight/ obesity Key findings/areas of concern: child poverty, access to social/emotional support, low college graduation rates, physical inactivity	www. weisermemorialhospital.org/assets/2016-implementation-plan_ march2018-.pdf	Helpful charts in implementation plan showing goals and status for each focus area
PHD 3 & 4 (Ada, Canyon, and Gem Co's)	St. Als and United Way	www.saintalphonsus.org/ assets/documents/boise/ communityhealthneedassessment2017. pdf	2017	Local Health District, Health Systems, Transportation, IDHW, Chamber of Commerce, Dental, United Way, Education, BCI Foundation, Housing, nonprofits	Employment and Economic Security, Housing and Homelessness, Transportation, General Health and Well-Being, Access and Affordability of Health Care, Mental Health and Substance Abuse, Tobacco Use , Healthy Weight (physical activity, active transportation, nutrition and food security), Education	No	Focus on Health, Education, and Financial Stability using Maslow's Hierarchy of Needs and Frieden's Health Impact Pyramid. Address Policy, Systems and Environmental Changes (PSE) throughout assessment
PHD 4	St. Luke's Elmore	www.stlukesonline.org/about-stlukes/supporting-the-community/ communityhealth-needs-assessment-mccall	2016	3 categories: persons with special public health knowledge, individuals/organizations serving or representing the underserved/low income/minority populations, additional people in the community	Priorities: Prevention and management of obesity and diabetes, improve mental health and reduce suicide, prevent and reduce tobacco use	No	
PHD 4 and Canyon County	St. Luke's Boise/ Meridian	www.stlukesonline.org/~/media/ stlukes/do cuments/chna%202016%20 boisemeridian%20final% 209_28_2016.pdf	2016	Category I: Persons with special knowledge of public health. This includes persons from state, local, and/or regional governmental public health departments with knowledge, information, or expertise relevant to the health needs of our community. Category II: Individuals or organizations serving or representing the interests of the medically underserved, low-income, and minority populations in our community. Medically underserved populations include populations experiencing health disparities or at risk populations not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers. Category III: Additional people located in or serving our community including, but not limited to, health care advocates, nonprofit and community-based organizations, health care providers, community health centers, local school districts, and private businesses.	SIGNIFICANT HEALTH NEEDS: 1.Improve the Prevention, Detection and Treatment of Obesity and Diabetes 2. Improve the Prevention, Detection, and Management of Mental Illness and Reduce Suicide 3. Improve Access to Affordable Health Care and Affordable Health Insurance		

APPENDIX 2: CHNA RESULTS

Health District	Health Organization	Website	Date	Sectors at the Table	Priorities/Themes	Community Health Improvement Plan?	Helpful Things
PHD 4	St. Luke's McCall Hospital	www.stlukesonline.org/about-stlukes/supporting-the-community/communityhealth-needs-assessment-mccall	2016		Priorities: Prevention and management of obesity, improve mental health and reduce substance abuse, improve access to affordable healthcare and health insurance, prevent and reduce tobacco use	No	•Partner with not-for-profit provider agencies in the community for screen for depression in uninsured population (Behavioral Health network) pg. 6 •Work with police and pharmacies to install medication disposal drop boxes for unused prescriptions •Work with Cassia and Minidoka school districts to support Sources of Strength programs in schools - youth suicide prevention pg.7
PHD 5	Cassia Regional Medical Center (Intermountain Healthcare)	intermountainhealthcare.org/locations/cassia-regional-hospital/hospital-information/cassiaregional-hospital-chna-report/	2016	Community input meetings included people representing: local government, schools, senior services, safety net clinics, minority populations, uninsured and low-income people, social service providers, local businesses, advocates, healthcare providers, and the Idaho South Central Public Health District	Prevention of prediabetes, high blood pressure, depression, and prescription opioid misuse	Yes (same website)	• Access to Behavioral Health Services: Work with Crisis Center in Twin Falls, expand Telebehavioral Health Clinic and coordinate services, increase services to individuals of all ages, work with local entities to coordinate efforts around behavioral health (Proactive, Canyon View, Crisis Center, University of Utah, NCMC ER & Clinics) pg.4 • Drug & Alcohol Abuse in Teens: Work with school resource officers, partner with the Walker Center on a program targeting youth pg.6
PHD 5	North Canyon Medical Center	www.ncm-c.org/about/community-healthneeds-assessment/	2016	Individuals representing various community, business, educational and religious groups. Representatives from the local health care providers and the community health department	Coordination of Services, Urgent Care/extended hours, Behavioral Health Issues, Sliding fee/free clinic, Drug and alcohol use amongst teens	Yes (same website)	
PHD 5	St. Luke's Jerome	www.stlukesonline.org/about-stlukes/supporting-the-community/communityhealth-needs-assessment-jerome	2016	3 categories: persons with special public health knowledge, individuals/organizations serving or representing the underserved/low income/minority populations, additional people in the community (specifics on pg.172)	Improve Prevention and Management of Obesity and Diabetes; Improve Mental Health and Reduce Suicide; Improve Access to Affordable Health Insurance	No	
PHD 5	St. Luke's Wood River Medical Center	www.stlukesonline.org/about-stlukes/supporting-the-community/communityhealth-needs-assessment-wood-river	2016	3 categories: persons with special public health knowledge, individuals/organizations serving or representing the underserved/low income/minority populations, additional people in the community (specifics on pg.165)	Improve the Prevention and Management of Obesity and Diabetes; Improve Mental Health and Reduce Suicide; Improve Access to Affordable Health Insurance	No	
PHD 6	Bingham Memorial Hospital	www.binghammemorial.org/aboutbmh/community-health-needs-assessment	2016	Local healthcare providers/experts, local officials, local business owners, and/or patients. Nearly all volunteered and/or considered themselves community advocates in church, food banks, crisis centers, and economic development	High Cost of Care, Uninsured/Underinsured, Diabetes, Healthy Lifestyle Choices, Obesity, Mental Health Services, Heart Disease, Limited Health Knowledge, Drug/Alcohol Abuse, Health Screenings	Yes (same website)	Diabetes: Blackfoot Fire Dept - free classes for diabetes self management program (Part 2, pg. 1)

APPENDIX 2: CHNA RESULTS

Health District	Health Organization	Website	Date	Sectors at the Table	Priorities/Themes	Community Health Improvement Plan?	Helpful Things
PHD 6	Southeast Idaho Public Health		Available spring 2019				
PHD 7	Teton Valley Healthcare	ssuu.com/tvhealthcare/docs/2016_chna_final_long_smaller	2016	Local experts (individuals selected according to criteria required by the Federal guidelines and the hospital's desire to represent the region's geographically and ethnically diverse population)	Affordability/Accessiblity, Mental Health/Suicide, Prevention/Wellness, Alcohol Abuse/Substance Abuse, Accidents	No	
PHD 7	Eastern Idaho Public Health		Requested				
PHD 3	PHD3						
PHD 3	West Valley Medical Center	westvalleymedctr.com/search/results.dot?q=Community+Health+Assessment					
PHD 4	PHD 4	Part of United Way of Treasure Valley 2017 Community Assessment https://www.saintalphonsus.org/assets/documents/nampa/nampacommunityneedsassessment2017.pdf also at the table for St. Luke's Elmore County, McCall and Boise/Meridian assessments.		2017 - United Way 2016 - St. Luke's	Treasure Valley defined as Ada, Canyon and Gem counties		St. Luke's - Each with slightly different priorities. United Way 1. Health Care access and affordability 2. Nutrition, physical activity and weight status 3.Financial stability 4. Harmful Substance abuse 5. Mental health
PHD 5		www.stlukesonline.org/~/media/stlukes/documents/chna%202016%20magic%20valley%20final%209_23_16.pdf	2016 next to be completed in 2019	PHD5 was a community representative for St. Luke's Magic Valley CHNA 1. Improve the prevention and management of obesity and diabetes 2. Improve mental health & reduce suicide 3. Improve access to affordable health insurance	Themes identified in PHD5 CHIP 1. Overweight/Obesity and Diabetes 2. Cancer 3. Teen Pregnancy 4. Suicide		
	St. Lukes	www.stlukesonline.org/search?keyword=community+health+needs+assessments	2016	Local public health was at the table for each assessment	McCall, Jerome, Elmore, Wood River, Magic Valley and Boise/Meridian. They have slightly different priorities in different communities		

APPENDIX 3: AGENCIES PARTICIPATING IN GHI PARTNER MEETING, AUG. 6, 2019

Primary Care Association

Idaho Division of Public Health

Saint Alphonsus, Community Health Worker Alliance

American Heart Association

South Central Public Health

Center for Community and Justice

Genesis Community Health

Idaho Hospital Association

American Cancer Society Cancer Action Network

Office of Drug Policy

Idaho Division of Behavioral Health

Central District Health Department

Health Promotions

Idaho State Department of Education

Idaho State University

Southeastern Idaho Public Health District

Public Health North Central District

Idaho Division of Medicaid

Idaho Department of Environmental Quality

Eastern Idaho Public Health

Boise State University, Center of Aging

Blue Cross of Idaho Foundation for Health

Comagine Health

Idaho Academy of Family Physicians

Idaho Division of Welfare

Head Start Collaboration

Idaho Immunization Coalition

Idaho Division of Family and Community Services

Idaho Foodbank

Panhandle Health District

Idaho Oral Health Alliance

Appendix 4: GHI Partner Meeting Summary

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF PUBLIC HEALTH

Get Healthy Idaho Partner Meeting
Tuesday, August 6, 2019
10:00 a.m. – 4:00 p.m.
Boise State University

Meeting Overview

On Tuesday, August 6, 2019, the Idaho Department of Health and Welfare's Division of Public Health convened its Get Healthy Idaho Partner Meeting. The purpose of this meeting was to share data collected from the Statewide Health Assessment with key partners and stakeholders, identify priorities for Get Healthy Idaho 2.0, and begin discussing how to address social determinants of health at both the community and regional level to improve health outcomes across the state. Partners identified priorities through an iterative polling process that allowed for questions and dialogue on health outcomes of highest importance. Small group discussions were then facilitated in order to capture partner feedback and expertise on the resources and opportunities for addressing these priorities through collaborative and innovative approaches.

Meeting Summary

Get Healthy Idaho Accomplishments and Continuing Work

Traci Berreth, Chief of Business Operations, provided an overview of the first five years of the Get Healthy Idaho initiative, including completion of the statewide health assessment and the development of the health improvement plan. A number of strategies were developed to address the key priority areas of increasing access to care, reducing the burden of diabetes and obesity, and reducing the use of tobacco among Idahoans. Much of this work was supported by the Statewide Healthcare Innovation Plan grant, and resulted in a number of significant accomplishments. Please see the attached PowerPoint for more information.

Get Healthy Idaho 2.0 & Healthy and Resilient Communities

Elke Shaw-Tulloch, Division Administrator, provided an overview of the vision for GHI 2.0 as it relates to the Association of State and Territorial Health Officials (ASTHO) President's Challenge toward creating "healthy and resilient communities." Currently the United States has significantly lower life expectancy rates and significantly higher spending on health care than other developed countries. The goal of the healthy and resilient communities challenge is to improve national health outcomes by addressing social determinants of health (SDOH) at the community and regional levels. The next five-year phase of Get Healthy Idaho will focus on improving the health of Idahoans through a similar approach, engaging partners around key priorities at the local level and identifying innovative strategies for addressing SDOHs that will have broader impacts than traditional interventions. Strategies will be data-driven and implemented through collaborative efforts with a spectrum of partners. Please see attached PowerPoint for more information.

After providing information on this new direction for GHI 2.0, partners were invited to ask questions and share concerns they had. Comments were in strong support for this new direction. The word cloud

below shows partner responses when asked "What is one word that describes your thoughts about GHI 2.O?"

GHI Data Review

Joe Pollard, Health Data Analytics Program Manager, and Ryan Soukup, Communications and External Affairs Specialist, shared an overview of the data collected through the recently conducted Idaho Statewide Health Assessment. This assessment looked at leading health indicators, local and hospital community health needs assessments, and key informant interviews to identify what the most critical health issues and associated outcomes are across the state. This information can all be accessed from the Get Healthy Idaho Website.

Based on the data collected from the Statewide Health Assessment, Joe presented a list of health issues in Idaho that are either leading causes of death or contribute to the most significant number of years of life lost. Joe then asked partners to review the list and consider which health issues they would like to see the Division of Public Health and its partners begin to address through the developing Get Healthy Idaho 2.0 approach. Please see the attached PowerPoint for more information.

Priority Identification

Once partners had an opportunity to review and discuss the health outcomes that were associated with the leading causes of death, they were then asked to prioritize the outcomes they believe DHW and partners should focus on first. Through an iterative polling process, the following four priorities were identified:

- Mental/Behavioral Health Issues
- Diabetes
- Overweight/Obese
- Unintentional Injuries

Partners were then divided into four small groups and presented a series of questions for discussion around each of these priorities. Responses from each group are compiled below.

Mental/Behavioral Health Issues

1. What underlying social determinants of health contribute to the issue?
   - Access to mental health services
   - Incarceration rates
   - Social/civic engagement
   - Early education/childhood development
   - Neighborhood/built-in environment
   - ACEs score
   - Food insecurity
   - Toxic stress
   - Social context
   - Crime/violence
   - Trauma in household
   - Housing instability
   - Social media & bullying for teens
   - Economic stability
   - Poverty
   - Stigma/shame
   - Discrimination
   - Social isolation
   - Fear in communities (cultural considerations)
   - Health literacy
   - Family instability
   - Genetics

2. What benefits come from addressing the health issue?
   - Mental health affects ALL aspects of society
   - Health care cost savings
   - Reduce incarceration
   - Lower suicide rates
   - Lower violence overall
   - Lower stigma
   - Lower crime rates – shooting
   - Lower domestic abuse
   - It would affect unintentional accidents
   - Improving mental health frees up county resources
   - ER usage goes down
   - Increase quality of life
   - Increase contributions to society
   - Reduce homeless
   - Reduce drug and substance abuse
   - Improved quality of life
   - Improved economy
   - Reduce poverty
   - Intact families
   - Changed social norms
   - Stopping the cycle of generational mental illness
   - Decrease self-medicating

3. Which populations are the most vulnerable or at-risk for the health issue?
   - Rural populations – even more lack of resources
   - Children
   - Low income
   - Tribal communities
   - Homeless
   - Postpartum depression
   - Veterans
   - Adolescents
   - Adverse life events/major life events
   - Children of alcoholics
   - Children of parents with mental health issues
   - Cultural issues – race and ethnicity
   - ACEs
   - Elderly
   - Post-partum depression
   - First responders

- LGBTQ
- Incarcerated population

4. What assets, resources, partners, innovative ideas or best practices exist to support the health priority?
    - Regional mental health boards
    - New crisis centers
    - Telehealth potential
    - Project Echo (to build capacity in rural areas)
    - Community schools are good model (bring providers to schools, perhaps linkage to telehealth in rural areas)
    - Patient centered mental health
    - Veterans services
    - Suicide hotline
    - Sources of strength
    - Idaho resiliency website
    - EAP
    - Anti-bullying
    - Community building events (for specific populations – Latinx, LGBTQ)
    - Behavioral mental health integration with other services, such as healthcare clinics
    - Hospitals – social workers
    - QPR training, mental first aid, crisis response
    - Community programs that offer social support
    - Faith based communities
    - Family access networks
    - Trained staff in schools
    - Mankind Project / HER - programs that help in rural areas, implemented by people who have lived these experiences (not recognized by payors)

5. What state or community programs exist that are already addressing these priorities?
    - Division of Behavioral Health
    - FFP (Fit and Fall Proof)
    - Area Agency on Aging
    - Meals on Wheels
    - CHW
    - Early child home visiting
    - CHEMS
    - Idaho Resiliency Project
    - Prevention education
    - Veterans services
    - Universities
    - DHW
    - 211 Idaho Care Line
    - Suicide Hotline
    - NAMI - national organization
    - Mobile Crisis Units
    - Re-entry center – promising new initiative under the DOC

6. Which stakeholders are missing from this conversation?
    - Mental health providers
    - Groups addressing work force development (Psychiatric residencies, LSWs, employers, local non-profits, etc.)
    - VA
    - Division of Behavioral Health
    - Community Health Centers
    - Non-treatment folk doing assessments (i.e. Dentists doing assessment then making a referral)
    - CHW

- Area Agency on Aging
- HUD
- Native American groups
- Corrections
- School counselors
- Social workers
- Policy makers
- Population affected
- Diversity (LGBTQ, age, ethnicity, etc.)
- Tim Lay – Department of Corrections
- New Path
- Family services to support transition

7. What data sources can help with addressing the health issue?
    - BRFSS
    - Law enforcement
    - IHDE
    - Recovery centers
    - Crisis centers
    - Medicare/Medicaid as proxy data
    - Juvenile and adult justice centers
    - Syndromic surveillance
    - All-payer data
    - Pharmacy data
    - Prescription monitoring data
    - ACES
    - BRFSS
    - YRBS
    - TEDS – Treatment
    - Hospital Data
    - Corrections
    - Claims data
    - ED data
    - EMS data

8. What questions do you need answered?
    - How to attract mental health professionals to Idaho & rural areas?
    - In schools, how to address bullying (especially via social media)?
    - How can we build social connectedness across communities that might prevent mental health issues from escalating?
    - How do we build resiliency in communities that increase protective factors?
    - How can we engage businesses?
    - Focus more on primary prevention?
    - What specific conditions are we concerned about?
    - What are other states doing?
    - Options to incarceration?
    - What's working?
    - Who is going to compile and analyze date and how is it going to get back to stakeholders?

Unintentional Injuries

1. What underlying social determinants of health contribute to the issue?
    - Low SES
    - Lack of education
    - Environmental conditions – walkability, bike riding, traffic safety, commuter safety

- Falls = alcohol
- Drinking and driving
- Drug use
- Culture/Environmental influences – culture of safety, connectedness in community
- Poverty
- Health literacy
- Social cohesion/civic engagement
- Idaho's culture of "independence"
- Agriculture – farm injuries
- Rural nature and linkage to injuries & accidents
- Drownings – refugee populations and rural communities, lack of education
- Health behaviors – not wearing seatbelt, texting while driving
- Quality of housing

2. What benefits come from addressing the health issue?
    - Reduce ER costs
    - YPLL gets better
    - Reduce workers comp
    - Increase work productivity
    - Reduce medical costs
    - Longer lives
    - Economic health of family structure if breadwinner disabled or death
    - Grief affects entire family
    - Reduced TBI
    - Potential life saved
    - Changes to policies
    - Decreased morbidity, mortality, and disability
    - CAT funds impact
    - EMS burden reduced
    - Decreased disruption to communities (due to unexpected death)
    - Shift in norms in health behaviors
    - Cost savings to families
    - Emotional impact to families

3. Which populations are the most vulnerable or at-risk for the health issue?
    - Children
    - Elderly
    - Some professions – agricultural, construction, truckers
    - Low SES
    - Low income
    - Teenage boys
    - Teens – new drivers
    - Males
    - Rural
    - Controlled substance/substance use disorders

4. What assets, resources, partners, innovative ideas or best practices exist to support the health priority?
    - Fit & Fall Proof program
    - Dept. of Transportation
    - Parks and Recreation
    - Walkability assessments
    - Car seat training
    - Hunting safety
    - Bike helmets
    - Drivers education
    - Policy changes (seatbelts, helmets, firearms, swimming pools, personal floatation devices, distracted driving)
    - OSHA
    - Police/Fire/First Responders
    - Poison Control

- Cross-sector partnerships
- Youth Organizations (4H, Scouts, Boys/Girls Club)

5. What state or community programs exist that are already addressing these priorities?
   - Fit & Fall Proof
   - Walkability workshops
   - Blue Cross – High 5
   - Drivers Ed
   - Hunters Safety
   - ITD (transportation)
   - Gun shop owners
   - Bike lanes
   - Sidewalks (promoting, maintaining)
   - Children At-Risk
   - Drug Overdose Prevention
   - Poison Control
   - Safe Routes to Schools
   - Treasure Valley Cycling Alliance
   - Moms Demand Action
   - Idaho Voices for Children
   - Farm Workers Bureau
   - Irrigation Districts

6. Which stakeholders are missing from this conversation?
   - Dept. of Transportation
   - Parks and Recreation
   - IDFG
   - Water resources (canals, irrigation districts)
   - Fit & Fall Proof
   - Area Agency on Aging
   - No Injury prevention program
   - Fire Departments/EMS
   - Local, community-driven prevention program
   - Safe School Route programs
   - Policy makers/legislators
   - Motorcycle sales
   - Sheriff's Offices/Law Enforcement
   - Schools
   - Gun Safety advocacy groups
   - Water Safety advocacy groups
   - OSHA
   - Board of Pharmacy
   - Healthcare providers
   - Agriculture workers
   - Bike/walking commuters
   - Coroners

7. What data sources can help with addressing the health issue?
   - Mortality data
   - Fatal accident reporting system
   - ITD
   - Child mortality review team
   - BRFSS
   - Law enforcement
   - Trauma registry
   - YRBS
   - ER data
   - Syndromic Surveillance
   - ITD
   - Insurance claim data
   - OSHA
   - Vital records
   - Careline 2-1-1
   - Poison Control
   - Hospital discharge data
   - Home visiting
   - ISP Dispatch
   - PRATS

8. What questions do you need answered?

- More data on non-fatal accidents?
- Hospital discharge data
- How do we narrow the focus of this broad category?
- To Legislators – How can we navigate to best move policy change forward?
- Breakdown of unintentional injuries and respective populations (mortality data)
- Syndromic Surveillance (ER data)
- What are needed policy changes and system-level shifts that have worked or could be leveraged?
- Type of injury is needed to determine strategies.

Diabetes

1. What underlying social determinants of health contribute to the issue?
   - Poverty/Economic stability
   - Food insecurity/access to healthy food/nutrition
   - Early childhood development
   - Access to health services
   - Environmental conditions
   - All
   - Education
   - Unstable housing
   - Racial/ethnic disparities
   - Low SES
   - Family History
   - Walkability (lack of)
   - Talking about prevention/management
   - Considering CHW's and health care workers to diversity more
   - Cultural considerations
   - Research literature for what has the greatest impact

2. What benefits come from addressing the health issue?
   - Lower healthcare costs
   - Healthy and self-sufficient Idahoans
   - Quality/length of life
   - Reduced burden of medication management
   - Reduced stress
   - Improved family and household functionality
   - Fewer missed days of work and school
   - Reduced disability
   - Reduced co-morbidities (i.e. Heart disease, obesity)
   - Reduced diabetes complication
   - Improved productivity
   - Better patient outcomes
   - Economic stability for the state
   - Reducing disparities among populations

3. Which populations are the most vulnerable or at-risk for the health issue?
   - Low income
   - Low education
   - Older
   - Hispanic/Latinx
   - Employment
   - Higher ACE score
   - Inactive
   - Obese

- Native American
- African American
- Low SES
- Women with a history of GDM
- Rural population with less access to food and healthcare
- Immigrants

4. What assets, resources, partners, innovative ideas or best practices exist to support the health priority?
    - IPAN
    - Diabetes Program
    - Humphrey Diabetes
    - Heart Association
    - Idaho Food Bank
    - Farmer's Market
    - WIC/SNAP
    - Health Coaches – Blue Cross for disease management
    - Head Start
    - Mobile foodbanks
    - Pharmaceutical companies
    - Diabetes prevention
    - YMCA
    - Workplace wellness programs
    - Schools
    - DSME
    - Providers
    - Vending machines (healthy foods)
    - Apps – for diet and nutrition
    - Product pricing – stores
    - Menus on sugar/calories
    - Tea or sugar sweetened beverages
    - Community healthcare workers
    - Professional Associations
    - Family caregivers
    - Diabetes Alliance of Idaho
    - Evidence based programs
    - FQHC's serving priority populations
    - 4H
    - Department of Labor
    - SARMC – mobile grocery unit
    - Senior Centers
    - Meals on Wheels

5. What state or community programs exist that are already addressing these priorities?
    - IPAN
    - Diabetes Program
    - Humphrey Diabetes
    - Heart Association
    - Idaho Food Bank
    - Farmer's Market
    - WIC/SNAP
    - Health Coaches – Blue Cross for disease management
    - Head Start
    - Mobile foodbanks
    - Pharmaceutical companies
    - Diabetes prevention
    - YMCA
    - Workplace wellness programs
    - Schools/school nurses
    - DSME
    - Parks and Recreation
    - Wellness Programs
    - PhD's
    - Community Health
    - Creating registries in clinics to ensure workflow and follow up care
    - Area Agency on Aging
    - DPP recognized programs
    - SARMC parish nursing
    - Diabetes Alliance of Idaho
    - Idaho Physical Activity and Nutrition
    - CMS – total cost of care concept
    - State Department of Education

- Free and Charitable Clinics
- Municipality partners – walkability
- 340b – Federally funded pharmacy program

6. Which stakeholders are missing from this conversation?
    - Providers
    - Agriculture groups (beef, ag, food producers)
    - Legislators/policy makers
    - Tribes
    - Those with diabetes/consumers/patients
    - Health systems
    - Educators
    - Community EMS
    - SNAP
    - Community health workers
    - Lion's Club
    - Businesses
    - Groceries
    - Underserved populations at-risk
    - Homeless services
    - Businesses in the local communities
    - Rural representation
    - Workforce shortage in rural areas
    - Behavioral health

7. What data sources can help with addressing the health issue?
    - BRFSS
    - YRBS
    - Vital statistics
    - IHDE – Lab data
    - Syndromic Surveillance
    - Kaiser Org – county level data
    - Parks and Recreation – assessment of access to green space/activity spaces
    - Hospital discharge data
    - Insurance companies data
    - Medicaid/Medicare
    - Atlas Reports (wages -developing system)
    - Food deserts
    - Community Commons
    - CARES – University of Minnesota
    - EMS data

8. What questions do you need answered?
    - Type I vs II
    - Geographical data
    - Incidences vs. prevalence
    - Age of diagnosis – BRFSS
    - How to go upstream – looking at what prevents diabetes
    - Whose job is it to pull all the data together, analyze and help operationalize?
    - Need to identify hot spots in the state, by zip code

Overweight and Obese

1. What underlying social determinants of health contribute to the issue?
    - Poverty
    - Can't buy healthy food
    - Food insecurity
    - Walkability

- Safety of community
- Education on healthy food
- Food stamp
- Too much cheap fast food
- Rural areas can't walk to stores
- Parks
- Cultural influences and norms of types of foods
- School policies
- National policies
- Access to care
- Early childhood
- Prenatal care
- Food deserts

2. What benefits come from addressing the health issue?
   - Reduced medical costs
   - Reduced cancer rates
   - Reduced chronic diseases
   - Improved productivity
   - Reduced diabetes
   - Increased aptitude for learning in school
   - Positive impact on mental health
   - Lower healthcare costs
   - Extending years of productive life and work force
   - Quality of life
   - Will slow down development of other illnesses

3. Which populations are the most vulnerable or at-risk for the health issue?
   - Low SES
   - Rural
   - Older adults
   - Racial differences
   - Native
   - Hispanic
   - Children
   - Maternal and child healthy
   - Chronic pain
   - Kids (don't often get to choose their food)

4. What assets, resources, partners, innovative ideas or best practices exist to support the health priority?
   - State programs for diabetes
   - IPAM
   - SNAP
   - WIC
   - Community environments – walkability
   - Food and nutrition in schools
   - Access to apps
   - SNAP education
   - Cooking matters
   - Community garden
   - Farmers markets
   - Food prescriptions
   - Co-location of services
   - Double up food banks
   - Grocery shuttles for food deserts
   - Mobile pantries
   - Dental communities
   - Patient-centered medical homes
   - Pharmacy professionals
   - Head Start staff
   - Affected population
   - Address aging population

5. What state or community programs exist that are already addressing these priorities?

- SNAP
- WIC
- U of I extensions
- Diabetes
- PAN
- St. Als
- St. Lukes
- Federal commodity
- YMCA
- State Department of Education
- School pantry
- High 5 grants
- Diabetes Alliance of Idaho
- Health District partners
- Meals on Wheels
- Tribes
- Local non-profits/community based orgs.
- Healthy store initiative
- Community Health Workers
- Community Diabetes Educators

6. Which stakeholders are missing from this conversation?
    - St. Lukes
    - Groceries – Albertsons, Fred Meyer, etc.
    - Cities
    - Counties
    - FQHC's
    - YMCA
    - IAEYC
    - Area Agency on Aging
    - School lunch programs
    - Summer lunch programs
    - Home visiting programs (parents as teachers)
    - Community health workers
    - Diabetes Alliance of Idaho
    - Leadership of Camp Hodia

7. What data sources can help with addressing the health issue?
    - Food environment
    - Health Data Exchange – need this to work
    - YRBS
    - BMI – 3rd grade
    - Use claims data
    - Vital stats
    - BRFSS
    - Hospital discharge data system
    - IHDE

8. What questions do you need answered?
    - Food insecurity questions
    - How many are really overweight/obese?
    - How patient and family members to the table (for 3 degrees of prevention)
    - What do you wish you would have known before disease onset?
    - How do we get rural community voice to the table?

IDAHO DEPARTMENT OF

HEALTH & WELFARE

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