IDAHO DEPARTMENT OF
HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

GET HEALTHY IDAHO

2020-2024
-2023 UPDATE-

GetHealthy
IDAHO

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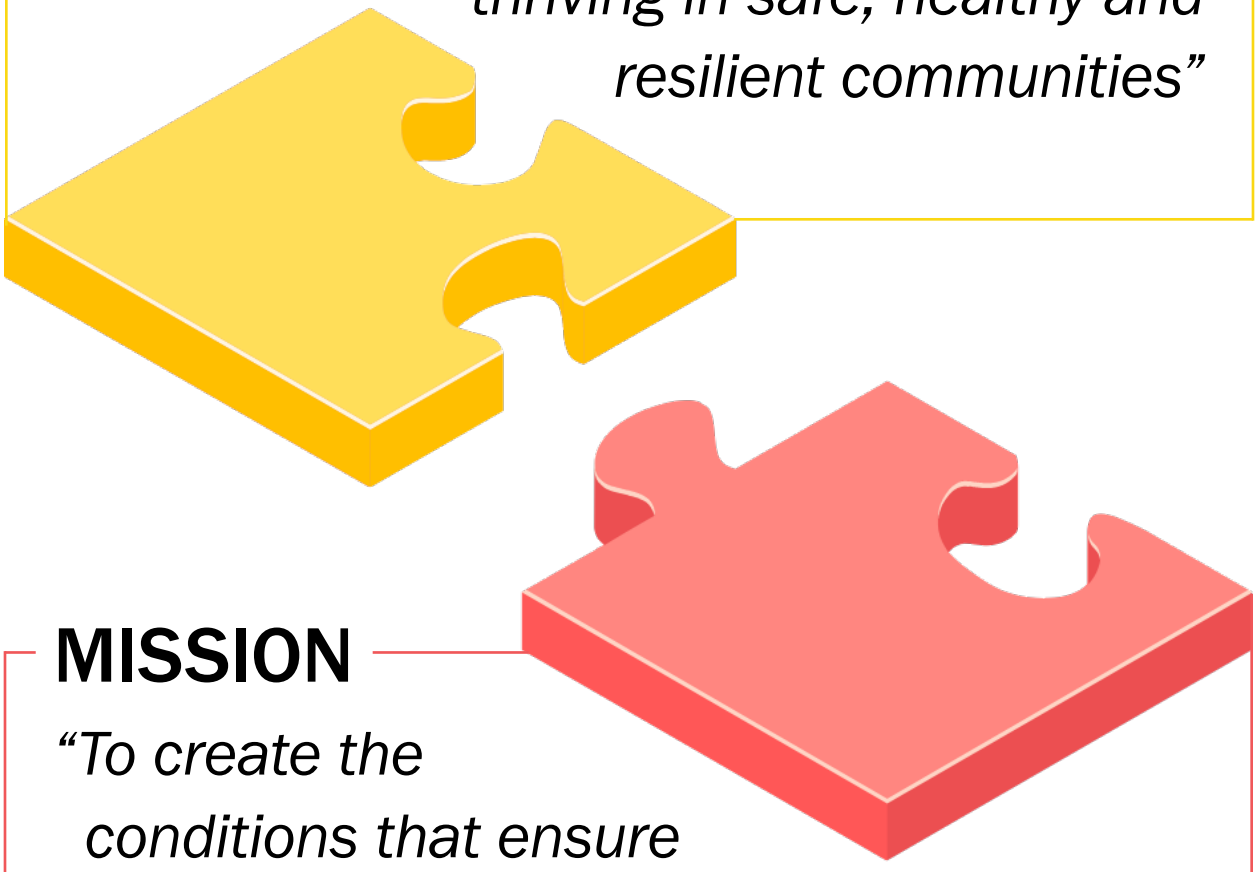
GetHealthy IDAHO

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

In January of 2020, the Division of Public Health (division) embarked on a journey to shift the way Idaho funds and addresses population-level prevention and health promotion strategies to improve health outcomes, lower healthcare costs, reduce health disparities, and improve health of all Idahoans. To do this work effectively and lay the foundation for collaboration, the division led the development and facilitation of a collaborative assessment process in 2019 to identify the state's top health priorities and develop a five-year plan to address those priorities. This comprehensive assessment and health improvement plan is known as Get Healthy Idaho: Building Healthy and Resilient Communities (GHI). The assessment included thorough review of leading indicators of morbidity and mortality, existing local and regional community health needs assessment priorities, and stakeholder interviews. The assessment process resulted in a list of Idaho's top health risk and outcome indicators, including leading causes of death, rates of chronic disease, health behaviors, and social determinants of health indicators (such as poverty and limited access to healthy food). Indicators were voted on and ranked by partners, who ultimately agreed on the state's top four health priorities: Diabetes, Obesity, Behavioral Health, and Unintentional Injury. This accompanying health improvement plan describes how the division and our partners will work together throughout the five year plan to improve the health of all Idahoans, serving as the roadmap for what we aim to achieve and a strategic vision to achieve it. Four priorities are divided into measurable objectives over 18 different strategies, with opportunities to coordinate resources aligned with each strategy.

The intent of the Get Healthy Idaho plan is to conduct annual updates to ensure it remains a living document which reflects Idaho's most current health needs and opportunities for improvement. After delays due to the Coronavirus pandemic, the first annual plan update timeline was completed in 2021 (year two) and extended to include activities outlined from January through December 2022 (year three). This update reviews the past year of activities and includes plans through February 2024 (year four).

The growth and advancement of investment in GHI communities continues to be supported by goals within both the division and department strategic plans. The SFY23 Division of Public Health Strategic Plan outlines GHI in Goal 1: Build Healthy and Resilient Communities, Objective 1.3 – "The DPH will secure funding to advance priority issues."

The work is outlined in Goal 3 of the Department of Health and Welfare Strategic Plan 2023-2027: "Help Idahoans become as healthy and self-sufficient as possible", Objective 3.2: Address health disparities in Idaho communities by implementing three strategies that focus on the social determinants of health (SDOH) by June 30, 2025. Task 3.2.1 specifically aligns with GHI as its focus aims to invest in one high-risk community each year through June 30, 2024.

> **"Help Idahoans become as healthy and self-sufficient as possible"**
>
> — Department Strategic Plan

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 38th of the 50 United States for total population and 14th for geographic size.[2,3,4] The 2022 census population estimate for Idaho was 1,939,033 and, because of its large size and relatively small population, Idaho remains one of the most rural states in the nation.[2,6] With a 2020 estimate of 22.3 people per square mile, Idaho ranks 44th of the 50 states in population density.[2] The national average population density is 93.8 people per square mile, a four-fold greater density than Idaho.[2] Thirty-five of Idaho's 44 counties are rural, with 16 of these considered remote, which means those counties have fewer than six people per square mile.[5]

The 2020 census diversity index shows that racial and ethnic diversity has increased in Idaho over the past decade. In 2020 the diversity index from Idaho was 35.9 percent, up from 28.2 percent in 2010. A diversity index of 0 percent would mean that everyone in the population has the same racial and ethnic characteristics, while a value close to 100 percent indicates that everyone in the population has different racial and ethnic characteristics. The diversity index for the United States was 61.1 percent in 2020, up from 54.9 percent in 2010.

The racial groups that comprised Idaho's population in 2021 were:[6]

- White alone, not Hispanic or Latino, 81.2 percent
- Black or African American alone, not Hispanic or Latino, 0.9 percent
- American Indian and Alaska Native alone, not Hispanic or Latino, 1.7 percent
- Asian alone, not Hispanic or Latino, 1.6 percent
- Native Hawaiian or Pacific Islander alone, not Hispanic or Latino, 0.2 percent
- Two or More Races 2.7 percent

Persons of Hispanic or Latino origin comprised 13.3 percent of Idaho's total 2021 population and could be of any racial group.[6] 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.[7] Idaho also has two refugee centers located in southwest Idaho (Ada County) and south-central Idaho (Twin Falls County).

Social Determinants and other Demographics

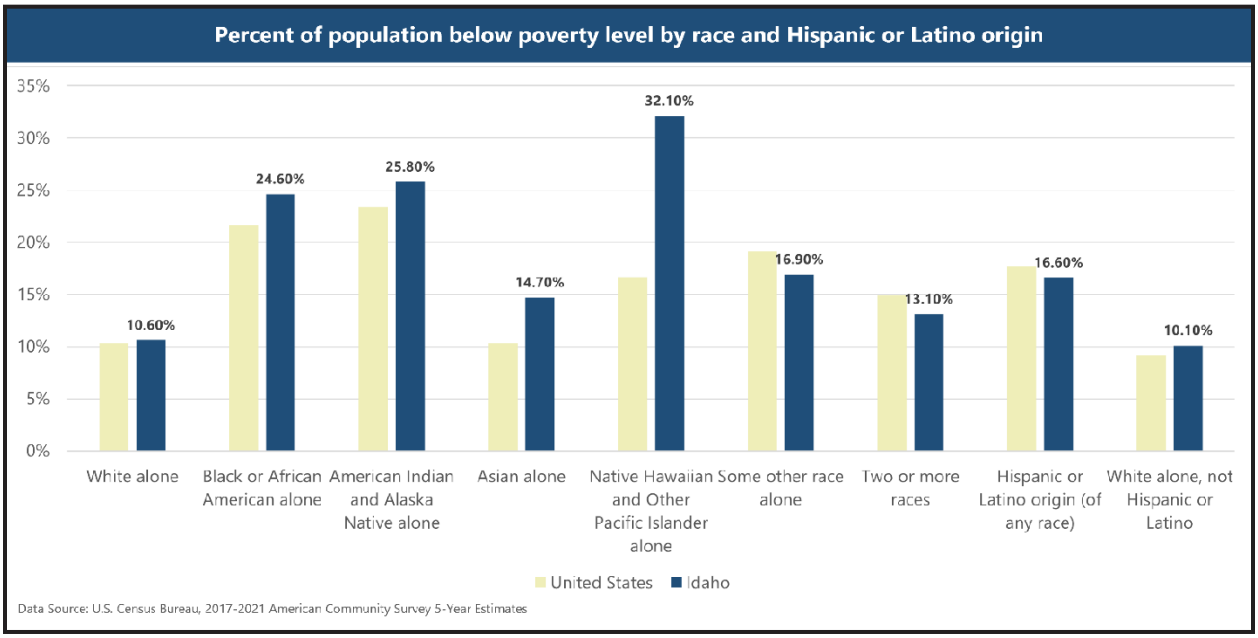
The conditions in which people are born, live, learn, work and play have a substantial impact on health outcomes and quality of life. Also known as the social determinants of health (SDOH), these conditions and the policies and systems that shape them, are the underlying, contributing factors of health inequities that result in differences in health outcomes for some populations. SDOH factors include income, education, housing, safe environment, access to healthy food, quality health care, social support, discrimination, and other factors that influence health choices, behaviors, and opportunities. The SDOH factors are complex and interconnected. For example, economic conditions contribute to availability of jobs, living wages and affordable housing, all of which impact an individual's ability to meet their basic needs.

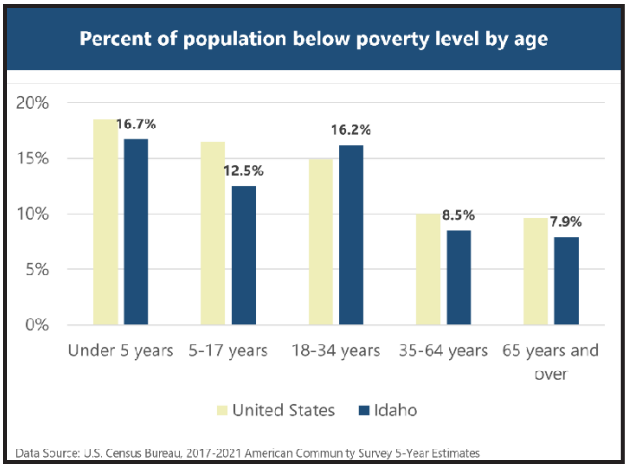
Multitudes of research conclude one of the clearest predictors of health disparities is geography – where people live - finding zip code to be a greater predictor of health and longevity than genetic code. This evidence is widely used by public and community health professionals to emphasize the importance of "place" and its influence on health and opportunity – not blood pressure, not cholesterol, not genetics. A more granular look indicates that one's neighborhood, from block to block, is an even greater predictor of health, where the social consequences of place often result in barriers to opportunity. The social, economic, and environmental factors and their influence on health can vary greatly depending on one's neighborhood or geography, and access to affordable housing, good jobs, healthy food, quality education and healthcare. In Idaho, mapping life expectancy by census tract shows a difference of as much as 20 years of life between the highest and lowest tracts, and many of these gaps occur in the same community. As an example, broadband infrastructure in rural and remote Idaho communities often lacks consistency, stability and reliability, limiting access to education, health care, employment and more for an estimated 260,000 Idahoans.[8] Place-based differences in income level, access to fair-wages, education level, affordable and healthy housing, and access to grocery stores and fresh food are contributing factors to gaps in health and life expectancy and examples of the systematic inequities that exist in the opportunities some groups have to achieve optimal health.

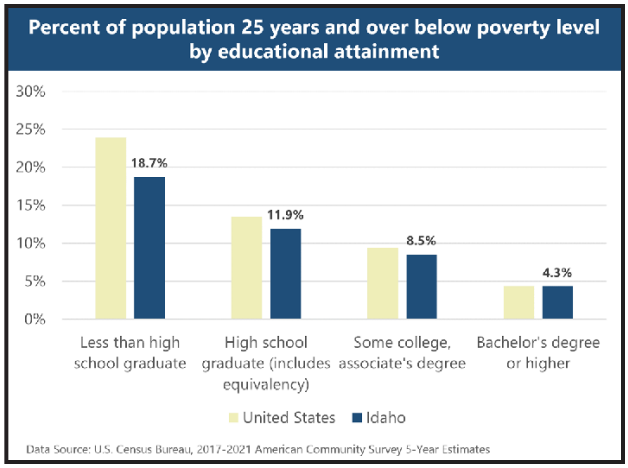
Economic Stability

Poverty is a strong predictor of poor health. According to the 2021 American Community 1-Year Survey (ACS), the median household income was $66,474 in Idaho compared to $69,717 nationally.[9] Similarly, per capita income was less in Idaho at $33,841, compared to $38,332 nationally. All racial and ethnic groups measured in the ACS had lower household and per capita incomes in Idaho than their counterparts nationally. Despite lower incomes, Idaho's overall poverty level of 11 percent is lower than the national average of 12.8 percent and has been decreasing.[9,10] Within Idaho, poverty has decreased from 2016 to 2021 in all racial groups and among the Hispanic and Latino population (2016 & 2021 5-year ACS). Regardless of the overall improvements, disparities do still exist among demographic groups and within certain areas. For instance, 24.6 percent of Black or African Americans, 25.8 percent of Native Americans and 16.6 percent of Idaho's Hispanic or Latino population is estimated to live at or below the poverty level in comparison to 10.6 percent of the white population who do not identify as Hispanic or Latino. Geographic disparities exist across

the state with poverty measured at the county level ranging from 24.3 percent in Madison County to 5.2 percent in Clark County.[10] The following charts highlight differences among poverty rates by race, Hispanic or Latino origin, age and educational level, both within Idaho and compared to national averages.







Access Limited Income Constrained Employed (ALICE)

In Idaho, ALICE identifies and defines those households who fall within the "gap" – though they have income above the Federal Poverty Level (FPL), they are ineligible for state or Federal benefits programs and struggle to make enough to support their families. According to UnitedforALICE.org, ALICE families are often forced to make difficult decisions when they don't have enough income to afford basic needs - housing, food, transportation, childcare, and health care. These decisions mean a family must decide between paying the rent or paying their childcare provider, or between buying groceries and filling a prescription. In 2021, the most recent ALICE data available, 11 percent of Idahoans fell under the FPL, while another 32 percent were ALICE. As Idaho's cost of living rises, driven by the skyrocketing growth in housing prices outpacing growth in wages, more households are finding their financial stability jeopardized.[11]

Idaho's low wages coupled with rising costs of living across the state has resulted in many wage-earners struggling to get out of poverty. The economic impact of COVID-19 on Idaho's economy and people is still being realized.

Education

Education and income go hand-in-hand. "A quality education is the best predictor of professional and financial success in the U.S., and the earliest years of a child's education lay a critical foundation for this success."[11] Quality early education increases the likelihood of children who are prepared for kindergarten, graduate from high school, achieve higher education degrees and future career success. Additionally, people with more education tend to have higher incomes and better health outcomes. College graduates are often able to secure better paying jobs with fewer safety hazards and income from these jobs can be used on higher quality housing as well as other health enhancing resources.[12]

A greater percentage of Idahoans over the age of 25 have graduated from high school (91.2 percent) than the national average of 88.9 percent.[10] Yet, the rate for those who go on to higher levels of education are lower in Idaho across most demographic groups. Nationally, 33.7 percent of the population over the age of 25 hold a bachelor's degree or higher, while 29.1 percent do in Idaho. Educational attainment disparities are also seen among various racial and ethnic groups. For Idaho's Hispanic and Latino population, 67.5 percent are high school graduates or higher compared to 71.2 percent nationally.[10] Also, 13.4 percent of Idaho's Hispanic and Latino population holds a bachelor's degree or higher compared to 18.4 percent across the U.S. Within Idaho's rural and remote counties, a smaller percentage of adults over the age of 25 have gone on to receive at least some post-secondary education than those living in urban counties, 55.4 percent compared to 67.6 percent.[10,5]

Quality and affordable early childhood education is a vital component necessary to support a child's lifelong educational attainment and future earnings. In turn, access to affordable childcare supports a healthy economy as it allows parents to go to work and earn a better living. The most recent United for ALICE report, released by the United Way in 2023, highlights the crisis in child care availability and cost that was brought to the forefront in the pandemic. Many childcare providers went out of business during the pandemic and 35 percent of that workforce has an income below the ALICE threshold. While childcare providers are struggling to stay afloat families are also challenged with cost as a family of four in Idaho can expect to spend $1,137 on childcare each month.[11]

Neighborhood and Built Environment

Community design and the quality of our built environments directly affect human health. The built environment refers to the physical spaces where we live, recreate and work. It is comprised of our homes, businesses, cultural institutions, parks, public spaces, roads, environmental conditions, utilities and other infrastructure. These neighborhood or community attributes have a profound impact on our health by promoting or restricting access to physical activity, transportation options, healthy foods, safe housing, and even social interactions.

Research has shown that people living in more affluent neighborhoods tend to have better

access to health promoting attributes like parks and safe connected sidewalks and pathways that are buffered from automobile traffic.[13] In contrast, people living in lower income neighborhoods tend to be exposed to unhealthy attributes such as higher levels of pollution from nearby freeways or industrial land uses. Emerging climate research also shows that residents living in lower income urban neighborhoods are exposed to higher summertime temperatures due to built environment conditions that include greater expanses of asphalt and concrete with fewer trees or green spaces.[14]

Food Security

Food security means "access by all people at all times to enough food for an active, healthy life." Food insecurity indicates a limited ability to secure adequate food due to insufficient resources.[15] Prior to COVID-19, Idaho was seeing improvements in the number of food insecure households. Data from Feeding America reported 8.7 percent of Idaho's population faced food insecurity in 2020.[16] According to the Idaho Food Bank and Idaho's Map the Meal Gap report, released in July 2022, national food insecurity did not increase in 2020 largely due to a strong public and private response to the pandemic. The economic downturn resulting from the pandemic did highlight and exacerbate disparities among populations who experience food insecurity. In Idaho, 17 percent of the Hispanic and Latino population faced food insecurity in 2020 compared to 8 percent of the white, non-Hispanic population.[16]

Among children enrolled in Idaho public schools during the 2021-2022 school year, 27.26 percent were eligible for free or reduced-price lunch, a reduction from the previous year when 36.11 percent were eligible.[17] Idaho's most rural counties tend to experience higher rates of food insecurity and limited access to healthy foods.[16,5] Shoshone County is estimated to have the highest food insecurity rate, with 15.7 percent overall, and 20.7 percent among children in the county. As a comparison, Jefferson County had the lowest food insecurity rate, at 6 percent. Food insecure households often rely on low cost, low nutrient foods resulting in a greater risk of obesity for this under-resourced population.[18] Adults with obesity are at increased risk for many diseases and health conditions including type 2 diabetes, stroke, and heart disease.

Transportation and Access to Physical Activity Opportunity

Maintaining a robust transportation system with safe options for all people regardless of age, income or ability to drive improves health. Transportation connects people to employment, healthcare, food, recreation and all the other places people need to access to live full and healthy lives. Without reliable and safe transportation, people are less likely to receive preventative healthcare and less able to participate in health promoting activities like healthy eating and physical activity.[19,20]

While only 3.9 percent of Idaho households do not have access to vehicles, 23.7 percent of households only have access to one vehicle, thereby increasing their reliance on alternative modes of transportation.[9] Many Idahoans also face difficulties paying maintenance costs for the vehicles that they own, and others drive less as they age. Although rural areas have different needs than urban areas, an equitable and health promoting transportation system that works for all Idahoans would include safe and ADA accessible walking routes, safe and connected bicycle infrastructure, street connectivity, public transportation or shuttle options

and diverse land uses so people have the opportunity to live within walking distance to key destinations.

In 2021, approximately 35 percent of Idaho adults making less than $15,000 per year reported no physical activity outside of work, compared to 11.8 percent of those who make $75,000 or more per year.[21] Neighborhood design may help to explain this discrepancy, as people who live in neighborhoods where it is safe and enjoyable to walk, or bike are more likely to participate in these activities. At a national level, the 2022 Dangerous by Design report by Smart Growth America, found that while lower-income neighborhoods (those with a median household income of $2,500-$43,000) make up 17 percent of the population, they account for more than 30 percent of all pedestrian deaths.[22] Communities that invest in active transportation options like sidewalks, protected bike lanes and public transportation not only help to protect the environment, but they also increase transportation equity and improve health.[20]

Housing

Housing costs started to decrease in 2022, although not at a rate commensurate with the rapid increases seen in recent years. Purchase prices for homes in the state increased 115.87% percent over the past 5 years (Period ended 2022 Q3).[23] Statewide, the median rent reportedly decreased 5.39 percent from December 2021 to 2022, down from a 58.0 percent increase from 2020 to 2021.[24] While slowing, the recent increase in the cost of housing without a comparable increase in income has resulted in many households struggling to meet living expenses. Many studies have shown that housing instability contributes to poor health and, as a result, increased healthcare costs.

People who rent housing comprise 28.1 percent of Idaho's occupied housing units, and of those who rent housing, 46.7 percent are cost burdened, meaning they pay 30 percent or more of household income toward their rent. For homeowners with a mortgage, 25.8 percent are cost burdened.[9] According to the National Low Income Housing Coalition there is a shortage of 24,486 rental homes affordable to low-income households whose incomes are at or below 30% of the area median income in Idaho. Among these extremely low-income renter households, 66 percent are severely cost burdened meaning they spend more than 50 percent of their income on housing.[25] Housing cost burdened families are unable to afford other necessities and essential services, leading to poor downstream consequences, such as missed medical or dental check-ups. These decisions are often the determining factor turning acute health issues into costly chronic health conditions.

The US Department of Housing and Urban Development (HUD) estimates that Fair Market Rent for a two-bedroom apartment in Idaho is $981.[26] To afford this level of rent without paying more than 30 percent of income on housing, a household must earn $3,272 monthly or $18.87 per hour for a 40-hour work week. However, the average wage for those who rent their housing in Idaho is $16.10. People who make the minimum wage would need to work 104 hours per week to afford a two-bedroom rental home. Based on the estimates, certain areas of the state require much higher wages to afford a two-bedroom apartment, $21.50 per hour in Boise and $21.46 per hour in Blaine County.[26]

Access to Healthcare

Health Professional Shortage

In 2022, 100 percent of Idaho was a federally designated mental health professional shortage area, 98.7 percent of Idaho was a federally designated shortage area in primary care and 95.7 percent of Idaho was a federally designated dental health professional shortage area.[27] Primary care and dental health shortages areas increased in Idaho from 2021 to 2022. In 2022, the Idaho Hospital Association reported 51 hospital members throughout the state. Twenty-seven of these hospitals are critical access hospitals, located in Idaho. These small, rural hospitals also own primary and specialty care clinics and may be co-located with the hospital or operate as remote clinics.[28]

Prior to 2018, there were no medical schools (either allopathic or osteopathic) in the state. 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) is a private, for-profit school which received pre-accreditation status while it continues working towards establishing full accreditation status from the Commission on Osteopathic College Accreditation. ICOM's mission is to train competent and caring physicians prepared to serve persons in Idaho, Montana, North and South Dakota, Wyoming, and beyond with an emphasis on rural, underserved areas within this five-state region.

Idaho Medicaid

In SFY 2022, on average 414,7330 Idahoans were enrolled in Medicaid, a 48 percent increase from SFY 2019 average enrollment. The growth is due to the Medicaid expansion program.[29] Medicaid serves individuals from birth to end of life, provided they meet eligibility criteria. In SFY 2022, 43.8% of Medicaid enrollees were children from birth to 18 years of age, another 6.6% are comprised of children with developmental disabilities up to age 21.[29] Medicaid enrollment typically 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.

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. "Prior to 2020, there were an estimated 78,000 Idaho residents in the coverage gap – ineligible for subsidies in the exchange and also ineligible for Medicaid."[30] The state implemented Medicaid expansion January 1, 2020. Estimates prior to the COVID-19 pandemic expected that an additional 91,000 people would be covered. As of January 2023, around 145,000 Idaho residents were enrolled in Medicaid expansion. These are individuals who have a monthly income of $1,563 or less, or are a family of four with a monthly income of $3,192 or less. Idaho hospitals report spending $42 million less on charity care and had $61 million less bad debt since Medicaid was expanded from 2019-2021.[31]

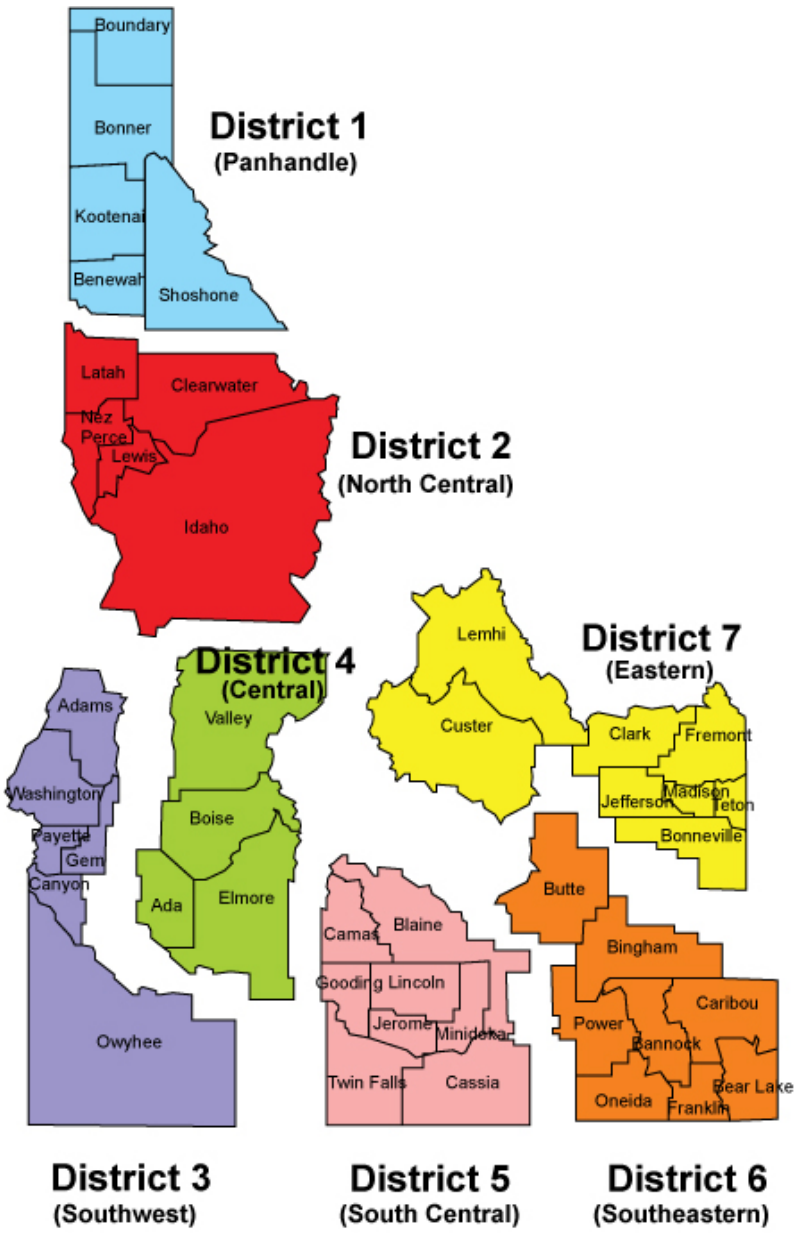
Idaho Kids Health Coverage

According to a 2021 Idaho Kids Covered report, a project of Idaho Voices for Children, "Idaho had the highest increase in the rate of uninsured children in the entire country between 2017 and 2018." The report emphasizes the critical importance of prioritizing health coverage for children, as they are "more likely to do better in school and grow up healthy." As of 2021, 5 percent of children in Idaho are uninsured. This equates to 24,000 kids who do not have health coverage. The report also illustrates disparities that exist across income, age and geography, confirming that a child's zip code impacts their health and access to care. Hispanic children are more likely than White children to be without coverage.[32]

Half of Idaho's children (51 percent) are covered by their families' employer-sponsored health insurance, while 35 percent are covered by Medicaid/CHIP, another 8 percent are covered through health insurance exchange, and 5 percent are uninsured.

Idaho's Local Public Health Districts

To facilitate the availability and delivery of public health services, the state aggregated contiguous counties into seven local public health districts in 1970. The boundaries that separate each of the seven areas include geographic barriers, transportation routes and population centers. Access to healthcare and other services remain 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.



Get Healthy Idaho Assessment Process: Overview

The Get Healthy Idaho model follows the guidance of the Community Health Assessment Toolkit, developed by the Association for Community Health Improvement, as described below. The steps provide guidance for organizations to collaborate with communities and partners as they walk through the community health assessment and action planning processes.

This update describes work accomplished across the division and through GHI place-based community improvement efforts over the past three years. The plan demonstrates the ongoing community health assessment process as GHI comes full-circle, once again moving into Step 1: Map Development Process. As public health reflects on the actions taken and outcomes that occurred during pandemic emergency response efforts, our priorities must shift back to a renewed and strategic focus on re-building systems that support health, re-engaging with priority populations and partners, and re-committing to our mission of creating conditions that ensure all people can achieve optimal health and resiliency. Moving through the cycle requires continuous reflection on the processes and strategies that worked well, partnerships and resources leveraged and needed, and opportunities for growth and improvement, assuring public health remains agile and open to re-direction. These steps support the advancement of individual and shared goals toward achieving meaningful, impactful, and equitable outcomes for all Idahoans.

American Hospital Association. (2023). Community Health Assessment Toolkit. Accessed at: https://www.healthycommunities.org/resources/community-health-assessment-toolkit

Get Healthy Idaho: Health Improvement Plan —

The Get Healthy Idaho: Building Healthy and Resilient Communities health needs assessment identified the following health priorities for calendar years 2020-2024:

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

Challenges and Opportunities Surrounding the Health Priorities

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 2021, the most recent data available through the National Survey on Drug Use and Health (NSDUH), an estimated 22.8 percent of adults nationwide, or 57.8 million people, had a mental illness during the past year.[33] Less than half of them (47.2 percent) received mental health services in that timeframe. Among the 43.7 million people ages 12 and older in 2021 who needed substance use disorder treatment in the past year, 3 million people received substance use treatment in a specialty facility in the past year. In 2021, an estimated 17.9 million adults ages 18 or older had a co-occurring mental illness and illicit drug or alcohol use disorder in the past year, with more than half of them (52.5 percent) receiving either substance use treatment at a specialty facility or mental health services in the past year. In 2021, adolescents ages 12 to 17 with a major depressive episode in the past year were more likely to have used illicit drugs (27.7 percent compared to 10.7 percent who did not have a major depressive episode in the past year).[33]

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.[27]

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.

Substance Use Disorders

The Division of Behavioral Health's Substance Use Disorders (SUD) Program is primarily funded with federal dollars from the Substance Abuse Prevention and Treatment Block Grant

(SABG) and State Opioid Response (SOR) grant, and in SFY 2022 also used funding from two additional federal discretionary grant sources:

- SABG supplemental funds available through the Coronavirus Response and Relief Supplemental Appropriations Act
- Treatment for Individuals Experiencing Homelessness (TIEH) grant

In State Fiscal Year (SFY) 2022, Idaho increased funds available for a variety of initiatives aimed to improve access to SUD services and improve Idaho's overall Recovery Oriented System of Care, including:

- Strengthened available residential and outpatient treatment, including a specialized residential/aftercare program called Project Hope
- Provided housing assistance for 382 individuals receiving substance use disorder treatment
- Implemented Oxford House recovery housing in northern Idaho, with plans to expand across the state
- Expanded prevention activities by supporting an additional 31 direct service and community-based prevention programs with mini-grant awards, launching a statewide Idaho College Health Coalition (ICHC) and developing a 5 year statewide strategic plan for primary prevention services
- Launched a successful media campaign informing Idahoans how to access help for a substance use disorder. During the campaign, calls for SUD assistance increased by 30 percent over the same period the previous year
- Established new Opioid Treatment Programs (OTPs) in Pocatello and Coeur d'Alene and new Office Based Opioid Treatment (OBOT) programs in Kellogg, Sandpoint, Rexburg, and five rural communities in the Magic Valley thereby greatly improving access to medication assisted treatment for individuals with an opioid use disorder
- Distributed more than 17,400 naloxone kits statewide (in partnership with the Division of Public Health)

The Division of Public Health established the Drug Overdose Prevention Program (DOPP) in 2017. Since its inception, DOPP and has worked collaboratively with its partnering agencies and stakeholders to advance the five-year statewide strategic plan to address the evolving opioid crisis. DOPP utilizes federal funds to plan and implement activities to address overdose within the state. The three federal funding sources include the Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A), CDC Promoting Population Health through Increased Capacity in Alcohol Epidemiology, as well as the Bureau of Justice Assistance (BJA) Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program (COSSAP).

In 2017, the Idaho Opioid Misuse and Overdose Strategic Plan was convened with support of the Idaho Department of Health and Welfare (DHW), Office of Drug Policy (ODP), and other key stakeholders with the joint vision of, "A safe and healthy Idaho, free of opioid misuse and untreated opioid use disorders." The five-year plan focuses on improving opioid prescribing practices, strengthening, and supporting families, expanding awareness and access to treatment, and educating prescribers, patients, and public. The statewide strategic

plan steers DHW in the collaboration efforts and initiatives included in this document. The first iteration of the Idaho Opioid Misuse and Overdose Strategic Plan ended August 2022. Currently, the ODP, through funding from DOPP, is organizing the development of the new statewide strategic plan to reduce opioid misuse and overdose within Idaho. DOPP delivers public health approaches to address the drug crisis, including:

- Educating prescribers on the CDC guidelines for opioid prescribing and promoting use of the Idaho Prescription Drug Monitoring Program.
- Funding local public health initiatives among Idaho's public health districts and Tribes, such as naloxone trainings, prescription drug take-back events, and healthcare provider education.
- Distributing naloxone, the medication that reverses an opioid overdose, to organizations that may encounter an opioid overdose, such as community organizations, hospitals, and first responders.
- Implementing public awareness campaigns to increase knowledge on the dangers of illicitly manufactured fentanyl and the availability of naloxone.
- Collecting and analyzing data to monitor the drug crisis and measure programmatic impacts.

Crisis

The Division of Behavioral Health (DBH) is committed to ensuring that individuals and families experiencing a behavioral health crisis receive treatment and support that is compassionate, resolution-focused, and effective. The goal is to deliver crisis services that are individualized and person-centered, that utilize solution-focused interventions, and support individuals with problem solving and developing strategies to prevent future crises. The crisis system envisioned includes a statewide centralized crisis line, mobile crisis response that is available 24/7, access in all regions to local community-based services trained to address crisis, specialized crisis services for children and youth, more options in other parts of the state for crisis stabilization centers, crisis care that integrates peers and Recovery Coaches, and medication-assisted treatment. To achieve that goal, the division will have to address challenges such as provider shortages, resources for rural and frontier parts of the state, stigma around accessing behavioral health services, and even technological barriers such as limited internet access in parts of the state.

In SFY 2022, the DBH led the state's implementation of The National Suicide and Crisis Lifeline, 988. DBH, in partnership with the Division of Public Health and the Idaho Crisis and Suicide Hotline, focused on connecting Idahoans in a behavioral health crisis with trained crisis workers and resources as a key goal in the initial phase of implementation. The launch of 988 on July 16, 2022, provided individuals, families, and communities an easy-to-remember three-digit behavioral health crisis and suicide prevention number.

Idaho had the fifth highest suicide rate in the nation in 2020 according to the CDC. In preparation of the launch of 988 in July of 2022, the division began centralizing crisis calls. All after-hours crisis calls were transitioned to the Idaho Crisis and Suicide Hotline and its call center of trained crisis call takers.

Since the launch of 988, from July to November 2022, the local 988 call center, The Idaho Crisis and Suicide Hotline, saw a 24 percent increase in total contacts from the prior year during the same time. In just that five-month period, 988 received over 10,000 calls, text, and chats. It is believed that the increased number of crisis contacts indicates that 988 is being used more and that there will continue to be increases in Idahoans using 988. Idahoans are becoming more aware of 988, that it is available to everyone, and that it is a free resource to call when they or a loved one is experiencing suicidal thoughts or in crisis. In the upcoming year the DBH plans to continue expansion and awareness of 988. The DBH is working toward collaboration with the new Managed Care Organization to develop the crisis workforce up to 24/7 availability, working with 911 dispatch centers across the state, and continuing to build a crisis care continuum by connecting crisis services across the state together to help Idahoans in crisis.

Diabetes

In 2020, an estimated 120,640 Idaho adults, or 8.8 percent of the adult population, live with diabetes. On a national scale, according to the CDC, the prevalence of prediabetes among adults (crude estimates for 2017-2020) is 38 percent and only 19 percent of adults with prediabetes reported being told by a health professional that they had this condition.[34] Improperly managed diabetes often leads to costly and serious complications, sometimes resulting in death (diabetes was the eighth leading cause of death in Idaho in 2021).[39] The conditions in which Idahoans live, learn, work, and age, affect their health, including diabetes. Social determinants of health such as neighborhoods, education, and access to healthcare, can influence lifelong well-being. Sustainable lifestyle changes can prevent pre-diabetes and type 2 diabetes. Addressing the social determinants of health can lead to productive and healthier lives for Idahoans.

In general, people with diabetes are more likely to have severe symptoms and complications if infected with any virus including COVID-19 regardless of having type 1, type 2, or gestational diabetes. Viral infections increase inflammation that could contribute to severe complications as well as hyperglycemia. The risk for severe complications is likely to be lower if diabetes is well managed. Up to date immunizations for all vaccine-preventable diseases and adherence to treatment regimens to manage diabetes are key prevention strategies.[35]

The Idaho Diabetes, Heart Disease, and Stroke Prevention Program is working with several partners including associations, state universities, National Diabetes Prevention Programs, Diabetes Self-Management Education and Support Programs, health systems, and pharmacies throughout Idaho to prevent and manage diabetes.

Overweight and Obesity

By targeting upstream, systemic factors that impact overweight and obesity, communities can decrease overall rates of obesity, overweight, and associated chronic health conditions. Idaho, like most states, is seeing a steady increase in the percentage of its population that is overweight or obese. According to the Idaho Behavioral Risk Factor Surveillance System (BRFSS), the percentage of Idaho adults aged 18 and older who report having obesity has increased from 20.5 percent in 2001 to 31.6 percent in 2021.[21] Like adults, Idaho youth are experiencing increased obesity rates. In 2021, 28.1 percent of Idaho high school

students described themselves as slightly or very overweight, and 11.9 percent were obese (Youth Risk Behavior Survey).[36] When looking at population groups in Idaho, those who are Hispanic, Latino, American Indian and Alaskan Native experience the highest rates of obesity. Obesity rates also vary by location and county. At the higher end, Canyon and Power counties have an estimated obesity rate of 37 percent while the rate is 25 percent for people living in Valley County.[37] Estimates of diabetes rates by county in 2019 ranged from 13 percent in Clark County to 8 percent in Teton and Valley counties.[37]

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. Obesity and overweight are important to address due to increased risk of co-morbid chronic conditions, such as heart disease, hypertension, high blood cholesterol, diabetes, and some cancers. Most importantly, these health issues are largely manageable and preventable when people are supported by community environments, systems and policies that promote health and well-being.

Obesity has also been shown to increase complications from COVID-19 infection, including risk of severe illness or hospitalization (CDC). COVID-19 has not affected all Americans equally; Black and Hispanic adults have been disproportionately impacted (CDC). Inequities in access to good jobs with fair wages, high quality and affordable education and housing, safe environments, and health care have historically contributed to poorer health outcomes, including obesity. These same inequities are at the root of these disproportionate impacts seen in the COVID-19 pandemic. Although these inequities exist currently, collaboratively supporting community-led policy, system and environmental changes can reduce disparities and ensure equal opportunities for health.

The State of Childhood Obesity Report, released in November 2022, critiques an over-reliance on Body Mass Index (BMI), “when we use BMI to put large-bodied people, including children, into categories of “obese” or “overweight,” we inadvertently activate weight-based stigma. This can cause lasting psychological trauma in kids – manifested through low self-esteem, stress, anxiety, isolation and eating disorders – which in turn contributes to poor health outcomes.” The report goes on to suggest new approaches to measuring health with consideration for nutritional adequacy, upstream factors affecting food supply, nutritional assistance and indicators of food quality and availability. The COVID-19 pandemic was a stark reminder that low-income families, those who quit or lost jobs, and children who rely on school meal programs faced challenges accessing healthy food. Income and food insecurity are significant contributing factors in rising obesity rates.[38]

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 are a significant concern in Idaho. They ranked fourth in Idaho's leading causes of death in 2021, with a total of 1,163 deaths.[39] Non-fatal accidental injury can result in permanent disability and significant economic impacts to individuals and families. Unintentional injuries can be prevented by studying the risks for injury and adopting proven intervention strategies. Accidental falls, motor vehicle accidents, and accidental poisoning were selected as Idaho's top injury priorities.

Falls

Falls, even among the older adult population, are preventable through lifestyle changes such as strengthening exercises, medication reviews, and safer home environments. Falls can cause broken bones, head injuries and hip fractures, leading to health complications and impacting quality of life. In 2021, 320 Idaho residents died as the result of a fall, 93 percent of these fatal falls were among adults aged 65 and older.[39] The overall fall rate represents 16.8 deaths per 100,000 population. CDC estimated the economic impact of falls in Idaho to adults aged 65 and older to be $164 million in 2014; the current cost is unknown but undoubtedly higher.[40]

Increased participation in injury prevention programs like Idaho's Fit and Fall Proof™ exercise program can help prevent falls and keep adults healthy. Fit and Fall Proof™ participants showed a significant improvement in mobility with a decreased fall risk after participating in classes from July through September in 2022. In addition to the health and strength improvements from regular exercise, participants report improved social connectedness and reduced feelings of loneliness and isolation as a result of the community-based program; two very important factors that, along with physical health, improve quality of life and longevity.

The COVID-19 pandemic had a significant impact on the ability of community programs to maintain and sustain attendance and participation. Due to the population's age demographics putting them at increased risk for severe disease and death from COVID-19, most Fit and Fall Proof™ class sites across Idaho closed for months during 2020 for the health and safety of their clientele, creating ripple effects that impacted the physical, emotional, and social wellbeing of participants. As our culture starts to normalize and adjust from the COVID-19 pandemic, many Fit and Fall Proof™ class sites have returned to the in-person environment, with class participant rates slowly returning to their pre-pandemic numbers. In 2022 Fit and Fall Proof™ class participation was up 28% from when the pandemic initially hit in 2020.

Motor Vehicle Crashes

In 2021, 314 Idaho residents died in motor vehicle crashes. This represents 16.5 deaths per 100,000 population compared to the national rate of 13.7 per 100,000.[39,41] Increased speeding on less congested roadways resulted in a 24 percent increase in all traffic fatality rates across the United States in 2020. It is theorized that congestion serves as an unintentional protective factor to reduce speeds and therefore reduce fatalities. Idaho did

not follow this national trend and instead experienced a 16.6 percent decrease in all traffic crashes in 2020 and a slight decrease in fatalities.[42] Sadly the reversal in Idaho did not continue and the number of motor vehicle crashes and fatalities increased dramatically by 22 percent and 27 percent, respectively, in 2021.[43] Youthful drivers aged 15-19 were 2.4 times as likely as all other drivers to be involved in a fatal or injury crash.[43] Other vulnerable roadway users include pedestrians, bicyclists, motorcyclists and people with disabilities. 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 in 2018 was $351 million.[44]

Fortunately, strategies ranging from increased seat belt use to safe roadway designs can be implemented to reduce the number of motor vehicle deaths in Idaho. A Vision Zero strategy being adopted by communities across North America aims to eliminate traffic fatalities and severe injuries. This strategy recognizes that people will sometimes make mistakes, so the road system and traffic policies should be designed to ensure that those mistakes do not result in severe injuries or fatalities. With a shared commitment that all people have the right to move safely in their communities, we can design a transportation system which does not result in the significant loss of life and injury that we see today.

Accidental Poisoning

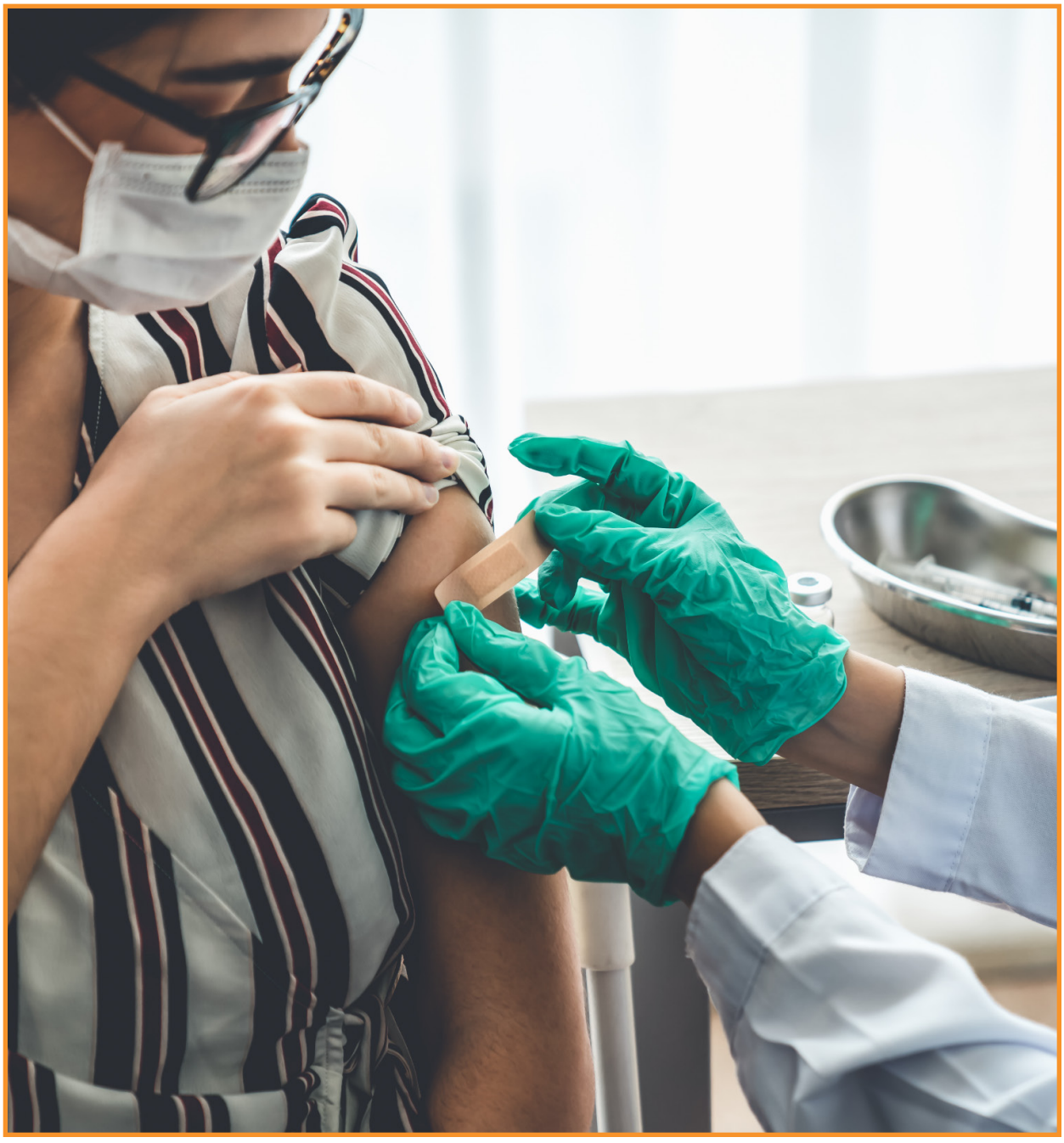
Accidental poisoning from drugs and other noxious substances is a serious public health crisis with devastating consequences. Accidental poisonings in Idaho occur in many forms including accidentally taking the wrong dose of a prescription or over the counter medication, chemical exposure in homes or workplaces, or even consumption of poisonous plants and fungi. Most accidental poisonings are related to recreational drug use and overdose and the causes are often but not always interrelated to those discussed in the behavioral health section.

The National Institute on Drug Abuse reported increasing deaths due to drug overdoses, with 106,000 deaths from drug-involved overdoses in the United States in 2021. Idaho has also experienced the impact of steadily increasing drug overdose deaths. From 2017-2021, 1,394 Idaho residents died from a drug overdose. Between 2020-2021, Idaho's rate of drug overdose deaths increased by 23 percent, while the rate of fentanyl overdose deaths doubled. In 2021, 85 percent of all drug overdose deaths in Idaho were accidental (unintentional injury), 8 percent were undetermined intent, 7 percent were intentional self-harm (suicide), and 0 percent were assault (homicide). Among drug overdose deaths that involved fentanyl for 2021, 95 percent were accidental (unintentional injury), 4 percent were undetermined intent, 1 percent were intentional self-harm (suicide), and 0 percent were assault (homicide).[39]

The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.[45] The opioid epidemic is a complex and evolving issue facing the nation and Idaho. A comprehensive and multifaceted public health approach that includes improving access to treatment, support and recovery, improving surveillance, and reducing stigma, among others, is required to reduce drug overdose deaths.

COVID-19 Pandemic

As referenced in each priority area, the COVID-19 pandemic presented an unprecedented challenge to public health, social services, and health care and has simultaneously illuminated both the fragility and resilience in each of these systems. The economic and social disruption has taken a devastating toll across the globe and has highlighted and exacerbated the disparities among vulnerable and underserved Idahoans, including racial and ethnic minority populations and rural and underserved communities. The division seized this opportunity to center and advance health equity during and after the pandemic emergency response, prioritize strategies that address ongoing public health challenges, and re-think and re-build systems and structures to ensure they serve the needs of all Idahoans.



SFY22 Department and Division Strategic Plan Review —

The department's SFY 2022 Strategic Plan included goals and objectives in alignment with the Division's goals for GHI, specifically through Goal 3: Help Idahoans become as healthy and self-sufficient as possible.

Obj 3.2: *Address health disparities and the social determinants of health (SDOH) associated with the priority health issues (diabetes, obesity, injury, and behavioral health) by partnering with and investing in at least one high-risk community per year, through June 2024*

Review of SFY22 task progress under objective 3.2:

Objective 3.2 - Task:	Person/Program Responsible	Progress
1. Award second high-risk GHI community and execute new subgrant by Oct. 1, 2021.	GHI Team	**Complete.** Southeast Idaho United Way started their four-year GHI initiative to improve health of underserved residents in Bannock County in October 2021.
2. Establish partnerships with the Idaho Funders Network and other agencies to support community needs by June 30, 2024.	GHI Program Manager	**Ongoing.** The Idaho Funders Network held an in-person summit in October 2022 defining goals for CY2023. Priority topics for learning and collaboration identified during the summit included housing, behavioral health, and childcare. Additional processes will be identified in 2023 to support measurement of network impact and areas where alignment is made.
3. Create a plan to identify and develop the Healthy Idaho Places Index (HIPI) by Oct. 1, 2021.	Health Data Analytics Manager	**Complete.** The division's health data analytics manager has identified data sources, including health outcomes, demographics, community conditions (social determinant of health data) and other indicators which will be built into a dashboard specific to Idaho.
4. Complete the initial phase of the Get Healthy Idaho Index by Jan. 1, 2022.	Health Data Analytics Manager	**In progress.** The Get Healthy Idaho Index (formerly referred to as the HIPI) continues to be refined in preparation for launch. Identification and analysis of index data is nearing completion in addition to development of the dashboard.
5. Launch the HIPI by June 30, 2022.	Health Data Analytics Manager	**In progress.** The GHI Index has been delayed and is anticipated to launch in the second quarter of 2023.

Review: 2022 GHI Health Improvement Plan Goals Overarching goals for calendar year 2022 were selected to advance the mission of GHI and focus on building and sustaining the infrastructure necessary to support priority communities and populations by advancing equity, enhancing partnerships, developing financial longevity, and creating an equity-centered data system to better identify disparities at the community level.		**Responsible Program**
Goal 1: Advance Equity		
Obj 1.1	**Advance Equity Across the Division** **Progress**: A) The Bureau of Equity and Strategic Partnerships (BESP) was formally launched in May 2022. BESP has implemented the Structure-Process-Outcomes (SPO) business model methodology for structuring the integration of equity concepts into operations with elements that enable BESP to measure effectiveness of capacity (i.e., structure) to enable processes. B) BESP leadership convened Learning and Action Networks (LANs) under three LAN structures: i. Idaho Health Equity Taskforce ii. DPH LAN iii. Idaho Tribes and Public Health LAN C) BESP Bureau Chief has presented to numerous bureaus, task forces, and during monthly Division Open House on topics of equity and cultural sensitivity. D) BESP team members are engaged in research, review and revision of DPH-025 Health Equity Policy	Bureau of Equity and Strategic Partnerships (BESP)
Obj 1.2	**Deploy an Equitable Response to and Recovery from COVID-19** **Progress:** The CDC's *State Actions to Address COVID-19 Health Disparities* grant released funding opportunities during SFY22 and SFY23 to community organizations working to address gaps and barriers for underserved Idahoans. During SFY22, a total of $4,741,385 funds were awarded, and during SFY23, a total of $5,569,052 funds were awarded, supporting a combined 52 grantees working in every corner across the state. Equitable distribution of vaccine: Funding was awarded/allocated and is being spent by Public Health Districts on activities supporting the distribution of vaccine, such as clinic operations, homebound vaccinations, and community events. Each district includes a list of moderate-high SVI counties, in which 21 of Idaho's 44 counties are listed as such. Vaccine distribution activities are ongoing. Funding must be spent by June 2024.	Division of Public Health (DPH), BESP, Idaho Immunization Program

Obj 1.3	**Expand Health Equity Work Group to Ensure Equitable COVID-19 Response** **Progress:** With the COVID-19 pandemic moving out of statewide emergency/ healthcare capacity phase, BESP leveraged the formalized structure of the COVID-19 Health Equity Task Force to broaden the priority topic beyond COVID-19 to focus on advancing health equity for all of Idaho's priority populations, thus convening Learning and Action Networks (LANs) as the hub of learning and applying knowledge into practice in equity context. BESP has formed three LAN structures whose members meet monthly: a. Idaho Health Equity Taskforce b. DPH LAN c. Idaho Tribes and Public Health LAN	BESP
Goal 2: Enhance Partnerships		
Obj 2.1	**Explore & Cultivate Partnerships to Support and Advance Mission of GHI.** **Progress:** To advance the mission of GHI and enhance community priorities in Elmore and Bannock Counties, team leads from each funded community were introduced to subject matter experts working in the field of public health: a) To support the Community Health Worker and Community Health-EMS projects in Elmore County, the GHI team connected the Elmore County leads from PHD4 to two of the foremost experts and leaders in these fields in Idaho: Dr. Ryan Lindsay and Mike Mikitish at Idaho State University. b) To deepen relationships and connection to health and social service programs, the Bannock County leadership team at United Way of Southeastern Idaho (UWSEI) was introduced to staff at Southeastern Idaho Public Health (SIPH). As a result, health services provided by SIPH across the county were included in the health and health care landscape analysis conducted by the community action team and SIPH staff now participate on the Bannock County Health Collaborative. Additional connections made in support of GHI priority areas: a) Connected Idaho refugee resettlement agency leaders with Idaho Transportation Department – Division of Motor Vehicles (ITD-DMV) staff to discuss needs for culturally sensitive translation services for new refugee drivers during drivers' training and the written test. b) Connected Medicaid's Children's Health Insurance Program (CHIP) team with Idaho's Community Schools Coalition to advance partnerships, leverage funding and align goals to fund nurses in low-income neighborhood schools.	Get Healthy Idaho (GHI) Team

Obj 2.2	**Identify Cross-Sector Partnerships to Advance Equity** **Progress:** a) Since 2020, GHI has participated as a member of the Idaho Funders Network (IFN) comprised of statewide and regional private, non-profit and community foundations and public sector funders (such as GHI), convened by the Blue Cross of Idaho Foundation for Health. The IFN seeks to build relationships among members and align resources and assets to support communities to identify and address the Social Determinants of Health (SDOH) by facilitating knowledge and information exchange and building capacity of and support for communities to identify and address SDOH barriers and advance equity. In 2022, the IFN formed an Advisory Committee where member and GHI Manager, Katie Lamansky, was nominated as Vice Chair, stepping into the chair position in July 2023. In October 2022, the IFN held a summit for all members in Boise, with attendance by 11 organizations. Members explored and discussed priority health topics, including Civility, Behavioral Health, Basic Needs (i.e. food access), Education/Early Ed/Childcare, Housing, and Access to Care/Healthcare Workforce. The Network is spending 2023 learning about these topics more in depth in effort to develop a plan for collaborative support that meets community needs. In early 2022, Dr. John Rusche, former Legislator from Lewiston and past-President of the Lewis-Clark Valley Healthcare Foundation, expressed interest in GHI's place-based funding initiative and partnership. Key health partners from the region, including Public Health – Idaho North Central District Director and lead staff from Innovia Foundation, were brought together in conversation throughout 2022 to discuss regional needs, opportunities, and priority populations in effort to align goals toward collaboratively funding a community in Summer 2023.	GHI Team
Goal 3: Financial Longevity of Place-Based Initiatives		
Obj 3.1	**Grow and Diversify Funding to Sustain the Initiative** **Progress:** Additional funding to cover increases in personnel was provided by the Overdose Data to Action Grant, while the annual allocation from Substance Use Prevention and Treatment Block Grant was increased by $25,000. To diversify and grow the funding in effort to add a third community during 2022, the GHI team met with numerous programs to explore opportunities for support of place-based funding initiatives. These include: the Idaho Child Care Program in Division of Welfare (Self Reliance); Idaho Diabetes, Heart Disease, and Stroke Prevention Program in Bureau of Community Health; and the Mental Health Services Block Grant in Division of Behavioral Health.	GHI Team

Obj 3.2	**Support Communities to Secure Local Financial Sustainability** **Progress:** Sustainability plans are requested from each funded community at the end of Year 3 of their GHI project. The Elmore County team, led by the Western Idaho Community Health Collaborative (WICHC), will complete a sustainability plan by September 2023. Bannock County, led by United Way Southeast Idaho, will complete and submit sustainability plan by September 2024.	GHI Team
Goal 4: Create an Equity-Centered Data System		
Obj 4.1	**Ensure Data Infrastructure that Allows for Consistent, Equitable, Data Collection** **Progress**: The purpose of the GHI Index is to provide a data-driven tool to explore those conditions (i.e., SDOH and other health-related measures) which may impact the overall health and resiliency of communities in Idaho. The GHI Index dataset analysis has been completed and is currently being added to the GHI Index dashboard. Once the GHI Index dashboard has been updated with the finalized index scores and ranks it will be ready for sharing with a wider audience. Focusing on quality improvement and data accuracy, cross-division teams identified opportunities to improve collection of race and ethnicity data in benefits eligibility applications. Efforts are underway to mitigate data uptake issues, allowing for greater accuracy of data which can be used to identify disparities in certain populations and focus strategic prevention efforts.	Health Data Analytics Manager; COVID-19 HD Team

2023 Health Improvement Plan Process and Goals —

Results-Based Accountability

In preparation for the annual GHI Plan update, the Results-Based Accountability (RBA) framework was selected to identify and move more quickly from "talk to action" on meaningful strategies in alignment with the health improvement plan priorities that are known to improve population health outcomes and supported by programs and partners. Communities and states across the nation use RBA to improve the lives of children, youth, adults, and families. The health improvement plan team held a kick-off meeting with cross-division staff from the Divisions of Public Health, Behavioral Health and Medicaid to introduce RBA, its purpose and intended outcomes, and the process in place for updating the plan using RBA methodology. Three work groups were formed, totaling 63 staff who play a primary or supporting role in impacting the GHI health priorities: Diabetes/Obesity, Behavioral Health and Unintentional Injury. Each member received a survey to gather information from programs in advance of the work group meetings. Survey questions gathered information on priority populations, data, quality of life conditions, partners, and best practices. Each work group was led through the RBA process over a two-hour period where they discussed appropriate indicators of progress, best- and promising-practices, innovative ideas, and partners who were missing but integral to successful achievement of intended results. Comments and ideas were captured during discussions and then summarized and crafted into measurable and actionable strategies of focus. The work group was brought back together one more time to review and approve the priority strategies and actions. One work group will be convened monthly, on a revolving schedule, ensuring each priority topic receives progress updates once per quarter.

Moving forward, the RBA framework will be used to plan, evaluate, and improve programs, community-level initiatives, and statewide efforts. It will ensure this health improvement plan is inclusive of the contributions of people and programs toward achieving greater health, well-being, and equity for Idahoans.

Cross-Cutting and Emerging Goals and Strategies:

Strategies in this section were specifically lifted out of each GHI priority area strategy for either of the following reasons: 1) they reflect activities that cross multiple GHI health priority areas; 2) they reflect activities that cross the work of multiple programs and divisions in the department.

Goal 1: Advance health equity for priority populations	
Objective: Integrate data-informed strategies to advance health equity across the division's policies, programs, and practices	
Strategy 1	**Revise and implement modifications to DPH-025 Health Equity Policy and Health Equity Framework.**
Measure:	• Policy updated and adopted • # of equity trainings conducted; rate of staff who attended • # of Equity LAN projects initiated with partners
Action 1:	1. Review, revise or develop and implement new policies that assure health equity. a. DPH will adopt, and Bureau of Equity & Strategic Partnerships (BESP) will train, all DPH staff on updated and revised division policy: DPH-025 Health Equity Policy and framework. b. Pilot DPH Equity Evaluation and Assessment Tool to evaluate its effectiveness in integrating equity into all aspects of program design. c. Research the value of developing an Equity Impact Assessment or Equity Impact Review process to examine how communities and populations will be affected by proposed programs, policies, or laws.
Action 2:	1. Strengthen partnerships and relationships with priority populations to advance health equity. a. Create opportunities through established Learning and Action Network Structures for community members to participate in innovative planning, design, and implementation of programs or interventions to advance equity.
Action 3:	1. Strengthen capacity to collect, analyze and use data to advance health equity a. Optimize GHI Index to support programmatic and partner decision making b. Work with programs and data analysts to identify data-informed approach to identify priority, underserved populations.
Timeframe	2023-2025
Lead	Bureau of Equity and Strategic Partnership (BESP); Health Data Analytics Manager
Strategy 2:	**(Cross-Cutting) Increase the number of GHI-funded communities**
Measure:	• Two additional funded communities by 2025
Actions	1. Increase DPH leadership support for integrating GHI mission and strategy into all applicable program strategies and grant applications. 2. Increase contributions to braided GHI fund. 3. Release solicitation in 2023 and 2024 for communities to apply and award funds.

Timeframe	2023-2025
Lead Partners	Get Healthy Idaho (GHI) Team BESP, DPH leadership
Strategy 3:	**(Cross-Cutting) Health Policy Analysis: Explore best practice policies and strategies across all GHI plan priority areas to identify existing policy gaps and opportunities to support solutions that advance equity.**
Measure:	• Completed analysis and list of policy recommendations
Actions	1. Research best practices and model policies 2. Analyze their applicability in Idaho. 3. Disseminate findings and discuss opportunities with partner agencies.
Timeframe	2024-2025
Lead Partners	Communications and Policy Manager, GHI Team DPH Programs
Strategy 4:	**(Cross-Cutting) Establish Public Health Liaison pilot to cultivate relationships with community partners and agencies to advance policies and strategies that promote safe and healthy communities and prevent chronic disease and unintentional injury.**
Measure:	• Number and strength of partnerships established
Actions	1. Conduct outreach and develop partnerships with local governments and community-based organizations in high-risk communities to promote and support best-practices for injury and chronic disease prevention. a. Promote and support health and health equity in community development, land use and transportation planning decisions and policies.
Timeframe	2023-2025
Lead Partners	GHI, BESP, Idaho Physical Activity and Nutrition (IPAN) Program, Injury Prevention State and local transportation departments and agencies, walk/bike advocacy organizations, community-based organizations
Strategy 5:	**(Cross-Cutting) Increase support for secondary prevention strategies and policies**
Measure	• Level of access to secondary prevention resources/services to priority populations and reduction of self-harm
Actions	1. Identify cross-department program partners. 2. Develop educational resources/talking points about secondary prevention and harm reduction. 3. Identify key external champions to support legislation and educational messaging toward comprehensive "harm reduction" methods.
Timeframe	2023-2025
Lead Partners	DPH Drug Overdose Prevention Program (DOPP), Division of Behavioral Health (DBH), Office of Drug Policy (ODP), first responders, community-based organizations

Strategy 6:	**(Cross-Cutting) Advance and elevate Community Health Workers (CHW's) in Idaho by demonstrating the value of CHWs to support a path toward sustainability.**
Measure	• Number of case studies developed and distributed
Actions	1. Coordinate opportunities and support partners to expand access and training for CHWs statewide and a path to sustainability. 2. Create Case-Studies of existing CHW programs to demonstrate effectiveness. 3. Policy recommendation: Identify champions and implement Medicaid reimbursement for CHW services
Timeframe	2023-2025
Lead Partners	Bureau of Community Health (BCH), BESP Bureau of Emergency Medical Systems and Preparedness (EMS-P), Idaho Community Health Workers Association (ICHWA), Idaho State University (ISU), health clinics and health system partners.
Strategy 7:	**(Cross-Cutting) Coordinate and implement three cross-department, integrated Adverse Childhood Experiences (ACEs) prevention strategies to promote healthy and resilient individuals, families, schools, and communities across the lifespan.**
Measure	• Three ACEs strategies implemented
Actions	1. Support DHW Strategic Plan-ACEs 3.3.4 work groups to identify three strategies to support cross-department ACEs goals. 2. Implement cross-department, prevention-focused ACEs strategies. 3. Identify data gaps and advance data capacity, such as by leveraging the positive childhood experiences module in BRFSS
Timeframe	2023-2025
Lead Partners	Division of Public Health Cross-Department programs, ACEs work group
Strategy 8:	**(Cross-Cutting) Partner with and support Data Modernization efforts led through CDC's Public Health Infrastructure Grant to ensure gaps in race and ethnicity data are assessed**
Measure	• Policies and procedures implemented to allow for health disparity data to be at the forefront of data collection and analysis practices
Actions	1. Participate in cross-department data gaps, improvement, and opportunity analysis activities.
Timeframe	2023-2024
Lead Partners	Division of Public Health, Medicaid, Behavioral Health, Self-Reliance, Family and Community Services (FACS)

PRIORITY AREA: DIABETES & OBESITY

INTENDED RESULT

All Idahoans live in communities with equitable access to healthy food, physical activity opportunities and the support and resources needed to promote, protect, and improve their health.

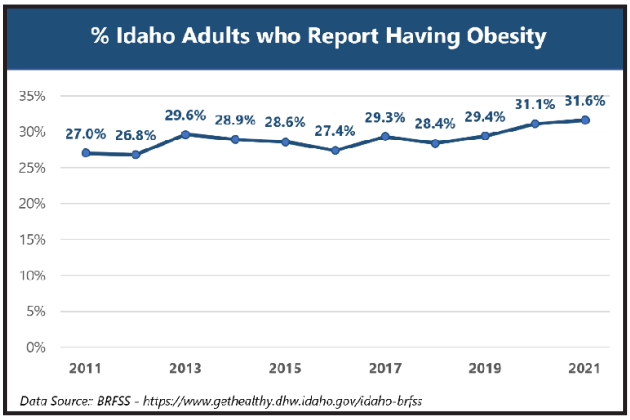
PRIORITY POPULATIONS

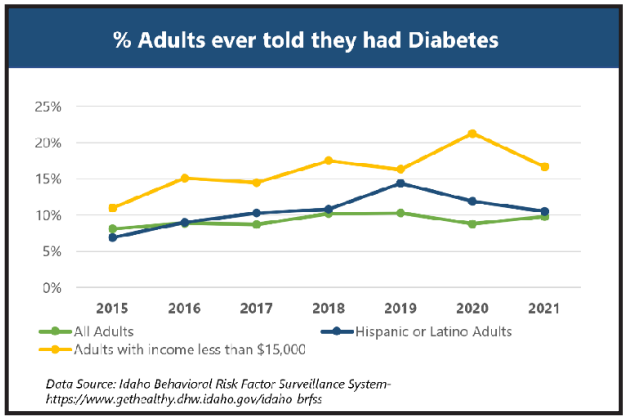
All Idahoans who have or are at risk for diabetes or obesity due to risk factors and disparities. Particular attention is placed on children to create upstream and long-lasting population health improvements.

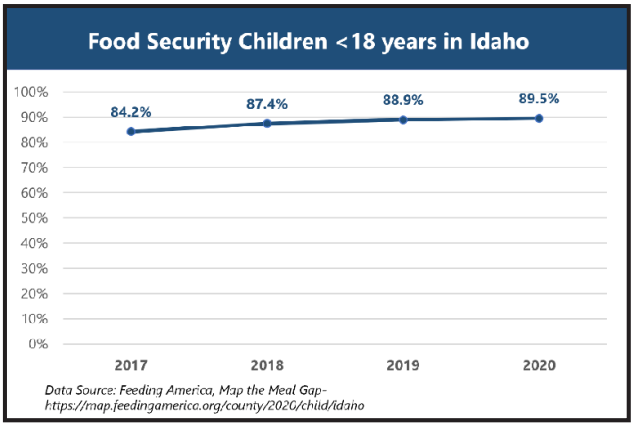
INDICATORS:

- Percentage of adults who have obesity (CDC, BRFSS)
- Percentage of adults who have diabetes (CDC, BRFSS)
- Percentage of children with food security (Map the Meal Gap)

CURRENT DATA TRENDED OVER TIME







HOW ARE WE DOING?

Obesity prevalence has increased significantly in Idaho, with nearly 1 in 3 adults having obesity in 2021 (1.2 times higher than in 2011). In addition, adults in 2021 were 1.2 times more likely to have diagnosed diabetes relative to 2015. These trends were also found among adults making less than $15,000 per year, potentially reflecting socio-economic associations with obesity and diabetes.

STORY BEHIND THE DATA: UNDERLYING CONDITIONS, ROOT CAUSES, ENVIRONMENTS

Obesity is a complex health condition whose contributing risk factors range from the built and social environments, genetics, family influence and behaviors such as poor diet and physical inactivity. Obesity increases risk of developing other serious health conditions, including hypertension, heart disease and diabetes.[46] Weight stigma may negatively influence mental health and further exacerbate poor physical health outcomes.[45] Too many Idahoans face difficulties in maintaining a healthy and nutritious diet. Poverty, limited ability or time to cook and limited access to nutritious food in rural and underserved areas all contribute.

Transportation barriers and policies restricting participation also limit the number of people who utilize Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) benefits. Too often, unhealthy choices are much easier to access and are directly marketed to children and families. Children growing up in households with poor access to, and consumption of, nutritious foods are more likely to develop the same poor health outcomes as their parents and are less likely to have a palate for healthy foods. Children today also spend significant time in front of screens and consequently spend less time being physically active. This is exacerbated by limited low/no-cost opportunities for physical activity close to home, many communities lack safe and connected facilities for biking and walking and have limited park space.

Diabetes prevention and management programs with a lifestyle change approach, including support for healthy pregnancies, have been shown to be effective. Obesity and diabetes rates vary across race/ethnicity, age, educational achievement, and income. The greatest disparities in prevalence are among American Indian/Alaska Native and Hispanic/Latino Idahoans, those not having graduated from college, and those whose incomes are less than $15,000. There is a hidden story in the relatively larger percentages among Hispanic/Latino adults in Idaho. Diabetes prevalence increases with age, yet Idaho's Hispanic/Latino population skews younger in age, so all things equal, diabetes prevalence should be lower among this population. When the confounding effect of age is taken into account, age-adjusted percentages of diabetes among Hispanic/Latino adults is about double those for non-Hispanic adults. That is, the Hispanic/Latino adult population is developing diabetes at younger ages.

PARTNERS/POTENTIAL PARTNERS

The following partners can help to create the conditions where all Idahoans live in communities with equitable access to healthy food, physical activity opportunities and the support and resources needed to promote, protect, and improve their health.

Governmental & Healthcare	Non-profit/ Community Organizations	Additional Partnerships Needed
• Idaho National Diabetes Prevention Programs • Diabetes Self-Management Education & Support Programs • University of Idaho Extension • Idaho's Public Health Districts • Federally Qualified Health Clinics, Free and Charitable clinics • Critical Access Hospitals and rural health clinics	• Diabetes Alliance of Idaho • Idaho Farmers Market Association • Idaho Hunger Relief Taskforce • Idaho Foodbank	• State and Local agencies responsible for transportation, land use, recreation, and open space • Organizations and agencies that work within and across the Social Determinants of Health (SDOH) including housing, food access, transportation, social services, healthcare, and economic mobility • Organizations supporting urban agriculture, such as community gardens • Health systems and clinics in priority counties. • Employers • Early Care and Education: Schools, daycares, Idaho Head Start

2023 Diabetes and Obesity Strategy:
Intended Result: All Idahoans live in communities with equitable access to healthy food, physical activity opportunities and the support and resources needed to promote, protect and improve their health.

Idaho Health Report Card Indicator Diabetes Prevalence: 9.8% of Idaho adults diagnosed (2021)
Target: 8.2% by 2028

Idaho Health Report Card Indicator Obesity Prevalence: 31.6% of Idaho adults had obesity (2021)
Target: 27.3% by 2028

Strategy 1:	**Reduce disparities in health among populations disproportionately affected by diabetes by implementing and promoting interventions that improve the quality of and access to diabetes care and education.**
Measure	1. # and type of staff trained on SDOH strategies and training type 2. # of participants (total # and # from priority populations) enrolled by CDC-recognized National DPP delivery organizations

Actions	1. Improve the capacity of the diabetes workforce to address factors related to the SDOH that impact health outcomes for priority populations with, and at risk for, diabetes. 2. Expand access and reduce barriers to encourage sustained participation in National Diabetes Prevention Programs. 3. Policy Recommendation: Partner with Medicaid to address reimbursement of Diabetes Prevention Program (DPP).
Timeframe	2023-2028
Lead Partners	Diabetes, Heart Disease and Stroke Prevention Program (DHDSP) Idaho diabetes workforce; Division of Medicaid
Strategy 2:	**Increase access to nutritious foods for children by expanding programs, such as Farm to Early Care and Education (ECE), to expose kids to a variety of healthy foods and nutrition education**
Measure:	# ECE sites / # children participating in Farm to ECE
Actions	1. Expand Idaho Farm to ECE program 2. Use data-informed decision-making to identify communities with higher rates of childhood food insecurity, child and adult obesity rates, and other SDOH risk factors. 3. Lead Farm to ECE and nutrition trainings via IdahoSTARS to expand accessibility of content to childcare providers statewide.
Timeframe	2023-2027
Lead Partners	IPAN Uofl Extension, Farm to Early Care and Education program coordinator

PRIORITY AREA: BEHAVIORAL HEALTH

INTENDED RESULT

Idahoans are safe and supported across the lifespan with the resources and care available to meet their needs, improve their health and live healthy lives.

PRIORITY POPULATIONS

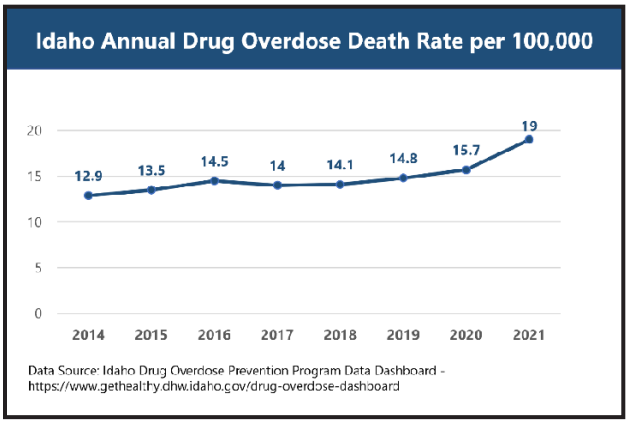
Idahoans who have, are at risk for, and are impacted by behavioral health conditions.

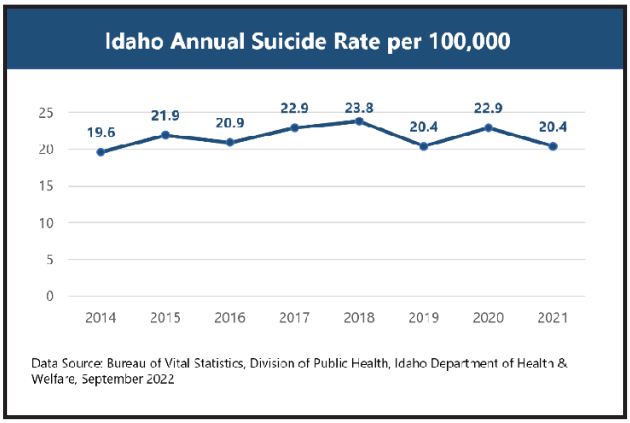
INDICATORS:

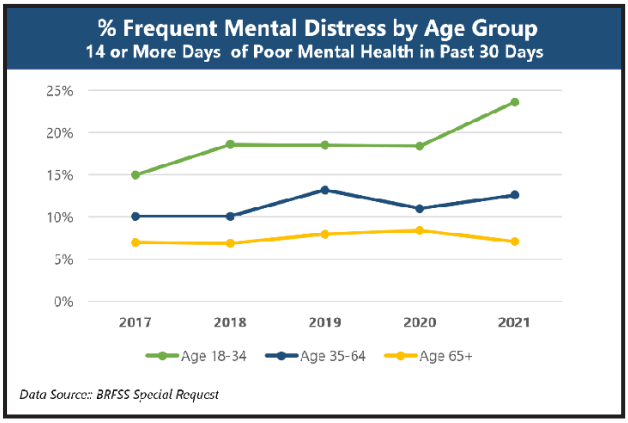
The Behavioral Health working group expressed an interest in utilizing positive indicators of progress for the plan. Accessible and timely positive data that captures the desired result is limited. The following indicators were selected for their relevance to the desired result, accessibility, and ability to stratify data for specific populations and groups. Development of positive indicators has been placed in the data workplan.

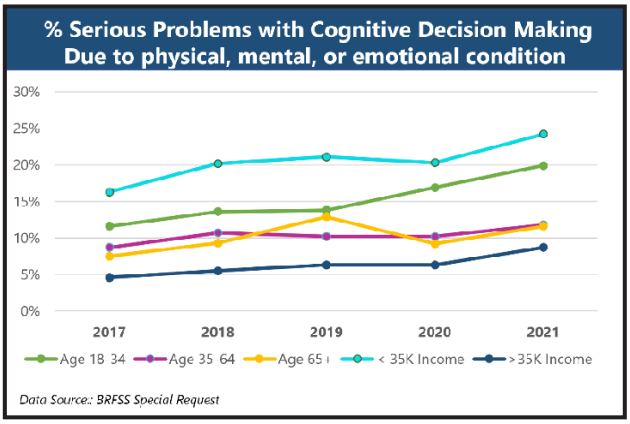
- Reduced rate of suicide
- Reduced rate of overdose deaths
- Reduced Emergency Room visits for suicide and overdose
- Frequent Mental Distress -14 or fewer poor mental health days – BRFSS
- Serious problems with cognitive decision making – BRFSS

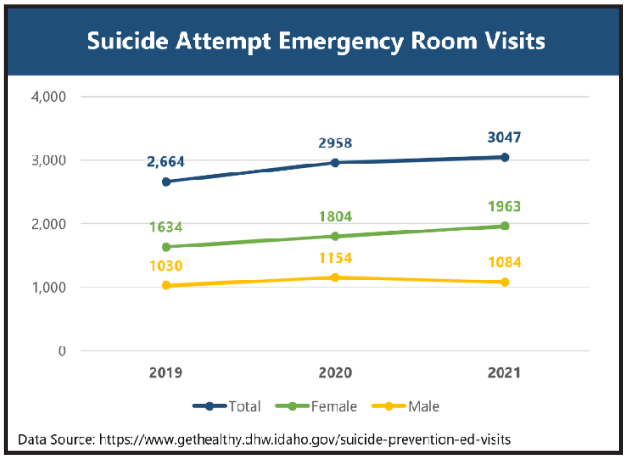
CURRENT DATA TRENDED OVER TIME

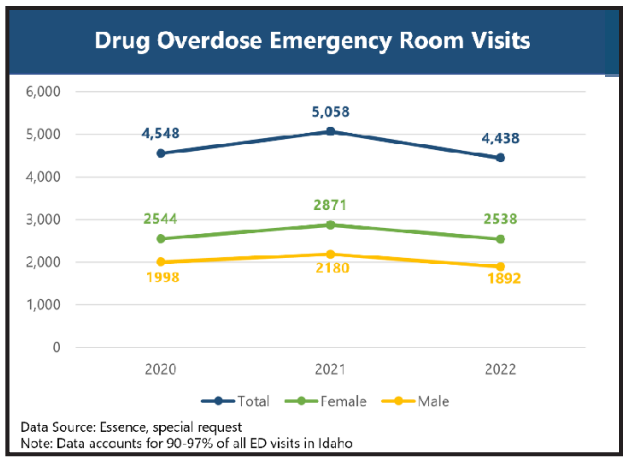












HOW ARE WE DOING?

The incidence of mental illness and behavioral health disorders are steadily trending upward in Idaho. The percentage of adults who report poor mental health and serious problems with cognitive decision making are both trending upward. Youth mental health, as demonstrated by the Idaho Healthy Youth Survey 2021 State Report sponsored by the Governor's Office of Drug Policy, is particularly concerning showing 19 percent of Idaho students surveyed reported feeling hopeless" all the time" or "most of the time." In the past 30 days, 20 percent "seriously considered" attempting suicide, 16 percent made a plan to attempt suicide, and 6 percent attempted suicide in the past year. Idaho's suicide rate was 1.6 times the national rate in 2021 and has historically ranked in the top 10 among states. Among all age groups, the Idaho suicide rate for males was five times higher than for females and was the second leading cause of death for Idaho youth under age 19.[29] Drug overdose deaths in Idaho are steadily increasing, from 13/100,000 residents in 2014 to 19/100,000 in 2021. Fentanyl-involved overdose deaths rose dramatically from 2020 to 2021, as did suspected opioid overdose emergency department visits. From 2020 to 2021, there was a 23 percent increase in drug overdose deaths, and the rate of fentanyl-related overdose deaths doubled in Idaho. The department is taking a close look at the effects of Adverse Childhood Experiences (ACEs) on Idahoan's health and wellbeing, including correlations between ACEs, chronic disease, and behavioral health issues. The 2020 BRFSS reports 31 percent of Idaho adults experienced 3 or more ACEs as a child.

STORY BEHIND THE DATA: UNDERLYING CONDITIONS, ROOT CAUSES, ENVIRONMENTS

Mental and physical health and wellbeing are strongly linked and shaped by myriad factors. It is difficult to know the extent to which the pandemic and related social and economic stressors have impacted the physical and mental health and wellbeing of families, children, and adults in Idaho. Changes to schools, workplaces, the economy, along with increased illness and loss have all likely contributed to poor mental and behavioral health outcomes. While needs are increasing, resources and supports are not always available. Access to treatment for substance use disorder (SUD) and mental health is limited, as all of Idaho is a federally designated mental health professional shortage area and there are very few resources for early intervention, including few child psychiatrists. Schools can play a critical role in helping families and students find support outside of the medical system through school-based resources, especially at community schools, where available.

Idaho data show a statistically higher risk of reporting poor health conditions or risk behaviors among those who have experienced one or more ACEs. Analysis shows that some demographic groups have statistically different risks for ACEs experience than other groups, for example, adults with higher levels of educational attainment have a lower risk of experiencing ACEs as a child.

Challenges in reaching Idaho residents with behavioral health services relate to rapid population growth, high rurality, geographic isolation, and a shortage of clinical health providers. Stigma surrounding mental and behavioral health conditions and crisis feed into policies that can halt individuals from getting the help and treatment they need. Community suicide prevention education such as QPR gatekeeper, Applied Suicide Intervention Skills Training (ASIST), and the youth-focused Sources of Strength training can help. Language impacts stigma, for example, saying “committed suicide” connotates a crime with personal culpability while “died by suicide” or “died from suicide” reflects the crisis which occurred. Similarly, understanding that substance use disorders are a disease is important for policy makers and the community. Fentanyl test strips have been shown to be an effective harm reduction tool but are currently considered drug paraphernalia in Idaho.

Policies, lack of community support systems, political climate and feeling unwanted are all contributing factors to experiencing more days of depression for LGBTQ youth than their cis-straight counterparts. This further demonstrates the need for a culturally competent and trauma-informed health care workforce.

Peer-reviewed research on the topic of “deaths of despair” (DoD) conclude that “low socioeconomic position and education levels and working in jobs with high insecurity, unemployment, and living in rural areas were identified as the most relevant social determinants of DoD.”[47] More research on this topic and the relationship between social and economic drivers of despair-related mortality is needed, particularly given Idaho’s unique geo-social-political landscape.

PARTNERS/POTENTIAL PARTNERS

The following behavioral health partners can help to ensure that Idahoans are safe and supported across the lifespan with the resources and care available to meet their needs, improve their health and live healthy lives.

Governmental	Non-profit/ Community Organizations	Additional Partners Needed
• Idaho Lives Project • Idaho Office of Drug Policy • Oregon-Idaho High Intensity Drug Trafficking Agency (HIDTA) • Idaho State Police • Idaho Department of Corrections • Idaho Supreme Court • EMS Agencies • State Department of Education Idaho Public Health Districts (7)	• Recovery Community • Safer Syringe Programs • Idaho Crisis and Suicide • Prevention Hotline • Women and Children's Alliance • Idaho Anti-Trafficking Coalition • Idaho Coalition Against Sexual and Domestic Violence • NAMI Idaho • Idaho Suicide Prevention Action Collective and The • American Foundation for Suicide Prevention	• People with lived experience • Local businesses • Healthcare payers/Insurance companies • Policy/lawmakers • Educational institutions, community schools, school districts • Providers including crisis centers, treatment, recovery • Veterans Administration • Aging and Lifespan advocates/commissions

2023 Behavioral Health Strategy **Intended Result:** Idahoans are safe and supported across the lifespan with the resources and care available to meet their needs, improve their health and live healthy lives.	
Idaho Health Report Card Indicator (Suicide 2021): 20.4/100,000 Target: 19.0/100,000 **Idaho Health Report Card Indicator (Drug Overdose Deaths 2021): 19/100,000** Target: 14.1/100,000	
Strategy 1:	**Develop landscape analysis of potential and current support the department provides to promote and protect the health of Idaho's unhoused or housing unstable population.**
Measure	• Completed analysis
Actions	1. Work with legislative affairs manager to develop housing support policy brief. 2. Identify strategies and funding the division/department currently utilizes to support unhoused Idahoans, for example wrap-around services for Idahoans with, or at risk for, behavioral health conditions.
	3. Identify gaps and barriers in federal funding availability for providing supportive services and opportunities to connect programs.
Timeframe	2023-2024
Lead Partners	Legislative Affairs Manager, GHI Team Cross-department programs

Strategy 2:	**Improve state, tribal and local capacity to address equity and risk disparities in high suicide risk population segments.**
Measure	• Percent increase in callers who receive support from a crisis call responder
Actions	1. Identify and support prevention, intervention and postvention strategies for priority populations with disproportionate rates of suicide. 2. Support Idaho 5-year prevention plan goals a. Idaho Suicide Prevention Action Collective (ISPAC) Annual priorities b. Support subgrants with State Department of Education and Public Health Districts. 3. Support and increase the utilization of the Idaho Crisis & Suicide Hotline and Behavioral Health Crisis Centers 4. Establish a minimum of four Zero Suicide Care Model pilot sites and work with community health partners for implementation and support.
Timeframe	2023-2025
Lead Partners	Idaho Suicide Prevention Program (SPP) ISPAC, Drug Overdose Prevention Program (DOPP), Divisions of Behavioral Health (DBH) and Medicaid
Strategy 3:	**Increase access to and utilization of local prevention, treatment and recovery services to address substance use among all high and rising-risk populations**
Measure	• # of trainings on recovery coach/peer support programs
Actions	1. Advocate for and support Peer Support/Recovery Coach programs 2. Utilize search query data from FindHelpIdaho, and other sources, to help inform local needs and deployment of support and resources.
Timeframe	2023-2025
Lead Partners	DOPP DBH, Recovery Centers, Idaho Tribes

PRIORITY AREA: UNINTENTIONAL INJURY

INTENDED RESULT

All Idahoans live, work, learn and play in safe homes and communities with the conditions and resources necessary to live injury-free and thrive.

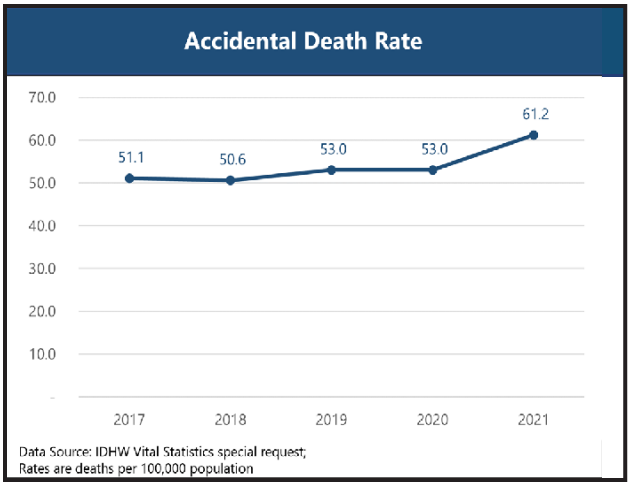
PRIORITY POPULATIONS

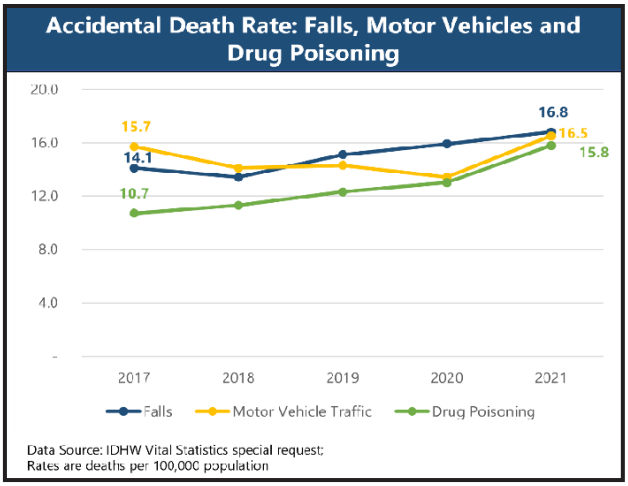
All Idahoans at risk for unintentional injury from traffic crashes, falls and accidental poisoning.

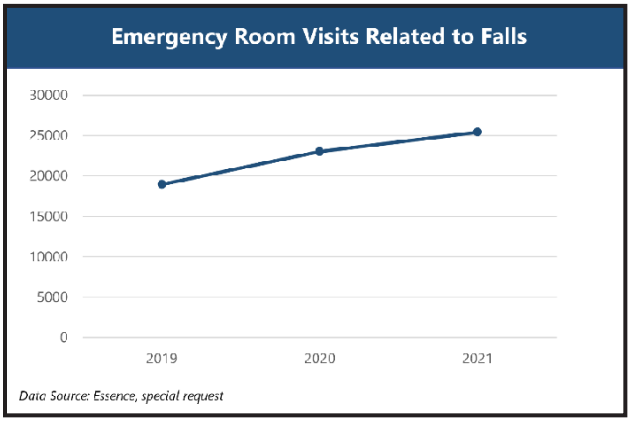
INDICATORS:

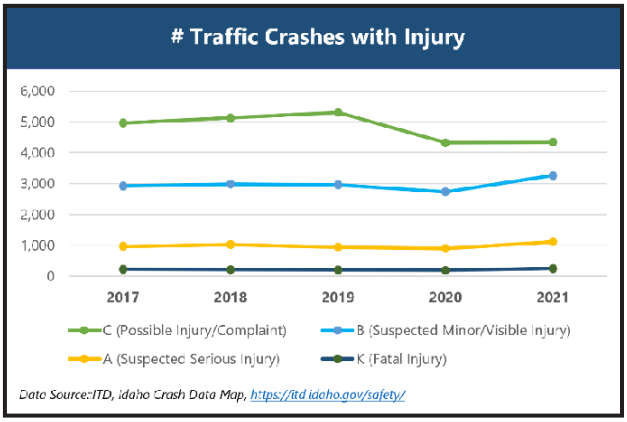
- Mortality data for falls, traffic crashes and accidental poisoning (Vital Statistics)
- Injuries resulting from traffic crashes (ITD)
- Falls resulting in injury 2019-2021 (Emergency Room Visits)
- Unintentional injury mortality rate

CURRENT DATA TRENDED OVER TIME









HOW ARE WE DOING?

Unintentional injury from falls, motor vehicle accidents, and accidental poisoning, including exposure to noxious substances, are the leading causes of unintentional injury death in Idaho. In 2021, falls were the number one accidental injury in Idaho, rising above car accidents, and adults 65 years and older are the most susceptible to falls, leading to serious injury and death. Motor vehicle accidents were the leading cause of death for Idahoans aged 1-24 years of age during the 5-year period from 2016-2020. In 2020, the most recent mortality data available, 258 Idahoans died from accidental poisoning; 238 of these 258 deaths were due to drugs, with the remaining 20 from other noxious substances.

STORY BEHIND THE DATA: UNDERLYING CONDITIONS, ROOT CAUSES, ENVIRONMENTS

Many Idahoans live in rural environments and appreciate the beauty, recreation and rugged independence offered. While there are numerous benefits, people living in rural areas often lack easy access to prevention resources. Distance to hospitals and limited EMS can lengthen response times after a serious injury. Within communities, and in Idaho's urban areas, highways and wide roadway design encourage high speed, increasing risk and incidence of severe crashes. These roadways often have limited infrastructure for vulnerable road uses (bikes, pedestrians, wheelchair users and those with limited mobility) with few crossings. Additionally, Idaho does not have a universal helmet law for all users of motorcycles or bicycles. Idaho's seatbelt laws are secondary, with a low $10.00 fine. Highway road designs within communities and adjacent to destination land-uses sometimes create unsafe conditions which contribute to higher rates of preventable injury and death.

Idaho's population is aging. The proportion of Idahoans aged 65 and over increased from 12.9 percent of the population in 2011 to 16.5 percent in 2021. Unintentional falls resulting in injury have also increased as Idaho's population ages. Most falls happen within the home or residential setting. Fall mortality data from 2020 report 183 out of 291 deaths from falls occurred in the home setting, while another 79 occurred in a residential/public institution (assisted living/nursing home). The division continues to support work to reduce fall risk in homes and to increase individual strength and balance through Fit and Fall Proof™ classes.

Accidental poisonings have been increasing, and the rate of deaths due to fentanyl overdose has doubled, largely impacting younger Idahoans, with 23.3 percent of overdose deaths involving fentanyl in residents ages 25-34 years old. Idahoans buying and consuming illicit drugs may not be aware of the increased risk of drugs containing unknown amounts of fentanyl, which can prove deadly. The potency of street drugs can vary dramatically and even those who have knowingly consumed fentanyl with few problems can be exposed toa lethal dose in the future.

PARTNERS/POTENTIAL PARTNERS

The following unintentional injury partners can help to ensure all Idahoans live, work, learn and play in safe homes and communities with the conditions and resources necessary to live injury-free and thrive.

Governmental	Non-profit/ Community Organizations	Healthcare and Facilities	Additional Partnerships Needed
• Idaho Transportation Department • Law enforcement • Fire Departments (Home Safety Checks) • Fit and Fall Proof™ Idaho Public Health Districts • BSU Center for the Study of Aging	• Transportation advocacy groups (Idaho Walk Bike Alliance) • Area Agencies on Aging • Idaho Caregivers Alliance	• Residential assisted living facilities • Fall reduction-home health agencies • Community Health Workers • Community Health EMS providers • Idaho hospitals	• State and Local agencies responsible for transportation and land use • Transportation providers & Local Highway Districts • Media • State associations responsible for the care of children aged 6 and under

2023 Unintentional Injury Strategy **Intended Result:** All Idahoans live, work, learn and play in safe homes and communities with the conditions and resources necessary to live injury-free and thrive.	
Idaho Health Report Card Indicator (Unintentional Injury Deaths 2021): 61.5/100,000 Target: 45.0	
Strategy 1:	**Reduce accidental poisoning deaths, including from fentanyl and other opioid overdoses, by increasing community-level awareness and distribution of Naloxone kits to priority populations**
Measure	• # of Naloxone kits distributed (tentative pending legislation) • # of campaign messages disseminated
Actions	1. Increase access to naloxone to vulnerable populations, first responders, and healthcare organizations (tentative due to potential legislative restrictions) 2. Develop fentanyl awareness campaign for those at high- and rising-risk for overdose, to include resources and supports for fentanyl overdose prevention.
Timeframe	2023-2025
Lead Partners	DOPP Office of Drug Policy, local public health districts
Strategy 2:	**Develop and Implement Idaho Injury Prevention Strategy**
Measures	• Strategic plan adopted and implemented • Partner engagement in communication plan development and implementation • Communication and outreach plan adopted and implemented

2.1:	**Develop Injury Prevention Strategic Plan focusing on the internal/external programs, partners, priority populations, emerging data, and best practices in the field.**
Actions	1. Develop Injury and Violence Prevention structure, process, and outcomes for Injury Prevention in DPH. 2. Use the shared risk and protective factors framework. 3. Utilize Safe States Alliance model of state health department IVP programs. 4. Review and conduct Safe states self-assessment tool for state health department IVP programs. 5. Establish data work group and plan to: a. improve coordinated data collection, analysis, and dissemination b. prioritize injury topics, disparities, priority populations and actions. 6. Convene partners to identify injury prevention approaches. 7. Implement cross-cutting strategies and best practices with partners focused on falls, traffic crashes and accidental poisoning.
2.2:	**Develop a communication and outreach plan to a) enhance prevention messaging and b) support statewide injury prevention capacity needs.**
Actions	1. Work with internal and external partners to identify injury prevention messaging opportunities for priority audiences. 2. Identify and meet with key partners to understand capacity and resource needs, challenges, and opportunities for collaboration.
2.3:	**Conduct transportation and health policy analysis to identify best-practice strategies and policies with focus on transportation/community design as strategies to improve health, reduce injury and prevent chronic disease.**
Actions	1. Introduce topic in DPH policy brief strategy. 2. Analyze community-level data to inform areas of high need or disadvantage. 3. Research and develop effective, realistic, and timely strategy incorporating policy, systems, and environmental change recommendations for improved safety and mobility in communities. 4. Include strategies for dissemination of information and develop next steps for the division/department to educate, influence and support partners and stakeholders.
Timeframe	2024-Ongoing
Lead Partners	Injury Prevention Manager Legislative Affairs Manager, BESP, Bureau of Community Health, Bureau of EMS-P, other key DHW staff, community stakeholders
Strategy 3	**Establish and Expand Multi-Sector Partnerships to Advance Statewide Older Adult Fall Prevention Goals**
Measure	# new partnerships created or established
Actions	1. Participate in and support efforts of statewide fall prevention coalition 2. Assess Health Systems Partnerships for Fit and Fall Proof ™ (FFP) Referrals
Timeframe	2023-Ongoing
Lead Partners	IPAN, Fit and Fall Proof™ Program Health district coordinators, Idaho Commission on Aging, health systems, Bureau of EMS-Preparedness, trauma response partners.

Prioritizing Action Through Policy, Systems, and Environmental Changes

Population health improvements require comprehensive multilevel interventions specifically through effecting changes to policies, systems, and environments. The following table summarizes policies which directly impact or intersect the four GHI priorities:

Health Priority Area	Policy Recommendations*
Cross-Cutting/Advance Equity	Medicaid reimbursement for CHW services.
Cross-Cutting/Advance Equity	Health Policy Analysis: Conduct research and analyze best practice policies and strategies across health priorities. Identify existing policy gaps and opportunities to support solutions that advance equity.
Unintentional Injury	Transportation and Health Policy Analysis: Conduct research and identify best-practice strategies and policies with focus on transportation/community design as a public health strategy to improve health, reduce injury and prevent chronic disease.
Cross-Cutting/Advance Equity	Increase support for comprehensive harm reduction strategies and policies
Diabetes / Obesity	Idaho Medicaid reimbursement of nationally recognized Diabetes Prevention Program (DPP).

* Each of the following policy recommendations are included in this plan's priority strategies. They were recommended by division staff specifically as transformative opportunities that will support efforts to improve and advance health equity and reduce disparities among priority populations.

Place-Based Initiatives

Since the launch of GHI's place-based initiative in calendar year (CY) 2021, the division continues to serve in lead convenor/facilitator role, providing technical assistance, resources, and tools to support GHI-funded communities advance their capacity and knowledge to implement policies, systems and practices that ensure meaningful, long-lasting solutions. Internal resources and assets supporting implementation of this work include financial capital provided through a braided funding model and learning collaborative opportunities for community teams to share knowledge and troubleshoot ideas. This ensures a greater degree of flexibility than the traditional public health model, allowing funded communities to implement solutions that best fit their unique needs.

During CY2022, the GHI-funded collaborative in Elmore County moved into planning, development, and collaboration with county-wide partners and agencies to further advance the priority strategies in their community action plan. The plan addresses GHI priorities (diabetes, obesity, unintentional injury and behavioral health) by focusing upstream to reflect the diverse interests and common threads that ultimately connect residents together, specifically through improving access to public lands and open space, human-centered health care services, and behavioral health support. The strategies Elmore County collaborative members are moving forward include increasing access to care through

Community Health Workers (CHWs), piloting a Community Health-EMS (CHEMS) program to advance care for residents with behavioral health needs or diabetes, improving cultural competency, and increasing active transportation options. By focusing on partnership building and system-level change, the results of this work will create long-term solutions to address the unique challenges, needs, and opportunities identified by the community.

GHI's second funded community, led by the United Way of Southeast Idaho, was awarded funds in October 2021 focused on health improvements for vulnerable residents of Bannock County. The collaborative identified transportation as a major barrier to health and is developing a system and community-supported infrastructure to improve mobility for vulnerable residents in the county. Through partnerships with health clinics and local transportation service providers, the GHI-supported effort is piloting an on-demand ride share and delivery program called RideUnited to support uninsured residents access health care and other health promoting services. RideUnited is integrated into FindHelpIdaho and is working to utilize case managers to order rides via rideshare to ensure community members get to the places they need to be when they need to be there. To further advance this effort, partnering organizations will provide courses to teach residents how to use the Pocatello transit system, ultimately helping residents practice self-advocacy. This community-led and supported infrastructure will help clients access the care they need at the Pocatello Free Clinic, the southeast Idaho behavioral health crisis center, and the Hope and Recovery Resource Center, among others, which will in turn enable clinicians to better care for their patients and achieve healthier outcomes.

The GHI team in the division supports place-based initiatives and funded communities by drawing from the large body of expertise from across the department to aid in identifying resources and strategies to further support community goals. Get Healthy Idaho emphasizes the importance of authentically engaging with communities. Collaborative efforts to improve health must ensure inclusion of diverse voices and individuals with lived expertise in every step of the process, actively listening, co-creating ideas, and developing solutions that are effective, equitable, scalable, and sustainable in order to have the most impact on improving health outcomes. Health happens where people live and the policies, systems, and environmental interventions identified should reflect the unique needs and culture of each community.

Publication of the Assessment and Plan

The ***Get Healthy Idaho: Building Healthy and Resilient Communities*** assessment and plan are located publicly at http://gethealthy.dhw.idaho.gov/. In CY 2020, the division expanded this site to include elements of the Health Improvement Plan, priority area details, community award progress updates, performance metrics, partner and community involvement, and population health data. The site serves as the central location for all information related to this initiative.

Tracking Progress and Next Steps

The division is committed to tracking progress and continuously improving processes to ensure results are recorded timely and accurately. To ensure all strategies remain on track, the GHI team will convene internal stakeholders monthly to track progress, barriers, opportunities, and successes, focusing on one of the four health priority areas on a rotating monthly schedule. This will ensure each priority area is updated on a quarterly basis. To ensure transparency in reporting, the division will utilize internal reporting tools to track progress status, details, and metrics which will be shared with division leadership monthly via the division performance dashboard.

Annually, the division will convene external partners to share and review prior year implementation plan progress, including reporting on effectiveness of proposed strategies and measures; changes to strategies or priorities; challenges or barriers encountered; and additional resources, support, and assets needed to achieve plan strategies. Partnering agencies and the department teams responsible for identified strategies will report progress. Local agencies leading GHI work in their communities will be invited to participate and present outcomes and successes of place-based, community-led efforts.

During 2020, the COVID-19 pandemic had a serious and significant impact on the regular priorities of department staff and community partners. As such, and in adherence with physical distancing, health, and safety guidelines, the GHI team did not convene partners in person to review data or modify the GHI plan. As a substitute for an in-person gathering, partners were convened virtually in April 2021 to provide progress updates from place-based efforts and an overview of a CDC funding opportunity to address health disparities related to COVID-19 in underserved, racial and ethnic minority, and rural communities. In 2022, the GHI team created a new opportunity to communicate with partners, developing and distributing two newsletters focused on GHI priority topics, data, community progress updates, and upcoming events, trainings, and funding opportunities. The newsletters were distributed out via GHI partner listserv and to all division employees. This communication modality will continue in 2023.

Building healthier and more resilient communities is the goal of GHI, while the heart of the initiative lies within the diverse infrastructure of state and local public and community health partners. The division embraces its role as leader, partner, and supporter of transformative changes across Idaho's health ecosystem, and looks forward to seeing results of empowered community leadership in building healthier, more equitable places for people to thrive.

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Appendix

LIST OF APPENDICES

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

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Get Healthy Idaho Partner Meeting

below shows partner responses when asked "What is one word that describes your thoughts about GHI 2.0?"

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.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Get Healthy Idaho Partner Meeting

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

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- 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

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- 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

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- 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

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- 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?

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- 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

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- 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

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- 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

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- 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?

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- 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?

APPENDIX 5: GET HEALTHY IDAHO WORKING GROUP SUMMARY OF RESULTS BASED ACCOUNTABILITY PROCESS

Three working group meetings were held in November and December of 2022 to follow a Results Based Accountability process for each of the health improvement plan priority areas of diabetes and obesity, behavioral health, and unintentional injury. Results Based Accountability is a data-driven, decision-making process which first asks participants to agree upon a desired result and then works through a series of steps to efficiently arrive at the actions needed to achieve the desired result. Working groups were primarily comprised of division of public health staff but also included representatives from the division of behavioral health and Medicaid. Each working group discussed and offered input on questions within each of the following steps related to their health priority area:

> Step 1: Who are the priority populations for this topic?
> Step 2: What is the "end result" or quality of life or condition of well-being we desire for this population?
> Step 3: What are data indicators of progress toward the "end result"?
> Step 4: How are we doing? Review data trends for the selected indicators of progress
> Step 5: Determine the story behind the data curve? What are the underlying conditions, root causes and environments impacting how we are doing?
> Step 6: Who are the partners that have a role to play in reaching our desired end result?
> Step 7: Thinking broadly what do you know works or could work to reach out desired end result?
> Step 8: What do we propose to do? What strategies should be included in the Health Improvement Plan.

A final working group meeting was held in February 2023 to review outcomes of the results-based accountability process. The desired result and ideas generated that could work to achieve the result are listed below. These broad lists were narrowed down by the working groups to specific and achievable strategies have been incorporated in the Get Healthy Idaho plan. The following broad list of ideas can be revisited to consider feasibility in future plans.

DIABETES AND OBESITY WORKING GROUP

INTENDED RESULT

All Idahoans live in communities with equitable access to healthy food, physical activity opportunities and the support and resources needed to promote, protect, and improve their health.

PARTICIPANT LIST: Casey Suter, Gina Pannell, Amanda Rodgers, Song Boucree, Sherry Deiter, Ashley Rundle, Tessa Meyer, Cristi Litzsinger, Alicia Fong, Leah Sallas, Mara Stauss

FACILITATION: Katie Lamansky, Karla Nelson, Megan Farrow

BROAD LIST OF WHAT COULD WORK TO ACHIEVE THE INTENDED RESULT

Primary, secondary, and tertiary interventions to drive change in prevalence of diabetes and obesity must occur at all levels, with strategies that impact health across the individual, organizational, community, systems/societal and policy levels.

- Encourage and promote optimal breastfeeding practices and policies through peer support services, lactation consultants, adoption and implementation of Baby Friendly Hospital Initiatives, and workplace lactation support policies.
- Support programs, such as Cooking Matters classes and Eat Smart Idaho, that build skills for low-income families to purchase and cook healthy meals.
- Expand access to programs such as Farm to Early Care and Education to expose kids to a variety of healthy foods.
- Improve access to healthy foods and limit unhealthy foods through school nutrition programs, WIC, SNAP, and Idaho Foodbank/food pantries.
- Promote land use policies that allow for community gardens/urban agriculture.
- Expand access to programs that provide skills-based learning for home gardeners.
- Decrease screen time for children and strengthen obesity prevention policies and standards in early care and education settings.
- Increase physical activity among youth to recommended amounts (60 minutes/day) through partnerships with schools, such as improving physical education standards and establishing joint-use agreements.
- Support local governments to adopt policies that prioritize walkable and bikeable infrastructure.
- Provide people of all abilities with equitable access to recreation options that are low or no cost.
- Expand funding for and access to evidence-based obesity prevention programs.
- Expand access and reduce barriers to encourage sustained participation in National Diabetes Prevention Program (DPP) and Diabetes Self-Management Education and Support Program (DSMES).
- Comprehensive Medicaid and state health plan coverage for: diabetes-based clinical practice and standards of care, including DPP, DSMES programs, and medical nutrition therapy.
- Payer coverage for remote patient monitoring devices and telehealth services.
- Ensure all people with diabetes have access to affordable insulin.
- Enhance care coordination for people with both obesity, diabetes and mental illness.
- Support Community Health Workers to address diabetes and obesity-related chronic health conditions and prevention in populations with the greatest need.
- Provide screening, diagnosis and counseling/referral for prediabetes at outpatient primary care clinics.
- Reduce health disparities in priority populations disproportionately affected by diabetes.

BEHAVIORAL HEALTH WORKING GROUP

INTENDED RESULT

Idahoans are safe and supported across the lifespan with the resources and care available to meet their needs, improve their health and live healthy lives.

PARTICIPANT LIST: Betsy Hammar, Megan Hartigan, Natalie Bodine, Traci Berreth, Heidi Cook, Katherine Humphrey, Tiffany Robb, Josh Lamansky, Rosie Andueza, DaNae Schoenborn, Ana Vidales, Scott Rasmussen, Martijn Van Beek, Teresa Abbot, Collin Elias, Vallenthia Johnson, Tyrin Stevenson

FACILITATION: Katie Lamansky, Karla Nelson, Megan Farrow

BROAD LIST OF WHAT COULD WORK TO ACHIEVE THE INTENDED RESULT

- Support Idaho's community schools' efforts, which help parents find supports in settings outside of medical systems.
- Implement and scale the Icelandic Model (BSU) in Idaho to connect kids with positive activities and role models
- Improve access to early intervention programs, particularly in schools, to identify and address mental health conditions as early as possible, to include Mental Health First Aid for Youth training and Social and Emotional Learning.
- Implement strategies that reduce risk factors (ACEs, mood disorders, easy access to firearms, use of substances, exposure to violence) and increase protective factors (supportive adults, social-emotional competence, positive school climate, quality after-school activities) that impact youth mental health.
- Implement mental health first aid training for frontline workers.
- Implement universal validated screening in pediatric clinics for postpartum depression and anxiety during the first year of an infant's life, to include referral and follow-up.
- Elevate the voices of children, youth and their families in program and service design and delivery.
- Integrate behavioral health into primary care at the community level; mental health screenings with resources for referral, when needed.
- Implement intergenerational programming for increased inclusion and better outcomes across the lifespan.

  Ex: Innovative housing models and school-based programs that benefit both youth and older adults.
- Advocate for permanent supportive housing with wrap-around behavioral health and social services for people experiencing chronic homelessness.
- Trauma-informed approaches for those seeking treatment in behavioral health settings and among service providers.
- Improve access to affordable, effective behavioral health services (100 percent of Idaho is a mental health professional shortage area.)

- Increase SUD treatment availability.
- Harm reduction practices and polices including safer syringe programs, fentanyl test strips, naloxone distribution, non-punitive approach to substance use in pregnancy.
- Stigma education and messaging that destigmatizes substance use disorders and help-seeking behavior.
- Build Idaho Crisis and Suicide Hotline capacity and promote awareness of 988 crisis line.
- Equip health care systems with the tools and mechanisms needed for suicide safe care through Zero Suicide care model.
- Provide evidence-based treatment, including medication, for opioid use disorder.
- Diversion programs and treatment court, offering people with drug dependency an alternative to incarceration.
- Utilize overdose fatality review committee comprised of a multidisciplinary team to evaluate patterns of need and opportunity within agencies and across systems in response to overdose deaths.
- Implement peer support groups such as loss survivors support groups and veterans supporting veterans.
- Gatekeeper and intervention skills trainings, such as ASIST and Sources of Strength youth trainings, designed to teach the warning signs of a suicide crisis and how to respond.

UNINTENTIONAL INJURY WORKING GROUP

INTENDED RESULT

All Idahoans live, work, learn and play in safe homes and communities with the conditions and resources necessary to live injury-free and thrive.
PARTICIPANT LIST: James Aydelotte, Brooke Ambrose, Tiffany Robb, Grace Dehner, Joe Pollard, Traci Berreth, Melissa Ball
FACILITATION: Katie Lamansky, Karla Nelson, Megan Farrow

BROAD LIST OF WHAT COULD WORK TO ACHIEVE THE INTENDED RESULT

Traffic Crashes

- Safe driving programs with focus on high-risk behaviors
- Support and enforce policies to reduce distracted driving.
- Complete AARP livable communities' walk audit in communities of interest.
- Encourage roadway designs and policies, such as Vision Zero, that prioritize safety and accessibility.
- Encourage traffic calming design in high-crash intersections.
- Provision of complete transportation systems which allow for safe, multi-modal transportation uses.
- Culturally appropriate drivers' education that is relevant to immigrants, new Americans, and refugees.

- Primary seatbelt laws; Increased penalties for violating seatbelt laws, such as higher fines.
- Child car seat safety across the continuum of ages and seat stages.

Falls

- Support expansion of Fit and Fall ProofTM exercise-based fall prevention program for older adults.
- Make the home environment safer:
- Distribute AARP home retrofit information to alleviate fall risks and perform home assessments for fall risks.
- Partner with Idaho EMS/CHEMS/CHW to identify opportunities to build residential home safety evaluations for older adults into clinical workflow.

Accidental Poisoning

- Expand and support for harm reduction strategies, practices and policies, to include safer syringe programs, fentanyl test strips, naloxone distribution, non-punitive approach to substance use in pregnancy.
- Increase awareness among homeless shelters on SUD and treatments.
- Provide resources and support for parents and others in the community about the risk of accidental poisoning from drugs, including those containing fentanyl and other prescription medications.
- Increase naloxone availability and educate parents, youth, and policy makers on its use.
- Screen children for lead exposure.

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