Board of Health Meeting
Tuesday, August 27, 2024, 9:00 a.m.
13307 Miami Lane, Caldwell, ID 83607

Submit public comments specific to an agenda item for the August 27, 2024 Board of Health meeting can be submitted here or by mail to: SWDH Board of Health, Attn: Administration Office, 13307 Miami Lane, Caldwell, ID, 83607. The period to submit public comments will close at 9:00 a.m. on Monday, August 26, 2024. The meeting will be available through live streaming on the SWDH You Tube channel.

Agenda

A = Board Action Required **G =Guidance** **I = Information item**

9:00	A	Call the meeting to order	Chairman Kelly Aberasturi
9:01		Pledge of Allegiance	
9:02		Roll call	Chairman Kelly Aberasturi
9:04	A	Call for changes to agenda; vote to approve agenda	Chairman Kelly Aberasturi
9:05		In-person public comment	
9:10	I	Open discussion	
9:15	A	Approval of July 23, 2024 meeting minutes	Chairman Kelly Aberasturi
9:17	A	Approval of August 15, 2024 special meeting minutes	Chairman Kelly Aberasturi
9:20	I	July 2024 Expenditure and Revenue Report	Troy Cunningham
9:30	I	Sources of Strength program overview	Hannah Crumrine
9:50	A	Immigration physicals fee follow up	Beth Kriete, Dr. Perry Jansen
10:05	I	Measles response plan update	Ricky Bowman, Andy Nutting
10:25		Break	
10:40	I	Immunizations program update	Rick Stimpson
10:50	A	Social Security Administration 218 Staff Survey Results Review and Decision	Nikki Zogg
11:00	I	Resolution review and discussion	Nikki Zogg
		• Resolution to Increase WIC Participation in Idaho (24-PHD4) • Resolution to Clarify Roles Pertaining to Solid Waste Disposal in Idaho (24-PHD7)	
11:05	A	Resolution review and approval	Nikki Zogg
		• Resolution Concerning Prevention ... Through Prescriber Education (17-02) • Resolution Opposing the Legalization of Recreational (Non-Medical) Marijuana (19-03) • Resolution to Remove the Food Establishment License Fee in Idaho Code (22-02) • Resolution to Change Statute to Allow Public Health Districts to Leave State Treasury • Resolution to Support Immunizations	
11:30	G	Review and approve position statements	Nikki Zogg
11:45	I	Director's Report - IADBH Fall Conference registration and proxy forms	Nikki Zogg
11:50	G	Contract review and discussion	Nikki Zogg
11:55		Executive Session pursuant to Idaho Code 74-206(b)	
11:59	A	Action taken as a result of Executive Session	
12:00		Adjourn	

NEXT MEETING: Tuesday, September 17, 2024 – 9 a.m.
(NOTE: Third Tuesday in September due to Idaho Association of Counties (IAC) meeting)

BOARD OF HEALTH MEETING MINUTES
Tuesday, July 23, 2024

BOARD MEMBERS:
Jennifer Riebe, Commissioner, Payette County – present
Lyndon Haines, Commissioner, Washington County – present via Microsoft Teams
Zach Brooks, Commissioner, Canyon County – present
Kelly Aberasturi, Commissioner, Owyhee County – present
Viki Purdy, Commissioner, Adams County – present via Microsoft Teams
John Tribble, MD, Physician Representative – present
Bill Butticci, Commissioner, Gem County – present

STAFF MEMBERS:
In person: Nikki Zogg, Katrina Williams, Mitch Kiester, Don Lee, Rick Stimpson, Troy Cunningham, Charlene Cariou

Virtual attendees: Jeff Renn, David Tovar, Brennan Serrano

GUESTS: None

CALL THE MEETING TO ORDER
Chairman Kelly Aberasturi called the meeting to order at 9:02 a.m.

PLEDGE OF ALLEGIANCE
Meeting attendees participated in the pledge of allegiance.

ROLL CALL
Chairman Aberasturi – present; Dr. John Tribble – present; Commissioner Purdy – present via Microsoft Teams; Vice Chairman Haines – present via Microsoft Teams; Commissioner Brooks – present; Commissioner Riebe – present; Commissioner Butticci – present.

REQUEST FOR ADDITIONAL AGENDA ITEMS AND APPROVAL OF AGENDA
Chairman Kelly Aberasturi asked for additional agenda items. Board members had no additional agenda items or changes to the agenda.

MOTION: Commissioner Butticci made a motion to approve the agenda as presented. Commissioner Riebe seconded the motion. All in favor; motion passes.

IN-PERSON PUBLIC COMMENT
No public comment given. No members of the public present.

OPEN DISCUSSION
There were no items for open discussion.

APPROVAL OF MEETING MINUTES – JUNE 25, 2024
Board members reviewed meeting minutes from the June 25, 2024 meeting.

MOTION: Dr. Tribble made a motion to approve the June 25, 2024 meeting minutes as presented. Commissioner Butticci seconded the motion. All in favor; motion passes.

INTRODUCTION OF NEW EMPLOYEES
Division Administrators introduced new staff.

JUNE 2024 EXPENDITURE AND REVENUE REPORT
Troy Cunningham, Financial Manager, presented the June 2024 Expenditure and Revenue Report. At this point in the fiscal year, the target is 100%.

Troy began by explaining that revenues show as negative. The prime cause of this is adjustments made to correct revenue duplications that came in from Fiscal Year 2023. Almost $1 million in overstated revenue came specifically from income coming in from the previous year. When Luma went live in June 2023, all of the open invoices in the old legacy system needed to be recreated. Troy was concerned about duplicated revenue when re-keying those. Some of the invoices remained unpaid until about April 2024 when Department of Health and Welfare (DHW) began to be pressured to process the payments. The State Controller's Office did not make the adjustments and asked SWDH staff to manually reverse all of the revenue that came in.

Troy further explained that within Luma there is not yet a tool that can give a clear trial balance with an as of date. In August, the hope is to be able to provide a final cash balance and a request to commit funds. Troy is waiting on Luma to provide an initial trial balance or active balance sheet.

Board members discussed the challenges of providing full transparency when Luma is not providing accurate information. Commissioner Aberasturi asked if Troy and his team are sure about the reports being shared to the website. The State of Idaho is requiring transparency. Troy responded that based on the statute governing the health districts' budget processes, we upload data in December 2024 for Fiscal Year 2023. Fiscal Year 2024 won't hit until December 2025. Troy has met with Nikki and Don to discuss the frustrations and the discrepancies. At this point, Troy does not feel we are materially wrong. The differences between the reports are very immaterial and Troy expects the reports to balance.

Troy mentioned that SWDH staff have a meeting scheduled with the Office of Performance Evaluation (OPE) and that OPE also sent out a survey last week to collect input from staff. This survey and the meetings with staff are an avenue to provide feedback to hopefully help move things forward and reach favorable outcomes with the State Controller's Office.

From a revenue standpoint, county contributions landed where they needed to. Fees are slightly lower than anticipated due to an expected downturn in the economy.

Troy explained that another issue with closing out fiscal year 2024 (FY24) is that May's work was not billed until July. In August, the July activity will be billed. This billing shift creates a significant difference.

Personnel expenditures are roughly at 90%. Due to an overage in operating, some of personnel was shifted down. Capital outlay remains at 100%. Trustee and benefit is still at 49% in the primary districts' budget and budget remains the same.

Commissioner Brooks asked if SWDH has a policy for allocating unspent funds. Troy explained that SWDH has a policy stating that up to 3 months of expenses can be in uncommitted reserves to cover any short falls. Beyond that, those unspent funds would be committed by the Board and this process typically happens in August.

Troy noted that the Western Idaho Community Crisis Center (WIDCCC) shows expenditures over revenues due to a timing issue and lag in billing. The Western Idaho Youth Support Center (WIYSC) has had more contract revenue than anticipated. This revenue comes from new grants.

QUARTERLY CONTRACTS AND SERVICES REPORT QUARTERLY UPDATE

Troy provided an update on the quarterly contracts and services report. Commissioner Brooks asked who signs off on accepting and approving the contracts. Nikki explained that the majority are reoccurring contracts. Approving contracts is a delegated authority to Nikki from the Board of Health and she signs off on them. Contract copies are available on SharePoint. After the SWDH website undergoes an upgrade, contracts will be available there. Nikki further explained that many of the contracts are pass through and support statutorily required work.

Commissioner Brooks stated he was unaware that a prior Board delegated the authority of approving and signing contracts to Nikki. He said understanding some of this would help them understand what is going on in the building and what they are supposed to be overseeing.

Commissioner Butticci added that at Gem County, the Commissioners usually sign all the contracts. He had an opportunity to review the listing of SWDH contracts and now understands. Contract revenue is SWDH's main income and it would be hard for Board members to micromanage all the contracts. The majority of the contracts are revenue-based contracts that are narrow in scope.

Commissioner Purdy said she has asked the same question about contract approval and that reviewing the contracts prior to approval would be a good way for the Board to know what is going on with every single contract. She stated she previously asked for contract access and Katrina provided an electronic link to the contracts but the files were difficult to print out. Commissioner Purdy asked to be provided with printed copies of the contracts. She acknowledged it might be a lot of paper but said she would like to see them on paper and that trees are not a problem. Commissioner Purdy also asked if the Board can figure out a way to allow the Board to approve the contracts before they are approved.

Commissioner Riebe asked for clarification of the contract process and whether SWDH applies for the contracts. Nikki responded that Idaho Department of Health and Welfare (IDHW) decides what the state needs based on the available data and then pursues funding based on those decisions. In most cases, IDHW sub awards the funding allowing SWDH to be the doer.

Commissioner Riebe asked about the origins of the pre-prosecution diversion grant. Nikki explained that the grant resulted from sequential intercept model training through Judicial District Three and in the course of conversations with partners. When funding became available through Idaho Department of

Corrections, Canyon County thought it was a good fit. Canyon County then reached out to SWDH for assistance.

NEW CLINIC SERVICE FEE APPROVAL REQUEST

Rick Stimpson, Clinic Manager, asked for Board member approval for a new clinic fee for immigration physicals. This physical requires a doctor certified as a civil surgeon and Dr. Jansen, Medical Director, now has that certification. These exams include an overall wellness exam, screening for infectious disease, and an immunization review. The requested cost for this service is $550 which is on track for a 60-minute visit with a physician.

Commissioner Brooks asked where individuals go to receive this service now. Rick explained that there are five or six providers with the required designation of civil surgeon in our area. Providing this service would allow clients to have all the services provided in one place. There is a high demand for this service. Rick explained that SWDH has received multiple phone calls inquiring about availability of the immigration physicals.

The immigration physical is not covered by insurance. Board members expressed concerns about SWDH, as a government entity, undercutting the market for these exams by offering a significantly lower price than other providers. Dr. Tribble noted that it is a fairly common occurrence to look at fees across the board. If you're looking for the baseline fee, the low end, that is typically the health department.

Rick further explained that Dr. Jansen works just two half-days per week and is the only one that would be able to provide this service. Board members asked questions about the citizenship status of those seeking this exam, how long individuals have been in the U.S. before they start the green card process, and the time limit for completing the process.

Commissioner Brooks indicated he is not against providing these physical examinations but wants to ensure the cost charge of the service does not exceed the lowest price of other providers. Commissioner Aberasturi agrees SWDH should not be competing with private industry. He asked how great the demand for the service is and if the doctors already offering the exam are meeting that need or are they turning people away or in a waitlist situation?

Rick will gather information to address Board member concerns and questions and bring the information back to a future Board meeting. Per board member preference, if Dr. Jansen is available to attend the Board meeting where Rick shares follow up information that would be helpful.

MOTION: None.

BOARD OF HEALTH BYLAWS APPROVAL

Board members reviewed the Board of Health bylaws. There were no suggested changes during last month's review. Board members had no requests for changes or amendments.

Commissioner Brooks asked that the Board of Health physician recruitment process be added to the bylaws for future reference. Nikki has updated the bylaws to include the process used when Dr. Tribble was recommended as Board physician.

MOTION: Commissioner Brooks made a motion to approve the Board of Health bylaws as amended and presented. Commissioner Riebe seconded the motion. All in favor; motion passes.

IDAHO BEHAVIORAL HEALTH PLAN OVERVIEW

David Tovar, Network Director, and Brennan Serrano, Marketing and Communications Manager, Magellan, attended the meeting virtually and provided an overview of the Idaho Behavioral Health Plan (IBHP), some of its staff and initiatives, and shared an implementation status update. David shared some challenges and some successes encountered during the first few weeks of rollout for the new contract. He explained that Magellan is a nationwide brand but has Idaho staff and has been conducting in – person meetings across the state. Magellan has three offices in Idaho with the main office in Boise covering regions 3 and 4, an office in Coeur d'Alene and an office in Pocatello. Primarily, Idaho staff are working remotely.

The IBHP represents a partnership with Idaho Health and Welfare's Division of Medicaid, Division of Behavioral Health (DBH) and the Idaho Department of Juvenile Corrections. This is an integrated contract with a full continuum of care regarding behavioral health. All behavioral health services through Medicaid will be managed through Magellan and Magellan aims to provide a health network which starts with local teams.

Brennan shared that Magellan is using several strategic outreach strategies. Division of Behavioral Health has implemented a Center of Excellence. That team is helping ensure all the resources are available. An Assertive Community Team (ACT) to help address Severe Persistent Mental Illness (SPMI) has also been formed.

Board members asked about the reasoning behind the decision to eliminate crisis centers' third-party payers and move to flat fee services. David explained that the State wanted to go that direction. Magellan took funds available and simply made it the monthly funding amount based on what DBH suggested. Commissioner Aberasturi noted that this change puts a financial strain on centers that see more clients. David is willing to look at the billing to see if returning to a third-party payer option is a change that can be made as the rate is developed.

FUNDING OPPORTUNITY

Charlene Cariou, SWDH Program Manager, presented a funding opportunity for a 1-year period of funding through IDHW of up to $620,000 to expend prior to April 2025. Charlene does not anticipate SWDH activities would require this much funding. The agreement includes some general approved categories that align with broader subgrant objectives. The title of the grant includes COVID language and the language is very COVID specific but activities can be anything immunization related and anything that builds the trust between SWDH and the community. If the title is a concern to Board members, Charlene can reach out to see about edits.

Commissioner Brooks stated he appreciates the opportunity being brought forward and the suggestion of editing the title but he does not support anything that involves COVID. Dr. Tribble agreed and has several concerns with the wording of the grant as it appears to be disingenuous. Commissioner Riebe commented that the activities Charlene suggested are things we are already doing and while it would be nice to have the additional funding, she sees a lot of opportunity for this to be communicated poorly. Commissioner Butticci agreed and indicated he would support the vaccines for other preventable diseases, but SWDH is already providing this service and he is not interested in revisiting anything related to COVID-19.

Commissioner Purdy supports Commissioner Brooks' comments. She wants this to go away and doesn't feel we need to message it anymore. Commissioner Haines also agrees with the rest of the board and feels that at this point, if a funding opportunity is titled COVID-19, it will not build trust with our

community. Chairman Aberasturi is in agreement as well that our region's citizens will not be supportive. Board members unanimously do not support moving forward with this funding opportunity without a change in the title.

Dr. Tribble suggested reviewing what funds are being used for COVID vaccination and if the public would support us continuing to do that. He also asked for information on the number of COVID vaccines the SWDH clinic has administered this calendar year.

Rick Stimpson will gather some information on the number of COVID vaccines clinic staff have administered this calendar year as well as which funding sources are being used.

MOTION: None.

PARENTAL CONSENT CHANGE IMPLEMENTATION
Don Lee, Chief Operating Officer, provided information on the recent implementation of changes to parental consent following the passing of Senate Bill 1329. New forms are posted to the website and have been shared with the other health districts. Staff are tracking how many minor patients are falling into this category but will be unable to measure how many minor patients don't seek service due to lack of parental consent.

IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH (IADBH) RESOLUTIONS/POLICY STATEMENT INPUT
Nikki discussed current resolutions IADBH has in place. As a reminder, once the resolutions are approved by the IADBH members at the business meeting each year, they are in place for three years. The current date shown on the resolutions represents when they were created or adopted. There is a statewide resolution on the books to oppose legalization of recreational marijuana. Nikki shared that she anticipates marketing of marijuana products in the State of Idaho may be brought to the legislative session next year. There is currently nothing prohibiting that.

She also suggested reviewing the resolution on supporting immunizations. This resolution was not originally drafted by SWDH but the data are old and knowing there have been conversations around data and efficacy of vaccines we may want to propose an update to that resolution.

Commissioner Brooks asked about the food establishment license fee and stated it would be nice to have a resolution supporting the state legislature increasing the food inspection fee. Nikki explained there are currently two different resolutions around that topic. Nikki reminded board members that SWDH staff took the lead working with the other districts to come up with a methodology to propose to industry and it was difficult to get buy in from the other districts. The amount of staff time being spent on this project was not worth it given the lack of response from other districts. This effort to change the food establishment license fee has been paused.

Commissioner Riebe asked if the word addiction can be added to resolution 17-02 or if we can suggest a revision. Dr. Tribble asked for clarification about the purpose of the resolutions. He also noted that the Board may not want to endorse some of the aggressive taxism. For example, medically we may not endorse tobacco or nicotine delivery systems, but we are also not a proponent of taxing them.

Nikki explained that when staff revise a resolution or create a new resolution for consideration at the annual meeting, our Board must first approve it. Then the resolution must be reviewed by the other district peers and boards. This process needs to be completed before the annual IADBH meeting in October. Board members are agreeable with adding language to indicate opposition to marketing of

marijuana and updating the immunization data. Nikki will bring draft resolution changes back to Board members for review next month.

DIRECTOR'S REPORT
Last month Board members asked for more information regarding measles trends and vaccines. Our staff are working on that and will need more time.

Last Social Security Participation Vote Learning Session
The last Social Security Administration 218 Referendum vote informational session is scheduled for July 30. Based on some feedback, Don reached out to Nationwide and a personal retirement consultant will be on-site for one-on-one appointments with staff. Commissioner Riebe asked if the consultant can present information at the last informational session. Don will reach out to ask his availability to talk about options employees have for investing this money.

Fiscal Year Change Evaluation completed for Idaho Association of District Boards of Health
Executive Council members of the Idaho Association of District Boards of Health had asked for an evaluation of what it would look like to change fiscal year cycles from state to federal. The cost to switch fiscal years in the Luma system would be over $3 million plus ongoing costs.

H5N1 Avian Influenza Follow Up
As requested at last month's Board meeting, Nikki provided follow-up information regarding H5N1 avian influenza testing. The test for H5N1 in humans used at the state public health lab is the Real -Time RT-PCR. The full title is the CDC Human Influenza Real-Time RT-PCR Flu Diagnostic Panel. If a sample tests positive for Flu A, the lab will then use the CDC Influenza A Subtyping kit. When a sample tests positive for Flu A(H5) virus by rRT-PCR at the state public health lab, the specimen is submitted to CDC for additional testing.

There being no further business, the meeting adjourned at 12:14 p.m.

Respectfully submitted: Approved as written:

Nikole Zogg
Secretary to the Board

Kelly Aberasturi
Chairman

Date: August 27, 2024

SPECIAL BOARD OF HEALTH MEETING MINUTES
Thursday, August 15, 2024

BOARD MEMBERS:
Jennifer Riebe, Commissioner, Payette County – present via Microsoft Teams
Lyndon Haines, Commissioner, Washington County – present via Microsoft Teams
Zach Brooks, Commissioner, Canyon County – present via Microsoft Teams
Kelly Aberasturi, Commissioner, Owyhee County – present
Viki Purdy, Commissioner, Adams County – present via Microsoft Teams
John Tribble, MD, Physician Representative – not present
Bill Butticci, Commissioner, Gem County – present via Microsoft Teams

STAFF MEMBERS:
In person: Nikki Zogg, Katrina Williams, Don Lee, Ligia Powell

Virtual attendees: Jeff Renn

GUESTS: Mark Knudson via Microsoft Teams

CALL THE MEETING TO ORDER
Chairman Kelly Aberasturi called the meeting to order at 9:02 a.m.

PLEDGE OF ALLEGIANCE
Meeting attendees participated in the pledge of allegiance.

ROLL CALL
Chairman Aberasturi – present; Dr. John Tribble – not present; Commissioner Purdy – present via Microsoft Teams; Vice Chairman Haines – present via Microsoft Teams; Commissioner Brooks – present via Microsoft Teams; Commissioner Riebe – present via Microsoft Teams; Commissioner Butticci – present via Microsoft Teams.

IN-PERSON PUBLIC COMMENT
No public comment given. No members of the public present.

LUMA IMPLEMENTATION OF 401(a)
Don Lee, Chief Operating Officer, and Nikki Zogg, District Director, asked Board members to approve funding of a 401(a) capability in Luma. Currently, Luma does not have a mechanism for 401(a) contributions and this will need to be built out. As part of the Memorandum of Understanding established following House Bill 316 between Southwest District Health (SWDH) and the State Controller's Office (SCO), SWDH must pay for development of requested modifications. The estimated cost of developing the 401(a) capability is $20,000 to $30,000 with an estimated timeframe for activation of approximately 12 weeks.

MOTION: Commissioner Riebe made a motion that in the event of a no vote we dedicate funds to build out Luma. Commissioner Butticci seconded the motion. All in favor. None opposed.

401(a) EMPLOYEE CONTRIBUTION

Board members discussed options should the majority of SWDH staff vote no on the Social Security Administration (SSA) 218 Referendum vote, which would mean no longer contributing to SSA. Board members also discussed the 401(a) requirement that all employees contribute the same amount. While employees can each manage their individual accounts at the risk they are comfortable with, such as aggressive or moderate, the percentage staff contribute will be the same across the board.
Don and Nikki presented results from a staff survey sent out to gauge staff preference for how the 12.4% is handled if the overall SSA 218 vote is no, which means no longer contributing to SSA. Board members asked why the survey had a low response rate as results indicate the percentage of staff that completed the survey questions ranged between 41% and 46%. Board members asked Don and Nikki to allow staff to have further additional time to provide their input by completing the survey.

Board members appreciated the employees' survey input and agree that aligning their decision with staff preference is best. If the expanded response time allowed for the survey creates a shift in the employee preference data, Board members will consider revising their decision at a later date.

MOTION: Commissioner Butticci made a motion that in the event of a no vote, SWDH proceed with submitting 6.2% for the employer portion and 6.2% for the employee portion into a 401(a) account. Commissioner Riebe seconded the motion. All in favor.

There being no further business, the meeting adjourned at 12:16 p.m.

Respectfully submitted:	Approved as written:	
Nikole Zogg Secretary to the Board	Kelly Aberasturi Chairman	Date: August 27, 2024

SOUTHWEST DISTRICT HEALTH

REVENUES & EXPENDITURE REPORT FOR FY2025

Cash Basis

Jul-24

Target **8.3%**

Fund Balances	FY Beginning	Ending
General Operating Fund	$ 636,900	$ 495,646
Millennium Fund	$ -	$ -
LGIP Operating	$ 6,938,818	$ 6,974,105
LGIP Vehicle Replacement	$ 108,497	$ 108,962
LGIP Capital	$ 1,299,174	$ 1,299,174
Total	**$ 8,983,390**	**$ 8,877,887**

** held in fund 29000*

Income Statement Information	YTD	Month
Net Revenue:	**$ 1,427,231**	**$ 1,427,231**
Expenditures:	$ (796,641)	$ (796,640)
Net Income:	**$ 630,590**	**$ 630,590**

Revenue

	Office of the Director	Clinic Services	Env & Community Health	District Operations	Total	YTD	Total Budget	Percent Budget to Actual
County Contributions	$ 280,170	$ -	$ -	$ -	$ 280,170	$ 280,170	$ 3,122,831	9%
Fees	$ -	$ 35,764	$ 72,009	$ -	$ 107,773	$ 107,773	$ 1,704,841	6%
Contract Revenue	$ -	$ 331,795	$ 542,625	$ 163,949	$ 1,038,369	$ 1,038,369	$ 5,909,579	18%
Sale of Assets	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0%
Interest	$ -	$ -	$ -	$ -	$ -	$ -	$ 337,850	0%
Other	$ 918	$ -	$ -	$ -	$ 918	$ 918	$ 713,920	0%
Monthly Revenue	**$ 281,088**	**$ 367,559**	**$ 614,634**	**$ 163,949**	**$ 1,427,231**	$ 1,427,231	$ 11,789,021	12%
Year-to-Date Revenue	**$ 281,088**	**$ 367,559**	**$ 614,634**	**$ 163,949**	**$ 1,427,231**	DIRECT BUDGET		

Expenditures

	Office of the Director	Clinic Services	Env & Community Health	District Operations	Total	YTD	Total Budget **Shift personnel savings down**	Percent Budget to Actual
Personnel	$ 34,991	$ 254,391	$ 224,635	$ 118,261	$ 632,278	$ 632,278	$ 9,227,555	7%
Operating	$ 9,290	$ 102,336	$ 33,006	$ 18,014	$ 162,646	$ 162,646	$ 2,342,716	7%
Capital Outlay	$ -	$ -	$ -	$ -	$ -	$ -	$ 80,000	0%
Trustee & Benefits	$ -	$ -	$ 1,716	$ -	$ 1,716	$ 1,716	$ 138,750	1%
Monthly Expenditures	**$ 44,281**	**$ 356,727**	**$ 259,358**	**$ 136,274**	**$ 796,640**	$ 796,641	$ 11,789,021	7%
Year-to-Date Expenditures	**$ 44,281**	**$ 356,727**	**$ 259,358**	**$ 136,274**	**$ 796,640**	DIRECT BUDGET		

SOUTHWEST DISTRICT HEALTH - ADULT CRISIS CENTER ACTIVITY

Jul-24

REVENUES & EXPENDITURE REPORT FOR FY2024

Cash Basis

Target **8.3%**

Income Statement Information		YTD		Month
Net Revenue:	**$**	**237,546**	**$**	**237,546**
Expenditures:	$	(85,085)	$	(85,084)
Net Income:	**$**	**152,461**	**$**	**152,461**

Adult Crisis Activity - Fund 29001

Revenue

	Crisis Center	YTD	Total Budget	Percent Budget to Actual
Contract Revenue	$ 237,546	$ 237,546	$ 1,020,000	23%
Monthly Revenue	$ 237,546	$ 237,546	$ 1,020,000	23%
		DIRECT BUDGET		

Expenditures

	Crisis Center	YTD	Total Budget	Percent Budget to Actual
Personnel	$ 1,673	$ 1,673	$ 18,870	9%
Operating	$ 83,411	$ 83,411	$ 77,495	108%
Capital Outlay	$ -	$ -	$ -	0%
Trustee & Benefits	$ -	$ -	$ 923,635	0%
Monthly Expenditures	$ 85,084	$ 85,085	$ 1,020,000	8%
		DIRECT BUDGET		

SOUTHWEST DISTRICT HEALTH - YOUTH CRISIS CENTER ACTIVITY

Jul-24

REVENUES & EXPENDITURE REPORT FOR FY2024

Cash Basis

Target 8.3%

Income Statement Information	YTD	Month
Restricted Funds:	$ 2,635,187	$ -
Net Revenues:	$ -	$ -
Expenditures:	$ (105,516)	$ (105,515)
Net Income:	**$ 2,529,671**	**$ (105,515)**

Youth Crisis Activity - Fund 29002

Revenue

	Crisis Center	YTD	Total Budget	Percent Budget to Actual
Carry Over Restricted	$ -	$ 2,635,187	$ 2,635,187	100%
Other (Donations & Grants)	$ -	$ -	$ -	0%
Contract Revenue	$ -	$ -	$ 348,165	0%
Monthly Revenue	$ -	$ 2,635,187	$ 2,983,352	88%
		DIRECT BUDGET		

Expenditures

	Crisis Center	YTD	Total Budget	Percent Budget to Actual
Personnel	$ 17,533	$ 17,533	$ 319,100	5%
Operating	$ 87,983	$ 87,983	$ 778,379	11%
Capital Outlay	$ -	$ -	$ -	0%
Trustee & Benefits	$ -	$ -	$ 1,885,873	0%
Monthly Expenditures	$ 105,515	$ 105,516	$ 2,983,352	4%
		DIRECT BUDGET		

Idaho Department of Education

Idaho Youth Suicide Prevention Program

Program Overview

IDAHO YOUTH SUICIDE PREVENTION PROGRAM

Regional Support

Youth Suicide Prevention Contractors

- Districts 1 and 2
- Districts 3 and 4
- District 5
- Districts 6 and 7

Gatekeeper Trainings

216 school personnel from PHD3 trained in Suicide Prevention Fundamentals Instruction (SPFI)

639 adults statewide trained in Question, Persuade, Refer (QPR)

SCAN ME

Supplemental Enrichment Trainings

Suicide Intervention Protocols

Sudden Death Postvention Protocols

Non-Suicidal Self-Injury Intervention

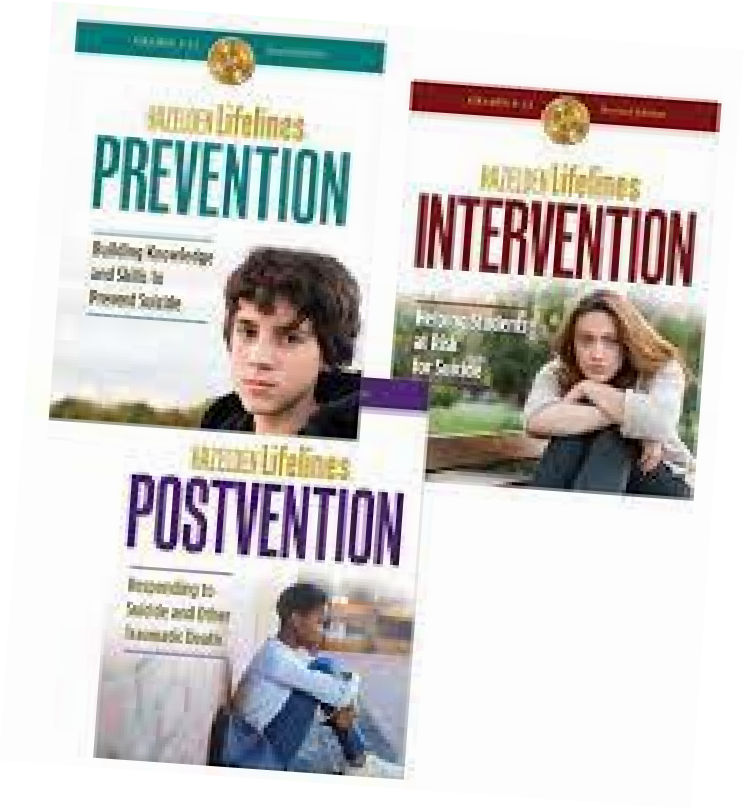
Special Populations

Lifelines Trilogy

Procedures and policies for postvention and intervention in schools

Classroom-based curriculum for grades 5-12

Supplemental PE Teachers and Coaches training



PREPaRE Crisis Response

Prevent and prepare for crises

Reaffirm physical health & welfare, and perceptions of safety & security

Evaluate psychological trauma risk

Provide interventions

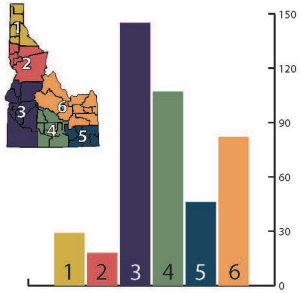
and

Respond to mental health needs

Examine the effectiveness of crisis preparedness

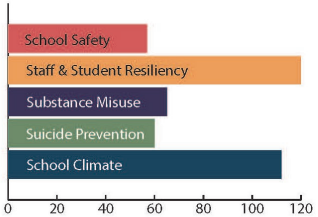
Idaho Prevention & Support Conference

Informational Sessions - 40
Presenters and Speakers - 45
Pre-Conference Participants - 171
Trivia Night Participants - 60
Main Conference Participants - 440
Idaho Cities Represented - 85
Out of State Participants - 8

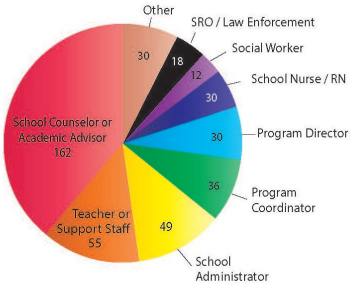


Participants by Region

4.2★
average rating



Participants by Track



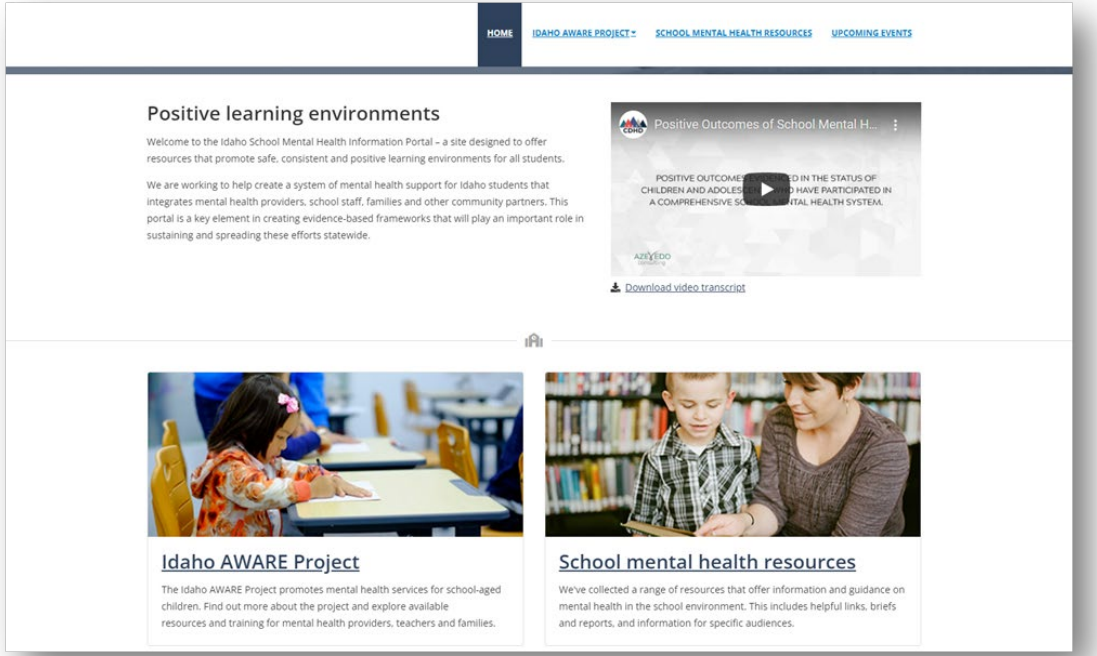
Participants by Role

Clinician Training

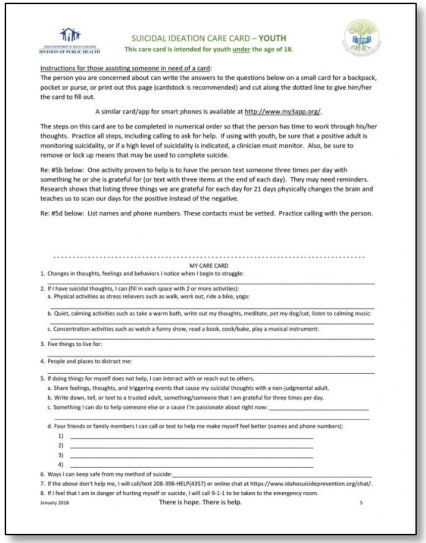
Assessing and Treating Suicide Risk with Dr. David Rudd

May 21 and 22 in Meridian

idahoschoolmentalhealth.org



Prevention Materials



SUICIDAL IDEATION CARE CARD – **YOUTH**

This care card is intended for youth under the age of 18.

Instructions for those assisting someone in need of a card:

The person you are concerned about can write the answers to the questions below on a small card for a backpack, pocket or purse, or print out this page (cardstock is recommended) and cut along the dotted line to give him/her the card to fill out.

A similar card/app for smart phones is available at http://www.my3app.org/.

The steps on this card are to be completed in numerical order so that the person has time to work through his/her thoughts. Practice all steps, including calling to ask for help. If using with youth, be sure that a positive adult is monitoring suicidality, or if a high level of suicidality is indicated, a clinician must monitor. Also, be sure to remove or lock up means that may be used to complete suicide.

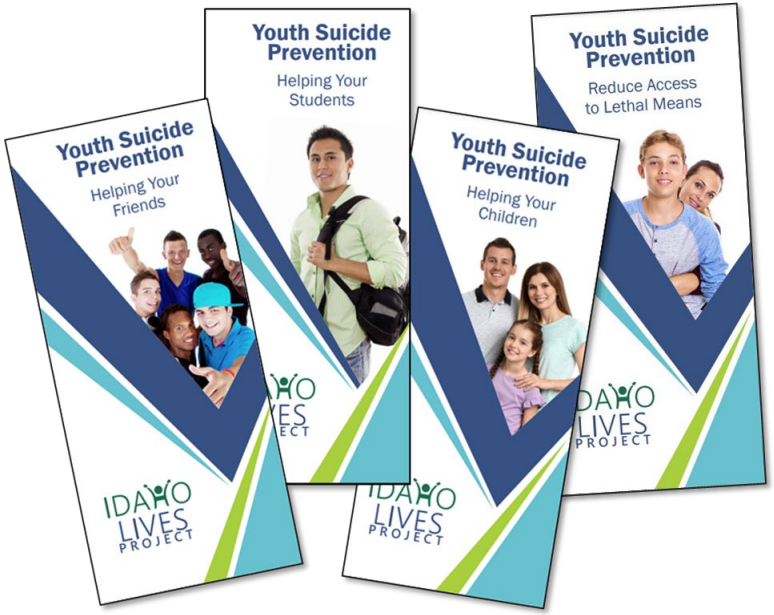
Re: #5b below: One activity proven to help is to have the person text someone three times per day with something he or she is grateful for (or text with three items at the end of each day). They may need reminders. Research shows that listing three things we are grateful for each day for 21 days physically changes the brain and teaches us to scan our days for the positive instead of the negative.

Re: #5d below: List names and phone numbers. These contacts must be vetted. Practice calling with the person.

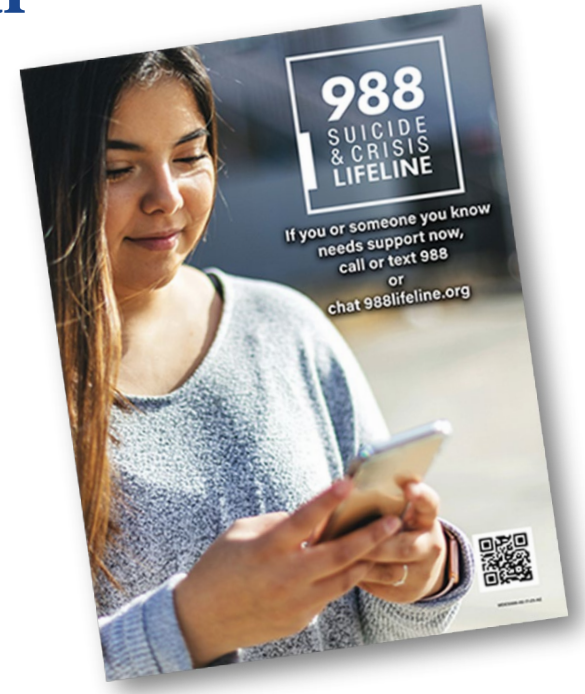
MY CARE CARD

1. Changes in thoughts, feelings and behaviors I notice when I begin to struggle: _____
2. If I have suicidal thoughts, I can (fill in each space with 2 or more activities):
   a. Physical activities as stress relievers such as walk, work out, ride a bike, yoga: _____
   b. Quiet, calming activities such as take a warm bath, write out my thoughts, meditate, pet my dog/cat, listen to calming music: _____
   c. Concentration activities such as watch a funny show, read a book, cook/bake, play a musical instrument: _____
3. Five things to live for: _____
4. People and places to distract me: _____
5. If doing things for myself does not help, I can interact with or reach out to others.
   a. Share feelings, thoughts, and triggering events that cause my suicidal thoughts with a non-judgmental adult.
   b. Write down, tell, or text to a trusted adult, something/someone that I am grateful for three times per day.
   c. Something I can do to help someone else or a cause I'm passionate about right now: _____
   d. Four friends or family members I can call or text to help me make myself feel better (names and phone numbers):
      1) _____
      2) _____
      3) _____
      4) _____
6. Ways I can keep safe from my method of suicide: _____
7. If the above don't help me, I will call/text 208-398-HELP(4357) or online chat at https://www.idahosuicideprevention.org/chat/.
8. If I feel that I am in danger of hurting myself or suicide, I will call 9-1-1 to be taken to the emergency room.

January 2018 There is hope. There is help. 5



988 Promotional Materials



Regional Case Managers

Provide suicide assessments for youth in cases where the family has no other resources.

Act as an advocate for students who have made a suicide attempt or have been out of school due to serious suicide ideation.

Referral Line at (208) 947-5155
Monday – Friday from 9 am to 5 pm MT

Student and Family Assistance Program (SFAP)

- Connect you (or your family) with a licensed, professional counselor who will consult with you
- Connect you (or your family) with community resources that can address your situation
- Assist with an insurance or community-based referral if your situation requires further treatment or additional resources.

Referral Line at (208) 935-3816

Sources of Strength

Thank You!

Hannah Crumrine

Youth Suicide Prevention Coordinator

Idaho Department of Education

(208) 332-6816

hcrumrine@sde.idaho.gov

sde.idaho.gov/iyspp

Idaho Department of Education

Immigration Medical Exams – SW Idaho Comparison

Clinic Name	Price	Service Location
Valley Family Health Care	$400 Exam only. Excludes labs, imaging, and vaccines.	Emmett
Full Circle Health	$400 Exam only. Excludes labs, imaging, and vaccines	Boise
Proposed Southwest District Health	$550 Exam only. Excludes labs, imaging, and vaccines.	Caldwell
Clinica Santa Maria, Inc.	$879 Exam only. Excludes labs, imaging, and vaccines.	Caldwell
Two Rivers Medical Clinic	$520 Visit. Includes exam and labs. Excludes imaging and vaccines.	Weiser
Idaho Health Neighborhood Center	$1,200 Visit. Includes exam, labs, imaging, and transportation to imagining. $1,500 Visit + Vaccines. Includes above plus vaccines.	Nampa
Saint Alphonsus International Clinic	N/A - Immunization Review only. Not offering exams currently.	Boise

Measles Response Plan Update

Follow-up from June Board of Health Meeting

August 27, 2024

Purpose and Intent

The purpose of this presentation is to follow up on requests for additional information from members of the board at June's Board of Health meeting.

Overview

- History of Measles in the U.S.
- Mortality of Measles
- Long Term Disability of Measles
- Overseas Data of Measles
- Measles Vaccine
  - Idaho Vaccination Rates
  - Efficacy and Safety of Measles Vaccine
- Origin of Public Health Recommendations

History of Measles in the U.S.

- In the decade before the vaccine (1963) nearly all children had measles by 15 years old
- Prior to the vaccine, each year in the U.S. it was estimated that
  - 3 to 4 million people were infected
  - 400 to 500 died
  - 48,000 were hospitalized
  - 1,000 experienced encephalitis (brain swelling)

CDC May 9, 2024

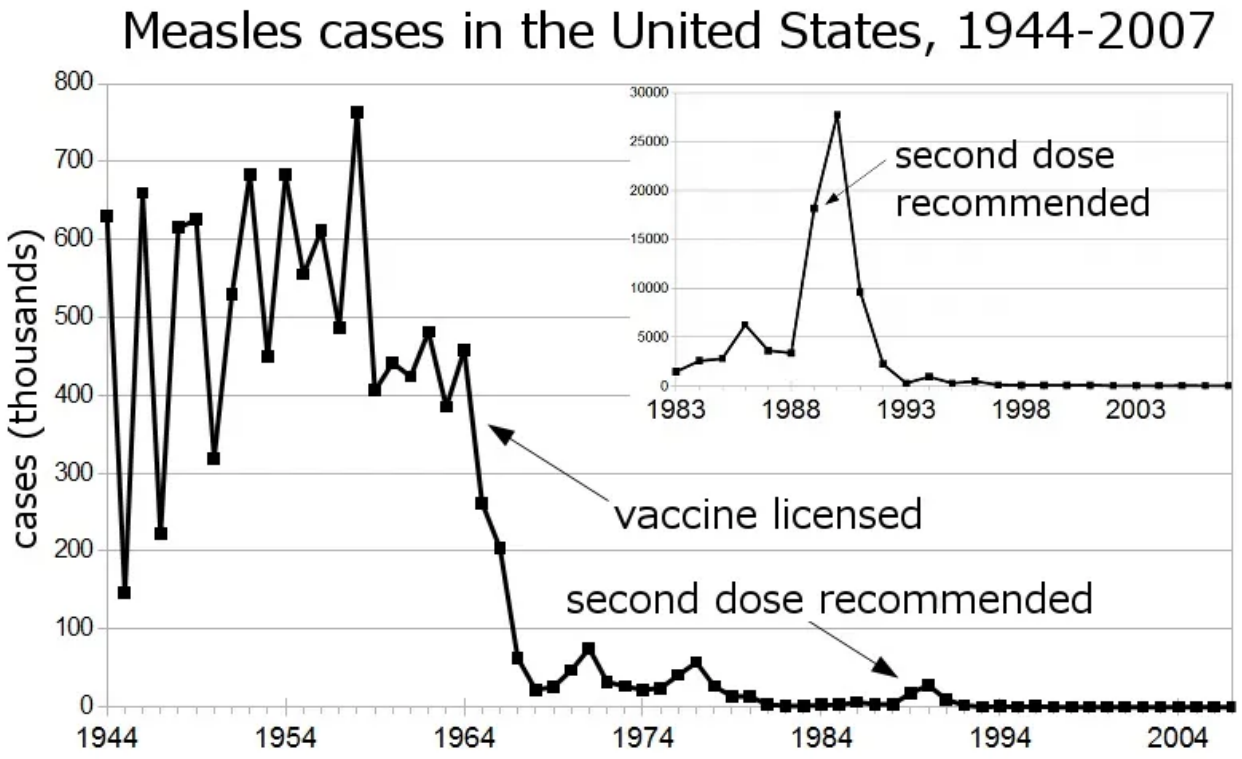
History of Measles in the U.S.

First measles vaccine developed
1963

Second dose recommended
1989

1968
Improved vaccine released*

2000
U.S. achieved measles elimination status**



* Current vaccine in use

**Measles is still commonly transmitted in other countries in Europe, the Middle East, Asia, the Americas, and Africa

CDC: Morbidity and Mortality Weekly Report 1993 **42**(No. 53) and Morbidity and Mortality Weekly Report 2007; **56**(No. 53)

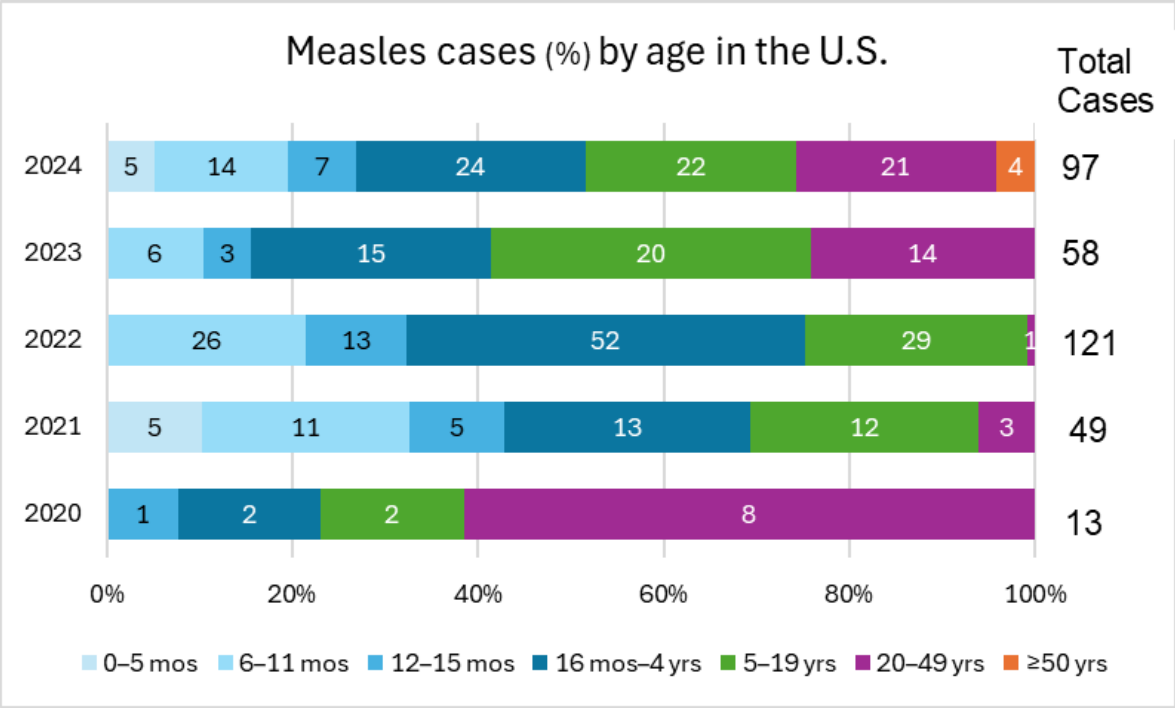
Current State of Measles in the U.S.

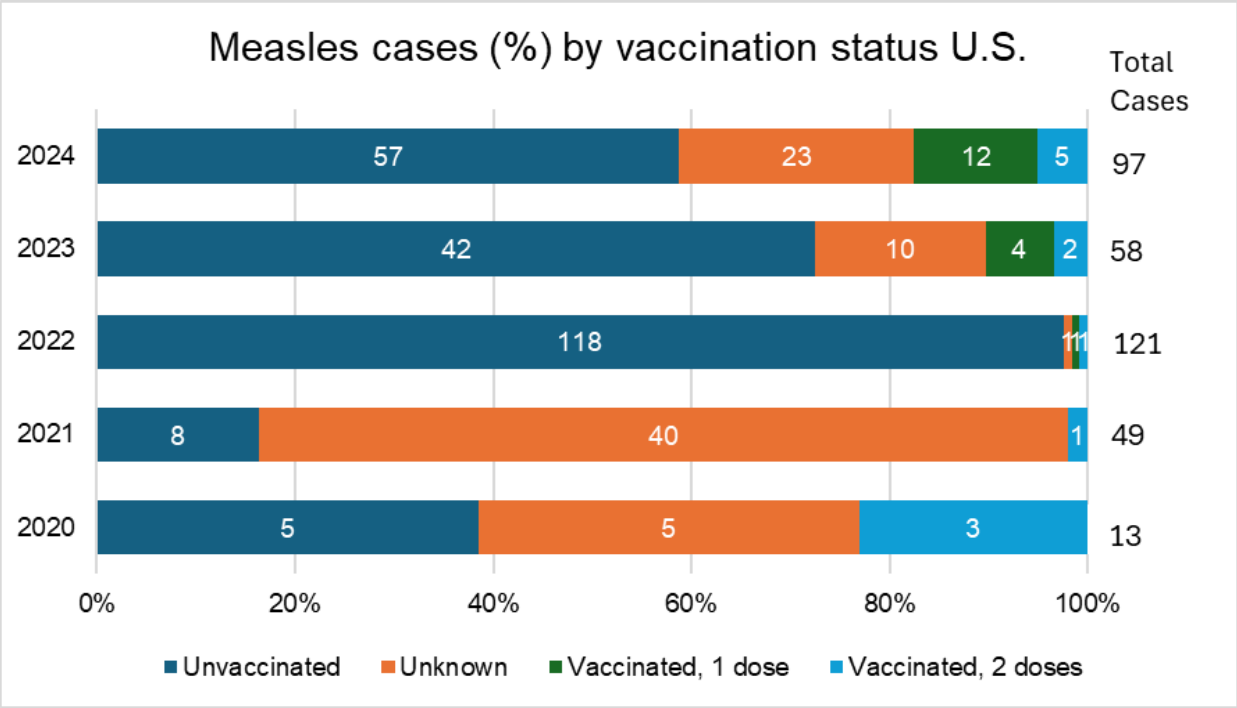
- 219 cases in the U.S. since the start of 2024
- Measles was declared eliminated from the U.S. in 2000
  - The disease was no longer spreading within the country and new cases were only found when someone returned from abroad with measles
  - This is why two or more laboratory confirmed cases is considered an outbreak

Elimination of Measles in the U.S. - Measles outbreak 2024, why measles is back in the US (AMA)

CDC August 16, 2024

Measles Morbidity by Age in U.S.





Total number of cases reported in each category.

Mathis et. al., 2024

Risk Groups for Measles Complications

- Infants and children aged <5 years
- Adults aged >20 years
- Pregnant people
- People with weakened immune systems
  - For example, those with leukemia and HIV infection

Measles Complications Can Contribute to Disability

Prior to vaccine introduction (1963), each year[1]:

- 48,000 hospitalizations
  - Currently, 1 in 5 unvaccinated people with measles are hospitalized in the U.S.
- 1,000 people developed chronic disability from acute encephalitis
- Subacute sclerosing panencephalitis (SSPE)
  - Behavioral and intellectual deterioration
  - Seizures 7 to 10 years after infection
  - 7 to 11 out of every 100,000

CDC May 9, 2024

Measles Complications Can Contribute to Disability

Other Complications:

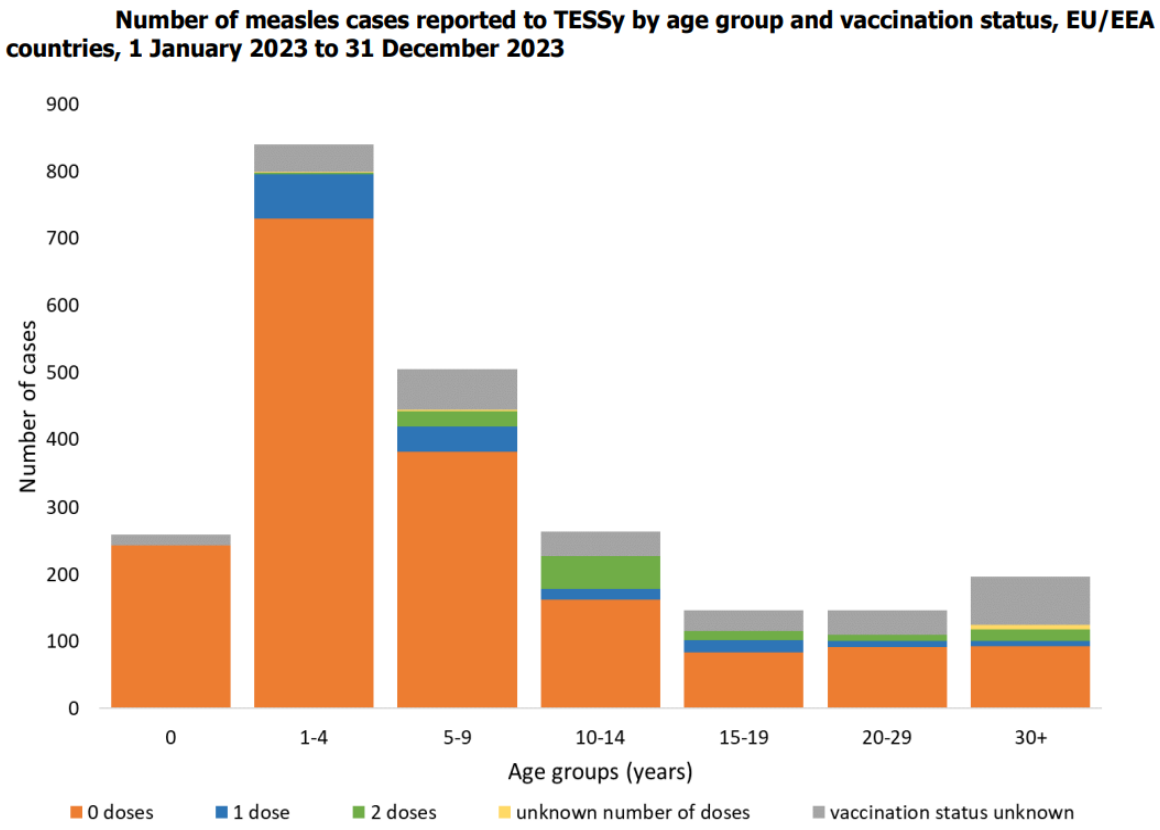
- Diarrhea (1 in 10 children)
- Ear Infection (1 in 10 children) → Hearing loss
- Pneumonia (1 in 20 children)
- Encephalitis (1 in 1000 children) → intellectual deterioration, hearing and vision loss
- Pregnancy complications (3 in 5 pregnancies)
  - Premature birth
  - Low birth weight
  - Miscarriage
  - Maternal death

CDC January 2021

Overseas Data on Measles

According to WHO:

- In 2023:
  - 74% of children received both doses of the measles vaccine
  - 83% of the world's children received one dose of measles vaccine by their first birthday
  - ~22 million infants missed at least one dose of measles vaccine
- In 2022:
  - ~136,000 measles deaths globally
    - Primarily in unvaccinated or under-vaccinated children under the age of 5 years.



European Centre for Disease Prevention and Control, 2024

Vaccine Rates in Idaho – Local Level

- No usable data are available for local level vaccine rates
  - No way of determining whether they are still a resident of the six counties served by SWDH
  - Boosters
  - Counting who is vaccinated (those who need boosters)
  - Some vaccine history is not available (those who served military may not have records in IRIS or those who moved here)

- The age of the IRIS registry and the resources needed to clean the data are barriers to understanding the current and accurate vaccination coverage in the district

Efficacy and Safety of MMR Vaccine - RCT

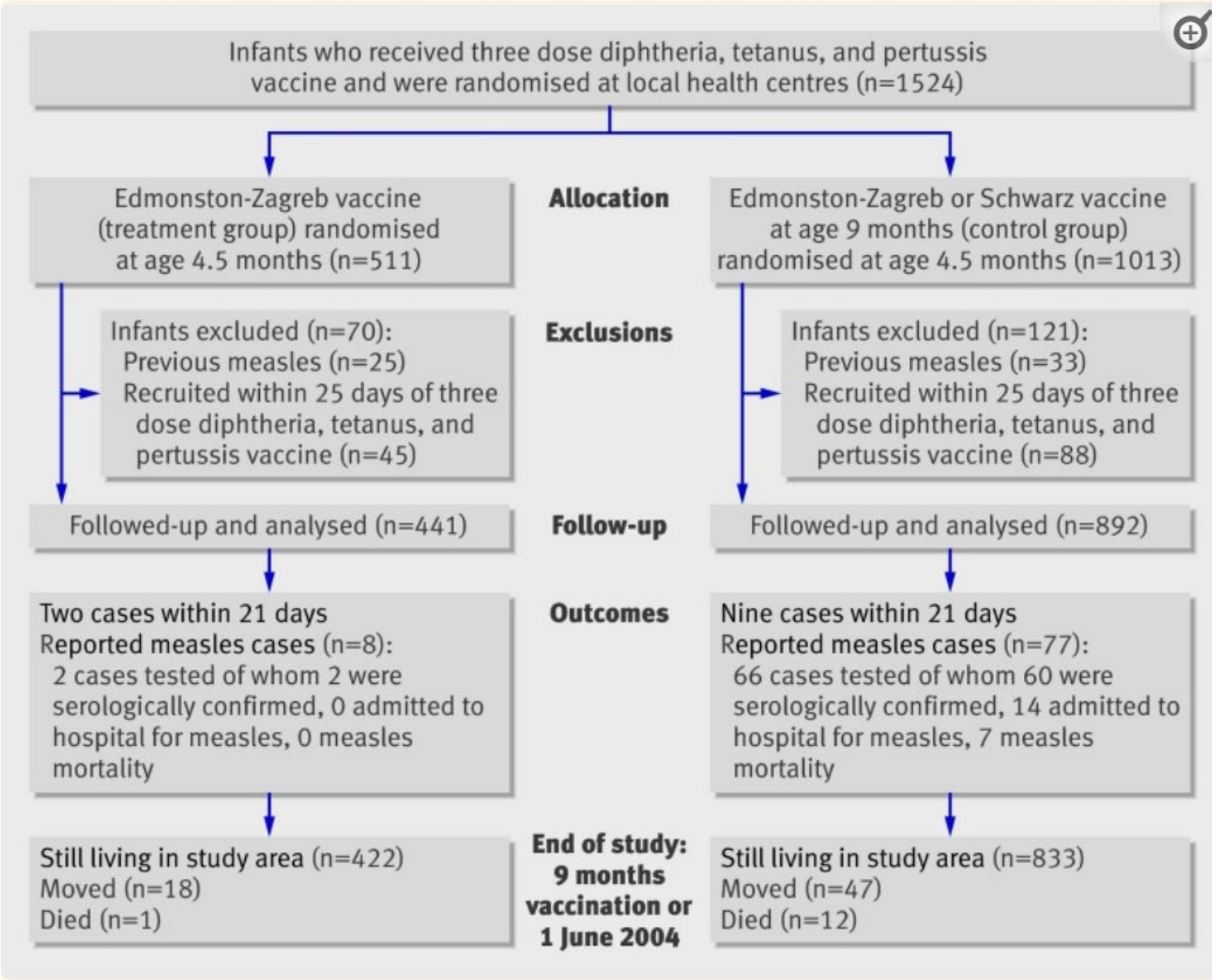
Randomized control trial (RCT)

- 2008 - Urban area in Guinea-Bissau
- 1333 infants aged 4.5 months: 441 in treatment group and 892 in control group
- During the start of the trial a measles outbreak occurred
- During the outbreak, 96 children in the trial developed measles
- 19% of unvaccinated children had measles before 9 months of age
  - The monthly incidence of measles among the 441 children enrolled in the treatment arm was 0.7%
  - 892 enrolled in the control arm was 3.1%

Conclusion: Outbreaks of measles may be curtailed by measles vaccination using the Edmonston-Zagreb vaccine as early as 4.5 months of age

Martins et.al., 2008

RCT (cont.)



Martins et.al., 2008

Efficacy and Safety of MMR Vaccine

- MMR vaccine has been around a long time
- Extensive Systematic Review of safety and effectiveness of the measles vaccine in 2021
  - Di Pietrantonj C, Rivetti A, Marchione P, Debalini MG, Demicheli V. *Vaccines for measles, mumps, rubella, and varicella in children*. *Cochrane Database of Systematic Reviews 2021, Issue 11*. Art. No.: CD004407. DOI: 10.1002/14651858.CD004407.pub5. Accessed 23 July 2024.

Efficacy and Safety of MMR Vaccine – Systematic Review

- Evidence supporting an association between aseptic meningitis and MMR vaccines containing Urabe and Leningrad-Zagreb mumps strains (rr 1.30, 95% CI 0.66 to 2.56; low certainty evidence)
  - No evidence supporting this association for MMR vaccines containing Jeryl Lynn mumps strains (Strain primarily used in U.S.)
- Evidence supporting an association between MMR/MMR+V/MMRV vaccines (Jeryl Lynn strain) and febrile seizures
  - Febrile seizures vaccine-induced is estimated to be from 1 per 1700 to 1 per 1150 administered doses
  - Febrile seizures normally occur in 2 to 5 out of 100 healthy children at least once before the age of 5
- There is no evidence of an association between MMR immunization and encephalitis or encephalopathy, autistic spectrum disorders, cognitive delay, type 1 diabetes, asthma, dermatitis/eczema, hay fever, leukemia, multiple sclerosis, gait disturbance, and bacterial or viral infections.

Di Pietrantonj et. al., 2021

Measles Vaccine

- Measles, Mumps, Rubella (MMR) or MMRV (V is for Varicella)
- One dose of MMR is **93%** effective against measles
- Two doses of MMR are **97%** effective against measles

CDC, January 2021

Side Effects and Complications of Measles Vaccine

- Soreness, redness, or swelling where the shot was given
- Fever
- Mild rash
- Temporary pain and stiffness in the joints
- Serious complications include high fevers that could cause seizures or hives, but are extremely rare

FDA, Merck Sharp & Dohme LLC, Patient Product Insert - BL 101069

Public Health Measures to Prevent the Spread of Measles

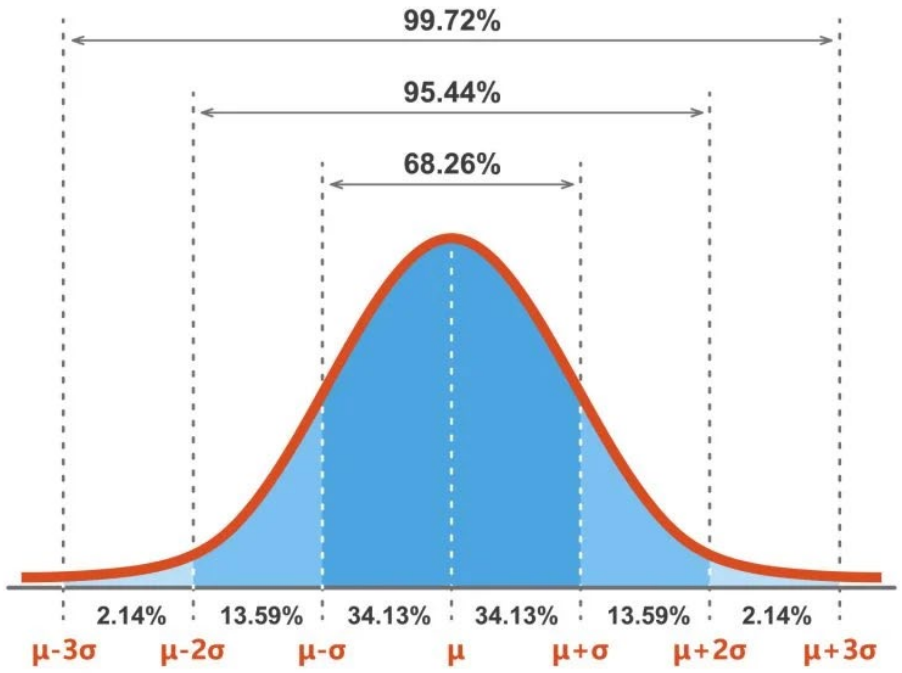
- Prevention through education
- When measles is present in the population
  - Voluntary compliance
    - Measles is a reportable and restrictable disease in daycare, healthcare, and school settings (IDAPA 16.02.10.460 & 16.02.10.050)
    - While contagious, persons will measles are required to be isolated from the above settings and in occupations where there is direct contact with children to prevent further spread
    - Susceptible children must be excluded until adequate immunization is obtained or the threat of further spread of the disease is contained (Sections 33-512(7) and 39-1118 Idaho Code)
  - When there is non-compliance
    - Legal orders can be used to protect the public's health when it is a practical option

Public Health Measures to Prevent the Spread of Measles

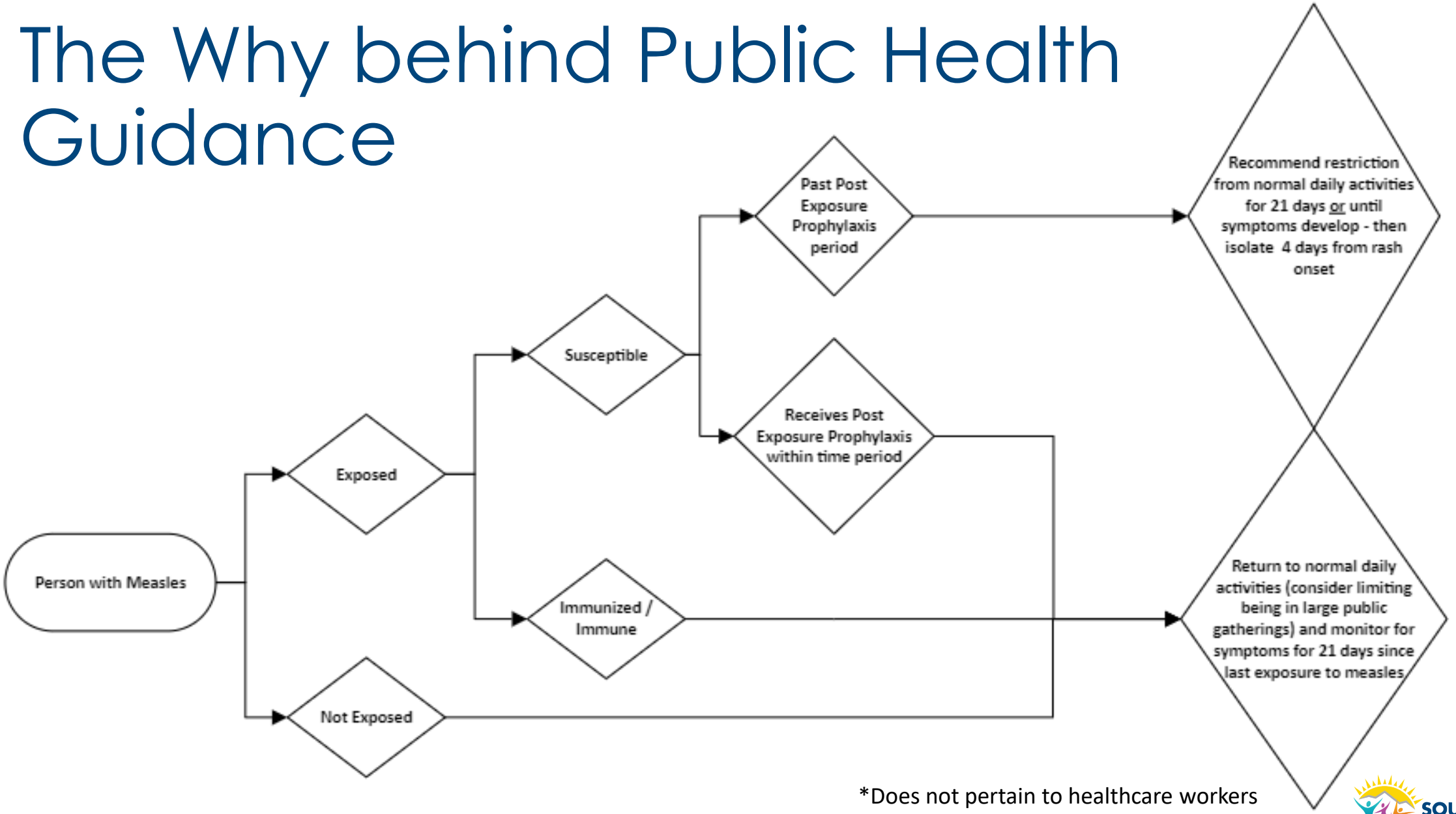
- Quarantine
  - Used in cases where healthy individuals are asked to separate or limit their exposure to others after being exposed to an infectious disease to see if they become ill
    - Goal is to limit the number of people exposed during a person's infectious period, which can happen before a person starts showing signs of being ill
  - e.g., There is a stomach bug going on at our house. I am not sick, but I'm going stay home in case I start to get sick while visiting you.
- Isolation
  - Used in cases where sick individuals are asked to separate from others who are healthy
    - Goal is to limit the number of people exposed and to stop the spread of disease during a person's most infectious period
  - e.g., I am sick, and I don't want to get anyone else sick, so I am going to stay home.

The Why Behind a 21-Day Quarantine

- Symptoms can take up to 21 days to develop
  - Observing the clinical manifestation of measles (Misin et.al.,2020 & Startwell, 1966)
- Ensures persons who were exposed to measles won't be in a public space and spreading it to other people who may be susceptible
- The average incubation period before onset of rash is 14 days
  - With a range of 7-21 days
- A systematic review by Strebel et.al., 2013 estimated the median incubation period to be 12.5 days (95% confidence interval [CI], 11.8-13.2)



The Why behind Public Health Guidance



*Does not pertain to healthcare workers

COVID Vaccine: Nov 2023 to Aug 2024

- Purchased 120 doses for $12,000.00
  - Unused doses are part of an exchange program
- Received 80 doses from State of Idaho
- Administered 115 doses

COVID-19 Vaccine

Anna Briggs, Ph.D.
20 August 2024

Problem Statement

The SARS-CoV-2 virus causes COVID-19 disease and started an officially declared global pandemic in March 2020[1]. While COVID-19 is no longer considered a Public Health Emergency by the World Health Organization and the U.S. federal government, it still poses a health threat with seasons of increased spread[1–3]. One tool to mitigate the risks and complications of COVID-19 disease is the COVID-19 vaccine, however many members of the public question the safety, effectiveness, and complications of the vaccine. This review aims to highlight current scientific literature on the effectiveness, and complications and safety associated with the COVID-19 vaccine.

Summary of Literature

Vaccine Effectiveness

The primary goal of the COVID-19 vaccine is to prevent severe disease and death[4]. Other goals include reducing critical illness, hospitalization, COVID-19 associated medical visits, and symptomatic COVID-19[4]. One study on the Pfizer-BioNTech mRNA vaccine reported the effectiveness on adolescents aged 12-18 (n = 464)[5]. The study reported that 97% of adolescents hospitalized for COVID-19 were unvaccinated, and of the 3% that were vaccinated and hospitalized, none were admitted to the ICU[5]. Studies in the U.S. and the U.K. have shown that COVID-19 vaccines are effective in preventing disease in the first few months following the second vaccination, but that over time the effectiveness is reduced ($n_{\text{COVID-19 encounters}}$ = 128,825, $n_{\text{COVID-19 hospitalizations}}$ = 37,503)[6] (n = 3,436,957)[7]. Additionally, COVID-19 vaccines protect against severe disease and hospitalization for longer, and booster vaccines restore effectiveness[6–8] (n = 620,793)[8]. Unvaccinated individuals are also more likely to experience long COVID-19 (n = 481)[9].

Vaccine Complications and Safety

Deaths and adverse reactions to the COVID-19 vaccine have been reported on the Vaccine Adverse Event Reporting System (VAERS), and studies have been completed comparing reports. Data show that anaphylaxis, a severe allergic reaction, occurs in an estimated five cases per one million administered COVID-19 vaccines[10], but ranges vary based on study time range and the specific vaccine administered[11,12]. One group reported fewer anaphylactic reactions with the COVID-19 vaccine in the U.S. compared to Europe[13] and similar number of anaphylactic reactions with COVID-19 vaccines compared to other vaccines[14]. After mRNA COVID-19 vaccination, rare occurrences of myocarditis and pericarditis, inflammation of the heart and heart lining, were observed in

12 to 39 year olds, with a majority being male[15–18]. Full recovery has been observed in many individuals[19]. Guillain-Barre Syndrome, muscle weakness and paralysis due to nerve cell damage by the body's immune system, was associated with the J&J/Janssen COVID-19 vaccination, but not Pfizer-BioNTech or Moderna vaccination[10]. Thrombosis with Thrombocytopenia Syndrome, blood clotting with low platelet counts, associated with the J&J/Janssen COVID-19 vaccine is reported to occur in approximately four cases per one million doses administered[20–22]. The J&J/Janssen COVID-19 vaccination is no longer available in the United States. One study found no difference between deaths due to causes other than COVID-19 among vaccinated people and people who were unvaccinated across and adjusting for age, sex, race and ethnicity, and study site[23]. An additional two studies by separate groups show COVID-19 vaccination associated mortality rates are lower than all-cause death rates[24,25].

Summary

As with most medications and vaccinations, there are risks associated with receiving the COVID-19 vaccine. While COVID-19 vaccination does not completely eliminate infection, the protection provided by COVID-19 vaccination reduces hospitalization, severe disease, and pre-mature death attributed to COVID-19. Overall, studies show that COVID-19 vaccination, including mRNA vaccines, do not increase mortality above other causes or morbidity above other vaccines.

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Resolution 24-PHD4

RESOLUTION TO INCREASE WIC PARTICIPATION IN IDAHO

WHEREAS, WIC saves lives and improves the health of nutritionally at-risk women, infants and children.[1]

WHEREAS, The results of studies conducted by FNS and other non-government entities prove that WIC is one of the nation's most successful and cost-effective nutrition intervention programs.[1]

WHEREAS, A series of reports published by USDA based on WIC and Medicaid data on over 100,000 births found that every dollar spent on prenatal WIC participation for low-income Medicaid women in 5 states resulted in savings in health care costs from $1.77 to $3.13 within the first 60 days after birth.[1]

WHEREAS, WIC reduces fetal deaths and infant mortality.[1]

WHEREAS, WIC reduces low birthweight rates and increases the duration of pregnancy.[1]

WHEREAS, WIC improves the growth of nutritionally at-risk infants and children.[1]

WHEREAS, WIC decreases the incidence of iron deficiency anemia in children.[1]

WHEREAS, WIC improves the dietary intake of pregnant and postpartum women and improves weight gain in pregnant women.[1]

WHEREAS, WIC participation significantly improves childhood immunization rates.[1]

WHEREAS, Pregnant women participating in WIC receive prenatal care earlier.[1]

WHEREAS, Children enrolled in WIC are more likely to have a regular source of medical care and have more up to date immunizations.[1]

WHEREAS, WIC helps get children ready to start school: children who receive WIC benefits demonstrate improved intellectual development.[1]

WHEREAS, WIC significantly improves children's diets.[1]

WHEREAS, according to the United States Department of Agriculture's most recent state level assessment shows that only 44.2% of WIC eligible families in Idaho participate in WIC. According to this report, Idaho WIC participation is one of the lowest in the country ranking 38th.[2]

WHEREAS, WIC is a significant referral source for other evidence-based public health services such as home visiting which has demonstrated positive impacts for families such as reducing child abuse and neglect and increasing children's school readiness and school success.

THEREFORE, BE IT RESOLVED that the Idaho Association of District Boards of Health supports having the Department of Health and Welfare create a database that cross references Medicaid enrollment with WIC enrollment and share contact information for WIC eligible individuals who are not participating with the public health districts.

THEREFORE, BE IT FURTHER RESOLVED that the Idaho Association of District Boards of Health supports having every Medicaid applicant who is pregnant, postpartum, or is a child under age 5 be routinely and automatically referred to WIC.

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[1] *U.S. Department of Agriculture*. (2023, May 23). Retrieved from About WIC: How WIC Helps: https://www.fns.usda.gov/wic/about-wic-how-wic-helps

[2] https://www.fns.usda.gov/research/wic/eligibility-and-program-reach-estimates-2021

Idaho Association of District

Boards of Health

Resolution Proposal Cover Sheet

To be complete and included with an IADBH Resolution Proposal.

Resolution Title: Support to Clarify Roles Pertaining to Solid Waste Disposal in Idaho

Sponsor:

Statutes Affected: Idaho Code 39-7406 (c)

Proposal Purpose

Background Information: To remove Public Health Districts from Idaho Code or clarify responsibilities of DEQ and Local Public Health Districts on the regulations of sites

Desired Action: Remove PHD from Idaho Code

Arguments and Entities in Support: Idaho Solid Waste Association (ISWA)

Argument and Entities Against: Click or tap here to enter text.

Fiscal Impact: Limited savings to each Health District from unfunded mandate that does not have a fee attached to program as well as reduce the threat of potential legal liability.

Resolution 24-PHD7-IADBH Member Name

Support to Clarify Roles Pertaining to Solid Waste Disposal in Idaho

WHEREAS, the accumulation of poorly disposed solid waste poses significant environmental hazards, including potential contamination of soil, water, and air; and

WHEREAS, improper disposal of solid waste can lead to public health risks, attracting pests, and cause disease; and

WHEREAS, Idaho is known for opportunities in recreation and business growth due to its beauty; and

WHEREAS, Total annual municipal solid waste (MSW) generation in the U.S. has increased by 93% since 1980 to 2018[1]; and

WHEREAS, Idaho Code 31-4402 grants authority to county commissioners to acquire, establish, maintain, and operate solid waste disposal systems; and

WHEREAS, complexity of different waste streams and EPA requirements require increased expertise; and

WHEREAS, current state code on solid waste management are outdated, unclear, and inadequate in describing responsibilities of stakeholders; and

WHEREAS, potential conflict of interest as counties are being regulated by a subsidiary (PHD); and

WHEREAS, solid waste operators are uncertain of what entity to contact for education, resources, and next on-site inspection; and

WHEREAS, PHD's would not have the adequate resources to responsibly provide adjudication and counties would not be able to provide the necessary funding in a prolonged legal situation; and

WHEREAS, it is in the best interest of the state to protect its natural resources, promote public health, and enhance the quality of life for its residents through effective waste management practices;

THEREFORE, BE IT RESOLVED, IADBH desires to update Idaho Code to provide clear guidelines, reduce ambiguity of roles, reduce red tape, and provide expertise to serve public and solid waste; and

THEREFORE, BE IT FURTHER RESOLVED, remove "health district" from section IC 39-7406 (c) and replace with DEQ to provide increased clarity and reduce complexity for solid waste operators in Idaho.

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[1]U.S. Environmental Protection Agency (EPA) (2020) Advancing Sustainable Materials Management: 2018 Fact Sheet.

Idaho Association of District

Boards of Health

Resolution Proposal Cover Sheet

To be completed and included with an IADBH Resolution Proposal.

Resolution Title: Resolution Concerning the Prevention of Opioid Drug Addiction and Overdose through Prescriber Education (Revision)

Sponsor: Public Health District 3

Statutes Affected: None

Proposal Purpose

Background Information: Idaho's drug related overdose deaths have continued to rise from 5.3 deaths per 100,000 in 1999 to 22.7 deaths per 100,000 in 2022. Idaho's Prescription Drug Monitoring Program (PDMP) is a tool that can provide timely information about controlled substance prescribing and dispensing practices and patient behaviors. When populated with accurate and timely data, it can be used to help mitigate prescription misuse and divert people entering or suffering from addiction to treatment. Both prescribers and dispensers are required by Idaho law (IDAPA 24.36.01.600) to update the PDMP on a daily basis. However, compliance remains an issue across the state.

Desired Action: Public Health District 3 is requesting public health agencies across the state and institutions of higher education educate and inform prescribers and dispensers about the dangers of opioid addiction and overdose and the benefits of using the statewide PDMP.

Arguments and Entities in Support:
1. The more timely and accurate use of the PDMP the more likely it is to be a useful tool in preventing addiction and overdose.
2. Reoccurring education about the PDMP is necessary to teach new prescribers and dispensers about their legal obligation and the beneficial uses of the system and address hesitancy or barriers to use by existing prescribers and dispensers.

Argument and Entities Against:
1. Prescribers and dispensers may be hesitant or have barriers to receive education about the PDMP and the importance of its use.
2. There may be hesitancy to use the system if it is unclear how secure, useful, and accurate the information is.

Fiscal Impact:
1. There is no notable cost change to prescribers or dispensers because by law (IDAPA 24.36.01.600), specified data on controlled substances must be reported to the PDMP on a daily basis.
2. Staff time and resources at the public health districts will be used to educate and inform prescribers and dispensers. Staff time and related activities can be covered with opioid settlement funding.

Resolution 17-02
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RESOLUTION CONCERNING THE PREVENTION OF OPIOID DRUG ADDICTION AND OVERDOSE THROUGH PRESCRIBER EDUCATION

WHEREAS, sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014[1]**; and**

WHEREAS, in 2019, healthcare providers wrote 153 million prescriptions for painkillers, enough for 75% of American adults to have a bottle of pills[2]; and

WHEREAS, during 2019, drug overdoses accounted for 70,630 U.S. deaths, of those, 70% involved an opioid[3]; and

WHEREAS, overall, more Americans die every year from drug overdoses than they do in motor vehicle crashes[4], making nonprescription use of opiates now the second most common cause of substance abuse disorder in the U.S.[6]; and

WHEREAS, as a result, prescription drug abuse prevention is a top priority for the Centers for Disease Control and Prevention; and

WHEREAS, per 100 people, Idaho healthcare providers prescribed 53.4 painkiller prescriptions in 2019[4]; and

WHEREAS, Idaho ranked 27th in the nation in 2019 for nonmedical use of prescription pain relievers among persons aged 12 years and older[5]; and over 14% of high school students reported taking prescriptions not prescribed by a doctor[5]; and

WHEREAS, in 2019, an Idahoan died every 33 hours from drugs, more than tripling the drug-induced death rate since 2000[5]; and

WHEREAS, Idaho Public Health Districts are responsible to promote and protect the health of Idaho citizens; and

WHEREAS, Idaho Public Health Districts provide services to individuals and families who are affected by prescription drug abuse;

THEREFORE BE IT RESOLVED that Idaho Public Health Districts seek opportunities to collaborate with stakeholders such as the Office of Drug Policy, Idaho Department of Health and Welfare, and institutions of higher education, as well as other pertinent community organizations, to prevent the addiction, misuse, and abuse of prescription drugs. The Idaho Public Health Districts will provide prescriber education on the opioid epidemic and encourage active use of Idaho's Prescription Monitoring Program (PMP).

Section: Other Community Health Issues
Adopted by the Idaho Association of District Boards of Health: June 9, 2017
Updated June 17, 2021; Replaced 13-02; August 27, 2024

Resolution 17-02 (continued)

Centers for Disease Control and Prevention. Increases in Drug and Opioid-Involved Overdose Deaths -- United States, 2010-2015. MMWR 2016; 65(50-51);1445–1452.
Centers for Disease Control and Prevention: 2019 U.S. Opioid Dispensing Rate Maps (2020)
Centers for Disease Control and Prevention: Drug Overdose Deaths (2021)
NHTSA: 2019 Fatality Data Show Continued Annual Decline in Traffic Deaths (2020)
Idaho Office of Drug Policy: Substance Misuse Prevention Needs Assessment (2019)

Idaho Association of District
Boards of Health

Resolution Proposal Cover Sheet

To be completed and included with an IADBH Resolution Proposal.

Resolution Title: Resolution Opposing the Legalization Of Recreational (Non-Medical) Marijuana (Revision)

Sponsor: Public Health District 3

Statutes Affected: Section 37, Chapter 27, Idaho Code

Proposal Purpose

Background Information: Marijuana is a controlled substance in Idaho pursuant to Section 37, Chapter 27 Idaho Code. However, the current law does not prohibit the marketing or advertising of marijuana in the state. With the growing number of marijuana distributors on Idaho's boarders, there is anecdotally a corresponding increase in billboards and other forms of advertisement intended to target Idahoans and market marijuana as a safe product. There is a growing body of evidence that indicates otherwise. For example, marijuana can affect memory, learning, concentration, and attention and may worsen manic symptoms in people with bipolar disorder and increase the risk of depression or worsen depression symptoms.

Desired Action: Public Health District 3 is requesting the 2025 Idaho legislature consider adopting new law to prohibit marijuana marketing and advertising in the state.

Arguments and Entities in Support:
1. Reducing advertising exposure may deter people from starting marijuana use and help those who are in their addiction recovery journey.
2. Children and adolescents should not be exposed to advertising for a product that is a controlled substance in Idaho and harmful to their health.

Argument and Entities Against:
Marijuana distributors outside of the state would like oppose this policy change because of potential impacts to their profit margins.

Fiscal Impact:
1. Banning advertising of marijuana distributors outside of Idaho may negatively impact their business and profits.
2. Education and resources may be needed to gain compliance once the policy became law these costs could be covered by existing programs and funding sources at the state level or by public health districts (e.g., Millennium Fund, Partnership for Success, etc.).

Resolution 19-03

RESOLUTION OPPOSING THE LEGALIZATION OF RECREATIONAL (NON-MEDICAL) MARIJUANA

WHEREAS, the Idaho Association of District Boards of Health is committed to the health and welfare of its citizens; and

WHEREAS, the Idaho Association of District Boards of Health strongly supports the success and positive future of the State's youth; and

WHEREAS, the sale, distribution, and possession of marijuana remains illegal under State and federal law; and

WHEREAS, studies from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, establishes that marijuana, like cigarettes, is addictive[1]; and

WHEREAS, recent analysis from the National Institute on Drug Abuse reveals the potency of marijuana has reached the highest level since scientific analysis of the drug began, with tetrahydrocannabinol (THC) [the principal psychoactive constituent of the cannabis plant] amounts rising from 4 percent in 1980s to 15 percent in 2012[2]; and

WHEREAS, marijuana concentrates, with potencies of 90 percent THC and above, [3] are becoming more and more common in states that have legalized marijuana, sold on their own or as part of kid-friendly edible products like candy, lollipops, and gummy bears indistinguishable from non-pot-laced products; and

WHEREAS, the higher potency of today's marijuana may be contributing to the substantial increase in the number of teenagers and adults in treatment for marijuana dependence[4]; and

WHEREAS, in the first two years of legalization in Colorado, arrests of Hispanic and African-American minors rose 29 percent and 58 percent, respectively[6]; and

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[1] "Is marijuana addictive?" *National Institute on Drug Abuse (NIDA).* Web. 24 May 2016. Available at http://www.drugabuse.gov/publications/research-reports/marijuana/marijuana-addictive.

[2] "Marijuana: Facts Parents Need to Know," *National Institute on Drug Abuse (NIDA).* Web. 24 May 2016. Available at https://www.drugabuse.gov/publications/marijuana-facts-parents-need-to-know/want-to- know-more-some-faqs-about-marijuana.

[3] "Concentrates 101: What's on the market, from kief and CO2 oil to BHO." *The Cannabist.* Web. 24 May 2016. Available at http://www.thecannabist.co/2015/06/19/marijuana-concentrates-kief-bho-water-hash- co2-oil-wax-shatter/36386/.

[4] *See, e.g.*, van der Pol, et al. (2014), Cross-sectional and prospective relation of cannabis potency, dosing and smoking behaviour with cannabis dependence: an ecological study. Addiction, 109: 1101–1109.

[6] Colorado Department of Public Safety. *Marijuana Legalization in Colorado, Early Findings: A Report Pursuant to Senate Bill 13-283.* N.p.: n.p., n.d. Mar. 2016. Web. 25 May 2016. Available at http://cdpsdocs.state.co.us/ors/docs/reports/2016-SB13-283-Rpt.pdf.

WHEREAS, marijuana shops that sell kid-friendly pot products like candy, lollipops, and gummy bears near where children live, are a risk to public health and safety; and

WHEREAS, Colorado, one of the first states to legalize marijuana, now ranks first in the nation for marijuana use among 12 to 17 year-olds, according to SAMHSA[7]; and

WHEREAS, marijuana use by minors is strongly associated with other illicit drug use and abuse/dependence,[8] as well as dependence on tobacco[9]; and

WHEREAS, adults who use marijuana are five times more likely to develop an alcohol problem[10]; and

WHEREAS, scientific research establishes that marijuana use is harmful to the adolescent brain, affecting memory, thinking, pleasure, concentration, learning, sensory and time perception, and coordinated movement[11]; and

WHEREAS, according to Quest Diagnostics, employers in the states of Colorado and Washington have rates of positive workplace marijuana tests well above the national average, and that rate is growing faster in both states than in the United States as a whole[17]; and

[7] "National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)." 2013-2014 *National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).* SAMHSA, n.d. Web. 25 May 2016. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.htm.

[8] Agrawal A, Neale MC, Prescott CA, Kendler KS. A twin study of early cannabis use and subsequent use and abuse/dependence of other illicit drugs. *Psychol Med.* 2004;34(7):1227-1237.

[9] Panlilio LV, Zanettini C, Barnes C, Solinas M, Goldberg SR. Prior exposure to THC increases the addictive effects of nicotine in rats. *Neuropsychopharmacol Off Publ Am Coll Neuropsychopharmacol.* 2013;38(7):1198-1208.

[10] Weinberger, Andrea H., Jonathan Platt, and Renee D. Goodwin. "Is Cannabis Use Associated With An Increased Risk Of Onset And Persistence Of Alcohol Use Disorders? A Three-Year Prospective Study Among Adults In The United States". *Drug and Alcohol Dependence* 161 (2016): 363-367. Web. 25 May 2016.

[11] *See, e.g.*, "DrugFacts: Marijuana." *DrugFacts. National Institute on Drug Abuse (NIDA),* Mar. 2016. Web. 24 May 2016. Available at https://www.drugabuse.gov/publications/drugfacts/marijuana; Medina et al. "Neuropsychological Functioning in Adolescent Marijuana Users: Subtle Deficits Detectable after a Month of Abstinence." *Journal of the International Neuropsychological Society : JINS*13.5 (2007): 807– 820. *PMC*. Web. 24 May 2016, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2269704/.

[17] "Press Releases." *Quest Diagnostics Newsroom*. Quest Diagnostics, 11 Sept. 2014. Web. 24 May 2016. Available at http://newsroom.questdiagnostics.com/2014-09-11-Workforce-Drug-Test-Positivity-Rate- Increases-for-the-First-Time-in-10-Years-Driven-by-Marijuana-and-Amphetamines-Finds-Quest- Diagnostics-Drug-Testing-Index-Analysis-of-Employment-Drug-Tests.

WHEREAS, the Idaho Association of District Boards of Health believes the effort to legalize marijuana is contrary to the interests of the public health, safety and welfare of its citizens, and desires to preserve the rights of citizens to live, work and play in communities where drug ~~abuse~~ use is not accepted and citizens are not subjected to the adverse effects of drug ~~abuse~~use; and

NOW, THEREFORE, be it RESOLVED, that the Idaho Association of District Boards of Health opposes legalizing the production, marketing, sale, distribution and possession of recreational (non- medical) marijuana, hashish, marijuana concentrates, and products made from marijuana concentrates.

Section: Other Community Health Issues

Adopted by the Idaho Association of District Boards of Health: *June 2019*

Updated Resolution 17-03; readopted June 9, 2022; updated August 27, 2024

Idaho Association of District

Boards of Health

Resolution Proposal Cover Sheet

To be completed and included with an IADBH Resolution Proposal.

Resolution Title: Resolution to Remove the Food Establishment License Fee in Idaho Code (Revision)

Sponsor: Public Health District 3

Statutes Affected: Section 39-1607 Idaho Code

Proposal Purpose

Background Information: For decades, public health districts have sought out solutions to cover the cost to administer the food protection program under the Food Establishment Act pursuant Section 39, Chapter 16 Idaho Code. Past negotiations with legislators and industry lobbyists have resulted in approximately 50% of the cost being covered by licensed establishments putting the remainder of the costs on the public health districts and taxpayer. In almost all other circumstances, the Boards of Health are permitted to set a fee to cover the cost to deliver a service.

Desired Action: Public Health District 3 is requesting the 2025 Idaho legislature remove Section 39-1607 Idaho Code, allowing the local Boards of Health to establish a fee to cover the cost to administer the food protection program pursuant Section 39-414(11) Idaho Code.

Arguments and Entities in Support:
1. In principle, a business should cover the costs necessary to operate, including permitting or licensing and the cost should not be on the shoulders of the county taxpayers.
2. Setting the fee at the cost to provide the service frees up county taxpayer dollars that could be better invested at the public health district to improve the health of the community.

Argument and Entities Against:
1. Legend has it, that there was a handshake deal made when the Food Establishment Act was adopted that the state, industry, and counties we share the cost of the program at equal contributions 33.3/33.3/33.3.
2. Since the state is requiring the license to operate, they should cover the cost of the program.
3. If public health districts can set the fee at their cost there is no mechanism or incentive to control the growth of the program.

Fiscal Impact: Approximately $1.8 million statewide (FY20 data)

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22-02 Resolution to Remove the Food Establishment License Fee in Idaho Code

WHEREAS, protecting the public from the hazards of food borne illness and disease is a primary function of Idaho's Public Health Districts; and

WHEREAS, the Centers for Disease Control and Prevention estimates that one in six Americans, or 48 million people, get sick from foodborne illnesses every year. Approximately 229,000 of these are hospitalized and 3,000 die[1]; and

WHEREAS, foodborne illness poses a $77.7 billion economic burden in the United States annually[2], and

WHEREAS, it is well recognized that foodborne outbreaks can be devastating to a food establishment business; and

WHEREAS, the Public Health Districts are committed to providing an appropriate balance between code enforcement and education while maintaining a balanced budget; and

WHEREAS, the food protection system in Idaho presently meets state standards, but fails to meet the national standards for inspection frequency for establishments deemed to be high risk for foodborne illness; and

WHEREAS, the Public Health Districts are required by the Idaho Food Code to perform at least one food safety inspection per year for each licensed food establishment; and

WHEREAS, general state appropriation funding is no longer provided to the Public Health Districts to subsidize food establishment inspection fees for private businesses, placing the full burden on the county tax payers;

THEREFORE BE IT RESOLVED that the Idaho Association of District Boards of Health requests~~supports~~ removing food establishment license fees in Idaho Code and allowing the local boards of health to establish a fee based on the actual cost to deliver the food safety inspection program.

Section: Environmental Health
Adopted by the Idaho Association of District Boards of Health: June 9, 2016
Readopted June 9, 2017; Revised June 9, 2022, Revised August 27, 2024

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[1]Centers for Disease Control and Prevention. "Estimates of Foodborne Illness in the United States," page last updated November 5, 2018, accessed March 10, 2022, http://www.cdc.gov/foodborneburden/

[2]Scharff, R.L. "Economic Burden from Health Losses Due to Foodborne Illness in the United States," (January 1,2012), accessed August 19, 2024. https://www.sciencedirect.com/science/article/pii/S0362028X2300426X #:~:text=The%20total%20health-related%20cost,%2C%20%2428.6%20to%20%24144.6%20billion

Idaho Association of District

Boards of Health

Resolution Proposal Cover Sheet

To be completed and included with an IADBH Resolution Proposal.

Resolution Title: Resolution to request a statute change to allow Southwest District Health the option to shift fiscal operations from State Treasury to an alternate banking institution that is FDIC insured.

Sponsor: Public Health District 3

Statutes Affected: 39-422

Proposal Purpose

Background Information: On July 1, 2023, State agencies and fringe agencies, which includes Southwest District Health (SWDH), were required to shift fiscal operations into LUMA which serves as the statewide accounting, procurement and human capital management system. Deployment was problematic and all impacted customers expended significant effort to reestablish core functionality necessary to support basic business needs and carry out core mission functions. Following several months of SWDH being unable to obtain reliable financial data from LUMA a meeting was held between SWDH Director Nikole Zogg, SWDH Financial Officer Troy Cunningham, and Idaho State Treasurer Julie Ellsworth to request her permission to connect an alternative financial software package into the state treasury. The request was denied on the grounds that only one Enterprise Resource Planning software system was allowed to connect to the state treasury. This denial returned the district to LUMA-based operations and its associated substandard performance issues for the remainder of SFY24. Year-end financial closeout activities were inordinately labor intensive and 50+ days after the end of State Fiscal Year 2024 (SFY24) closeout reports are unable to balance. SWDH is likely to have findings in upcoming financial audits based upon LUMA related issues. The Legislative Services Office audit division has become involved and has identified numerous issues and lack of controls in LUMA. The Office of Performance Evaluation has initiated a statewide review of LUMA based upon performance issues. Two separate audits into LUMA from global accounting firm Baker Tilly have also been conducted.

Desired Action: Request the Idaho Association of District Boards of Health (IADBH) support a statute change to allow SWDH to shift banking from Idaho State Treasury to alternative FDIC insured banking institution, thereby allowing connection of a to be procured financial software package for SWDH fiscal operations rather than continuing to operate exclusively in labor intensive and error prone LUMA system.

Arguments and Entities in Support:

Southwest District Health Leadership team and Fiscal Manager believe that increased efficiency, increased accuracy, decreased audit risk and decreased opportunity costs can be realized by allowing SWDH fiscal operations to shift away from LUMA and into an alternative software package which would only be allowable if the funds for SWDH were allowed to be deposited into an alternative banking institution and account other than that outlined in 39-422 .

Argument and Entities Against:

At the time of this proposal SWDH Leadership is unaware of any entities that would oppose.

Possible objections could be raised by the State Treasurer's Office related to safe retention of public funds. All risk related to this objection would be addressed through utilization of an FDIC insured financial institution and conducting of annual external audit. Furthermore, there could be concerns that this shift would set a precedent for non-state government entities to utilize banking systems other than the State Treasury, however county funds are retained in systems outside the State Treasury.

Possible objections could be raised by the State Controller's Office related to fiscal transparency. All concerns related to this objection would be addressed through upload of fiscal documents currently required of SWDH related to annual budget, annual expenditure summary and related to Transparent Idaho.

Possible objections could be raised by Risk Management; however, this proposed change, if approved, would have no impact on the scope of district operations.

Fiscal Impact: Total fiscal impact of this proposed change is projected to be more than $100,000 annually, which would partially be attributed to direct cost savings as well as avoided opportunity costs. Direct annual savings of this shift are anticipated to be in excess of $100,000 based upon the difference in annual LUMA charges compared to projected purchase of external financial software packages. In addition to the direct savings, it is anticipated that there may be significant opportunity costs that can be avoided through utilization of a more user-friendly system.

Resolution 24-PHD 03-Southwest District Health

DISTRICT HEALTH BANKING FLEXIBILITY

WHEREAS, the protection of public health is a primary function of Idaho's Public Health Districts; and

WHEREAS, sound business practices are an integral component of Public Health District Operations both now and into the future; and

WHEREAS, use of a reliable, efficient, accurate and auditable fiscal accounting system/software package supports sound business practices and district operations; and

WHEREAS, the existing LUMA fiscal system is challenging and time intensive to operate within even following refinements achieved throughout one year post deployment; and

WHEREAS, the state treasurer is required to establish a special fund for use by the health districts known as the public health district fund; and

WHEREAS, all income and receipts received by the districts are required to be deposited into the public health district fund; and

WHEREAS, Idaho State Treasurer will only allow one fiscal enterprise resource planning (ERP) system to plug into state treasury for fiscal operations; and

WHEREAS, direct and indirect costs at the district level could be reduced through utilization of a commercial off the shelf fiscal software package; and

WHEREAS, current fiscal reporting features from LUMA do not support current district business needs; and

WHEREAS, it is the responsibility of district leadership to identify risks and mitigate same in the most expedient and fiscally responsible manner; and

THEREFORE, BE IT RESOLVED, that the Southwest District Health Board of Health requests statutory modification necessary to allow the option to shift fiscal operations from State Treasury to alternate banking institution that is FDIC insured, thereby allowing shift of fiscal operations into a fiscal software package other than LUMA.

Idaho Association of District

Boards of Health

Resolution Proposal Cover Sheet

To be completed and included with an IADBH Resolution Proposal.

Resolution Title: Resolution Supporting Immunizations (Revision)

Sponsor: Public Health District 3

Statutes Affected: None

Proposal Purpose

Background Information: Childhood immunizations have prevented the disability and premature death of countless children over the past several decades. Despite the established safety and efficacy of childhood immunizations there is growing hesitancy about their use. Public health professionals need to remain vigilant and ensure the public has access to accurate information about vaccine safety and the personal and societal risks associated with not being immunized.

Desired Action: Public Health District 3 is requesting the Idaho Association of District Boards of Health to support childhood immunizations and to promote immunizations through public information.

Arguments and Entities in Support:
1. Healthcare providers and organizations largely support childhood immunizations.
2. American Academy of Pediatrics strongly recommends on-time routine immunization of all children and adolescents as does the American Academy of Family Physicians.
3. Passive immunity through vaccination is the safest way to develop immunity to childhood diseases.

Argument and Entities Against:

Fiscal Impact:
No fiscal impact.

Resolution 19-06

Resolution Supporting Immunizations

WHEREAS, Immunizations are heralded as one of the 20th century's most cost-effective public health achievements. Immunizations protect both individuals and the larger population, especially those people who have immune system disorders and cannot be vaccinated; and

WHEREAS, School vaccination requirements have been a key factor in the prevention and control of vaccine-preventable diseases in the United States; and

~~**WHEREAS,** in order to prevent a disease from spreading, it is recommended that 95% of the population be immunized, thereby achieving herd immunity;~~

WHEREAS, Idaho is one of 18 US states that allows religious/other exemptions from vaccines, and the exemption rate for Idaho children enrolled in kindergarten was ~~7.7~~12.1% during the 20~~18~~22-~~19~~23 school year;

WHEREAS, the majority of exemptions recorded in Idaho during the 20~~18~~22-~~19~~23 school year were for nonmedical reasons: ~~7.4~~11.5%, marking a concerning increase from ~~6.4~~9.2% the previous school year. In contrast, the US median, nonmedical exemption rate was ~~2~~3.2%.

WHEREAS, exemption rates, specifically, nonmedical exemptions, are rising in Idaho and pose a serious public health threat to the state. With outbreaks of vaccine preventable diseases like measles appearing across the US, and in neighboring states, it is critical that we stand for the science-backed immunization standards;

WHEREAS, communicable disease outbreaks can be best mitigated when there is an appropriate level of population immunity. In Idaho, the 2022-2023 kindergarten class had 81.3% MMR coverage, but because of the high level of contagion measles possesses a population immunity rate of 92% to 96% is required to limit the spread of disease[1];

WHEREAS, vaccines are a community's greatest line of defense to protect the most vulnerable among us, whether they are infants too young to get vaccinated or others who are immunocompromised, like those going through chemotherapy;

THEREFORE BE IT RESOLVED, that the Idaho Association of District Boards of Health support ~~Childhood~~ childhood ~~Immunizations~~immunizations, and will promote immunizations through public information.

Section: Children's Health
Adopted by the Idaho Association of District Boards of Health: June 2019
Readopted June 9, 2022; Updated August 27, 2024

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[1] Gromis, A. and Ka-Yuet, L. (2021, December 23). Spatial clustering of vaccine exemptions on the risk of a measles outbreak. *Pediatrics*, 149(1). DOI: 10.1542/peds.2021-050971. Accessed on August 15, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9037455/#:~:text=The%20MMR%20vaccine%20is%20effective,required%20to%20achieve%20herd%20immunity.

2025 Policy and Position Statements, and Funding Priorities

Southwest District Health's (SWDH) 2025 policy and position statements, and funding priorities are informed by known gaps, barriers, threats, or opportunities that impact the health of Idahoans across the six-county region.

This information is intended to inform legislators, local elected officials, and leaders in our community so they can, as they deem appropriate, propose or adopt policy or direct funding that will improve the health and vitality of Idahoans. The statements are brief and concise, and intended to be used if or when needed to communicate the district's position. They may be further accompanied by supporting data and information, when requested.

An executive summary is provided on page 2. Specific and brief position statements pertaining to issues impacting the public's health are provided on pages 3 to 10.

Contents

Executive Summary

Southwest District Health (SWDH) has identified five areas that if focused on could result in significant health improvements for Idahoans now and for generations to come. This could be accomplished by changes to policy at the local or state level, programs or services, and funding investments in strategic areas.

SWDH's position statements and funding priorities are broadly described below. More detailed information starts on page 5.

FAMILY UNIT. SWDH supports policies and funding commitments that aim to strengthen the health and wellbeing of the family unit.

HOUSING. SWDH supports policies and funding commitments that aim to develop healthier housing and neighborhoods for everyone.

ACCESS TO CARE. SWDH supports policies and funding commitments that aim to fill gaps in the healthcare and behavioral health care system, strengthen the coordination between healthcare organizations and providers, address workforce shortages, and improve affordability of care and access to primary prevention services (e.g., wellness exams, nutrition education, health education, and immunizations).

GOVERNMENTAL PUBLIC HEALTH. SWDH supports policies and funding commitments that aim to enhance public health infrastructure to assure the public has access to high-performing agencies (health districts, DEQ, DHW, etc.) with professional and well-trained staff. Public health professionals should be counted on to collect, analyze, and report on the health of their community in a timely, accurate, and meaningful way, effectively plan for and respond to threats to the public's health, and deliver services as required by law and based on the needs of the local community.

ENVIRONMENT & LAND USE. SWDH supports policies and funding commitments that aim to improve the safety, accessibility, and interactions we have in our environment. The design of our communities, how we plan for and build the spaces we live in, including open spaces, has positive or negative effects on physical and mental health.

SWDH staff are seeking input and feedback from the board on this draft document with specific input requested for the areas highlighted in yellow.

Existing Idaho Association of District Boards of Health Resolutions

A resolution is a concise statement of the Idaho Association of District Boards of Health's (IADBH) stance towards a particular issue and serves as a call to action for the organization and its members. It describes and endorses a defined course of action directed towards a particular individual, organization, event, legislation, or policy.

Resolutions are used to educate and urge action by elected officials at all levels, other organizations, the media and the public about the IADBH's position on important public health issues. The resolutions in their entirety can be accessed at: https://idahopublichealthdistricts.org/resources/.

NUMBER	TITLE	CURRENT DATE*
15-03	Resolution to support an excise tax on electronic nicotine delivery systems	June 17, 2021
17-01	Resolution supporting prevention of excessive alcohol use	June 17, 2021
17-02	Resolution concerning the prevention of opioid drug overdose through prescriber education	June 17, 2021
17-04	Resolution to support tobacco tax increase in the State of Idaho	June 17, 2021
19-01	Resolution to support awareness, education, and prevention of suicide	June 9, 2022
19-03	Resolution opposing the legalization of recreational (non-medical) marijuana	June 9, 2022
19-05	Resolution to support the recognition of senior cognitive health as a public health issue	June 9, 2022
19-06	Resolution supporting immunizations	June 9, 2022
22-01	Resolution to support an excise tax on electronic nicotine delivery systems	June 9, 2022
22-02	Resolution to remove the food establishment license fee in Idaho Code	June 9, 2022
22-03	Resolution to support raising the minimum age of legal access and use of *Mitragyna speciosa* (kratom) products in Idaho to age 21	June 9, 2022
22-04	Resolution to support vaping prevention in schools	June 9, 2022
22-05	Resolution to support innovative funding streams to support awareness, education, and prevention of suicide	June 9, 2022

* Current date: IADBH resolutions are effective for three years. They can be extended or archived after three years.

Southwest District Health Resolutions

SWDH's Board of Health members may submit for consideration to the board or request SWDH staff draft resolution language to support or oppose a specific policy impacting governmental public health or the health and wellbeing of Idahoans. The Board of Health votes to approve resolutions.

NUMBER	TITLE	CURRENT DATE
Not assigned	Resolution to request a statute change to allow Southwest District Health the option to shift fiscal operations from State Treasury to an alternate banking institution that is FDIC insured	Proposed August 27, 2024

Southwest District Health Position Statements & Funding Priorities

SWDH's position statements and funding priorities reflect and align with our strategic priorities and support our mission and vision. Depending on the priority, SWDH may take the following approaches:

- Commit funding and/or seek out funding from a variety of sources including federal, state, and non-profit organizations to address current or emerging threats to health
- Advocate and educate policymakers on issues that impact governmental public health or the health of Idahoans
- Educate and coordinate with organizations and businesses on matters that impact the health of Idahoans

FOCUS AREA	PRIORITY	JUSTIFICATION
Family Unit	Supports access to healthy foods and health nutrition education for families.	A healthy diet that consists mostly of whole, plant-based foods, and limited meat and animal products is a cornerstone to good physical health and mental wellbeing. Creative solutions that could address affordability of healthy food include but are not limited to gleaning, farmer market vouchers, edible community gardens, urban agriculture (§22-1001 IC), cooking/ canning classes, foodbank partnerships, u-pick, and work & share.
Family Unit	Supports expansion of home visiting programs that develop self-sufficiency and improved health outcomes for families, parents, guardians, and caregivers of young children.	Idaho's local public health districts' home visiting programs work with families who are motivated and driven to be self-sufficient and are seeking knowledge, expertise, and skills to help them attain their goals. These evidence-based programs have demonstrated positive results in the short-term, but also long-term as they aim to break the cycles of poverty and justice system involvement. SWDH, consistently has a waiting list for these services.
Family Unit	Supports early and safe learning opportunities for all.	Early learning in a structured and safe environment that mitigates bullying and cyberbullying, limits cell phone use, particularly for young learners, and provides a joyful learning environment where children and youth can learn and practice essential and foundational social, emotional, problem-solving, and study skills needed to succeed through their schooling and into adulthood.

Focus Area	Priority	Justification
Housing	Supports tools that create and preserve safe housing for everyone.	Safe and affordable housing is foundational to good health. Tools and funding mechanisms like funding the Idaho Housing Trust Fund (Title 67, Chapter 81 IC) can be a helpful resource for communities trying to address their housing needs at the local level.
Access to Care	Supports making EMS an essential service in Idaho.	Establishing EMS as an essential service in Idaho law will expand opportunities to fund EMS services across the state at a level that can better serve the public's expectations, decrease disability and premature death, and reduce healthcare costs associated with delayed access to care.
Access to Care	Supports best practices that prevent injury, illness, disability, and premature death, and promote successful recovery.	Many people struggle with addictions of various kinds. Best practice interventions help reduce the long-term ramifications of substance abuse and can move people closer toward recovery. Research indicates it can take several attempts before a person can move out of addiction and into recovery.
Access to Care	Supports initiatives that improve health literacy by teaching people how to use the healthcare system more efficiently and affordably (where to go, when).	With a strained healthcare workforce and a prediction that it will get worse before it gets better, improving Idahoans' health literacy about "where to go, when" may both help improve efficiency and make healthcare more affordable. Similarly, promoting healthy choices and behaviors and preventative healthcare can reduce the demand on healthcare services that are more specialized, harder to access, and more expensive.
Environment and Land Use	Supports public water system infrastructure, ensuring safe drinking water for all communities.	Public water systems have deliberate controls which reduce the likelihood of exposure to drinking water contaminates. Public water systems can create more flexibility of design for land use as the Treasure Valley continues to grow.
Environment and Land Use	Supports initiatives, policies, and funding decisions to help municipalities make healthier planning decisions.	The built environment of a community is a direct predictor of longevity and quality of life. Physical spaces can expose people to toxins or pollutants and influence lifestyles that contribute to diabetes, coronary vascular disease, and asthma among other diseases and conditions.

Focus Area	Priority	Justification
Environment and Land Use	Supports policies that protect the groundwaters of Idaho, explore innovative water reuse practices, and ensure ample potable water for generations to come.	Idahoans across the state are experiencing unsafe levels of nitrates, arsenic, uranium, and other toxins in their private well water systems. Without monitoring and intentional practices to protect ground water and aquifers across the state, the risk for further contamination is high.
Environment and Land Use	Supports efforts that strengthen SWDH's ability to address public health nuisances and enforce law violations that pose a risk to the public's health.	Addressing nuisance complaints and law violations that jeopardize public health necessitates substantial time and effort. When resolution through educational initiatives proves ineffective, enforcement of compliance becomes challenging without the involvement of the county prosecutor's office. Obtaining support from the county prosecutor's office within the district would facilitate legal action against non-compliant individuals and businesses, thereby mitigating public health risks and preventing contamination of Idaho groundwater resources.
Governmental public health	Supports funding for governmental public health infrastructure and essential services.	Governmental public health works to assure critical infrastructure (e.g., safe drinking water, safe food, healthy housing, education/information for informed decision-making, preventative healthcare access, etc.) is in place to prevent disease, disability, and premature death of the population.

Southwest District Health Position Statements

While not identified as a top priority for the district, the following position statements received honorable mention because of their relevance to core public health and general importance to creating the conditions for Idahoans to thrive.

FOCUS AREA	POSITION STATEMENT	JUSTIFICATION
Family Unit	Supports healthy relationship and communication skill building education for young people starting at 6th grade with parental consent or participation.	Equipping youth with the communication skills to navigate interpersonal, intimate, and family relationships is important to strengthen healthy relationships and foster youth-parent trust and reduce the risk for unplanned pregnancy, sexual disease transmission, coercion, and partner violence.
Family Unit	Supports school-age, age-appropriate health programs with parental consent.	School-age health programs provide youth with education and information that allows them to make informed decisions about their health as a young person and into adulthood. This may include home economics, personal finance management and budgeting, interpersonal communication, communicable diseases, and healthy relationships. The decisions they make as young people and habits they establish will have long-term impacts on their health, both positively and negatively.
Family Unit	Supports drug overdose prevention training and resources in our local communities.	Equipping Idahoans with the knowledge and skills to respond to an overdose similar to other medical emergencies will help reduce overdose deaths and give those who experience an overdose an opportunity to achieve recovery.

Focus Area	Position Statement	Justification
Family Unit	Supports individual and community civic engagement and voter participation.	Civic engagement (e.g., voting, volunteering, attending public meetings, etc.) promotes social connectedness and wellbeing. Creating awareness and supporting civic participation opportunities leads to community cohesion, engagement, and healthier communities.
Family Unit	Supports funding investments that raise awareness through education about human trafficking (e.g., risk factors, warning signs, and where and how it happens) and education that helps cultivate healthy family dynamics.	One way to prevent human trafficking from occurring is to raise awareness of what it is and how it happens. Everyone from youth to parents and employers to consumers can benefit from understanding the risk factors and warning signs of human trafficking. 1 in 3 children can now expect to have an unwelcome sexual experience online before they turn 18 (ParentsTogether, 2023).
Access to Care	Supports access to affordable contraception.	90% of females 18 to 64 years have used contraception at some point in their reproductive years. Women and families should have access to affordable contraception to prevent unintended pregnancies.
Access to Care	Supports evidence-based mental health care access for all ages.	Idahoans of all ages attempt to access mental health services; however, many communities across the state have limited access to evidence-based providers or resources to access virtually available providers.
Access to Care	Supports policies that encourage and promote careers in healthcare and behavioral health.	From 2021 through 2036, the US is expected to experience the following workforce shortfalls: 69,610 counselors, 337,970 nurses, 23,320 dental hygienists and 8,790 dentists, 68,020 primary care physicians, 33,100 family medicine physicians (HRSA). Of note, rural communities tend to be harder hit by healthcare workforce shortages.

Focus Area	Position Statement	Justification
Environment & Land Use	Supports funding for critical infrastructure that accommodates population growth and community vitality (e.g., roads and other modes of transportation, bridges, schools, emergency services, and community spaces such as parks, libraries, and senior centers).	A person's environment affects their overall physical and mental health.
Environment & Land Use	Supports multi-modal/active transportation in municipalities.	Physical activity improves health outcomes while also decreasing traffic congestion, improving air quality, and decreasing long-term road maintenance and expansion costs.
Governmental Public Health	Supports policies and funding that are targeted toward primary prevention.	Primary prevention aims to prevent disease or injury before it ever occurs. This means people, young and old, have the greatest chance to live long, healthy lives, be thriving members of their community, and spend less on healthcare.
Governmental Public Health	Supports Idaho's de-centralized public health model and infrastructure to support and sustain it.	In a state with many rural counties, communities are best supported with public health services through a model that leverages multi-county, state, and federal funding. This ensures even the least populated counties have access to professional services to help their communities be healthy, safe, and thrive.
Governmental Public Health	Supports health in all policies, which integrates and articulates health considerations into policymaking across sectors to improve the health of communities.	A person's and a community's health is more influenced by their environment and behaviors than by the healthcare they receive. Through a health in all policies approach, local policymakers have the power and ability to consider the impacts on the health of their community in any policy decision they consider.

Scope of Work

I. GENERAL REQUIREMENTS:

A. This Subgrant is funded by the Epidemiology and Laboratory Capacity (ELC) for Prevention and Control of Emerging Infectious Disease supplemental CK19-1904 awarded May 20, 2020 through the U.S. Centers for Disease Control and Prevention (CDC) with a total award amount of $5,075,000.00 and by the ELC supplemental CK19-1904 awarded January 13, 2021 through the CDC with a total award amount of $102,860,572.00.

B. This Subgrant supports the Idaho Department of Health and Welfare Strategic Plan and the Division of Public Health priorities.

C. The Subgrantee must comply with Department policy on meals and refreshments, as provided by the Department.

D. The Subgrantee must adhere to the following:

1. Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments. www.ecfr.gov - CFR Title 45 Part 75, Subpart C, 75.201.

2. Consistent with 45 CFR 75.113, Subgrantees must disclose, within ten (10) calendar days of discovery, in writing to the Department and the Department of Health and Human Services (HHS) Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the Centers for Disease Control and Prevention (CDC) and to the HHS OIG at the following addresses:

a. CDC, Office of Grants Services; Karen Zion, Grants Management Specialist; Centers for Disease Control and Prevention; Infectious Disease Services Branch; 2939 Flowers Road, MS-TV-2; Atlanta, GA 30341; Telephone: 770-488-2729; Email: wvf8@cdc.gov (Include "Mandatory Grant Disclosures" in subject line). AND

b. U.S. Department of Health and Human Services; Office of the Inspector General; ATTN: Mandatory Grant Disclosures, Intake Coordinator; 330 Independence Avenue, SW; Cohen Building, Room 5527; Washington, DC 20201; Fax: (202)-205-0604 (Include "Mandatory Grant Disclosures" in subject line) or Email: MandatoryGranteeDisclosures@oig.hhs.gov.

E. The Subgrantee must read and comply with:

1. Idaho Administrative Procedures Act (IDAPA) 16.02.10 Idaho Reportable Diseases located at https://adminrules.idaho.gov/rules/current/16/160210.pdf.

2. The Idaho Investigative Guidelines for Public Health available on the external Epidemiology SharePoint site at https://idhw.sharepoint.com/sites/PublicHealth-EPP/CDP/EPI.

F. The Subgrantee must receive prior written approval from the Department for any deviations from the budgeted services or activities. The Subgrantee must be financially responsible for costs deemed unallowable or unapproved by the Subgrant Monitor. Unallowable costs are outlined in Cost/Billing Procedures, paragraph B.

G. The Subgrantee must share this scope of work with staff, as applicable, to ensure their knowledge of the expectations and ability to meet Subgrant requirements.

H. Staffing

1. The Subgrantee must maintain staffing with the knowledge and skills to accomplish Subgrant services and activities. Changes in key staff positions must be reported to the

Subgrant Monitor within thirty (30) calendar days.

2. Subgrantee's epidemiologists must have relevant competencies to perform Subgrant services/activities. The Subgrantee's epidemiologists must have at least relevant Tier One (1) Foundational epidemiology competencies to perform epidemiology functions. [Capability 13, Function 2, Resource Element S1: Staffing capacity to manage the routine epidemiological investigation systems.] Epidemiology competencies located at https://www.cste.org/group/CSTECDCAEC.

3. Subgrantee's disease investigators must have relevant competencies to perform Subgrant services/activities. The Subgrantee's disease investigators must have at least relevant investigator competencies to perform disease investigation functions: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/training-investigators.html

I. Monitoring
   1. The Subgrantee must comply with all programmatic and financial monitoring activities required by the Department as outlined in this Subgrant, including on-site review as requested, and as outlined in the Subgrant Terms and Conditions, Sections 3-5.

   2. The Subgrantee must have available for review, upon request, any documents, papers, or other records which are pertinent to this Subgrant. The Subgrantee must provide timely and reasonable access to personnel for the purposes of interview and discussion related to such documents.

   3. The Subgrantee must respond to all deficiencies pertaining to monitoring of the Subgrant in a timely and appropriate manner.

   4. The Subgrantee's risk level has been assessed as high for this Subgrant year and is reassessed annually.
      a. Enhanced monitoring will be conducted monthly to include technical assistance calls with the Division of Public Health. When monthly reports are required, calls will coincide with the submission of reports and prior to authorizing payment.
         i. A technical assistance site visit, to include the program and Division of Public Health Federal Compliance Officer will be scheduled.

J. Acknowledging Federal Support:
   1. The Subgrantee must acknowledge federal funds when developing any documents describing programs or projects, issuing statements, press releases, and requests for proposals, bid invitations, and other documents funded in whole or in part by federal funds using the following disclaimer template:
      a. Publications -- "This publication was made possible by [number of grant] from [name of Federal Agency]. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department or [name of Federal Agency]. [Local Agency Name] [Date]."

      b. Conference Materials -- The Subgrantee must ensure that conference materials, including promotional materials, the agenda and any websites that advertise the conference, acknowledge that the federal agency funding this Subgrant provided support for the conference, in whole or in part. The acknowledgement must be accompanied by the following disclaimer:
         i. "Funding for this conference was made possible [in part, if applicable] by [grant or cooperative agreement number] from [name of Federal Agency]. The views expressed in written conference materials or publications and by speakers and moderators do not reflect the official policies of the Department or [name of Federal Agency] nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. [Local Agency Name] [Date]."

c. Audio-visuals -- "The production of this [type of audiovisual (motion picture, television program, etc.] was supported by grant [number of grant] from [name of Federal Agency]. Its contents are solely the responsibility of [name of recipient] and do not necessarily represent the official views of the Department or [name of Federal Agency]."

K. The Subgrantee must comply with subaward and executive compensation reporting requirements as required by the Federal Funding Accountability and Transparency Act (FFATA). 2 CFR 170.

L. Reserved.

M. DEFINITIONS

1. Epidemiologist: A person who studies the occurrence of disease and other health-related conditions or events in defined populations. The control of disease in populations is often also considered to be the task for the epidemiologist.

2. Disease investigator: A person responsible for reaching out to people with laboratory-confirmed, probable, and suspected diagnoses of diseases/conditions and providing health education and guidance in order to interrupt ongoing disease transmission. The disease investigator must conduct interviews with patients to gather information including symptom history, source of illness, list of close contacts, and activity history while infectious. The disease investigator must provide patients with instructions for isolation, quarantine, and make appropriate referrals to testing, clinical services, and other essential support services, as indicated. A disease investigator may also be referred to as a "Disease Intervention Specialist."

3. Case investigation: The gathering and review of clinical, laboratory, source, and exposure information for inclusion in epidemiologic monitoring and analysis, including the interview of an individual or proxy, about symptoms, time, circumstances of acquisition, and other specifics of their illness or condition.

4. Epidemiological investigation: The combined activities designed to discover the cause of an outbreak. This involves a case investigation combined with other data collected which may include, but is not limited to, laboratory investigations, food establishment inspections, other environmental inspections, and other academic epidemiologic techniques such as line listings, epidemic curves, and statistical analysis.

5. (AMD 2) Active Surveillance: A system, often used in conjunction with epidemiologic investigation, leveraging public health staff to regularly contact healthcare providers or the population to seek information about health or diseases/conditions.

6. Case classification: The process of case determination according to applicable case definitions of morbidity reports, laboratory reports, or exposure reports and the completion of minimum reporting fields.

7. Contact investigation: The process of contacting, notifying, and referring individuals who are suspected to be a source or have had exposure to a disease or condition to public health or medical interventions.

8. Infection prevention and control (IPC): The practice of preventing or stopping the spread of infections during healthcare delivery in facilities including but not limited to hospitals, outpatient clinics, dialysis centers, long-term care facilities, or traditional practitioners.

9. (AMD 3) Infection Prevention Specialist: A person who detects, prevents, and controls the spread of disease in healthcare settings using infection prevention and control strategies.

10. Antibiotic/Antimicrobial resistance (AR): The ability of organisms, including but not limited to bacteria and fungi, to defeat the drugs designed to kill them. Resistance means the organisms are not killed and can continue to grow.

11. Antimicrobial stewardship (AS): The effort to measure and improve how antibiotics are prescribed by clinicians and used by patients.

12. Healthcare associated infection (HAI): Infections that occur as a result of contact with the healthcare system in its widest sense, from care provided in a patient's own home, to primary care, nursing home care, and care in acute hospitals.

II. SUBGRANT SERVICES AND ACTIVITIES

A. (AMD 2) Establish, enhance, and sustain ability to aggressively identify cluster/outbreak-associated cases, conduct active surveillance for viral respiratory diseases (e.g., COVID-19, influenza, RSV) as specified in the Idaho Investigative Guidelines for Public Health.

1. (AMD 2) The Subgrantee must conduct active surveillance weekly, unless an alternative timeframe is approved by the Department, and report findings to the Department.
   a. (AMD 2) The Subgrantee must document active surveillance attempts and findings using the Department provided data collection tool.
      i. (AMD 2) If active surveillance efforts identify a cluster/outbreak, the Subgrantee must refer to II.A.3.

   b. (AMD 2) The Subgrantee must conduct additional active surveillance in settings not specified in the Idaho Investigative Guidelines as requested by the Department.

2. (AMD 2) The Subgrantee must document via Idaho National Electronic Disease Surveillance System (NEDSS) Base System (NBS) viral respiratory diseases (e.g., COVID-19, influenza, RSV) investigations as specified in the Idaho Investigative Guidelines for Public Health.
   a. Subgrant funds must not be used to support any costs for data entry, implementation, or maintenance of non-NBS surveillance systems or databases, unless approved by the Department.

   b. (AMD 2) Language removed in Amendment 2.

   c. The Subgrantee must review and improve upon, to the extent possible, the Department's assessment of documented investigation data quality and completeness.

3. The Subgrantee must conduct an epidemiologic investigation on all clusters and outbreaks of viral respiratory diseases (e.g., COVID-19, influenza, RSV) as specified in the Idaho Investigative Guidelines for Public Health and as requested by the Department.
   a. (AMD 2) The Subgrantee must request a unique Idaho outbreak number for each epidemiologic investigation and document that outbreak number in NBS for each associated case.

   b. (AMD 2) The Subgrantee must document epidemiologic investigations using the Department provided electronic Outbreak Report Form for each unique investigation.

4. (AMD 2) The Subgrantee must conduct an investigation of close contacts identified through epidemiologic investigation as specified in the Idaho Investigative Guidelines for Public Health.

5. (AMD 2) The Subgrantee must proactively inform the Department’s Epidemiology Section about disease investigator, epidemiologist, and contact tracer staffing capacity and

capacity needs and accept Department Epidemiology Section staff deployment when determined appropriate in collaboration with the Department. Indicators prompting communication between the Department and Subgrantee and potential deployment of Department Epidemiology Section staff include:

a. The Subgrantee recognizing unforeseen or outside circumstances resulting in Subgrant performance concerns, OR,

b. (AMD 2) The number of reported cases of COVID-19 associated with an epidemiologic investigation exceeds the Subgrantee's ability to respond, OR,

c. (AMD 2) The number of non-COVID-19 reported cases is greater than or equal to two (2) standard deviations above the expected mean from the week prior as determined by the Department, OR,

d. (AMD 2) The number of open investigations for non-COVID-19 disease(s)/condition(s) of public health interest exceeds the average proportion of investigations submitted by the respective Subgrantee over the prior five (5) years out of the statewide total as determined by the Department, OR,

e. The Subgrantee experiences changes in key disease investigator(s) or staff epidemiologist(s).

6. The Subgrantee must collaborate with the Department on wastewater surveillance (WWS) epidemiologic response.
   a. (AMD 2) The Subgrantee must designate a disease investigator or epidemiologist to be the primary point of contact with the Department for Idaho WWS communication and coordination of response activities.

   b. (AMD 2) Language removed in Amendment 2.

   c. (AMD 2) Language removed in Amendment 2.

   d. (AMD 2) The Subgrantee must review and provide feedback on revisions to "Guidance for Idaho public health communication and response to WWS data", as requested by the Department, found on the external epidemiology SharePoint site when displaying or communicating about WWS data or analytics.

   e. The Subgrantee must follow the most current version of "Guidance for Idaho public health communication and response to WWS data" found on the external Epidemiology SharePoint site when displaying or communicating about WWS data or analytics.

   f. The Subgrantee must respond to Department requests to collaborate on messaging to the public and healthcare providers regarding WWS data and analytics.

7. The Subgrantee must contact the Department for prior approval to use Subgrant funds to pay for support or wraparound services that promote case and contact adherence to recommended containment measures.

8. (AMD 2) The Subgrantee must support the Department with multisystem inflammatory syndrome in children (MIS-C) investigations as requested by the Department.

9. The Subgrantee must provide written certification that staff responsible for Subgrant Services and Activities in II.A:
   a. Have read and will comply with documents outlined under General Requirements I.E within thirty (30) calendar days of Subgrant execution for existing staff and within thirty (30) calendar days of start date for newly hired staff.

b. Meet the staffing competency expectations detailed under General Requirements I.H (foundational [Tier 1] for epidemiologists, DIS competencies), within thirty calendar (30) days of Subgrant execution for existing staff and within thirty (30) calendar days of start date for newly hired staff.

10. (AMD 2) If epidemiologic investigation involves a healthcare worker or a resident of a congregate living setting, IPC response must be coordinated with the Department's HAI Program.

11. (AMD 3) If epidemiologic investigation involves a healthcare facility or healthcare worker(s), IPC response must be coordinated with the Department's HAI Program.

B. (AMD 2) Sustain laboratory testing and reporting capacity

1. (AMD 2) The Subgrantee may use Subgrant funds to collaborate with the Idaho Bureau of Laboratories (IBL) to build capacity for testing of SARS-CoV-2.

a. (AMD 2) The Subgrantee may use funds to acquire testing equipment or testing kits to conduct testing for SARS-CoV-2 and support staff time for such testing.

b. (AMD 2) The Subgrantee may serve as an additional SARS-CoV-2 testing distribution center for their jurisdiction.

i. The Subgrantee must contact the IBL State Testing Coordinator if the Subgrantee plans to serve as an additional testing distribution resource for kindergarten through twelfth grade schools, school districts, or summer or day camps serving that population.

(AMD 3) ii.

ii. The Subgrantee must not submit LTCF SARS-CoV-2 cluster/outbreak specimens for testing to IBL unless pre-approved by IBL.

c. (AMD 2) Language removed in Amendment 2.

2. (AMD 2) Language removed in Amendment 2.

3. The Subgrantee may use Subgrant funds to conduct appropriate specimen collection and testing within their jurisdiction.

C. Prevent and control viral respiratory diseases (e.g., COVID-19, influenza, RSV) in specific settings at increased risk.

1. The Subgrantee must assist the Department with building IPC knowledge.

a. The Subgrantee must collaborate with the Department and support communication efforts to promote the awareness of Project Firstline (PFL) key concepts, goals, and educational opportunities.

i. The Subgrantee must designate a PFL staff person to be the primary point of contact with the Department for Idaho PFL promotion communication and coordination of activities.

ii. (AMD 3) The Subgrantee must refer any healthcare facility staff, residential care facility staff, correctional facilities staff, school or school district staff, childcare agency staff, and others interested in infection prevention and control (IPC) and/or PFL educational offerings or resources to the Department by calling 208-334-5871 or e-mailing HAI@dhw.idaho.gov within one (1) working day of being contacted by the interested party.

2. The Subgrantee must assist the Department with building and maintaining capacity for rapid containment of viral respiratory diseases (e.g., COVID-19, influenza, RSV) and other diseases/conditions of public health interest in healthcare and residential care facilities.

a. The Subgrantee must collaborate with and support the Department's HAI Program efforts to promote and strengthen infection prevention and control practices.
   i. (AMD 3) Within one (1) working day of being contacted, the Subgrantee must refer any healthcare provider, healthcare facility staff, or residential care staff to the Department by calling or e-mailing, as defined in the HAI Program Priorities and Responsibilities for Public Health Districts supplemental document on the external Epidemiology SharePoint within one (1) working day of being contacted. This includes all IPC technical assistance or consultation requests; AR technical assistance or consultation requests; Antimicrobial stewardship (AMS) technical assistance or consultation requests; and Investigations of multi-drug resistant organism(s) (MDROs).

   ii. The Subgrantee may request IPC, AR, AMS, and MDRO technical assistance from the Department's HAI Program as needed, during execution of activities II.A.1, II.A.3, and II.A.4.

   iii. (AMD 3) The HAI Program will lead all targeted MDRO investigations in healthcare facilities, including those in residential care facilities.

3. (AMD 2) The Subgrantee must ensure adequate disease investigator and epidemiologist staffing capacity to respond to clusters/outbreaks of viral respiratory diseases (e.g., COVID-19, influenza, RSV).

4.

D. (AMD 2) Language removed in Amendment 2.
1. (AMD 2) Language removed in Amendment 2.

E. (AMD 2) Language removed in Amendment 2.

F. (AMD 2) The Subgrantee may use Subgrant funds to increase capacity for timely data management, analysis, and reporting for clusters/outbreaks of viral respiratory diseases (e.g., COVID-19, influenza, RSV).
   1. (AMD 2) Language removed in Amendment 2.

G. Improve surveillance and reporting of electronic health data
   1. (AMD 2) Language removed in Amendment 2.

   2. (AMD 2) Language removed in Amendment 2.

   3. (AMD 2) The Subgrantee may make viral respiratory diseases (e.g., COVID-19, influenza, RSV) surveillance data available to the public, as appropriate to maintain privacy and confidentiality.

   4. (AMD 2) The Subgrantee may use Subgrant funds for viral respiratory diseases (e.g., COVID-19, influenza, RSV) surveillance data analysis and visualization, with prior approval from the Department.

   5. (AMD 2) Language removed in Amendment 2.
      a. (AMD 2) Language removed in Amendment 2.

(AMD3) H. Subgrantee may use funds to support response to highly pathogenic avian influenza [influenza A(H5N1)] with prior approval of the Department.

I. Subgrant compliance monitoring collaboration
   1. The Subgrantee must participate in a quarterly call with the Department, as scheduled and coordinated by the Department, to discuss funding spend down, Subgrant performance, barriers being encountered prohibiting execution of activities, successes,

and to provide pertinent staffing updates.

III. RECORDS AND DOCUMENTATION

A. Within thirty (30) calendar days of Subgrant execution for existing staff and within thirty (30) calendar days of start date for newly hired staff, the Subgrantee must use the template provided by the Department to certify that:

1. Staff responsible for Subgrant Services and Activities II.A have read and will comply with documents outlined under General Requirements I.E;

2. Staff responsible for Subgrant Services and Activities II.A meet the staffing competency expectations detailed under General Requirements I.H (foundational [Tier 1] for epidemiologists, DIS competencies); and

3. Staff responsible for any Subgrant Services and Activities have been provided a copy of the Subgrant as outlined under General Requirements I.G.