**Board of Health Meeting**
Tuesday, August 26, 2025
13307 Miami Lane, Caldwell, ID 83607

Public comments specific to an agenda item for the August 26, 2025 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 10:00 a.m. on Monday, August 25, 2025. 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 Meeting to Order | Chairman Kelly Aberasturi |
| 9:01 | | Pledge of Allegiance | |
| 9:04 | | Roll Call | Chairman Kelly Aberasturi |
| 9:07 | A | Call for changes to agenda; vote to approve agenda | Chairman Kelly Aberasturi |
| 9:10 | | In-person public comment | |
| 9:12 | I | Introduction of new employees | Division Administrators |
| 9:18 | A | Approval of July 2025 meeting minutes | Chairman Kelly Aberasturi |
| 9:20 | I | June 2025 Monthly Expenditure and Revenue Report | Michele Hanrahan |
| 9:40 | I | Youth and Adult Crisis Centers Overview | Cas Waldron |
| 10:00 | | Break | |
| 10:15 | I | Clearwater Financial Early Reporting – Demographics and Stakeholders | Abbey Erquiaga |
| 11:00 | G | Director Delegated Authorities – Part 2 | Nikki Zogg |
| 11:30 | I | IADBH Draft Resolutions and Position Statements<br>• Resolution in Support of Provision of Clinical Services | Nikki Zogg |
| 11:45 | I | Director's Report<br>• Federal Funding Update<br>• IADBH Travel<br>• New Idaho Department of Health and Welfare Director<br>• Notice of Violation – Septic System Installation<br>• SWDH Named in Lawsuit<br>• Partnership for Success Presentation Follow Up Information | |
| 11:58 | I | Future Agenda Items | |
| 12:00 | | Adjourn | |

**NEXT MEETING: Tuesday, September 23, 2025 – 9:00 a.m.**

**BOARD OF HEALTH MEETING MINUTES**
**Tuesday, July 22, 2025**

**BOARD MEMBERS**:
Jennifer Riebe, Commissioner, Payette County – present
Jim Harberd, Commissioner, Washington County – present
Zach Brooks, Commissioner, Canyon County – present
Kelly Aberasturi, Commissioner, Owyhee County – present
Viki Purdy, Commissioner, Adams County – present
John Tribble, MD, Physician Representative – present
Bill Butticci, Commissioner, Gem County – present

**STAFF MEMBERS:**
In person: Nikki Zogg, Katrina Williams, Don Lee, Beth Kriete, Ben Shatto, Yesenia Arrondondo, Michele Hanrahan

Virtual: Colton Osborne

**GUESTS**: Mike Kane

**CALL THE MEETING TO ORDER**
Chairman Kelly Aberasturi called the meeting to order at 9:01 a.m.

**ROLL CALL**
Chairman Aberasturi – present; Dr. John Tribble – present via Microsoft Teams ; Commissioner Purdy – present; Commissioner Harberd – present; Vice Chairman Brooks –present; Commissioner Riebe – present; Commissioner Butticci – not 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 Riebe made a motion to approve the agenda as presented. Commissioner Harberd seconded the motion. All in favor; motion passes.

**PUBLIC COMMENT**
No public comment was provided in person and no public comments were submitted through the online submission mechanism.

**INTRODUCTION OF NEW EMPLOYEES**
Division Administrators introduced the new employees.

**APPROVAL OF JUNE 2025 MEETING MINUTES**
Board members reviewed meeting minutes from the June 22, 2025, Board of Health meeting.

**MOTION:** Commissioner Harberd made a motion to approve the June 22, 2025 meeting minutes as corrected. Dr. Tribble seconded the motion. All in favor; motion passes.

**MAY 2025 EXPENDITURE AND REVENUE REPORT**
Michele Hanrahan, Financial Officer, provided the May 2025 Expenditure and Revenue Report.

**OPEN MEETING LAW AND BOARD CONDUCT BEST PRACTICES**
Mike Kane, SWDH Legal Counsel, provided an overview of Idaho Code §74-204, Open and Transparent Meeting Law, and the requirements for governing bodies of government meetings to comply with. Discussion topics included what constitutes a decision, posting requirements for meetings, and use of Roberts Rules of Order. Mike also discussed allowing and managing in-person attendance, spillover rooms, electronic access, and internet viewing. He reminded board members that trespassing attendees for disruptive behavior or for preventing the agency from doing business is allowed.

**BOARD OF HEALTH DELEGATED AUTHORITIES TO THE DIRECTOR**
In response to the direction provided by the Board last month, staff compiled information on subgrants, contracts, agreements, pending grant applications, and standing purchase orders over $5,000 to aid in evaluation of the District Director's delegated authority activities. Nikki asked for board member input regarding their preference for reviewing and discussing the material. Board members prefer to review and discuss the lengthy report in sections over three board meetings.

**ALCOHOL AND SUBSTANCE USE TRENDS AMONG YOUTH**
Tara Woodward, Program Planning and Development Specialist, provided an overview of the Partnership for Success program. The program's goals are to promote good mental health and prevent youth marijuana and alcohol substance use. To do this, staff work to understand local data and needs and provide funding for local evidence-informed projects.

During review of Tara's presentation, Commissioner Riebe asked what contributed to the seemingly drastic decrease in marijuana use in the 1990s. Tara will check into that and follow up with Board members.

**IADBH DRAFT RESOLUTIONS AND POSITION STATEMENTS**
Nikki shared draft resolutions and position statements to be discussed at the annual Idaho Association of District Boards of Health (IADBH) in October.

- 2025 Resolution in Support of Idaho Code §39-801
    - District 4 has asked for clarification in the new law for providing care for minors with communicable disease without parental consent
- Draft Resolution in Support of Treated Recreational Water Oversight
    - Re-establish and update rules to reflect the best practice standards for providing regulatory oversight for certain treated water facilities and authority to create reasonable rules
- IADBH Position Statement on Board of Health Membership
    - Being brought forward due to legislation brought forward the last few years requiring all board of health positions be elected. District 4 does not support making that change.

**DIRECTOR'S REPORT**

**Non Municipal Solid Waste Update**
Nikki shared documents regarding proposed changes for the non-municipal solid waste program. The health districts have been in communication with the director of the Department of Environmental Quality. Nikki asked if it is board members' preference to step away fully from non-municipal solid waste. Board members discussed this and prefer to not be removed fully from non-municipal solid waste oversight. The board's preference is that the district continue to provide oversight of municipal transfer stations and rural drop boxes. Nikki will reach out to Director Byrne at DEQ to negotiate.

**Lawful Presence Verification Update**
Implementation of lawful presence verification is going smoothly.

**EXECUTIVE SESSION PURSUANT TO IDAHO CODE 74-206(b)**
No executive session is needed today.

**ACTION FOLLOWING EXECUTIVE SESSION**
None. No executive session held.

There being no further business, the meeting adjourned at 11:50 a.m.

Respectfully submitted: Approved as written:

Nikole Zogg — Secretary to the Board
Kelly Aberasturi — Chairman
Date: August 26, 2025

# SOUTHWEST DISTRICT HEALTH

## REVENUES & EXPENDITURE REPORT FOR FY2025

*Cash Basis*

**June 2025**

**Target** **100.0%**

| Fund Balances | FY Beginning | June 2025 Ending |
|---|---|---|
| General Operating Fund | $ 636,900 | $ 1,127,287 |
| LGIP Operating | $ 6,938,818 | $ 5,650,546 |
| LGIP Vehicle Replacement | $ 108,497 | $ 113,809 |
| LGIP Capital | $ 1,299,174 | $ 1,299,174 |
| **Total** | **$ 8,983,390** | **$ 8,190,817** |

| Income Statement Information | YTD | Month |
|---|---|---|
| **Net Revenue:** | **$ 11,868,319** | **$ 526,944** |
| **Expenditures:** | $ (11,576,010) | $ (1,083,138) |
| **Net Income:** | **$ 292,309** | **$ (556,194)** |

# District Activity - Fund 29000

## Revenue

| | Office of the Director | Clinic Services | Env & Community Health | District Operations | Total | YTD | Total Budget | Percent Budget to Actual |
|---|---|---|---|---|---|---|---|---|
| County Contributions | $ - | $ - | $ - | $ - | $ - | $ 2,914,450 | $ 3,122,831 | 93% |
| Fees | $ - | $ 66,498 | $ 140,030 | $ - | $ 206,528 | $ 2,367,808 | $ 1,704,841 | 139% |
| Contract Revenue | $ - | $ 350,570 | $ (46,073) | $ (32,693) | $ 271,804 | $ 5,907,989 | $ 6,257,743 | 94% |
| Sale of Assets | $ - | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| Interest | $ - | $ - | $ - | $ - | $ - | $ 250,004 | $ 337,850 | 74% |
| Other | $ - | $ - | $ 48,613 | $ - | $ 48,613 | $ 428,069 | $ 1,656,666 | 26% |
| Monthly Revenue | **$ -** | **$ 417,067** | **$ 142,570** | **$ (32,693)** | **$ 526,944** | $ 11,868,319 | $ 13,079,931 | 91% |
| Year-to-Date Revenue | **$ 3,165,372** | **$ 3,783,897** | **$ 4,594,012** | **$ 325,038** | **$ 11,868,319** | 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 | $ 27,124 | $ 297,583 | $ 242,459 | $ 121,760 | $ 688,926 | $ 8,573,333 | $ 9,324,880 | 92% |
| Operating | $ 15,917 | $ 185,224 | $ 191,335 | $ (9,590) | $ 382,886 | $ 2,932,962 | $ 2,403,122 | 122% |
| Capital Outlay | $ - | $ - | $ - | $ - | $ - | $ 35,947 | $ 80,000 | 45% |
| Trustee & Benefits | $ - | $ - | $ 11,326 | $ - | $ 11,326 | $ 33,767 | $ 1,271,929 | 3% |
| Monthly Expenditures | **$ 43,041** | **$ 482,807** | **$ 445,120** | **$ 112,170** | **$ 1,083,138** | $ 11,576,010 | $ 13,079,931 | 89% |
| Year-to-Date Expenditures | **$ 426,161** | **$ 4,976,094** | **$ 3,859,997** | **$ 2,313,759** | **$ 11,576,010** | DIRECT BUDGET | | |

# SOUTHWEST DISTRICT HEALTH - ADULT CRISIS CENTER ACTIVITY

**June 2025**

**REVENUES & EXPENDITURE REPORT FOR FY2025**

*Cash Basis*

**Target** **100.0%**

| Income Statement Information | YTD | Month |
|---|---|---|
| **Net Revenue:** | **$ 1,652,546** | **$ 125,000** |
| **Expenditures:** | $ (1,305,448) | $ (122,989) |
| **Net Income:** | **$ 347,098** | **$ 2,011** |

## Adult Crisis Activity - Fund 29001

### Revenue

| | Crisis Center | YTD | Total Budget | Percent Budget to Actual |
|---|---|---|---|---|
| Contract Revenue | $ 125,000 | $ 1,652,546 | $ 1,020,000 | 162% |
| Monthly Revenue | $ 125,000 | $ 1,652,546 | $ 1,020,000 | 162% |
| | | DIRECT BUDGET | | |

### Expenditures

| | Crisis Center | YTD | Total Budget | Percent Budget to Actual |
|---|---|---|---|---|
| Personnel | $ 1,662 | $ 20,683 | $ 18,870 | 110% |
| Operating | $ 5,327 | $ 1,168,764 | $ 77,495 | 1508% |
| Capital Outlay | $ - | $ - | $ - | 0% |
| Trustee & Benefits | $ 116,000 | $ 116,000 | $ 923,635 | 13% |
| Monthly Expenditures | $ 122,989 | $ 1,305,448 | $ 1,020,000 | 128% |
| | | DIRECT BUDGET | | |

*117%* *(Including T&B Budget)*

# SOUTHWEST DISTRICT HEALTH - YOUTH CRISIS CENTER ACTIVITY

**June 2025**

## REVENUES & EXPENDITURE REPORT FOR FY2025

*Cash Basis*

**Target** **100.0%**

| Income Statement Information | YTD | Month |
|---|---|---|
| **Restricted Funds:** | **$ 1,336,691** | **$ -** |
| **Net Revenues:** | **$ 1,535,650** | **$ 125,000** |
| **Expenditures:** | $ (2,435,234) | $ (92,753) |
| **Net Income:** | **$ 437,107** | **$ 32,247** |

# Youth Crisis Activity - Fund 29002

## Revenue

| | Crisis Center | YTD | Total Budget | Percent Budget to Actual |
|---|---|---|---|---|
| Carry Over Restricted | $ - | $ 1,336,691 | $ 1,336,691 | 100% |
| Contract Revenue | $ 125,000 | $ 1,535,650 | $ 355,750 | 432% |
| Monthly Revenue | $ 125,000 | $ 2,872,341 | $ 1,692,441 | 170% |
| | | DIRECT BUDGET | | |

## Expenditures

| | Crisis Center | YTD | Total Budget | Percent Budget to Actual | | |
|---|---|---|---|---|---|---|
| Personnel | $ 10,236 | $ 143,413 | $ 221,775 | 65% | | |
| Operating | $ 22,804 | $ 1,250,625 | $ 717,973 | 174% | 117% | *(Including $350,000 T&B Budget)* |
| Capital Outlay | $ (7,359) | $ 656,192 | $ - | 0% | | |
| Trustee & Benefits | $ 67,071 | $ 385,003 | $ 752,693 | 51% | 96% | *(Excluding $350,000 T&B Budget)* |
| Monthly Expenditures | $ 92,753 | $ 2,435,234 | $ 1,692,441 | 144% | | |
| | | DIRECT BUDGET | | | | |

# Region 3 Youth and Adult Crisis Centers

Cas Waldron, Project Manager

# Overview

- Purpose of crisis centers
- Services and supports
- Crisis center video
- Census and demographics
- Impact and outcomes
- Funding and citations

# Purpose of Crisis Centers

**1. Primary:**

- Divert individuals from **unnecessary** interactions with law enforcement and involvement in the juvenile justice system and admissions to emergency departments/hospitals/in-patient **for a behavioral health crisis**
- Prevent individuals experiencing a behavioral health crisis from drug and alcohol use, self-harm, hurting others, and suicide
- De-escalate crisis and return individuals safely back into their homes and communities

**2. Secondary:**

- Support efforts toward recovery, well-being, resilience, and self-sufficiency through connections to care

# Crisis Center Services

- **Open all day every day – for youth ages 5-17 & adults 18+**
- **Stay for up to 23 hours and 59 minutes per crisis**
- **Free Services:**
  - Crisis de-escalation
  - Peer support and case management
  - Safety planning
  - Community-based referrals
- **Support:**
  - Food
  - Clean clothes & personal care items
  - A place to rest and recreate

Western Idaho COMMUNITY CRISIS CENTER

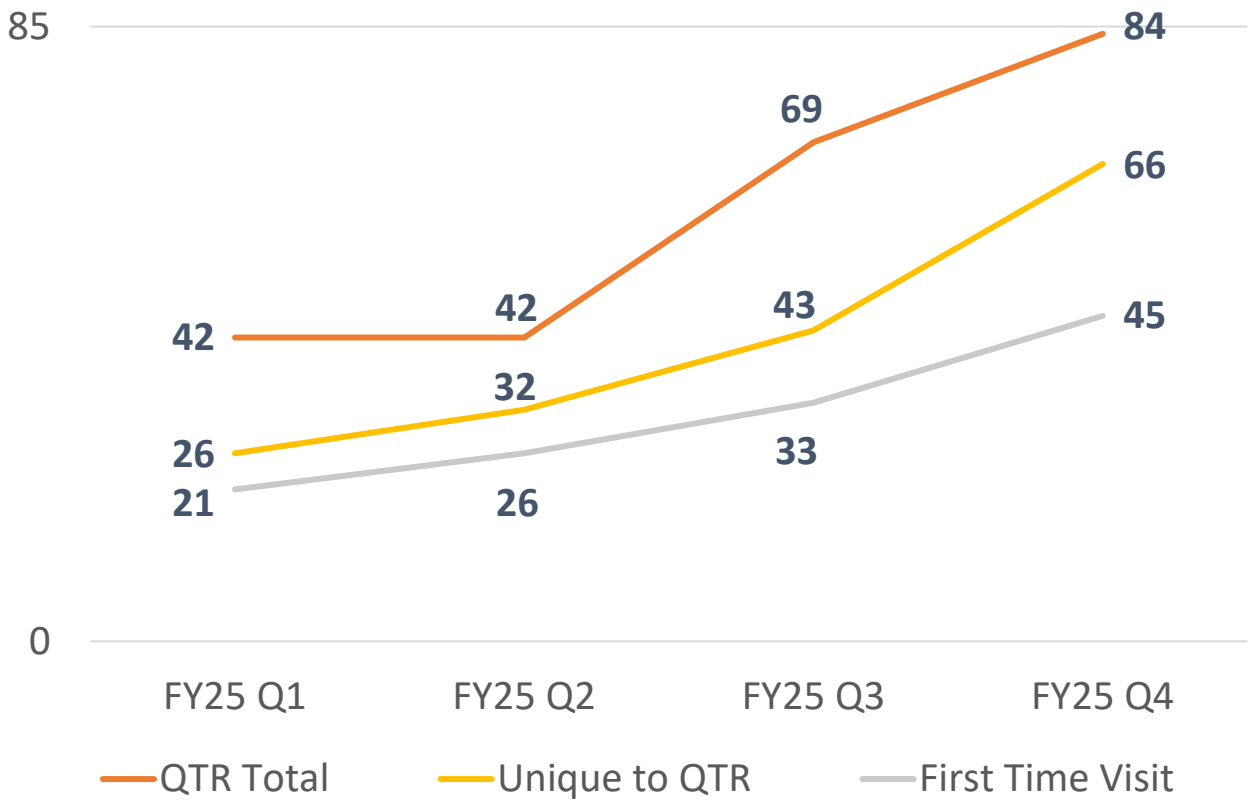
WESTERN IDAHO YOUTH SUPPORT CENTER

PROVIDING YOUTH A SAFE PATH FORWARD

# Vignette

- Link to Crisis Center video

# Western Idaho Youth Support Center - Census




**In FY25 WIYSC served 167 youth**

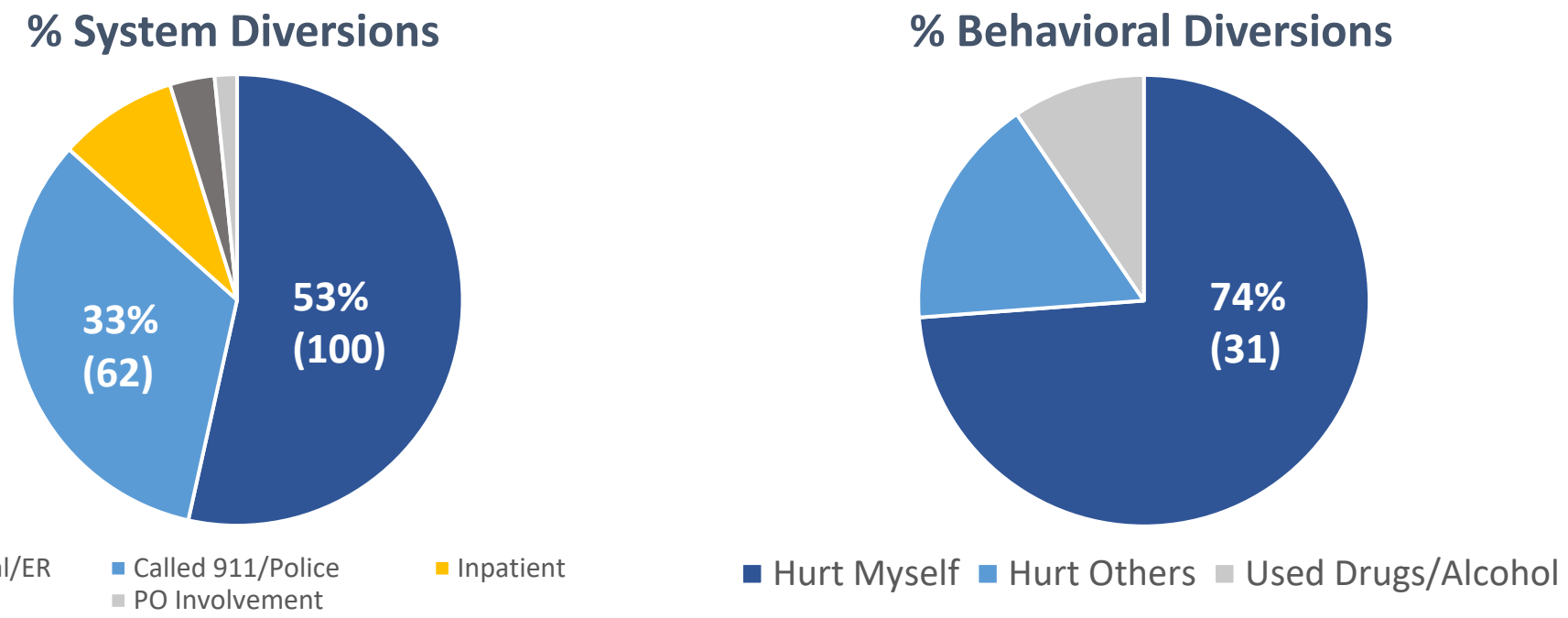
- 237 admissions
  - Average 59 visits per quarter
  - Average 19.7 visits per month
  - 125 youth came to WIYSC for the first time

# Western Idaho Youth Support Center - Demographics

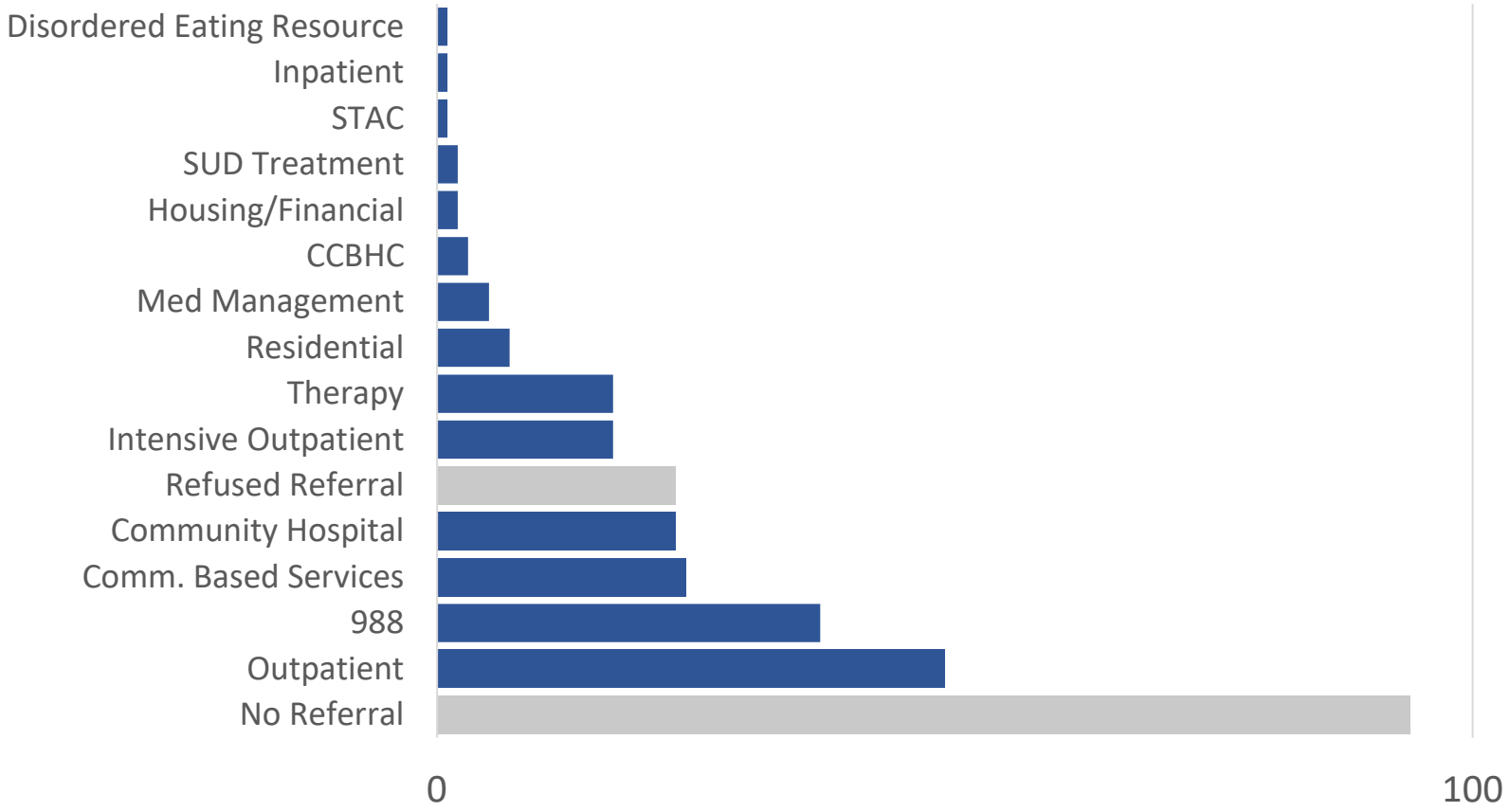
- **Gender** – 66% female / 34% male
- **Age** – average age 13 (oldest 17 years old / youngest 7 years old)
- **Race** – 52% white / 11% other race(s)
- **Ethnicity** – 47% not Hispanic / 19% Hispanic
- **Housing status** – 9% were homeless or at risk of losing housing
- **Insurance status** – 48% Medicaid / 16% private / 9% uninsured
- **County** – 62% Canyon County / 4% other SWDH counties

# Western Idaho Youth Support Center - Impact

- **Divert and Prevent:** On average, 26 youth were diverted from systems and harmful behaviors per quarter in FY25



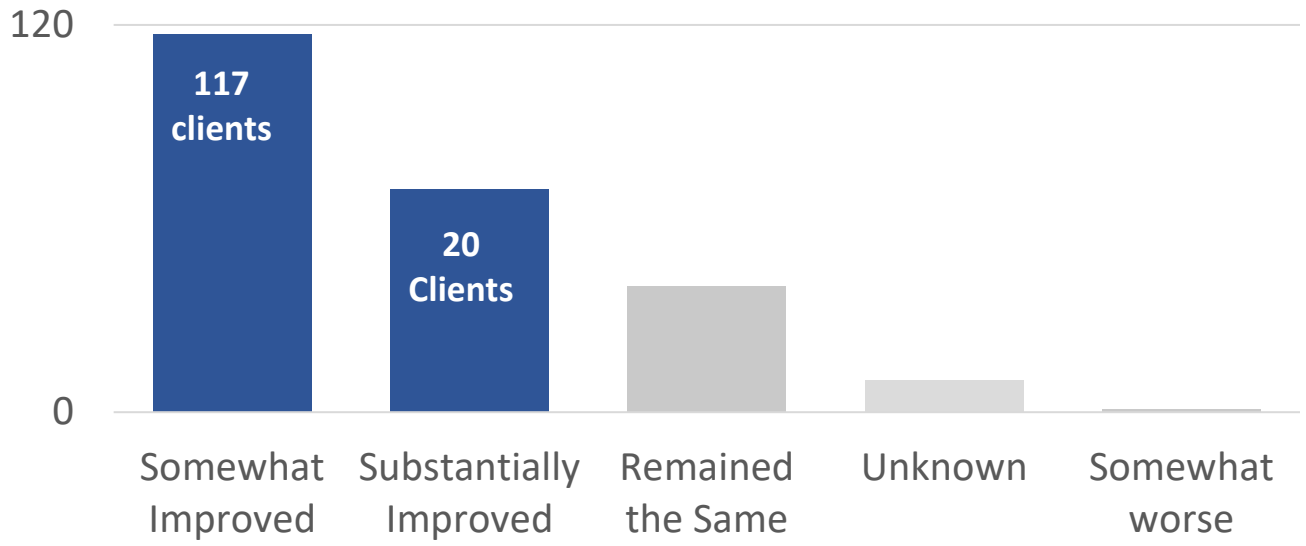
# Western Idaho Youth Support Center - Impact

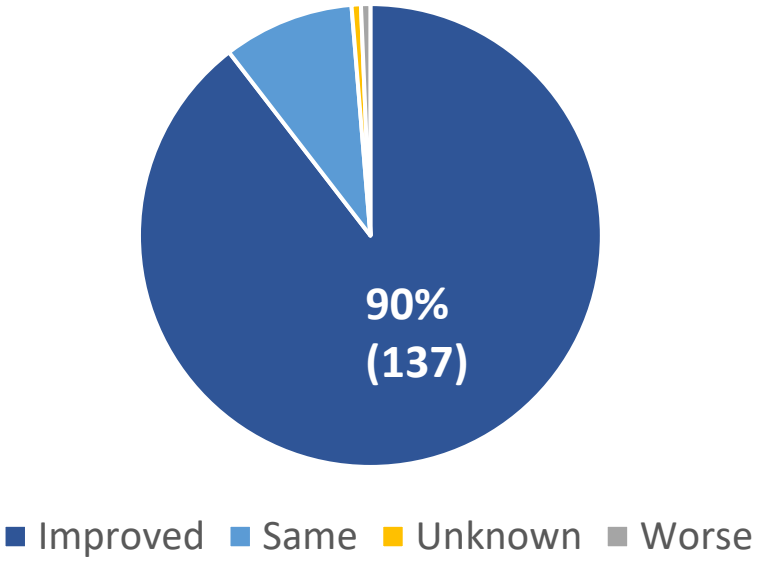



- **Connect:** 185 connections to care were made to 75 youth in FY25
- 49% of admissions resulted in at least one connection to care
- 45% of youth served accepted at least one connection to care

# Western Idaho Youth Support Center - Impact

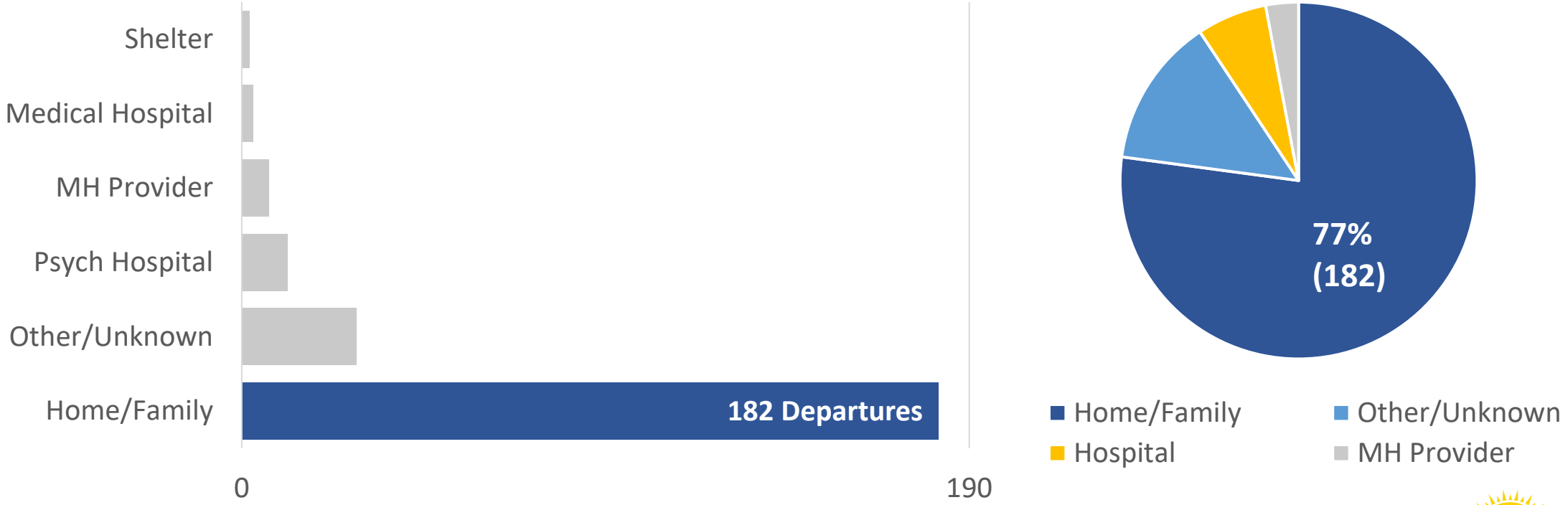
- **De-escalate:** In FY25, most clients' dispositions improved upon discharge



# Western Idaho Youth Support Center - Impact

- **Return:** most discharges were to the home/family in FY25



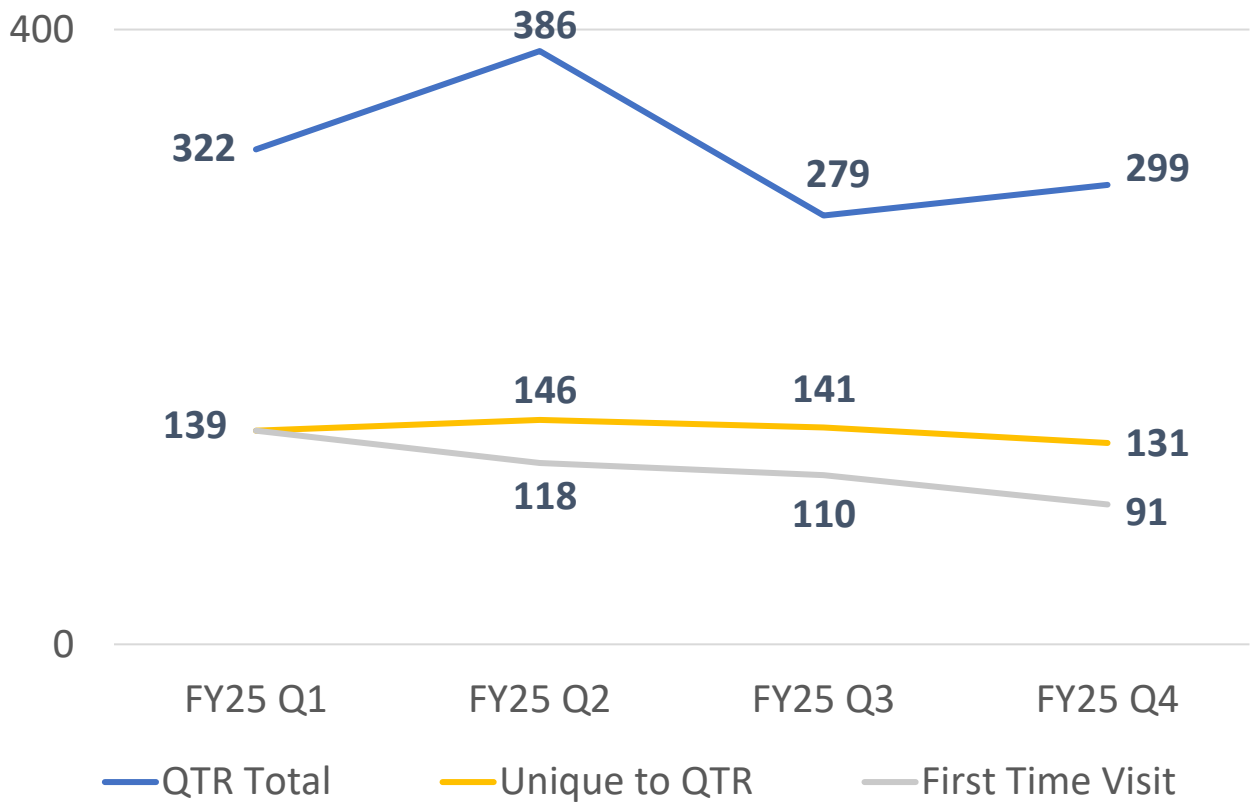
# Western Idaho Youth Support Center – Community Savings

| Diversion | # Diversions | Cost | Total Savings |
|---|---|---|---|
| Hospital/ER | 100 | $2,600 per hospital stay | $260,000 |
| 911/Police | 62 | $1,000 per interaction/transfer | $62,000 |
| Arrested/Jail | 5 | $138,868 per year (average length of stay 1.5 years) | $1,041,510 |
| In-Patient | 16 | $780/day (average length of stay 10-14 days) | $149,760 |
| | | **Total Community Savings in FY25:** | **$1,513,270** |

**19 youth reported they would have hurt themselves and 4 would have used drugs or alcohol** if not for WIYSC. The average return on investment for preventing death by suicide or overdose is almost **$1.4 million per person.**

These numbers are not included in the cost savings table because it is unknown if the harm to self or substance use would have resulted in death *and* death prevention return on investment may skew the conservative approach WIYSC takes to community cost savings.

# Western Idaho Community Crisis Center - Census




**In FY25 WIDCCC served 461 adults**

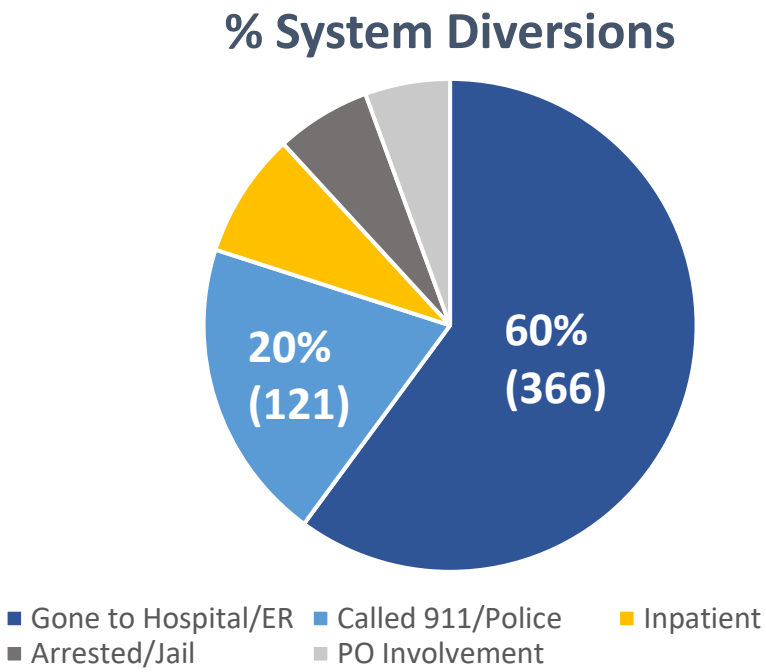
- 1286 admissions
  - Average 321 visits per quarter
  - Average 107 visits per month

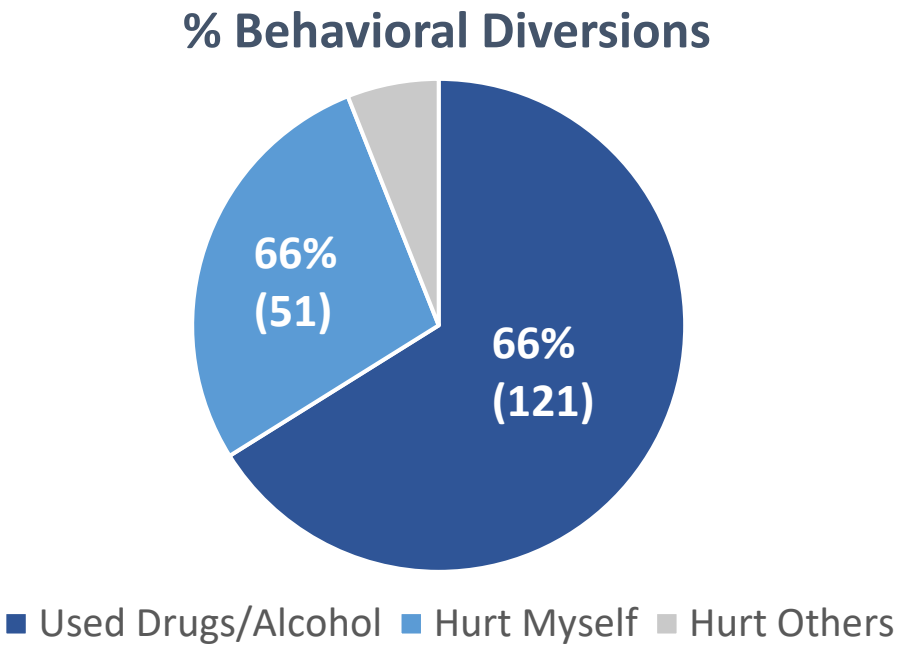
# Western Idaho Community Crisis Center - Demographics

- **Gender** – 38% female / 60% male
- **Age** – average age 40 (oldest 83 years old / youngest 18 years old)
- **Race** – 61% white / 9% other race(s)
- **Ethnicity** – 48% not Hispanic / 11% Hispanic
- **Housing status** – 77% were homeless or at risk of losing housing
- **Insurance status** – 68% public / 13% uninsured / 9% private
- **County** – 86% Canyon County / 2% other SWDH counties
- **Veteran Status** – 64% non-veteran / 3% veteran

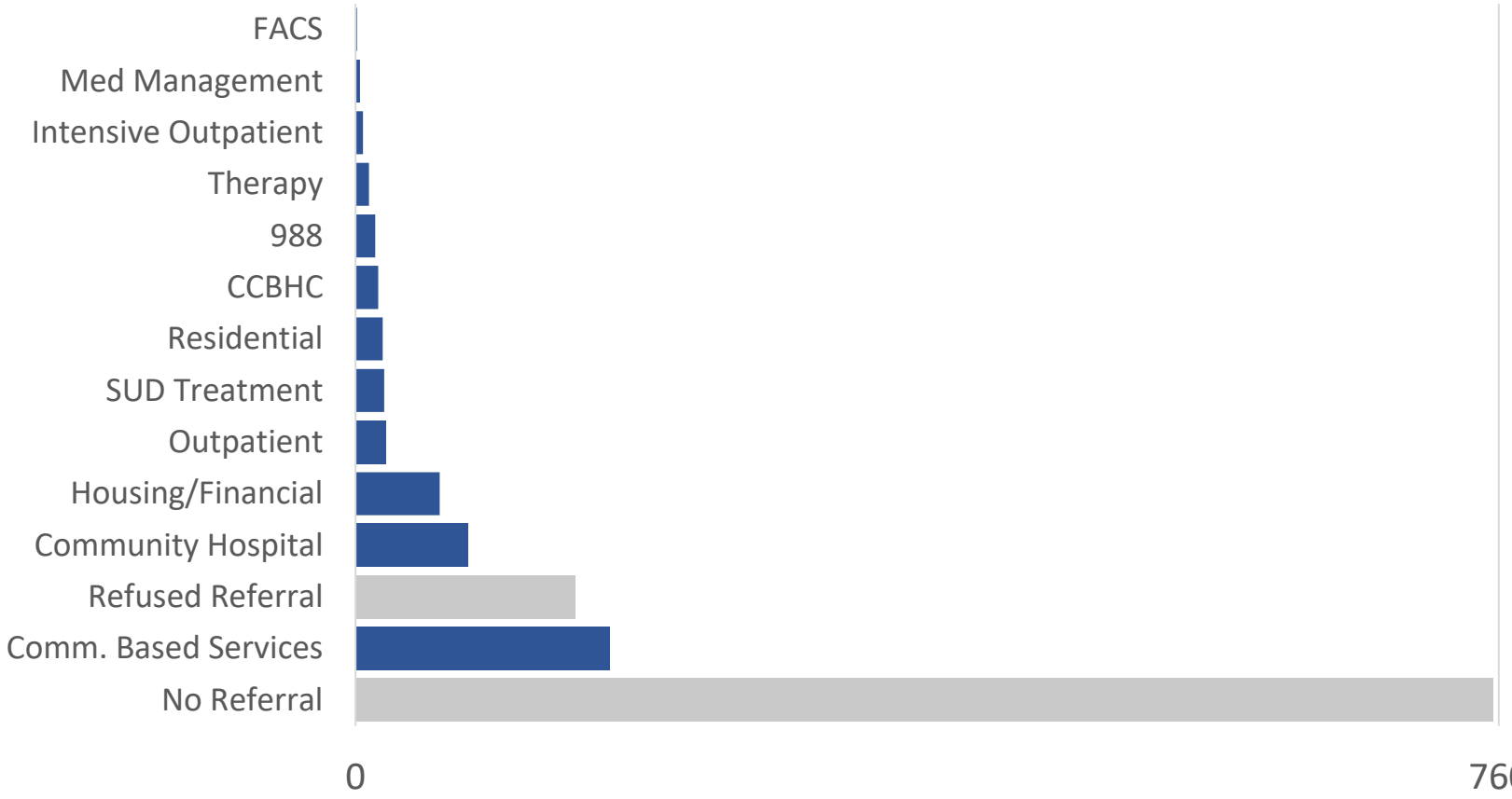
# Western Idaho Community Crisis Center - Impact

- **Divert and Prevent:** On average, 77 adults were diverted from systems and harmful behaviors per quarter in FY25



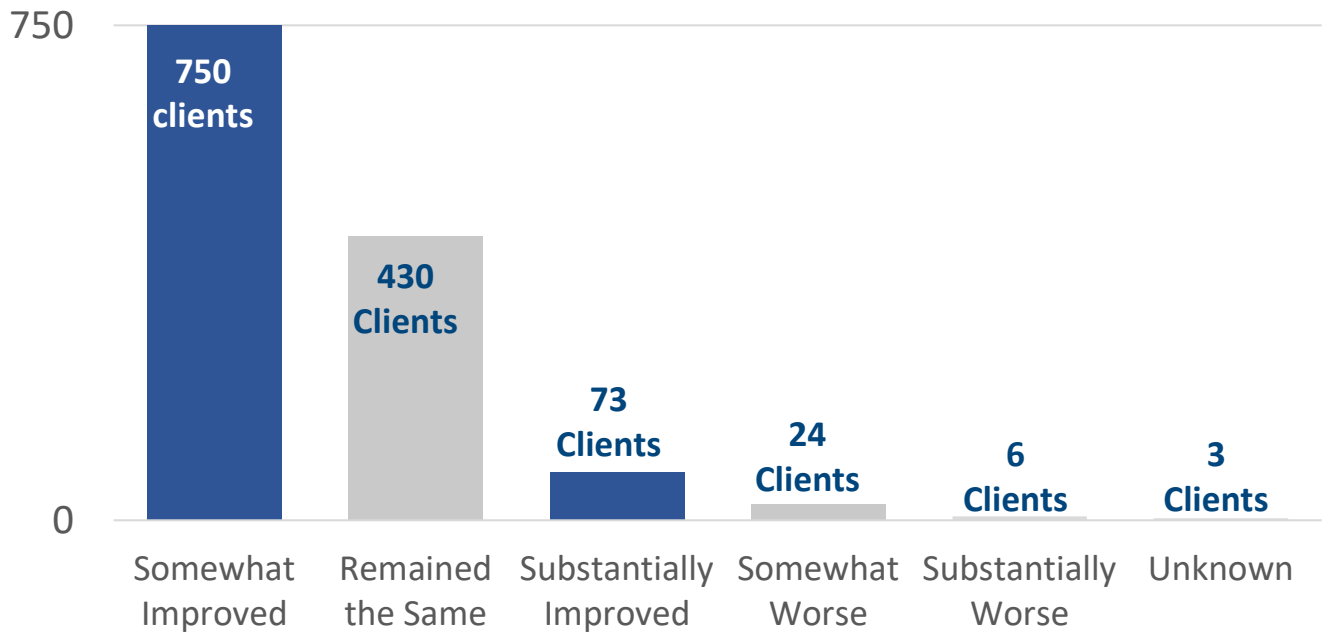
# Western Idaho Community Crisis Center - Impact

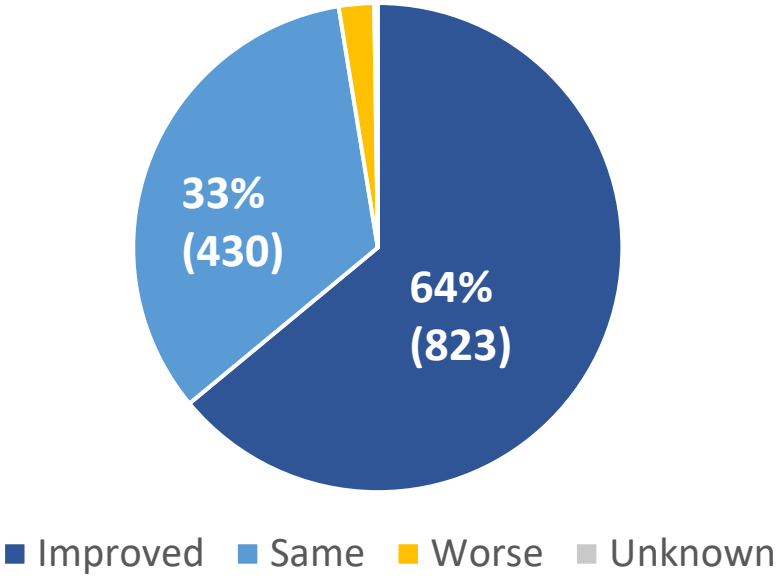



- **Connect:** 404 connections to care were made to 184 adults in FY25
- 30% of admissions resulted in at least one connection to care
- 40% of adults served accepted at least one connection to care

# Western Idaho Community Crisis Center - Impact

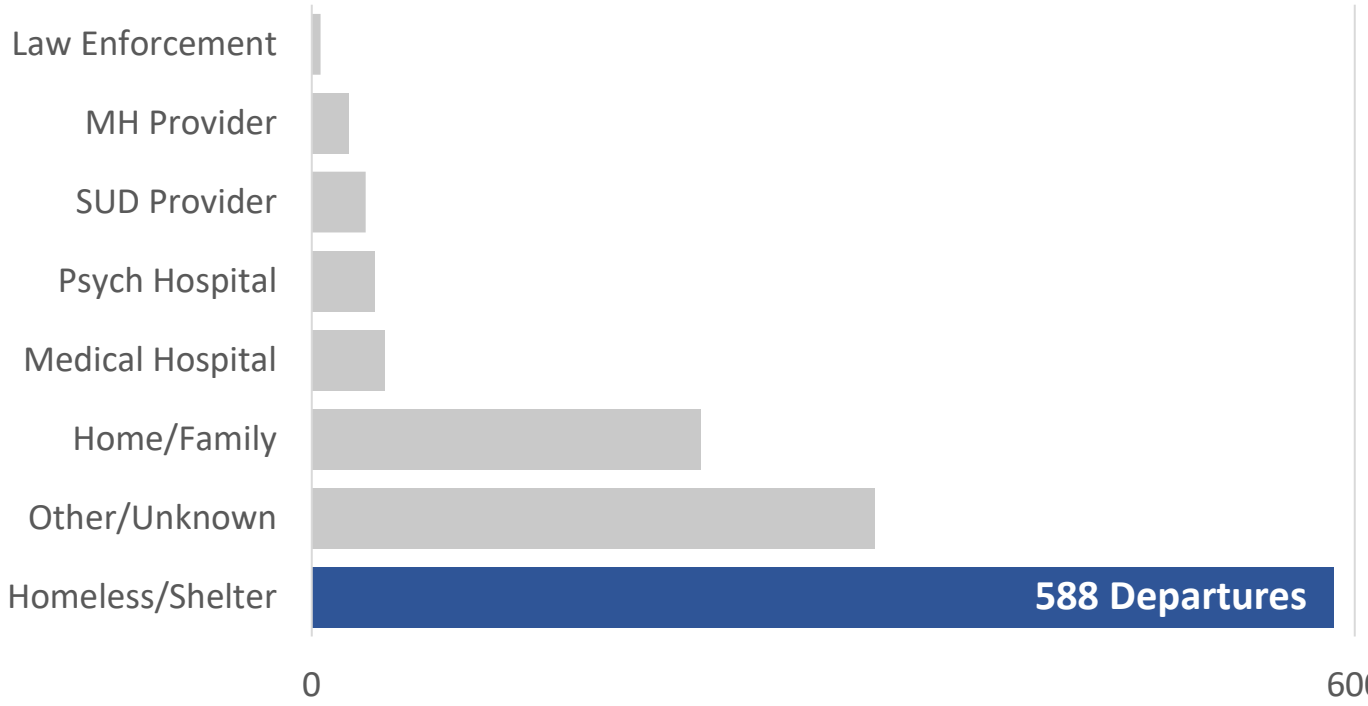
- **De-escalate:** In FY25, most clients' dispositions improved upon discharge

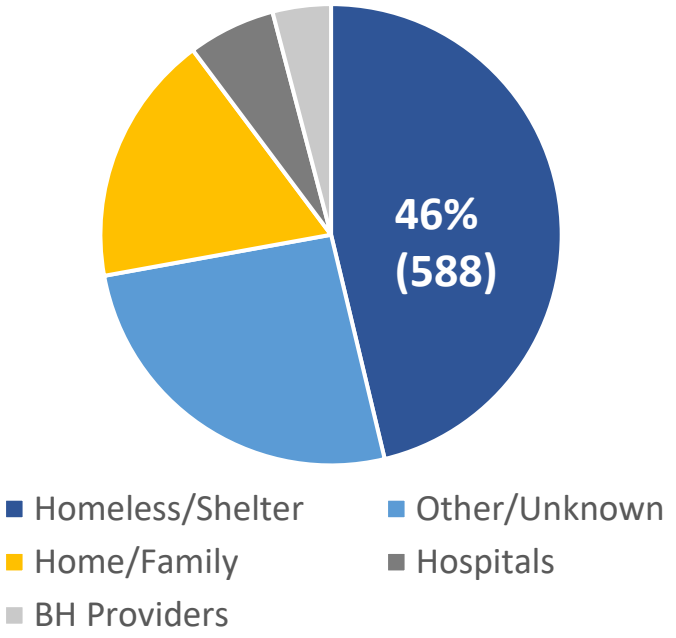


# Western Idaho Community Crisis Center - Impact

- **Return:** half of discharges were to shelters or to the community in FY25



# Western Idaho Community Crisis Center – Community Savings

| Diversion | # Diversions | Cost | Total Savings |
|---|---|---|---|
| Hospital/ER | 366 | $2,600 per hospital stay | $951,600 |
| 911/Police | 121 | $1,000 per interaction/transfer | $121,000 |
| Arrested/Jail | 38 | $80/day (average length of stay 14 days) | $42,560 |
| In-Patient | 50 | $780/day (average length of stay 7-10 days) | $331,500 |
| | | **Total Community Savings in FY25:** | **$1,446,660** |

**41 adults reported they would have hurt themselves and 74 would have used drugs/alcohol** if not for WIDCCC. The average return on investment for preventing death by suicide or overdose is almost **$1.4 million per person.**

These numbers are not included in the cost savings table because it is unknown if the harm to self or substance use would have resulted in death *and* death prevention return on investment may skew the conservative approach WIYSC takes to community cost savings.

# Crisis Center Funding

- **Funding Source:** Idaho Department of Health and Welfare's Division of Behavioral Health and Division of Medicaid
- **Pass-Through Agency:** Magellan of Idaho – Idaho's Behavioral Health Managed Care Organization
- **Funding Recipient:** Southwest District Health
- **Funding Duration:** annual contract
  - $125K per month per center

# Questions?

cas.waldron@swdh.id.gov

986-888-0601

# Community Savings and ROI Sources


Understanding the cost of in-home care and the cost of a hospital stay. (n.d.). MDC Healthcare.

Canyon County Paramedics. (2024).

Costs of responding to crime: Police, court, and legal services. (2010). RAND.

Removing Barriers to Youth and Family Success: The Role of State Juvenile Cost of Care Fees. (2021). Idaho Center for Fiscal Policy.

Email correspondence between SWDH and regional in-patient hospitals

Suicide and suicidal attempts in the United States: Costs and policy implications. Shepard, D.S., et al. (2016). The Official Journal of the American Association of Suicidology.

The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017. Florence, C., Luo, F., & Rice, K. (2021). Drug and Alcohol Dependence.

2025

# Southwest District Health Adjacency Report

PREPARED FOR SOUTHWEST DISTRICT HEALTH
AUGUST 2025

SOUTHWEST DISTRICT HEALTH

CLEARWATER FINANCIAL

amanda swails DESIGN

# SWDH DIVISIONS AND SERVICES

Southwest District Health (SWDH) is organized into three main divisions, each responsible for a distinct range of services supporting the health and well-being of Idaho communities.

The **Family and Clinic Services (FCS) division** oversees family-centered programs such as WIC (Women, Infants, and Children), provides a variety of clinical health services, and delivers behavioral health support.

The **Environmental and Community Health Services (ECHS) division** manages community facility inspections for food, childcare and public pool inspections, guides land development and oversees water, septic, and solid waste systems, coordinates the Public Health Emergency Preparedness Epidemiology Response (PHEPER), and leads outreach programs that promote community well-being.

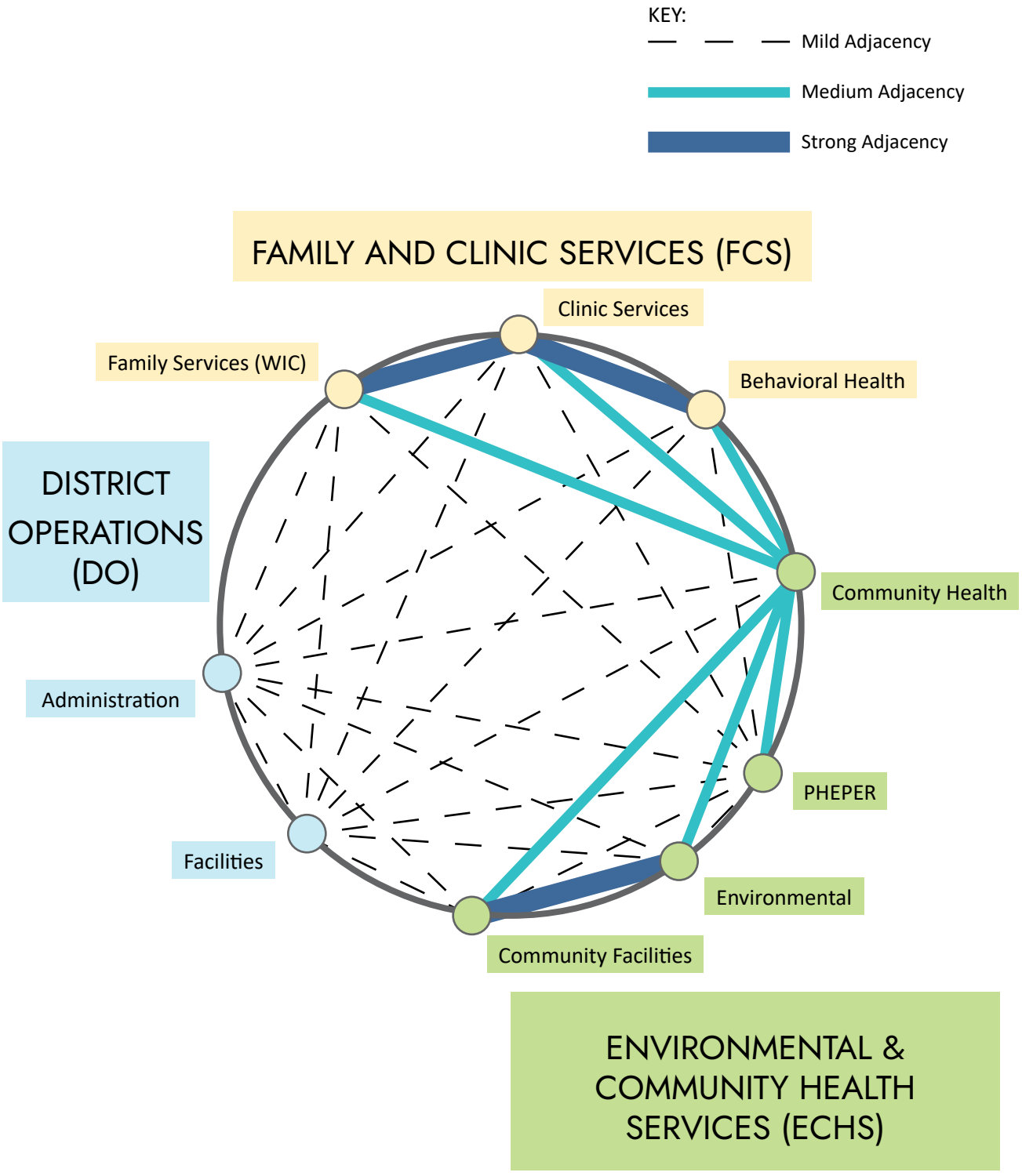
**District Operations (DO)** ensures the smooth functioning of SWDH, handling administration, finance and procurement, organizational development, information technology, human resources, customer service, and the maintenance of facilities.

Together, these divisions enable SWDH to offer comprehensive and accessible public health services across the region that includes six counties, both rural and urban.

The Caldwell Office serves as the main office, but three additional full service satellite offices, four WIC-only offices, and one clinic-only office span out across the six counties that SWDH is responsible for.

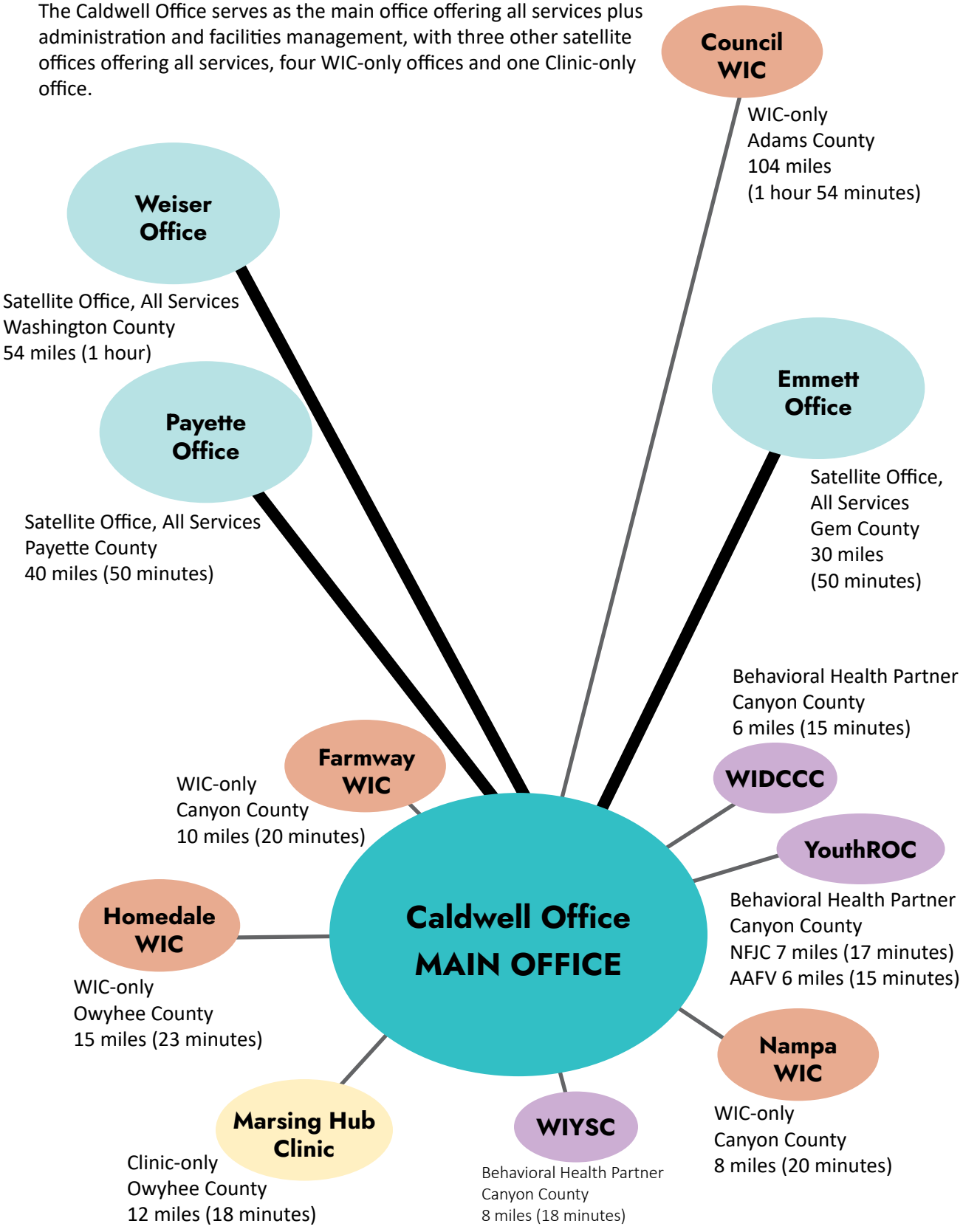
# ADJACENCY DIAGRAM

This diagram shows the physical adjacency needed between SWDH divisions and services.



# SWDH LOCATION PROXIMITY DIAGRAM

SWDH provides services to six counties located in Southwest Idaho. The Caldwell Office serves as the main office offering all services plus administration and facilities management, with three other satellite offices offering all services, four WIC-only offices and one Clinic-only office.



# SWDH SERVICES PER LOCATION

This table outlines the services provided at each physical location. Please note, District Operations (DO) and PHEPER operate out of the Caldwell Office but support each location remotely. Payette, Weiser and Emmett Offices are considered “all services” even though DO and PHEPER are not based there.

| | | FAMILY & CLINIC SERVICES (FCS) | | | ENVIRONMENTAL & COMMUNITY HEALTH SERVICES (ECHS) | | | | DISTRICT OPERATIONS (DO) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Own, Lease, or Share | Family Services (WIC) | Clinic Services | Behavioral Health | Community Facilities (Food, Childcare and Pool Inspections) | Environmental (Land Development, Water, Septic, Solid Waste) | PHEPER (Public Health Emergency Preparedness Epidemiology Response) | Community Health (Outreach Health Programs) | Administration (Finance & Procurement, Organization Development, IT, HR, Customer Service) | Facilities |
| **CALDWELL OFFICE** Caldwell, ID | Own | X | X | X | X | X | X | X | X | X |
| **PAYETTE OFFICE** Payette, ID | Own | X | X | X | Drop-off only | Drop-off only | | X | Customer service only | |
| **WEISER OFFICE** Weiser, ID | Own | X | X | X | Drop-off only | Drop-off only | | X | Customer service only | |
| **EMMETT OFFICE** Emmett, ID | Own | X | X | X | Drop-off only | Drop-off only | | X | Customer service only | |
| **NAMPA OFFICE** Idaho Hispanic Community Center (IH2C), Nampa, ID | Lease | X | | | | | | X | | |
| **HOMEDALE OFFICE** Old Homedale Library Homedale, ID | Share | X | | | | | | X | | |
| **FARMWAY OFFICE** Caldwell Housing Authority Caldwell, ID | Lease | X | | | | | | X | | |
| **COUNCIL OFFICE** Adams County Health Center (ACHC) Council, ID | Share | X | | | | | | X | | |
| **MARSING HUB** Marsing, ID | Share | | X | | | | | X | | |
| **WIYSC** Western Idaho Youth Support Center, Nampa, ID | | | | X | | | | X | | |
| **WIDCCC** Western Idaho Community Crisis Center, Caldwell, ID | | | | X | | | | X | | |
| **YouthROC** Nampa Family Justice Center (NFJC) & Advocates Against Family Violence (AAFV) | | | | X | | | | X | | |

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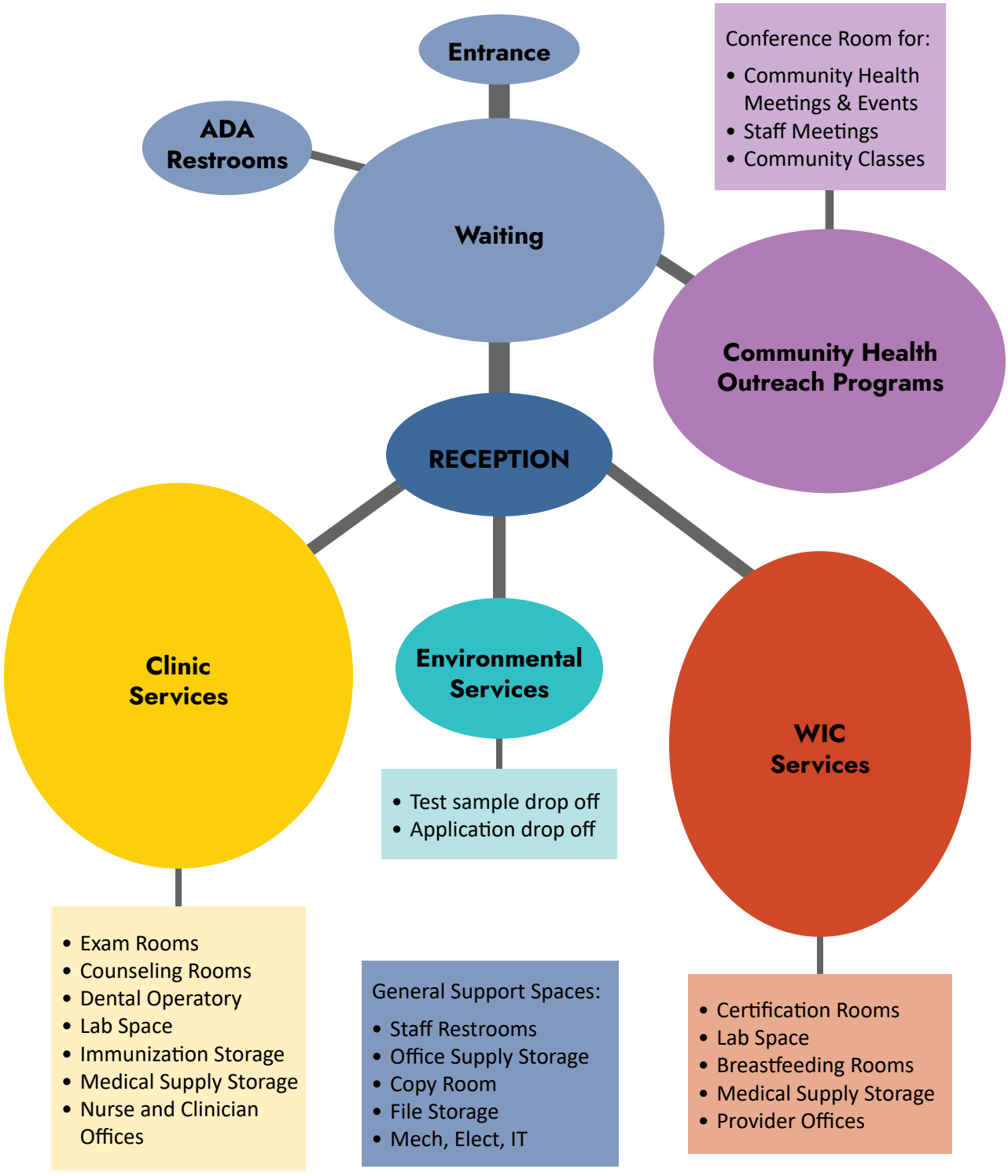
# FULL SERVICE SATELLITE OFFICE ADJACENCY DIAGRAM

This diagram illustrates room adjacency within the building. The reception desk serves as the primary point of contact for visitors, directing them to their appropriate destinations. Community Health Outreach Rooms, such as conference rooms, do not require initial access through the reception area; they may function independently or operate beyond standard hours, separate from the services managed by the reception desk.



2025

# Southwest District Health Land and Facility Report

PREPARED FOR SOUTHWEST DISTRICT HEALTH
AUGUST 2025

SOUTHWEST DISTRICT HEALTH

CLEARWATER FINANCIAL

amanda swails DESIGN

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# LAND AND FACILITY REPORT

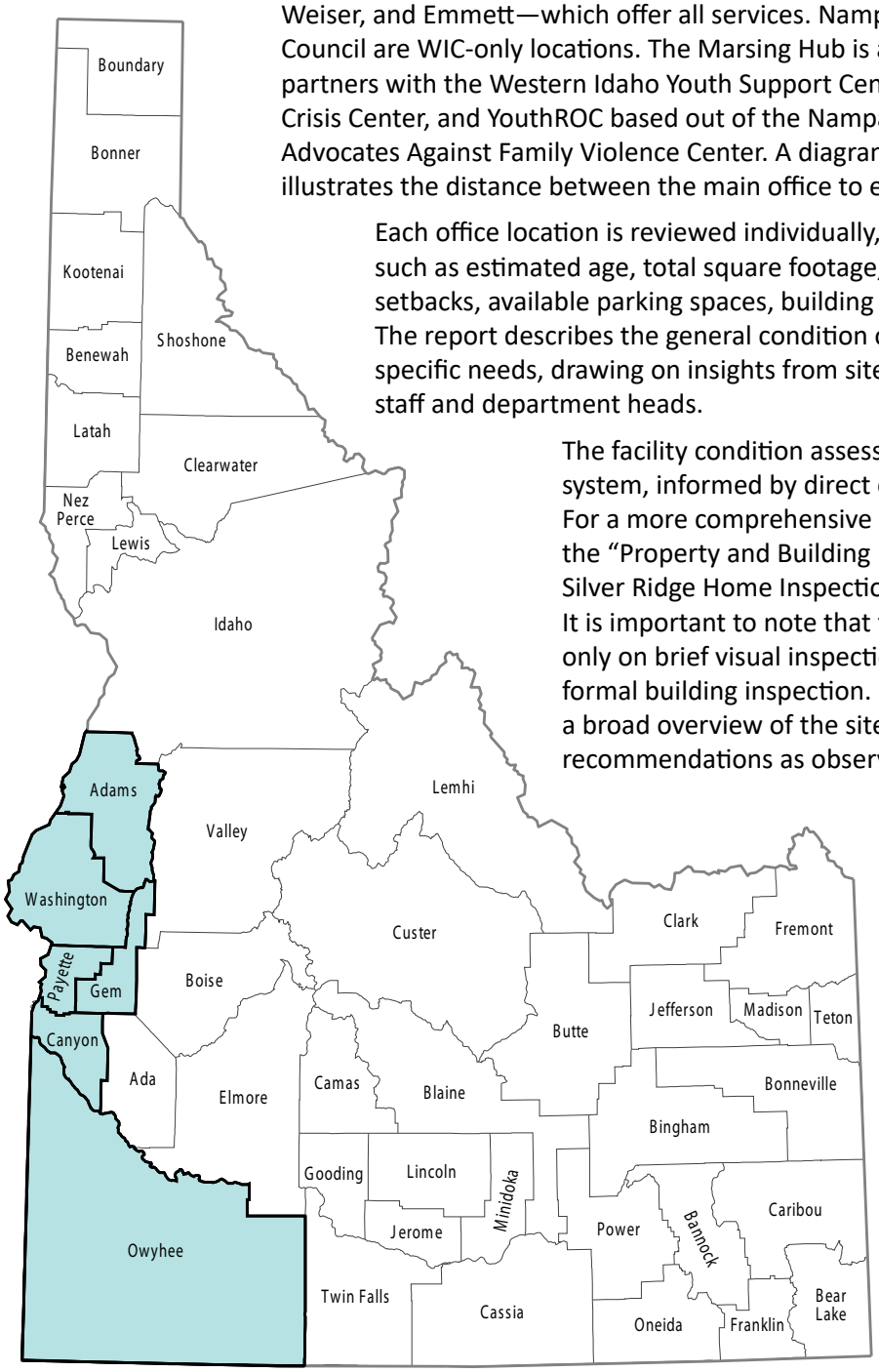
**Introduction**

Southwest District Health (SWDH) is one of Idaho's seven public health districts, delivering vital services across six counties—Adams, Canyon, Gem, Owyhee, Payette, and Washington. Spanning a large portion of Idaho, SWDH supports both rural and urban communities through its main office, three satellite locations, four WIC-only facilities, and one Clinic-only facility.

This report highlights SWDH's four owned sites—Caldwell (main office), Payette, Weiser, and Emmett—which offer all services. Nampa, Homedale, Farmway, and Council are WIC-only locations. The Marsing Hub is a Clinic-only location. SWDH partners with the Western Idaho Youth Support Center, Western Idaho Community Crisis Center, and YouthROC based out of the Nampa Family Justice Center and Advocates Against Family Violence Center. A diagram on the following page illustrates the distance between the main office to each location.

Each office location is reviewed individually, presenting key facility details such as estimated age, total square footage, construction type, zoning, setbacks, available parking spaces, building materials, and HVAC systems. The report describes the general condition of each facility and identifies specific needs, drawing on insights from site visits and conversations with staff and department heads.

The facility condition assessment uses a general rating system, informed by direct observations and staff input. For a more comprehensive analysis, reference is made to the "Property and Building Inspection Report" prepared by Silver Ridge Home Inspections, dated November 22, 2024. It is important to note that these assessments are based only on brief visual inspections and do not constitute a formal building inspection. Instead, this document provides a broad overview of the site visits, outlining findings and recommendations as observed.

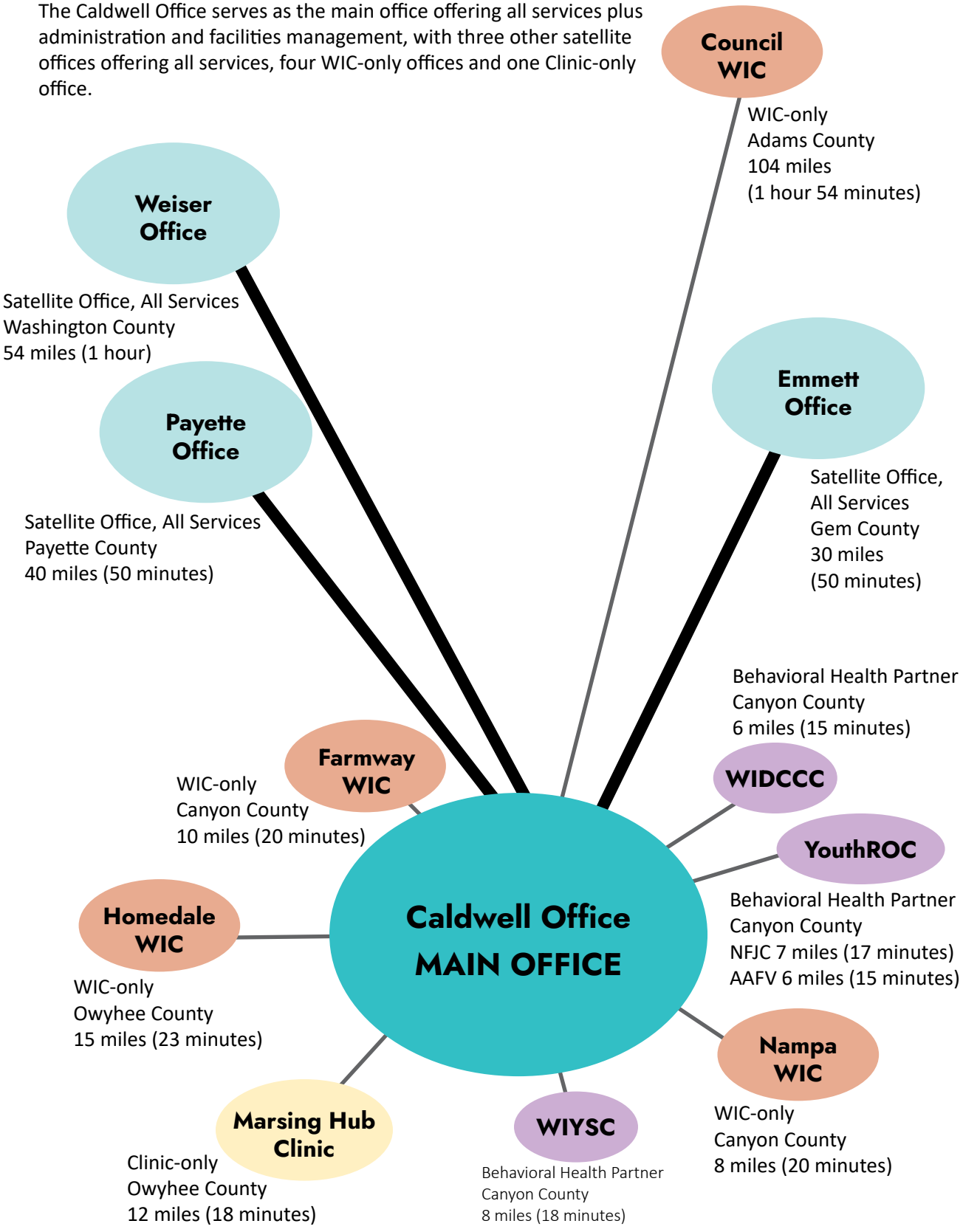



Counties served by SWDH shown shaded

Map Source: GISGeography.com

# SWDH LOCATION PROXIMITY DIAGRAM

SWDH provides services to six counties located in Southwest Idaho. The Caldwell Office serves as the main office offering all services plus administration and facilities management, with three other satellite offices offering all services, four WIC-only offices and one Clinic-only office.



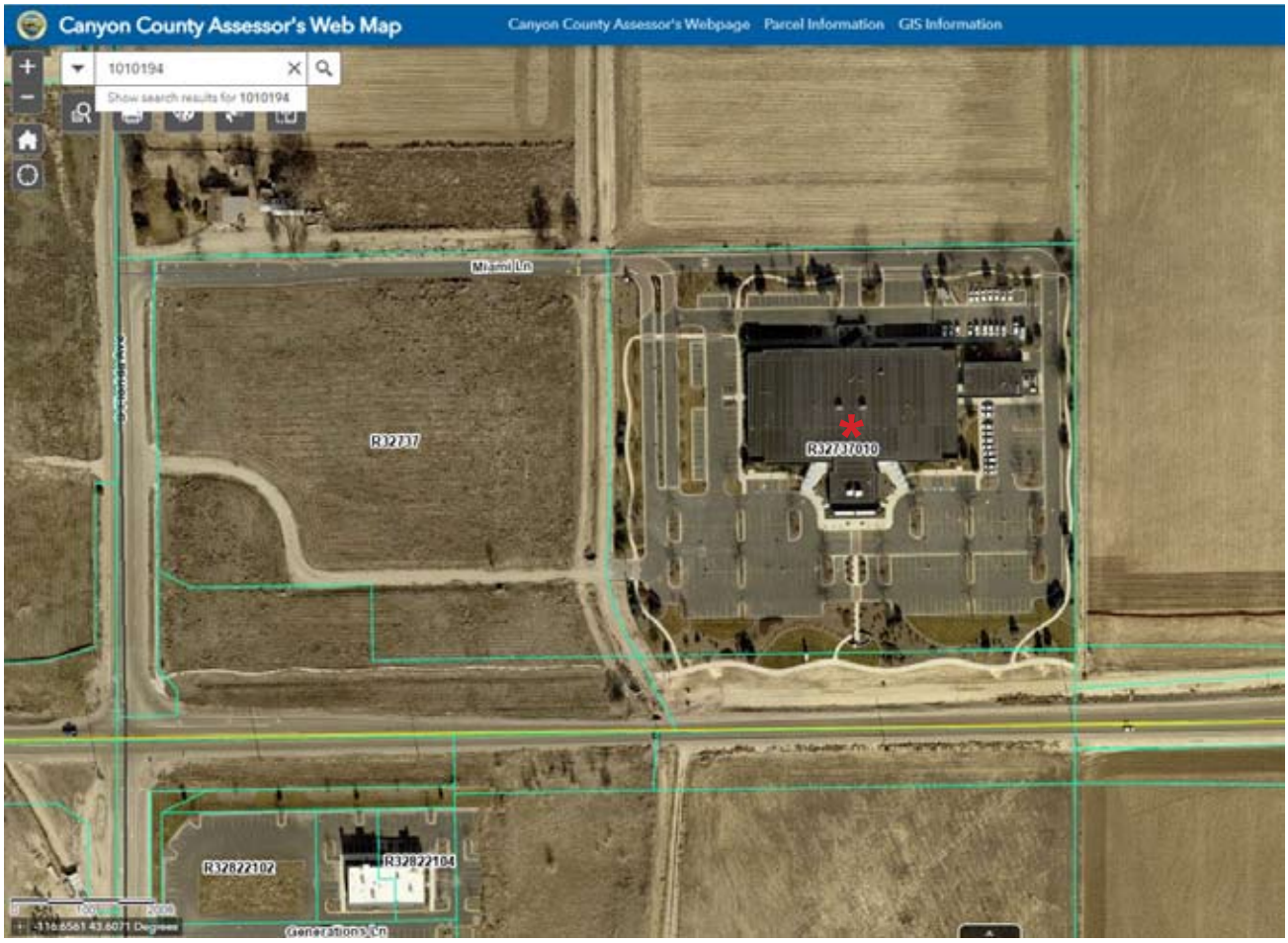

# SWDH LOCATIONS

| Name: | Address: | County: | Services: |
|---|---|---|---|
| Caldwell Office (Main Office) | 13307 Miami Lane<br>Caldwell, ID 83607 | Canyon | All Services<br>Main Office |
| Payette Office (Satellite Office) | 1155 3rd Ave North<br>Payette, ID 83661 | Payette | All Services |
| Weiser Office (Satellite Office) | 46 West Court St<br>Weiser, ID 83672 | Washington | All Services |
| Emmett Office (Satellite Office) | 1008 East Locust St<br>Emmett, ID 83617 | Gem | All Services |
| Nampa Office | Idaho Hispanic Community Center (IH2C)<br>315 Stampede Dr, Nampa, ID 83687 | Canyon | WIC Only |
| Homedale Office | Old Homedale Library<br>125 W Owyhee Ave, Homedale, ID 83628 | Owyhee | WIC Only |
| Farmway Office | Caldwell Housing Authority<br>22730 Farmway Rd #114, Caldwell, ID 83607 | Canyon | WIC Only |
| Council Office | Adams County Health Center (ACHC)<br>205 N Berkley St, Council, ID 83612 | Adams | WIC Only |
| Marsing Hub | The Marsing Hub<br>205 8th Ave W, Marsing, ID 83639 | Owyhee | Clinic Only |
| WIYSC | Western Idaho Youth Support Center<br>308 E Hawaii Ave, Nampa, ID 83686 | Canyon | Behavioral Health Partner |
| WIDCCC | Western Idaho Community Crisis Center<br>524 Cleveland Blvd #160, Caldwell, ID 83605 | Canyon | Behavioral Health Partner |
| YouthROC | Nampa Family Justice Center (NFJC)<br>1305 3rd St S, Nampa, ID 83651 | Canyon | Behavioral Health Partner |
| YouthROC | Advocates Against Family Violence (AAFV)<br>1508 Hope Ln, Caldwell, ID 83605 | Canyon | Behavioral Health Partner |

# CALDWELL OFFICE

SWDH Main Office
All SWDH Services - Canyon County
13307 Miami Lane
Caldwell, ID 83607

Open Weekdays 8am - 5pm (all services)




Map Data: Canyon County Assessor's Map Web Map, GIS Interactive Map, www.canyoncounty.id.gov/elected-officials/assessor/

## FACILITY LOCATION

Located in Canyon County, the Caldwell Office functions as SWDH's main office. All SWDH divisions are headquartered at this location, and all SWDH services are available here. This facility stores and distributes medications, supplies, and test kits to the satellite offices.

The building's location outside of Caldwell is relatively remote, which may present access challenges for the public. The site is not served by pedestrian routes or public bus transportation but is accessible via private vehicle.

# FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | Owned |
| Year of SWDH Occupation: | 2009, built for SWDH |
| Year Built: | 2009 |
| Estimated Building Age: | 16 years |
| Building Square Footage: | 51,911 sf |
| Floor(s): | 1 |
| Accessory Buildings: | 10x16 storage shed |
| Building Occupancy: | B |
| Type of Construction: | Type IIB |
| Construction Description: | Structural steel frame with brick veneer and metal siding |
| Parcel ID: | 32737010 0 |
| Site Zoning: | C-2 Community Commercial |
| Site Acreage: | 8.25 acres |
| Site Setbacks, R.O.W., | |
| Front setback = | 0'-0" |
| Rear setback = | 0'-0' |
| Side setback = | 0'-0" |
| Height maximum = | 55'-0" or 30'-0" if within 150'-0" of residential property |
| Flood Zone: | No, Zone X (Area of Minimal Flood Hazard) |
| Existing Standard Parking Spaces | 289 |
| Existing ADA Parking Spaces | 10 |
| Required Standard Parking Spaces | 160 |
| Required ADA Parking Spaces | 7 |

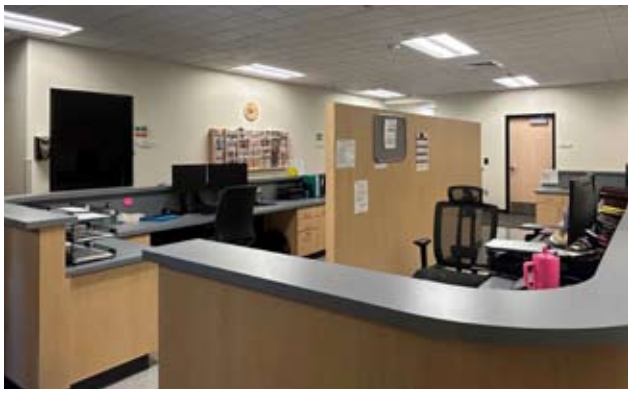
# BUILDING COMPONENTS

| | |
|---|---|
| Structural Framing: | Structural Steel Frame |
| Siding Material: | Brick, Metal Siding |
| Basement/Crawl Space/Slab: | Slab on Grade |
| Roofing Material: | Membrane |
| Attic Ventilation Type: | Mechanical Vent |
| HVAC Type: | Split System AC, Rooftop Units, Heat Pumps |
| Electrical Service Supply: | 200 amp |
| Water Source: | Public |
| Sewer: | Public |

# CALDWELL OFFICE

SWDH Main Office
All SWDH Services - Canyon County
13307 Miami Lane
Caldwell, ID 83607

Open Weekdays 8am - 5pm (all services)




## FACILITY CONDITION

The Caldwell Office serves as Southwest District Health's main office. It houses all divisions, including Family and Clinic Services (FCS), Environmental & Community Health (ECH), and District Operation (DO) services. Built in 2009, the building is well maintained but does have minor maintenance needs.

The roofing membrane is nearing the end of its lifecycle and is recommended for replacement within about three years. Tree roots are damaging the parking lot curbs and pavement. It is advisable to evaluate overgrown trees for potential replacement, followed by repairing the impacted curbs.

The HVAC system uses individual heat pumps. Replacing failed units is labor-intensive, disruptive, and costly. While a centralized system would simplify maintenance, its cost-effectiveness is unclear. For now, repair when needed.

# FACILITY CONDITION ASSESSMENT

This assessment uses a general rating system, informed by direct observations and staff input. For a more comprehensive analysis, refer to the "Property and Building Inspection Report" prepared by Silver Ridge Home Inspections, 2024. Amanda Swails Design, LLC did not inspect these systems. It is important to note that these assessments are based only on brief visual inspections and do not constitute a formal building inspection.

| | |
|---|---|
| **SITE** | |
| Landscaping/Sitework | 4 – Good |
| Parking Lot(s) | 4 – Good |
| Entrance/Walkways | 5 – Excellent |
| Comments: Tree root/curb repairs | |
| **BUILDING EXTERIOR** | |
| General Building Envelope | 5 – Excellent |
| Foundation | 5 – Excellent |
| Structure | 5 – Excellent |
| Roof/Gutters | 4 – Good |
| Exterior Stairs/Ramps/Railings | N/A |
| Doors/Windows | 5 – Excellent |
| Comments: Overall building is in excellent condition. Roof membrane replacement in the next few years. Heat pump repairs/replacement as needed. | |
| **BUILDING INTERIOR** | |
| General Interior Layout | 5 – Excellent |
| Interior Walls | 5 – Excellent |
| Interior Floors | 5 – Excellent |
| Interior Ceilings | 4 – Good |
| Comments: Minor water damage on some office ceilings | |
| **BUILDING SYSTEMS AND EQUIPMENT** | |
| Fire Sprinkler System | 5 – Excellent |
| HVAC | 4 – Good |
| Plumbing | 4 – Good |
| Electrical | 5 – Excellent |
| Generators | 0 |
| Communication Systems (incl. internet) | 3 – Fair |
| Comments: HVAC heat pump repairs, plumbing issues in breakroom and adjacent restrooms, inconsistent IT setups, meeting rooms lack standardized technology, unreliable equipment for virtual meetings. | |
| **ADA ACCESSIBILITY** | Yes, fully compliant |
| Comments: Fully ADA Compliant | |

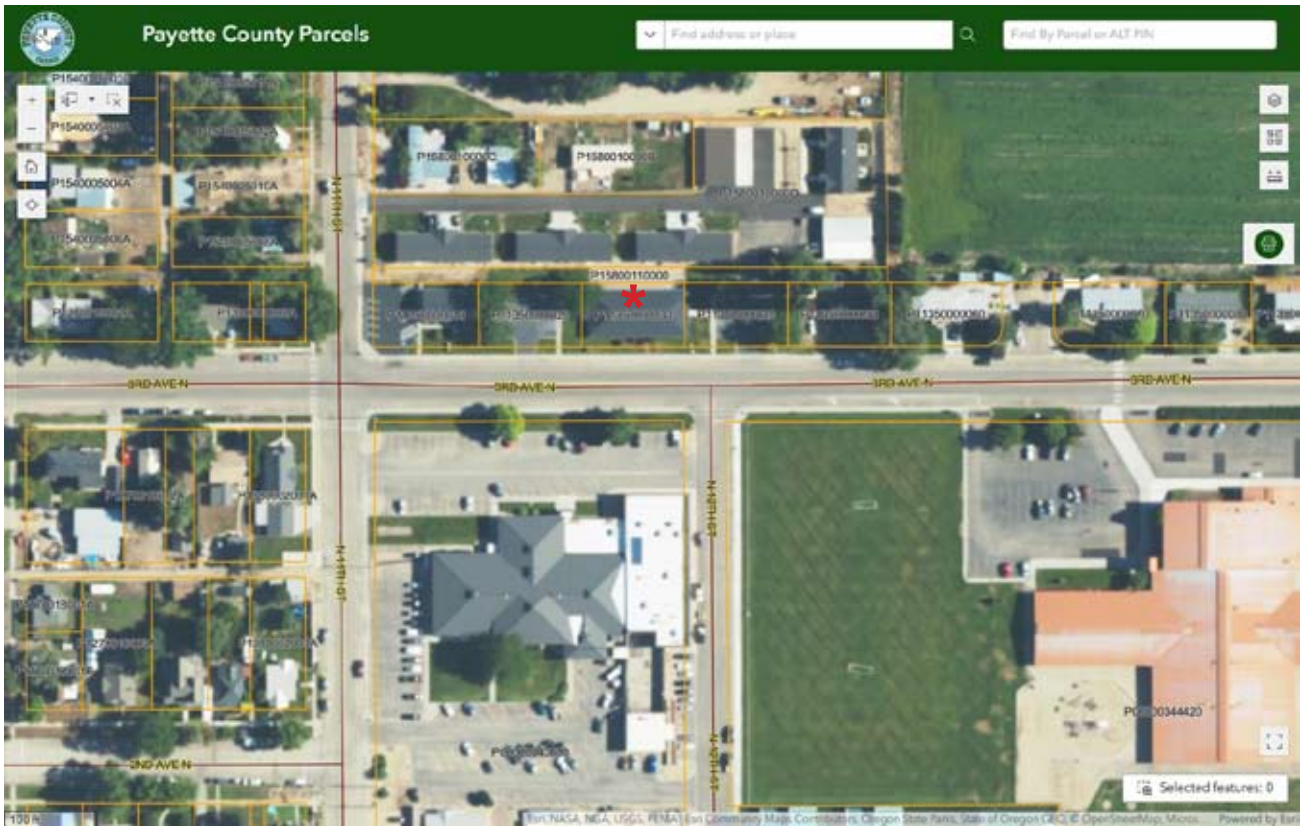
**Condition Ratings**

5 – Excellent: Only routine maintenance required.
4 – Good: Minor repairs may be needed; system functions properly.
3 – Fair: Occasional major and frequent minor repairs; sometimes fails.
2 – Poor: Major repairs needed, worn, outdated, limited function, or not up to code.
1 – Bad: Needs major repair or replacement; may be unsafe or not up to code.
0 – Not assessed, not examined.
N/A – Not applicable or present.

# PAYETTE OFFICE

All SWDH Services - Payette County
1155 3rd Ave North
Payette, ID 83661

Open Weekdays 8am - 5pm
WIC Mon/Wed/Fri 8am - 5pm




Map Data: Payette County Assessor's Parcels Map, Parcel Map STC,
https://experience.arcgis.com/experience/7d1e34f961e441cf8b5db2858aa04134/

## FACILITY LOCATION

The Payette Office is conveniently located in the heart of Payette, across from the Payette County Offices and Payette Primary School. There are no concerns with its location and accessibility.

# FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | Owned |
| Year of SWDH Occupation: | 1998, built for SWDH |
| Year Built: | 1998 |
| Estimated Building Age: | 27 years |
| Building Square Footage: | approximately 5000sf |
| Floor(s): | 1 |
| Accessory Buildings: | N/A |
| Building Occupancy: | B |
| Type of Construction: | Type V |
| Construction Description: | Wood frame with vinyl siding and brick veneer |
| Parcel ID: | 3 total parcels: P11350000030 (building), P11350000020 (west parking lot), P11350000040 (east lot) |
| Site Zoning: | B Residential |
| Site Acreage: | 0.17 acres each parcel = .51 acres total |
| Site Setbacks, R.O.W., | |
| Front setback = | 20'-0" |
| Rear setback = | 10'-0" |
| Side setback = | 5'-0" |
| Height maximum = | 2 stories maximum |
| Flood Zone: | No |
| Existing Standard Parking Spaces | 8 |
| Existing ADA Parking Spaces | 1 |
| Required Standard Parking Spaces | 25 spaces, Payette Zoning Code: 1 parking space for every 200 sf of floor area for medical, dental clinics, doctor's office and waiting rooms. |
| Required ADA Parking Spaces | 1 |

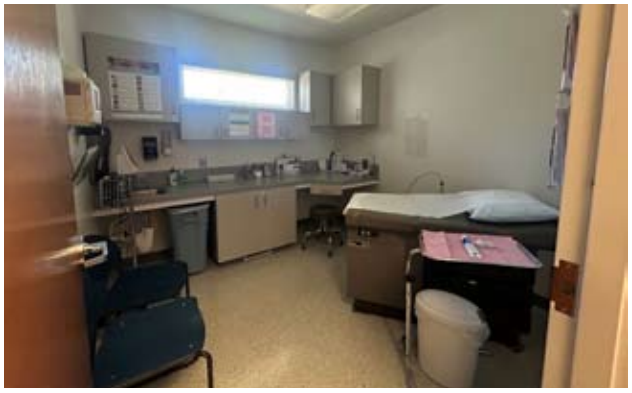
# BUILDING COMPONENTS

| | |
|---|---|
| Structural Framing: | Wood frame |
| Siding Material: | Vinyl, Brick |
| Basement/Crawl Space/Slab: | Crawl Space |
| Roofing Material: | Fiberglass/Asphalt |
| Attic Ventilation Type: | Ridge Vents |
| HVAC Type: | Forced Air |
| Electrical Service Supply: | 200 amp |
| Water Source: | Public |
| Sewer: | Public |

# PAYETTE OFFICE

All SWDH Services - Payette County
1155 3rd Ave North
Payette, ID 83661

Open Weekdays 8am - 5pm
WIC Mon/Wed/Fri 8am - 5pm



## FACILITY CONDITION

The Payette Office building is relatively new and in good condition. Water damage identified in November 2024 has been remediated. Downspout extensions are recommended to divert rainwater away from the foundation.

An automatic entrance door operator, while not required by ADA Code, would improve accessibility. Installing a speaker at the front reception desk could address sound transmission issues caused by the high counter and glass shield.

It is recommended to install IT infrastructure, such as monitors, speakers, and microphones, in the conference room to support hybrid meetings and community events.

# FACILITY CONDITION ASSESSMENT

This assessment uses a general rating system, informed by direct observations and staff input. For a more comprehensive analysis, refer to the "Property and Building Inspection Report" prepared by Silver Ridge Home Inspections, 2024. Amanda Swails Design, LLC did not inspect these systems. It is important to note that these assessments are based only on brief visual inspections and do not constitute a formal building inspection.

| | |
|---|---|
| **SITE** | |
| Landscaping/Sitework | 4 – Good |
| Parking Lot(s) | 5 – Excellent |
| Entrance/Walkways | 5 – Excellent |
| Comments: Divert downspout drainage away from foundation. | |
| **BUILDING EXTERIOR** | |
| General Building Envelope | 5 – Excellent |
| Foundation | 4 – Good |
| Structure | 5 – Excellent |
| Roof/Gutters | 4 – Good |
| Exterior Stairs/Ramps/Railings | N/A |
| Doors/Windows | 5 – Excellent |
| Comments: Overall building is in excellent condition. Divert downspout Drainage away from foundation. | |
| **BUILDING INTERIOR** | |
| General Interior Layout | 5 – Excellent |
| Interior Walls | 5 – Excellent |
| Interior Floors | 5 – Excellent |
| Interior Ceilings | 5 – Excellent |
| Comments: | |
| **BUILDING SYSTEMS AND EQUIPMENT** | |
| Fire Sprinkler System | 5 – Excellent |
| HVAC | 5 – Excellent |
| Plumbing | 5 – Excellent |
| Electrical | 5 – Excellent |
| Generators | N/A |
| Communication Systems (incl. internet) | 3 – Fair |
| Comments: IT infrastructure in conference room | |
| **ADA ACCESSIBILITY** | Yes, fully compliant. |
| Comments: While not required by ADA Code, an automatic entrance door operator would be useful. | |

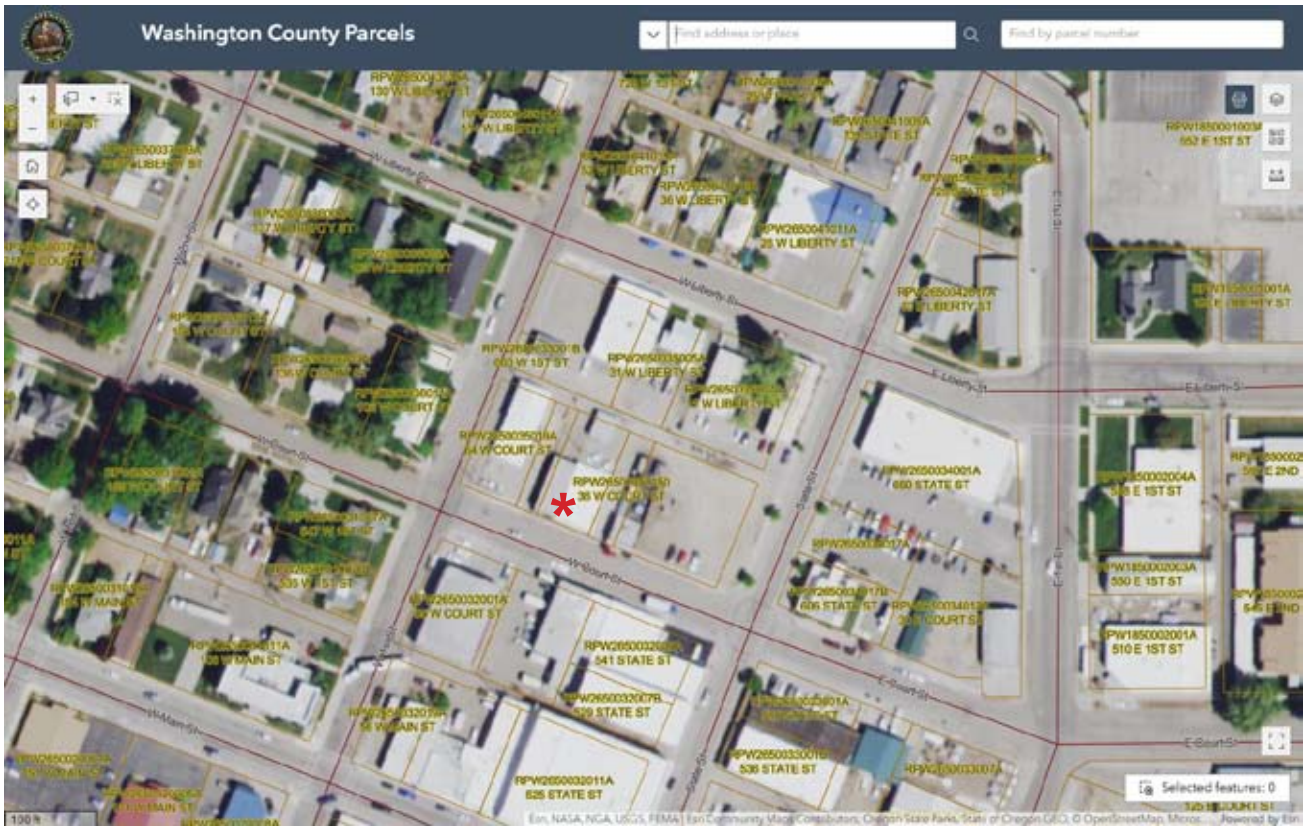
**Condition Ratings**

5 – Excellent: Only routine maintenance required.
4 – Good: Minor repairs may be needed; system functions properly.
3 – Fair: Occasional major and frequent minor repairs; sometimes fails.
2 – Poor: Major repairs needed, worn, outdated, limited function, or not up to code.
1 – Bad: Needs major repair or replacement; may be unsafe or not up to code.
0 – Not assessed, not examined.
N/A – Not applicable or present.

# WEISER OFFICE

All SWDH Services - Washington County
46 West Court St
Weiser, ID 83672

Open Weekdays 8am - 5pm
WIC Thursdays 8am - 5pm




Map Data: Washington County Assessor's Parcels Map, Powered by Esri,
https://experience.arcgis.com/experience/e6f99fb948e24f00a0e10fb696ceed6b

## FACILITY LOCATION

The Weiser Office is located right in the heart of downtown Weiser, offering convenient public access. With frequent community events nearby, this SWDH-owned building provides strong community visibility and involvement. Only public street parking is available for visitors. Staff have a small gravel lot behind the building. No dedicated ADA parking space exists at this facility.

# FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | Owned |
| Year of SWDH Occupation: | 1989, tenant improvement for SWDH |
| Year Built: | unknown |
| Estimated Building Age: | more than 40 years |
| Building Square Footage: | approximately 2200 sf |
| Floor(s): | 1 |
| Accessory Buildings: | 24x24 garage |
| Building Occupancy: | B |
| Type of Construction: | Type V |
| Construction Description: | Concrete block and wood frame interior |
| Parcel ID: | RPW2650035016A |
| Site Zoning: | C Commercial |
| Site Acreage: | 0.084 acres |
| Site Setbacks, R.O.W., | |
| Front setback = | 5'-0" |
| Rear setback = | 0'-0" |
| Side setback = | 0'-0" |
| Height maximum = | 4 stories maximum |
| Flood Zone: | No, Zone X (Area of Minimal Flood Hazard) |
| Existing Standard Parking Spaces | 3 Staff-only parking spaces behind building, Street parking for public |
| Existing ADA Parking Spaces | 0 |
| Required Standard Parking Spaces | 6 spaces, Weiser Zoning Code: At least 5 parking spaces for each staff member or visiting doctor, plus 1 space for each employee for Medical and dental clinics. |
| Required ADA Parking Spaces | 1 |

# BUILDING COMPONENTS

| | |
|---|---|
| Structural Framing: | Concrete Block and wood frame |
| Siding Material: | Concrete Block/Stone |
| Basement/Crawl Space/Slab: | Slab on grade |
| Roofing Material: | Membrane |
| Attic Ventilation Type: | Soffit Vents |
| HVAC Type: | Forced Air |
| Electrical Service Supply: | 200 amp |
| Water Source: | Public |
| Sewer: | Public |

# WEISER OFFICE

All SWDH Services - Washington County
46 West Court St
Weiser, ID 83672

Open Weekdays 8am - 5pm
WIC Thursdays 8am - 5pm

## FACILITY CONDITION

The office, located in downtown Weiser, offers easy public access and visibility. The building shares a concrete block wall on the west side with an adjoining chiropractor's office, while the east side includes an alley that leads to a gravel staff parking lot at the rear of the building. Public parking is available on the street, but no designated ADA-compliant spaces. Additionally, there is a two-stall garage behind the building for storage of emergency preparedness equipment, such as tables and tents.

The town of Weiser experiences periodic power outages several times annually. Due to budget constraints, the office does not have a generator; instead, it coordinates with the local hospital for immunization storage during outages.

Several ADA compliance issues are present, including the absence of accessible parking, inadequate transaction counter height at the reception desk, and threshold violations. While not required by ADA code, an entrance door operator would be very beneficial for all users. There is also evidence of ceiling leak damage in the mechanical storage area.

# FACILITY CONDITION ASSESSMENT

This assessment uses a general rating system, informed by direct observations and staff input. For a more comprehensive analysis, refer to the "Property and Building Inspection Report" prepared by Silver Ridge Home Inspections, 2024. Amanda Swails Design, LLC did not inspect these systems. It is important to note that these assessments are based only on brief visual inspections and do not constitute a formal building inspection.

| | |
|---|---|
| **SITE** | |
| Landscaping/Sitework | 4 – Good |
| Parking Lot(s) | 1 – Bad |
| Entrance/Walkways | 4 – Good |
| Comments: The parking lot behind the building is gravel and unmarked. There are no ADA parking spaces. | |
| BUILDING EXTERIOR | |
| General Building Envelope | 4 – Good |
| Foundation | 4 – Good |
| Structure | 4 – Good |
| Roof/Gutters | 4 – Good |
| Exterior Stairs/Ramps/Railings | N/A |
| Doors/Windows | 4 – Good |
| Comments: The exterior of the building is in decent shape for its age. Garage roof shows wear. | |
| **BUILDING INTERIOR** | |
| General Interior Layout | 1 – Bad |
| Interior Walls | 3 – Fair |
| Interior Floors | 3 – Fair |
| Interior Ceilings | 3 – Fair |
| Comments: The interior finishes are well maintained for their age, but the general layout of the rooms present challenges. Water damage on ceiling in storage/furnace room. | |
| **BUILDING SYSTEMS AND EQUIPMENT** | |
| Fire Sprinkler System | N/A |
| HVAC | 4 – Good |
| Plumbing | 4 – Good |
| Electrical | 2 – Poor |
| Generators | N/A |
| Communication Systems (incl. internet) | 3 – Fair |
| Comments: Electrical service is unreliable in the town of Weiser. A generator would be useful. | |
| **ADA ACCESSIBILITY** | No, see comments. |
| Comments: Reception desk not compliant, no ADA parking spaces, threshold height issues. While not required by ADA Code, an automatic entrance door operator would be useful. | |

**Condition Ratings**

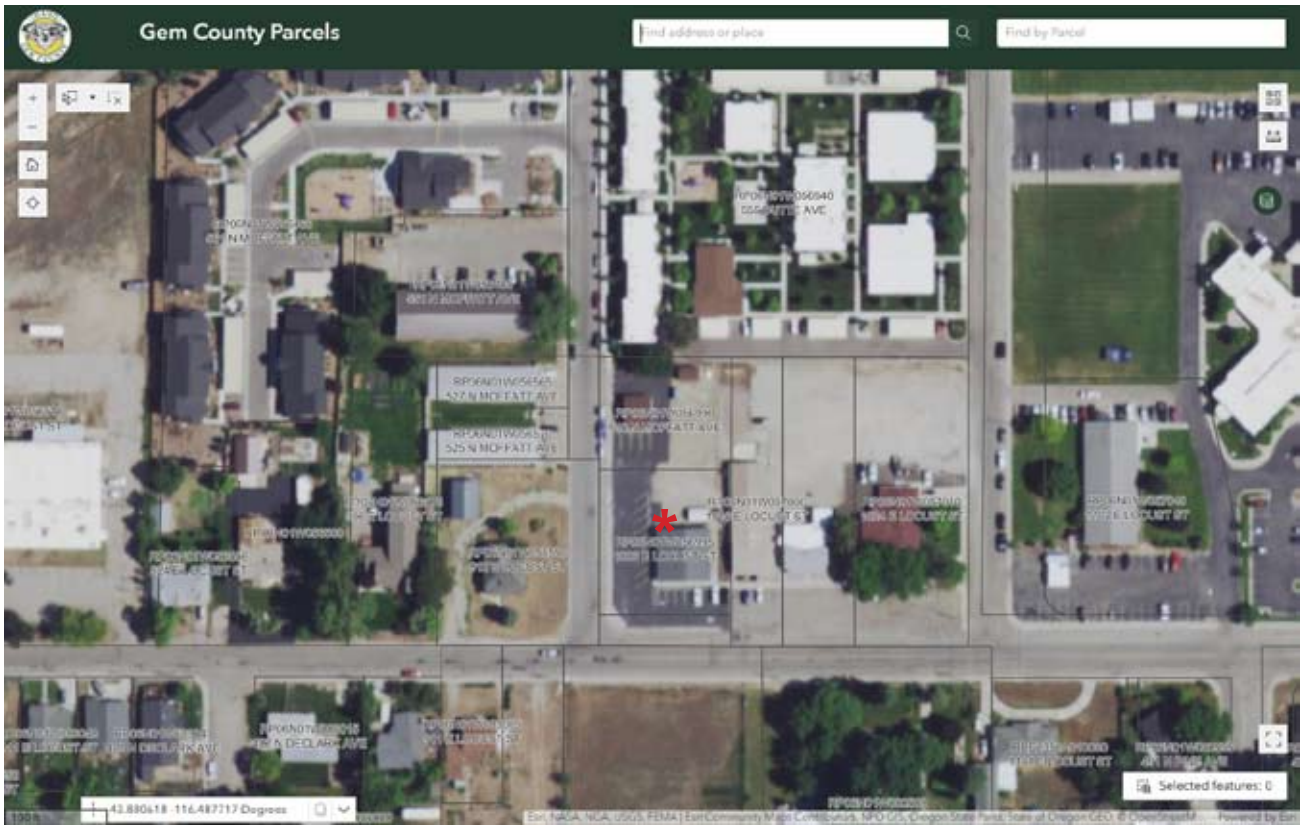
5 – Excellent: Only routine maintenance required.
4 – Good: Minor repairs may be needed; system functions properly.
3 – Fair: Occasional major and frequent minor repairs; sometimes fails.
2 – Poor: Major repairs needed, worn, outdated, limited function, or not up to code.
1 – Bad: Needs major repair or replacement; may be unsafe or not up to code.
0 – Not assessed, not examined.
N/A – Not applicable or present.

# EMMETT OFFICE

All SWDH Services - Gem County
1008 East Locust St
Emmett, ID 83617

Open Weekdays 8am - 5pm
WIC Tuesdays 8am - 5pm

Image: Google Street View, ©2025 Google, Image capture: Nov 2022




Map Data: Gem County Assessor's Parcels Map, Powered by Esri,
https://experience.arcgis.com/experience/e7af2f0fdf0e4b41bc872c17da9c94b8/

## FACILITY LOCATION

The facility is in the town of Emmett, one block from Valor Health Family Medicine and Urgent Care Center. While convenient for Emmett residents, it is less accessible for others in Gem County, who must walk, bike, drive, or carpool due to the lack of public transportation.

# FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | Owned |
| Year of SWDH Occupation: | July 1990 |
| Year Built: | before 1990 |
| Estimated Building Age: | more than 40 years |
| Building Square Footage: | approximately 2500 sf |
| Floor(s): | 1 |
| Accessory Buildings: | 10x16 storage shed |
| Building Occupancy: | B |
| Type of Construction: | Type V |
| Construction Description: | Wood frame with vinyl siding and brick veneer |
| Parcel ID: | RP06N01W056995 |
| Site Zoning: | P Public Use |
| Site Acreage: | 0.41 acres |
| Site Setbacks, R.O.W., | |
| Front setback = | 20'-0" |
| Rear setback = | 10'-0" |
| Side setback = | 10'-0" interior side, 20'-0" street side |
| Height maximum = | 60'-0" maximum |
| Flood Zone: | No, Zone X (Area of Minimal Flood Hazard) |
| Existing Standard Parking Spaces | 15 |
| Existing ADA Parking Spaces | 1 |
| Required Standard Parking Spaces | 7 spaces, Emmett Zoning Code: 1 for each 400 square feet of floor area for offices, public or professional administration or service buildings |
| Required ADA Parking Spaces | 1 |

# BUILDING COMPONENTS

| | |
|---|---|
| Structural Framing: | Wood frame |
| Siding Material: | Vinyl, Brick |
| Basement/Crawl Space/Slab: | Crawl Space |
| Roofing Material: | Fiberglass/Asphalt |
| Attic Ventilation Type: | Roof Vents |
| HVAC Type: | Forced Air |
| Electrical Service Supply: | 200 amp |
| Water Source: | Public |
| Sewer: | Public |

# EMMETT OFFICE

All SWDH Services - Gem County
1008 East Locust St
Emmett, ID 83617

Open Weekdays 8am - 5pm
WIC Tuesdays 8am - 5pm

Image: Google Street View, ©2025 Google, Image capture: Nov 2022


## FACILITY CONDITION

The Emmett Office building requires several maintenance improvements to ensure its safety, ADA accessibility, and long-term functionality. The small bathroom with the furnace closet requires flooring repairs due to past water damage.

The railing on the front entrance ramp is loose and requires immediate repair. This entrance ramp is wide enough for ADA standards, but it does not comply with the International Building code. Per 2021 IBC Chapter 10, Section 1012, ramp guardrails must have openings no larger than 4 inches, handrails on both sides, and edge protection. The landing at the front door must also be at least 60 x 60 inches. It is recommended that the entrance ramp be replaced. Additionally, installing a push-button door operator could improve accessibility for individuals using wheelchairs or strollers.

The rear stairs and railings are deteriorating and need repair. Roof replacement is expected in four to five years. The reception desk counter is too high for ADA compliance. ADA accessibility issues remain and require attention. Overall, the building has been well maintained and is in good shape for its age. It functions as needed and is conveniently located.

# FACILITY CONDITION ASSESSMENT

This assessment uses a general rating system, informed by direct observations and staff input. For a more comprehensive analysis, refer to the "Property and Building Inspection Report" prepared by Silver Ridge Home Inspections, 2024. Amanda Swails Design, LLC did not inspect these systems. It is important to note that these assessments are based only on brief visual inspections and do not constitute a formal building inspection.

| | |
|---|---|
| **SITE** | |
| Landscaping/Sitework | 4 – Good |
| Parking Lot(s) | 4 – Good |
| Entrance/Walkways | 1 – Bad |
| Comments: Railing on ramp is loose and not ADA or Building code compliant. | |
| BUILDING EXTERIOR | |
| General Building Envelope | 4 – Good |
| Foundation | 4 – Good |
| Structure | 4 – Good |
| Roof/Gutters | 4 – Good |
| Exterior Stairs/Ramps/Railings | 1 – Bad |
| Doors/Windows | 4 – Good |
| Comments: At minimum, repair loose ramp railing. The current ramp does not meet building code requirements. A new entrance ramp is recommended. | |
| **BUILDING INTERIOR** | |
| General Interior Layout | 3 – Fair |
| Interior Walls | 4 – Good |
| Interior Floors | 3 – Fair |
| Interior Ceilings | 3 – Fair |
| Comments: Flooring repair in restroom with furnace. Interior finishes are well maintained for their age. | |
| **BUILDING SYSTEMS AND EQUIPMENT** | |
| Fire Sprinkler System | N/A |
| HVAC | 4 – Good |
| Plumbing | 4 – Good |
| Electrical | 4 – Good |
| Generators | N/A |
| Communication Systems (incl. internet) | 3 – Fair |
| Comments: Standardized IT infrastructure in conference room | |
| **ADA ACCESSIBILITY** | No, see comments. |
| Comments: Reception desk is not compliant, the restroom labeled ADA does not have the required ADA knee space under the sink. | |

**Condition Ratings**

5 – Excellent: Only routine maintenance required.
4 – Good: Minor repairs may be needed; system functions properly.
3 – Fair: Occasional major and frequent minor repairs; sometimes fails.
2 – Poor: Major repairs needed, worn, outdated, limited function, or not up to code.
1 – Bad: Needs major repair or replacement; may be unsafe or not up to code.
0 – Not assessed, not examined.
N/A – Not applicable or present.

# NAMPA OFFICE

WIC Services Only - Canyon County
Idaho Hispanic Community Center (IH2C)
315 Stampede Dr
Nampa, ID 83687
Open Mon/Tues/Friday 9am-4pm

Image: Google Street View, ©2025 Google, Image capture: Oct 2016

## FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared | Leased, 1-year rental agreement |
| Year of SWDH Occupation: | 2024 |
| Year Built: | 2004 |
| Leased Square Footage: | unknown |
| Property Owner: | City of Nampa |
| Mixed-Use Building Occupants: | Idaho Hispanic Community Center |
| Building Occupancy: | Mixed Retail with Office Units |
| Parcel ID: | PIN: 67340100 0 |

## FACILITY NOTES

The Nampa WIC office is located on the second floor of the Idaho Hispanic Community Center (IH2C). This location provides strong visibility and facilitates outreach efforts. While public transportation options are limited in the area, the site remains accessible by foot and is easily reached by car.

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# HOMEDALE OFFICE

WIC Services Only - Owyhee County
Old Homedale Library
125 W Owyhee Ave
Homedale, ID 83628
Open Tues/Thurs 9am-4pm

Image: Google Street View, ©2025 Google, Image capture: Nov 2023

## FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | Shared, reserved room in the Old Homedale Library |
| Year of SWDH Occupation: | 2023 |
| Leased Square Footage: | unknown |
| Property Owner: | Gypsy Jackson Memorial Library |
| Mixed-Use Building Occupants: | Homedale Library |
| Parcel ID: | RPA0010050007A |

## FACILITY NOTES

The Homedale Office operates in a reserved, shared space within the Old Homedale Library. The lack of privacy and daily setup/breakdown are major challenges for staff. As the only WIC site in Owyhee County, it experiences high demand for services.

Note: The consultant team interviewed department heads and watched a staff-made video, but did not tour this facility in person.

# FARMWAY OFFICE

WIC Services Only - Canyon County
Caldwell Housing Authority
22730 Farmway Rd #114
Caldwell, ID 83607
Open 1st Monday of month 9am-4pm,
3rd Thursday of month 9am-7pm


## FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | Leased |
| Year of SWDH Occupation: | 2007 |
| Leased Square Footage: | approximately 600 sf |
| Property Owner: | Housing Authority of Caldwell |
| Mixed-Use Building Occupants: | Farmway Community Center, Terry Reilly Health Services |
| Parcel ID: | PIN: 34658000 0 |

## FACILITY NOTES

The Farmway Office provides WIC-only services. It is in Farmway Village which is operated by the Caldwell Housing Authority—the largest rural housing authority in the country. The building is shared with Terry Reilly (behavioral health) and the Farmway Community Center, which is a small event space.

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# COUNCIL OFFICE

WIC Services Only - Adams County
Adams County Health Center (ACHC)
205 N Berkley St
Council, ID 83612
Open 3rd Wednesday of even months

Image: Google Street View, ©2025 Google, Image capture: Sep 2024

## FACILITY INFORMATION

| | |
|---|---|
| Owned, Leased or Shared: | MOU shared space |
| Year of SWDH Occupation: | 2022 |
| Leased Square Footage: | unknown |
| Floor(s): | 1 |
| Parcel ID: | RPC012000000CB |
| Site Acreage: | 4.43 acres |

## FACILITY NOTES

The Council Office offers WIC-only services to Adams County and is SWDH's most distant site, located 104 miles (a 2-hour drive) from Caldwell. SWDH shares space there with the Adams County Health Center, operating on a limited schedule.

Note: The consultant team interviewed department heads and watched a staff-made video, but did not tour this facility in person.

# MARSING HUB

Clinic Services Only - Owyhee County
The Marsing Hub
205 8th Ave W
Marsing, ID 83639

Image: Google Street View, ©2025 Google, Image capture: Oct 2023

## FACILITY NOTES

The Marsing School District converted its former middle school into a community center, now called "The Hub." The Hub brings vital services under one roof. By using existing school infrastructure, the district was able to create a community center that offers educational, health, and social supports for residents of all ages. SWDH operates the school-based health center, offering clinical services to students within the Marsing School District as well as to members of the wider community. The clinic plays a vital role in meeting the healthcare needs of both students and residents in this rural area.

# Youth Resource & Opportunity Collaborative (YouthROC)

Partnership Only - Canyon County

Nampa Family Justice Center (NFJC)
1305 3rd St S, Nampa, ID 83651

Advocates Against Family Violence (AAFV)
1508 Hope Ln, Caldwell, ID 83605

## FACILITY NOTES

The Youth Resource & Opportunity Collaborative (YouthROC) offers support services and resources for youth. YouthROC operates out of two Canyon County locations: the Nampa Family Justice Center and Advocates Against Family Violence Center. SWDH's Behavioral Health refers youth to the YouthROC program.

Note: The consultant team did not interview facility staff nor tour this facility.

# Western Idaho Youth Support Center (WIYSC)

Partnership Only - Canyon County
Youth Crisis Center
308 E Hawaii Ave
Nampa, ID 83686

## FACILITY NOTES

The Western Idaho Youth Support Center (WIYSC), which opened in Nampa in 2024, is a youth crisis center. WIYSC offers 24/7 walk-in support to individuals ages 5–17 who are experiencing behavioral health emergencies, providing a safe environment prior to the need for intensive care. The center was established by SWDH in partnership with Clarvida.

Note: The consultant team interviewed facility staff, but did not tour this facility in person.

# Western Idaho Community Crisis Center (WIDCCC)

Partnership Only - Canyon County
Adult Crisis Center
524 Cleveland Blvd #160
Caldwell, ID 83605

## FACILITY NOTES

The Western Idaho Community Crisis Center (WIDCCC) in Nampa offers 24/7 walk-in crisis stabilization for adults experiencing behavioral health crises. The center was established in 2019 by SWDH in partnership with Lifeways.

Note: The consultant team interviewed facility staff, but did not tour this facility in person.

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# CONCLUSION

This Land and Facility Report for Southwest District Health presents evaluations of SWDH's owned and leased properties across six counties. Each recommendation is specifically tailored to address the individual circumstances of every facility.

The Caldwell and Payette Offices, built more recently, provide ample space and require only routine maintenance. The Weiser and Emmett offices are well maintained but need accessibility improvements to meet code and operational requirements. A revised floor plan layout could improve the functionality of the Weiser Office. WIC-only locations experience space constraints and privacy issues.

Prioritizing these improvements will bolster operational resilience, improve client access, and ensure SWDH continues delivering accessible public health services throughout its diverse rural and urban communities.

2025

# Southwest District Health Space Allocation Report

PREPARED FOR SOUTHWEST DISTRICT HEALTH
AUGUST 2025

SOUTHWEST DISTRICT HEALTH

CLEARWATER FINANCIAL

amanda swails DESIGN

# SPACE ALLOCATION REPORT

## Overview

This report assesses space allocation and the general layout of each SWDH owned facility. Data were collected through facility tours and interviews with staff and department heads. The evaluation consisted of visual site inspections only and should not be considered a formal building inspection. This document provides a general overview based on those brief visits and presents the findings accordingly. All existing square footage has been estimated based on sketches and floor plans provided by SWDH. No field measuring has occurred.

## Recommended Square Footages

The following chart shows recommended square footages according to industry best practices and the "State of Idaho Office Space Standards" from 2020. These figures do not include a 30% loading factor for circulation and other accessory uses.

| Room Type | Occupancy | Recommended Square Footage |
|---|---|---|
| Waiting Area* | 1 seat | 10 sf |
| *Square footage does not include hallways and other circulation* | 4 seats | 40 sf |
| | 8 seats | 80 sf |
| Reception, transaction counter* | 1 seat | 64 sf |
| Open Office Small Cubicle - *For part-time employees** | 1 seat | 36 sf |
| Open Office Medium Cubicle - *For typical employees, single occupant** | 1 seat | 64 sf |
| Open Office Large Cubicle - *For employees requiring a larger work surface or 1- 2 visitors** | 1 | 80 sf |
| Private Office Small - *For employees requiring confidentiality/ privacy and 1-3 visitors** | 1 | 120 sf |
| Private Office Medium - *For employees requiring confidentiality/ privacy and 4-6 visitors** | 1 | 160 sf |
| Private Office Large - *For employees requiring confidentiality/ privacy and 8-10 visitors** | 1 | 240 sf |
| Conference Room* | 8 seats | 160 sf |
| | 12 seats | 260 sf |
| | 20 seats | 450 sf |
| Clinic Exam Room | 1 | 120 sf |
| BH Exam/Office (Counseling Room) | 1 | 160 sf |
| WIC Exam Room | 1 | 160 sf |
| Nurse's Hallway Station | 1 | 36 sf |

*Please note:*
*These square footage guidelines are best suited for new construction; existing buildings often can't match these exact figures due to inherent constraints and limitations. Treat them as suggestions rather than rules, since renovations to meet these standards may be costlier than retaining current sizes.*

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]

# SPACE ALLOCATION STANDARDS

The “State of Idaho Office Space Standards” further specifies office size limits based on the type of employee, as detailed in their table below. In defining room types, this report does not consider the employee’s job title occupying the room. This report assigns room types according to the existing square footage of each room rather than the occupant’s job title, such as Division Administrator or Division Manager. A future evaluation with current staffing data could assess this more accurately.

| SPACE ALLOCATION STANDARDS WORKSHEET | | | | | | | Jan. 7, 2020 |
|---|---|---|---|---|---|---|---|
| AGENCY: | | | | LOCATION: | | | |
| CURRENT SQ FT: | | PROJECTED SQ FT: | | | | | |
| CURRENT FTE: | | PROJECTED FTE: | | | | | |
| Area/Room | # of | SF / FTE* | Total | Hard Walls or Open Office | #Data Ports | #Phone Ports | Remarks |
| **HARD WALL OFFICE:** | | | | | | | |
| Director of Department | 0 | 240 | 0 | | | | |
| Deputy Director | 0 | 160 | 0 | | | | Average 150 SF & no more than 10% of work spaces |
| Division Administrator | 0 | 160 | 0 | | | | |
| Bureau Chief/Director of Brd | 0 | 115 | 0 | | | | |
| Regional/Division Mangers | 0 | 115 | 0 | | | | |
| Staff Attorney | 0 | 115 | 0 | | | | |
| **OPEN OFFICE AREA:** | | | | | | | |
| Supervisor/Professional 80-96 SF | 0 | 96 | 0 | | | | |
| Case Worker 64-80 SF | 0 | 80 | 0 | | | | |
| Technical 48-64 SF | 0 | 64 | 0 | | | | Average open office workspace 64 SF (8'x8') |
| Clerical Staff 48-64 SF | 0 | 64 | 0 | | | | |
| Clerical Pool 36-48 SF | 0 | 48 | 0 | | | | |
| Receptionist | 0 | 64 | 0 | | | | |
| Adjunct Desk Area/Field Worker/Data Entry 36-48 SF | 0 | 48 | 0 | | | | (staff in office less than 60% of time) |
| Other: Anticipated growth | 0 | 80 | 0 | | | | |
| **SPECIALTY AREAS:** | **#/Rm** | **sf/person** | | | | | |
| **Waiting Area**/per person | 0 | 10 | 0 | Open Office | | | |
| Large **Conference**/per person (joint use among Agencies encouraged) | | 15 | 0 | Hard wall | | | conf. rooms should be occupied 15hrs or more per week |
| Small conf 4 to 8 seats | | 20 | 0 | | | | |
| **File Storage** (active files only, typically along interior circulation) | | | 0 | | | | inactive files stored off site |
| **Classroom**/ per person | | 30 | 0 | Hard wall | | | |
| Library | | | 0 | Hard Wall | | | |
| Mail Room | | 100 | 0 | Hard Wall | | | |
| Computer/Phone Rm | | | 0 | Hard Wall | | | |
| Laboratory | | 900 | 0 | Hard Wall | | | |
| Equipment storage room | | | 0 | Hard Wall | | | (not in finished area) |
| Other: | | | 0 | | | | |
| Total Net Square Feet (NSF) | | | 0 | | | | |
| Circulation Factor | | 0.25 | 0 | | | | |
| **TOTAL** Dept. Gross Square Footage(DGSF) | | | **0** | **Add 15% = 0** | | | **BLDG Gross SF** |

Open Office space is the standard design approach. Hard walled offices for staff below the Staff Attorney level require written justification. Average SF per workspace (open office & hard wall office) 80 SF. Endeavor to stay within 215 DGSF per FTE for entire space.

Parking Required: Employee: _____ Client: _____ Staff: _____ State: _____

Prepared By: _____ Date: _____

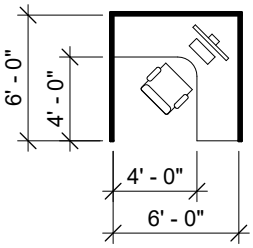
Authorized by: _____ Date: _____

FTE is a full time Employee — Restrooms are usually a part of common area

Table Data: Space Allocation Standards Worksheet, State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]

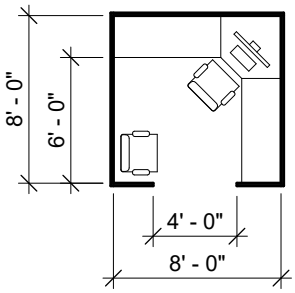
# OFFICE FLOOR PLANS

Office space layout examples following “State of Idaho Office Space Standards, 2020.”



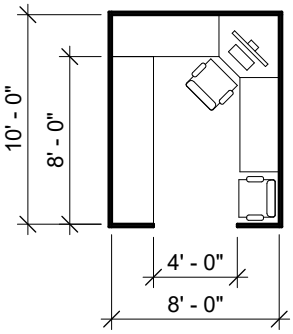

Open Office
Small Cubicle
36 nsf

*For part-time employees or those who work mainly, outside the office.*



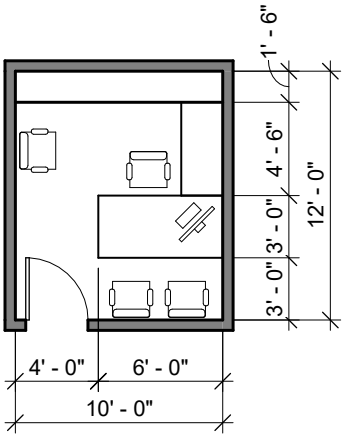

Open Office
Medium Cubicle
64 nsf

*For typical employees, single occupant.*



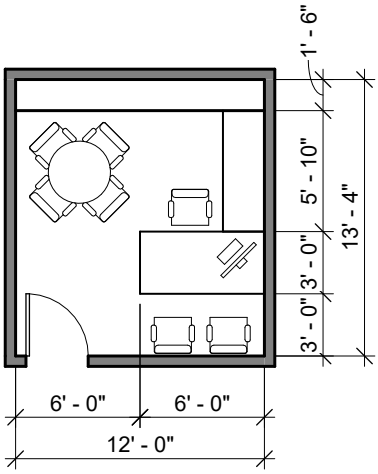

Open Office
Large Cubicle
80 nsf

*For employees requiring a larger work surface, storage or 1- 2 visitors.*



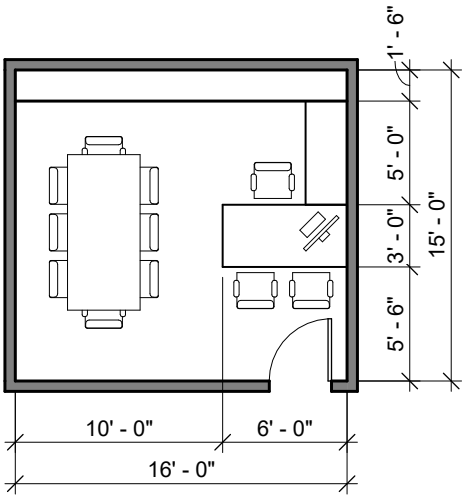

Private Office Small
120 nsf

*For employees requiring confidentiality/privacy and 1-3 visitors.*




Private Office Medium
160 nsf

*For employees requiring confidentiality/privacy and 4-6 visitors.*

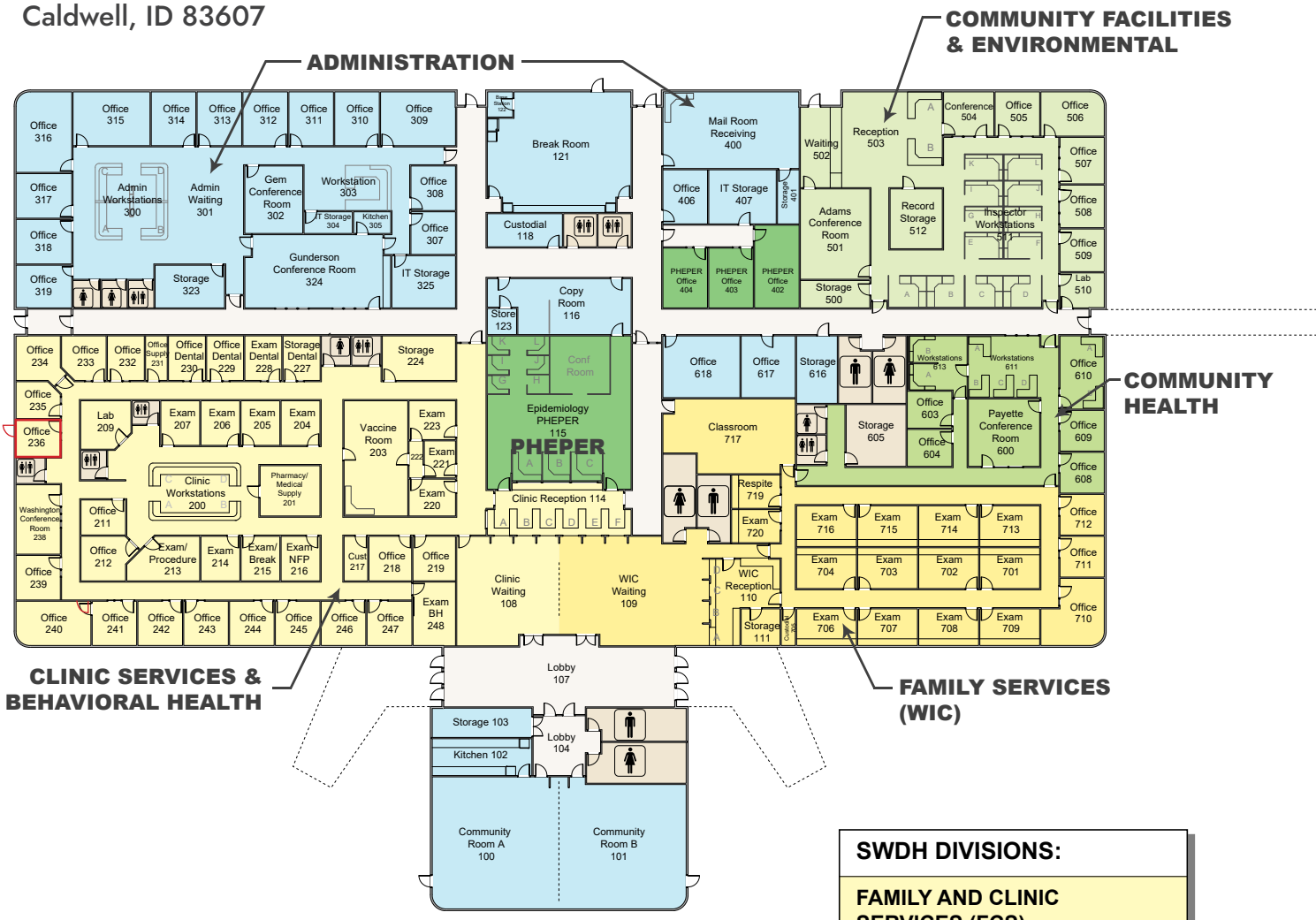



Private Office Large
240 nsf

*For employees requiring confidentiality/privacy and 8-10 visitors.*

# CALDWELL OFFICE

SWDH Main Office
All SWDH Services - Canyon County
13307 Miami Lane
Caldwell, ID 83607




## FACILITY DESCRIPTION

- The South side of the building serves the public directly with Clinical Services and WIC Programs. There is also a large Community Room for events.
- The North side of the building serves the less direct public Divisions. It houses the Environmental Health Division, which primarily operates through on-site inspections. Additional areas are Administration, Finance, Emergency Preparedness, IT, Shipping/Receiving, and support spaces.
- The central core of the building houses Community Health Programming and Epidemiology (PHEPER).
- The East side has a separate building for Mechanical and Electrical Rooms, and a large Maintenance Room used for storage. The mechanical and electrical systems are connected to the main building by an overhead link.

**SWDH DIVISIONS:**

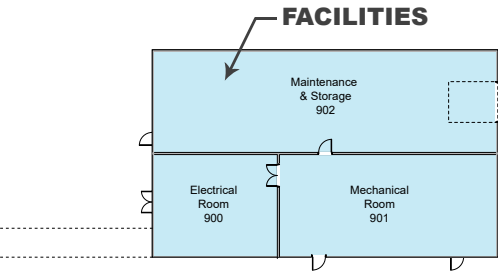
**FAMILY AND CLINIC SERVICES (FCS)**
- Family Services (WIC)
- Clinic Services
- Behavioral Health

**ENVIRONMENTAL & COMMUNITY HEALTH (ECHS)**
- Community Facilities (Food and Childcare Inspections)
- Environmental (Land Development, Water, Septic, Underfill)
- PHEPER (Public Health Emergency Preparedness Epidemiology Response)
- Community Health (Outreach Health Programs)

**DISTRICT OPERATIONS (DO)**
- Administration (Finance & Procurement, Organization Development, Information Technology, Human Resource, Customer Sevice)
- Facilities

# FACILITY SPACE ALLOCATION

There are storage inefficiencies throughout the building, with some divisions overcrowded and others underutilized. Much of the storage is in the separate Facilities building, making materials hard to access. Improved organization and better storage solutions are needed for materials like brochures and exercise bands.




Standardizing conference room software and equipment such as microphones, cameras, and displays can help ensure consistent performance for hybrid meetings and other events. Consistent IT infrastructure throughout all SWDH locations is essential.

Maximize community room use for SWDH and the public. Provide a sign-up method and clear reservation guidelines for all users.

### Clinic Services

The Caldwell Office is the main clinic location for SWDH. Its layout is very functional and has space to grow. However, they would like to relocate their Infectious Disease room. Room 204 is currently designated for this purpose, but its location may increase the risk of exposure within the building. A proper Infectious Disease Room that is accessed directly from outside and has a negatively pressured HVAC system will ensure airborne illnesses are contained and exhausted externally. This configuration could be implemented by adding an exterior door to Room 236 and adjusting the room's ventilation system.

### WIC Services

The Caldwell Office is the largest WIC location and serves as the storage hub for all sites. Space is limited, especially for breastfeeding equipment and handout materials. The current office layout and furniture hinder staff-participant interaction; smaller tables and more comfortable seating could help. Participants are young families, whose babies require a lot of gear (ex. Strollers, diaper bags, etc.) and often have siblings in tow. Adding child-friendly toys, books, and play areas would help occupy siblings during appointments. Extra maneuvering space is helpful in hallways and within WIC rooms.

### Community Facilities & Environmental Health

The Caldwell Office serves as the home base for Community Facilities and Environmental Health with inspectors conducting much of their work in the field. The staff workspace is heavily condensed compared to other SWDH departments, but it is not always occupied because inspectors mainly work off-site. There are layout inefficiencies, and some private offices are unused and have yet to be reassigned. Reconfiguring cubicles to decrease congestion, reallocating unused offices, and improving sound privacy is needed. This area is shown in further detail are on the next page.

### Community Health

The Caldwell Office is the planning hub for Community Health, which mainly operates through community outreach and partnerships. Staff depend on off-site locations for meetings, but these spaces are often inadequate. Dedicated, branded community meeting rooms with reliable hybrid meeting infrastructure is desired. Storage improvements and organization within the Caldwell Office are also needed.

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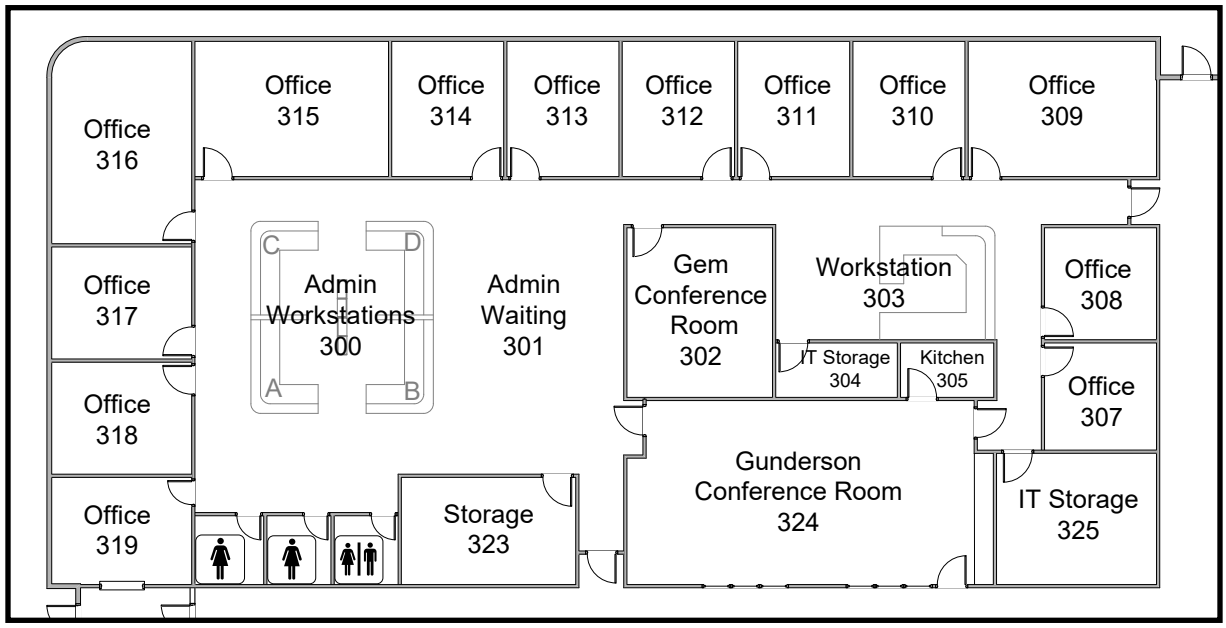
# ADMINISTRATION SPACE ALLOCATION

The Administrative areas are spacious and meet current staffing needs, with room for additional workstations at the core. Perimeter offices exceed the "State of Idaho Space Standards, 2020." While office size could be realigned with job titles, a remodel would not provide cost savings.

| Room Name | Existing Net Area | Comments | Recommended Area | Room Type | Surplus or Deficit |
|---|---|---|---|---|---|
| Admin Waiting | 210 SF | | | | |
| Admin Workstations 300 A-D | 80 SF each | 4 total workstations, 320 sf total | 80 | Open Office Large | 0 |
| Gunderson Conference Room | 707 SF | 450 sf for 20 people* 700 sf for 35 people | | Conference | |
| Gem Conference Room | 253 SF | 260 sf for 12 people* | | Conference | |
| Workstation 303 | 134 SF | 1-2 Workstations | 80 | Open Office Large | +54 |
| Office 307 | 138 SF | IT Office | 120 | Private Office Small | +18 |
| Office 308 | 130 SF | IT Office | 120 | Private Office Small | +10 |
| Office 309 | 277 SF | IT Office | 240 | Private Office Large | +37 |
| Offices 310-314 | 164 SF each | Admin Office | 160 | Private Office Medium | +4 sf each |
| Office 315 | 274 SF | Division Administrator | 240 | Private Office Large | +34 sf |
| Office 316 | 327 SF | Director's Office | 240 | Private Office Large | +87 sf |
| Offices 317-318 | 170 SF each | Admin Office | 160 | Private Office Medium | +10 sf each |
| Office 319 | 169 SF | Includes reception window | 160 | Private Office Medium | +9 sf |
| Office 406 | 207 SF | Finance Office | 160 | Private Office Medium | +47 sf |
| Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | | |

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]

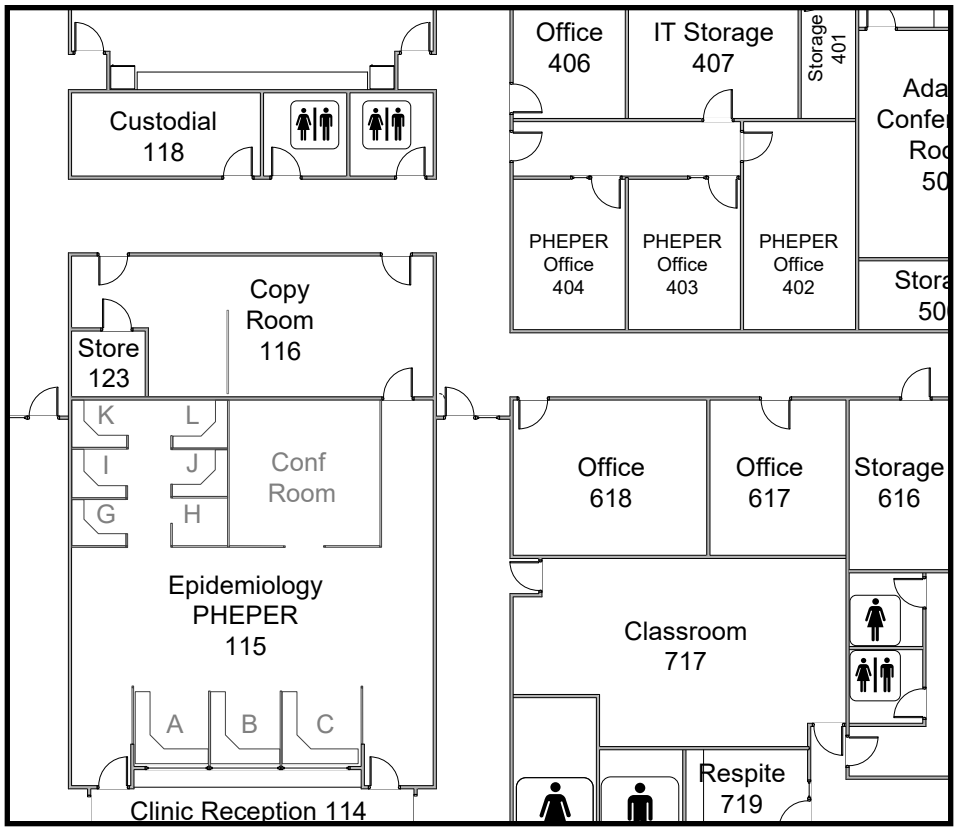


# EPIDEMIOLOGY (PHEPER) SPACE ALLOCATION

The Epidemiology (PHEPER) Room 115 is larger than required for current usage and not fully occupied. The room contains 8 cubicles, with 4 currently being staffed. It is equipped to serve as a command center during emergencies. The open plan format presents privacy concerns. There are also 3 additional PHEPER offices located outside the main PHEPER room.

| Room Name | Existing Net Area | Comments | Recommended Area | Room Type | Surplus or Deficit |
|---|---|---|---|---|---|
| Circulation | 864 SF | | | | |
| Workstations A-C | 72 SF each | 3 total workstations | 80 | Open Office Large | -8 sf |
| Workstations G-L | 29 SF each | 7 total workstations | 36 | Open Office Small | -7 sf |
| Conference Area | 234 SF | 260 sf for 12 people* | | Conference | |
| 402 Office | 254 SF | Division Administrator | 240 | Private Office Large | +14 sf |
| 403 Office | 183 SF | | 160 | Private Office Medium | +23 sf |
| 404 Office | 179 SF | | 160 | Private Office Medium | +19 sf |
| Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | | |

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]

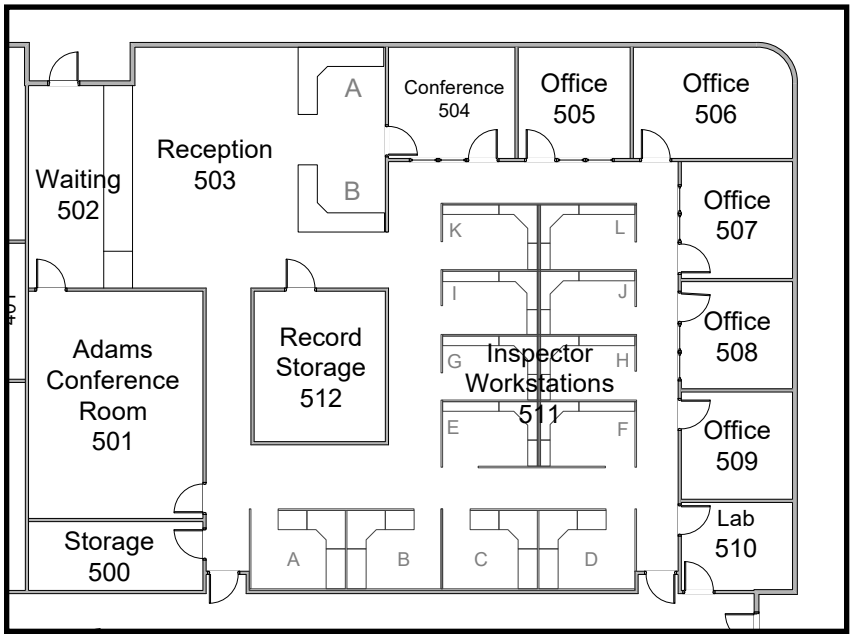


# COMMUNITY FACILITIES & ENVIRONMENTAL SPACE ALLOCATION

Many Environmental Health staff members serve as field inspectors and are present in the Caldwell Office only part-time. The current office space meets existing needs, but more workstations would be necessary if additional staff were hired. Adjustments such as reconfiguring cubicles and reallocating space within the current layout are feasible. According to "State of Idaho Office Space Standards," part-time employees or those who spend only part of their work time in the office require 36 sf of workspace. Reducing inspector workstation size from 68 sf to 36 sf could increase the number of available stations from 8 to 16. Additional workstations could also be added within the reception area and cubicle area A-D.

| Room Name | Existing Net Area | Comments | Recommended Area | Room Type | Surplus or Deficit |
|---|---|---|---|---|---|
| Waiting | 258 SF | | | | |
| Reception (incl. circulation) | 266 SF | | | | |
| Office 506 | 196 SF | Division Administrator | 240 sf | Private Office Large | +40 sf |
| Conference 504 | 158 SF | Client Interface Room | 160 sf, 8 seats | Conference | -2 sf |
| Offices 505, 507, 508, 509 | 135 SF each | | 120 sf | Private Office Small | +15 sf each, +60 sf total |
| Reception Workstations A-B | 75 SF each | 2 workstations, more could be added | 80 sf | Open Office Large | 5 sf each, +10 sf total |
| Inspector Workstations A-D | 83 SF each | | 80 sf | Open Office Large | +3 sf each, +12 sf total |
| Inspector Workstations E-L | 63 SF each | Part-time workstations, could be reduce in size | 64 sf (current) 36 sf (future?) | Open Office Medium | +27 sf each, +216 sf total if reduced to 36sf |
| Adams Conference Room | 390 SF | 375 sf for 16 people, 450 sf for 20 people* | | Conference | |
| Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | | |

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]

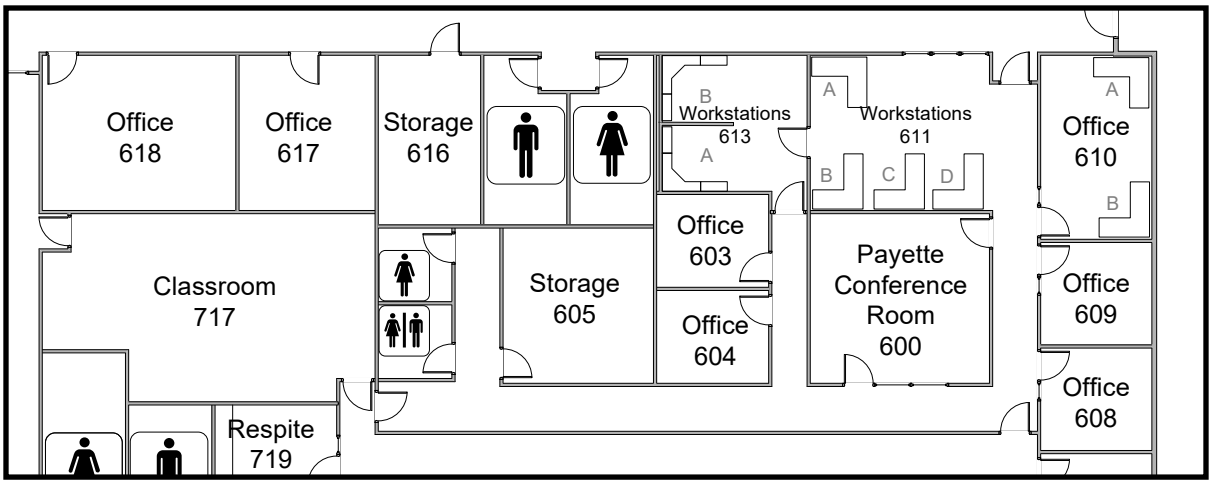


# COMMUNITY HEALTH SPACE ALLOCATION

Community Health values teamwork and collaboration spaces. They prefer flexible office layouts, such as a central hub design with individual offices arranged around a shared collaboration space. Room 611 is their current hub. Much of their work is off-site public engagement, but their planning and storing of supplies happens here. A more open office layout with dedicated storage space is desired.

| Room Name | Existing Net Area | Comments | Recommended Area | Room Type | Surplus or Deficit |
|---|---|---|---|---|---|
| Payette Conference Room | 320 SF | 375 sf for 16 people, 450 sf for 20 people* | | Conference | |
| Office 603 | 102 SF | | 120 | Private Office Small | -18 sf |
| Office 604 | 98 SF | Behavioral Health Office, sees Patients | 120 | Private Office Small | -22 sf |
| Storage 605 | 257 SF | | | Storage | |
| Office 608 | 130 SF | | 120 | Private Office Small | +10 sf |
| Office 609 | 130 SF | | 120 | Private Office Small | +10 sf |
| Office 610 | 239 SF | Shared by 2 staff | 240 | Private Office Large | -1 sf |
| Workstations 611 A-D | 36 SF | 4 total workstations | 36 | Open Office Small | 0 |
| Workspace 611 | 116 SF | | | | |
| Workstations 613 A-B | 64 SF | 2 total workstations | 64 | Open Office Medium | 0 |
| Storage 616 | 165 SF | | | Storage | |
| Office 617 | 259 SF | Behavioral Health Office, sees Patients | 160 | Private Office Medium | +99 sf |
| Office 618 | 285 SF | | 240 | Private Office Large | +45 sf |
| Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | | |

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]

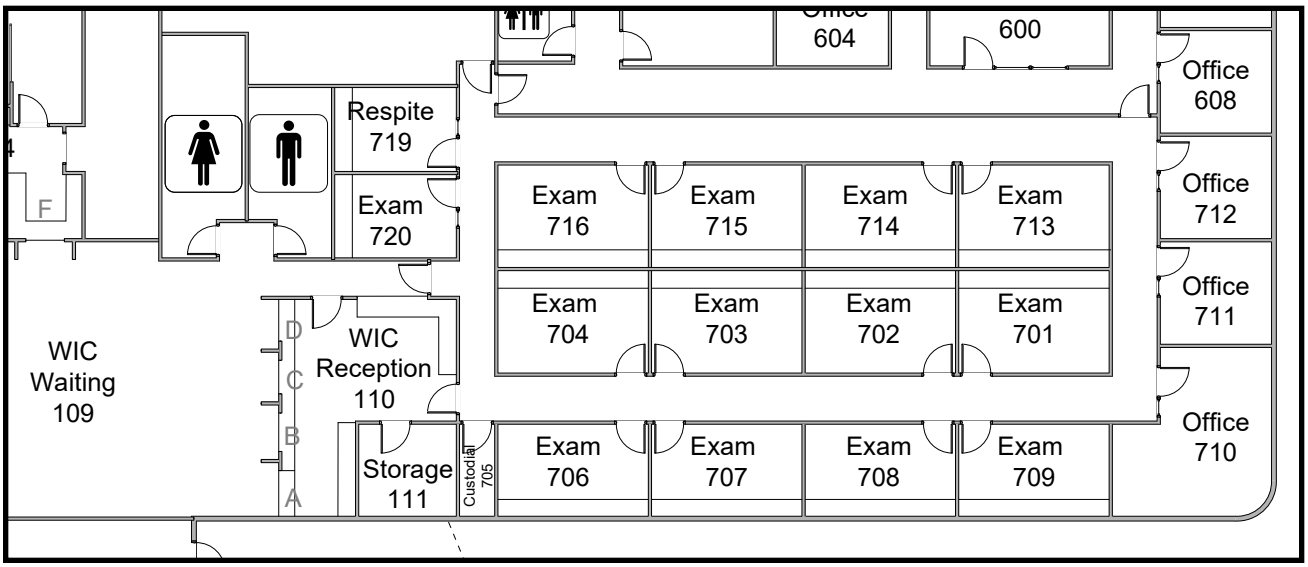


# FAMILY SERVICES (WIC) SPACE ALLOCATION

The Caldwell Office is the largest WIC location and serves as the storage hub for all sites. Space is limited, especially for breastfeeding equipment and handout materials. The current office layout and furniture hinder staff-participant interaction; smaller tables and more comfortable seating could help. Participants are young families, whose babies require a lot of gear (ex. Strollers, diaper bags, etc.) and often have siblings in tow. Adding child-friendly toys, books, and play areas would help occupy siblings during appointments. Extra maneuvering space is helpful in hallways and within WIC rooms.

| Room Name | Existing Net Area | Comments | Recommended area | Room Type | Surplus or Deficit |
|---|---|---|---|---|---|
| WIC Exam Rooms 701-704, 706-709, 713-716 | 160 SF | WIC Certification Rooms, 12 total rooms | 160 | Exam Medium | 0 |
| Office 710 | 266 SF | Division Administrator | 240 | Private Office Large | +26 sf |
| Office 711 | 129 SF | | 120 | Private Office Small | +9 sf |
| Office 712 | 130 SF | | 120 | Private Office Small | +10 sf |
| Classroom 717 | 528 SF | Serves all SWDH Divisions | | Conference | |
| Respite Room 719 | 108 SF | | 120 | Private Office Small | -12 sf |
| Exam Room 720 | 103 SF | | 120 | Exam Small | -17 sf |
| Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | | |

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]



# CLINIC SERVICES & BEHAVIORAL HEALTH SPACE ALLOCATION

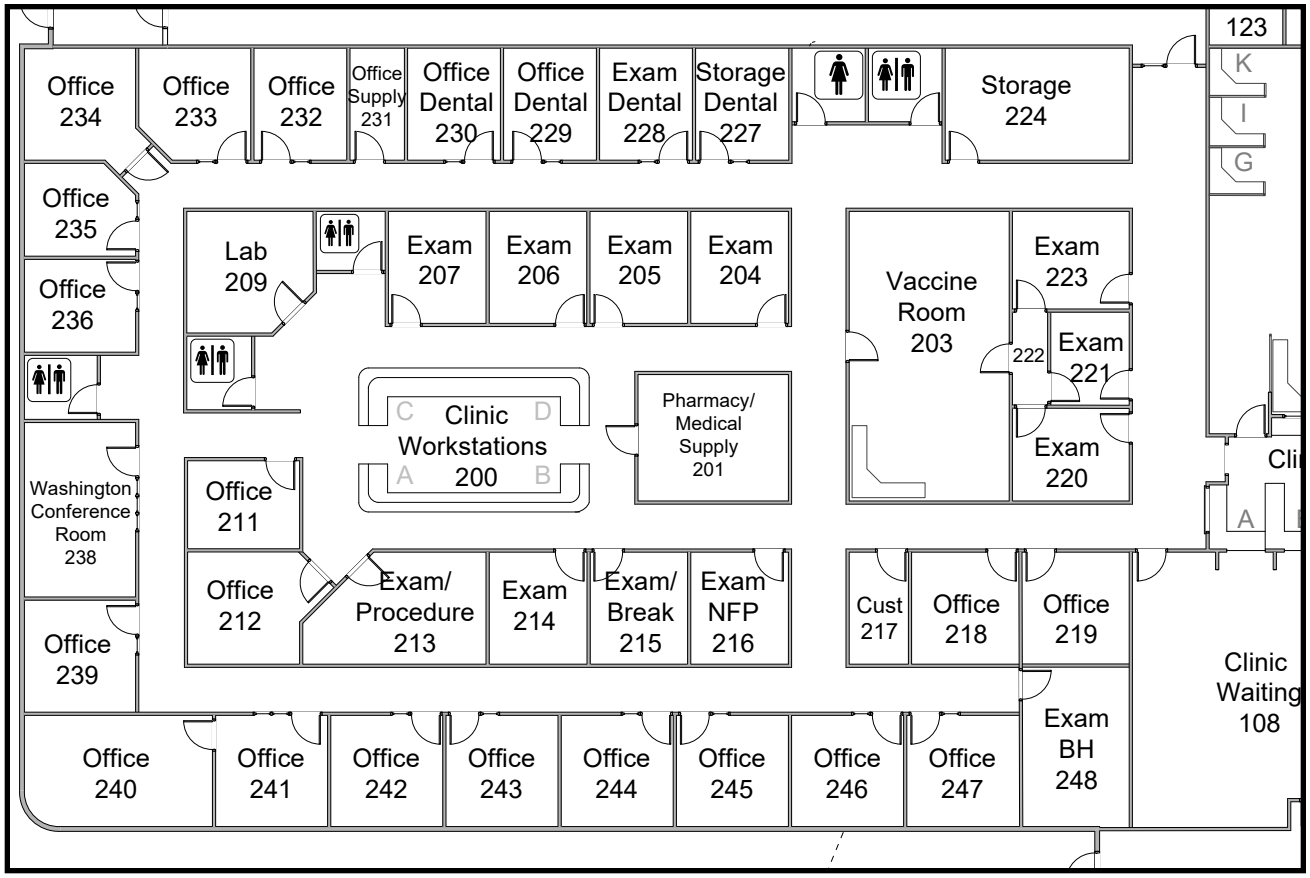
The Clinic Services and Behavioral Health area encompasses a wide range of services within its walls. This office includes standard medical examination rooms, behavioral health facilities, dental services, and several home visiting programs tailored for young families.

Office arrangements differ according to staff responsibilities: certain personnel require private offices for confidential patient consultations, while others work in private offices where confidentiality is essential but do not see patients directly. Additionally, some staff share private offices, work part-time, or perform home visits but still require a workstation as a home base.

| Room Name | Existing Net Area | Comments | Recommended Area | Room Type | Surplus or Deficit |
|---|---|---|---|---|---|
| Clinic Workstations 200 A-D | 80 SF each | 4 total workstations | 80 | Open Office Large | 0 |
| Pharmacy & Medical Supply 201 | 216 SF | | | | |
| Vaccine Room 203 | 496 SF | | | | |
| Clinic Exam Rooms 204-207 | 118 SF each | 4 total exam | 120 | Exam Small | -2 sf each, -8 sf total |
| Laboratory 209 | 154 SF | | | | |
| Office 211 | 108 SF | Medical Director | 120 | Private Office Small | -12 sf |
| Office 212 | 144 SF | Provider's Office, 2 staff | 160 | Private Office Medium | - 16 sf |
| Procedure Exam 213 | 194 SF | | 240 | Exam Large | -46 sf |
| Exam 214 | 116 SF | | 120 | Exam Small | -4 sf |
| Exam/Break 215 | 116 SF | Former exam room, currently a break room | 120 | Exam Small | -4 sf |
| Exam NFP 216 | 111 SF | NFP patient room | 160 | Exam Medium | -49 sf |
| Office 218 | 126 SF | Clinic Manager | 120 | Private Office Small | +6 sf |
| Office 219 | 125 SF | | 120 | Private Office Small | +5 sf |
| Clinic Exam Rooms 220-223 | 110 SF average | 3 total Vaccination and Phlebotomy Rooms | 120 | Exam Small | -10 sf each |
| Storage 224 | 226 SF | Includes dental water system equipment | | | |
| Dental Lab & Storage 227 | 114 SF | | | | |
| Dental Exam 228 | 114 SF | Dental Exam | 120 | Exam Small | -106 sf |
| Dental Offices 229-230 | 114 SF each | 2 total dental offices | 120 | Private Office Small | -6 sf |
| Office 232 | 114 SF | PAT, 2 staff | 120 | Private Office Small | -6 sf |
| Office 233 | 132 SF | PAT, 2 staff | 120 | Private Office Small | +12 sf |
| Office 234 | 145 SF | PAT Manager, 1 staff | 120 | Private Office Small | +25 sf |
| Office 235 | 111 SF | PAT, 1 staff | 120 | Private Office Small | -9 sf |
| Office 236 | 120 SF | BH, 1 staff | 120 | Private Office Small | 0 |
| Washington Conference Room | 216 SF | 260 sf for 12 people* | 260 | Conference | -44 sf |

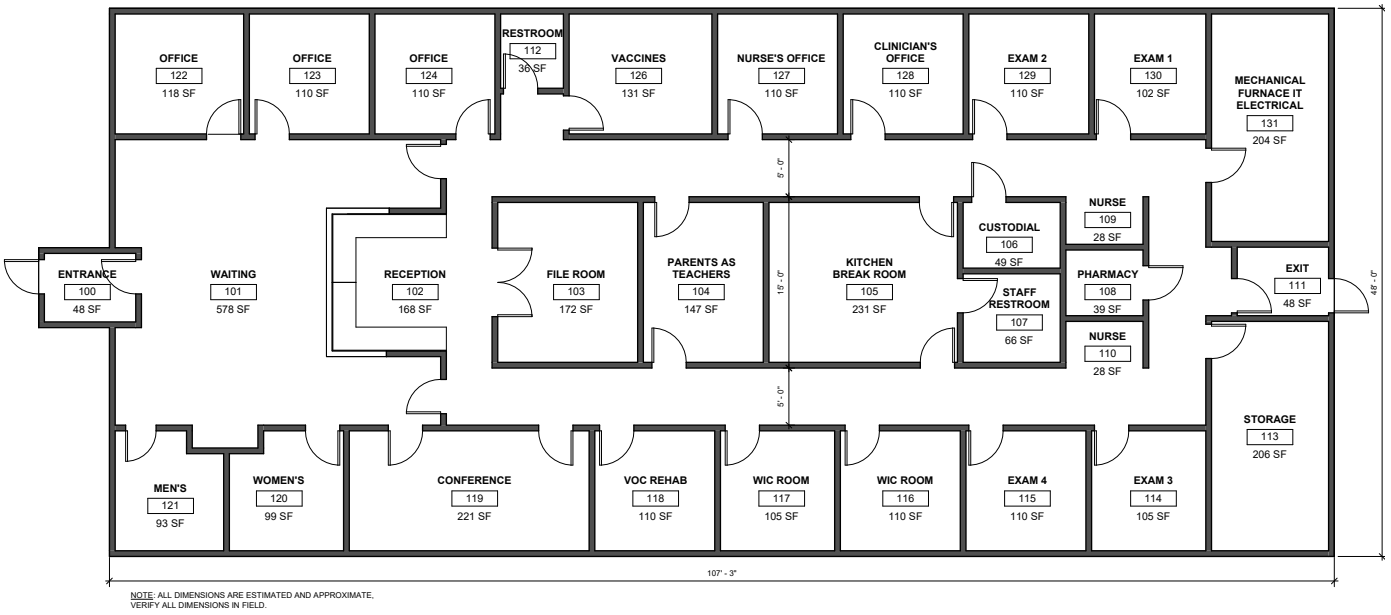
| | | | | | |
|---|---|---|---|---|---|
| Office 239 | 144 SF | NFP, 1 staff | 120 | Private Office Small | +24 sf |
| Office 240 | 228 SF | Division Administrator | 240 | Private Office Large | -12 sf |
| Offices 241 | 140 SF | FCS, 1 staff | 120 | Private Office Small | +20 sf |
| Office 242 | 140 SF | BH Program Manager, 1 staff | 120 | Private Office Small | +20 sf |
| Office 243 | 140 SF | BH Project Manager, 1 staff | 120 | Private Office Small | +20 sf |
| Office 244 | 139 SF | Office primarily, but also sees patients | 160 | Exam Medium | -21 sf |
| Offices 245 | 139 SF | NFP, 2 staff mainly offsite | 120 | Private Office Small | +19 sf |
| Office 246 | 140 SF | NFP, 2 staff mainly offsite | 120 | Private Office Small | +20 sf |
| Office 247 | 139 SF | NFP, 1 staff mainly offsite | 120 | Private Office Small | +19 sf |
| Exam BH 248 | 191 SF | BH Counseling Room, sees patience | 160 | Private Office Medium | +31 sf |
| Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | | |

*State of Idaho Office Space Standards, Department of Administration Division of Public Works, [01.07.2020]



# PAYETTE OFFICE

All SWDH Services - Payette County
1155 3rd Ave North
Payette, ID 83661




NOTE: ALL DIMENSIONS ARE ESTIMATED AND APPROXIMATE, VERIFY ALL DIMENSIONS IN FIELD.

## FACILITY SPACE ALLOCATION

Located in the town of Payette, the Payette Office building is well organized to accommodate a variety of health and community services. It has ample space distributed among clinical, WIC, administrative, and program-specific rooms.

Currently, several rooms are either vacant or utilized for storage purposes. Some office areas are shared with Payette's EMS department, which operates independently of SWDH. This surplus of space presents opportunities for community partnerships and program initiatives, such as offering community classes or other alternative uses. Additionally, the building's proximity to the Payette County Offices across the street creates further potential for shared and collaborative workspace.

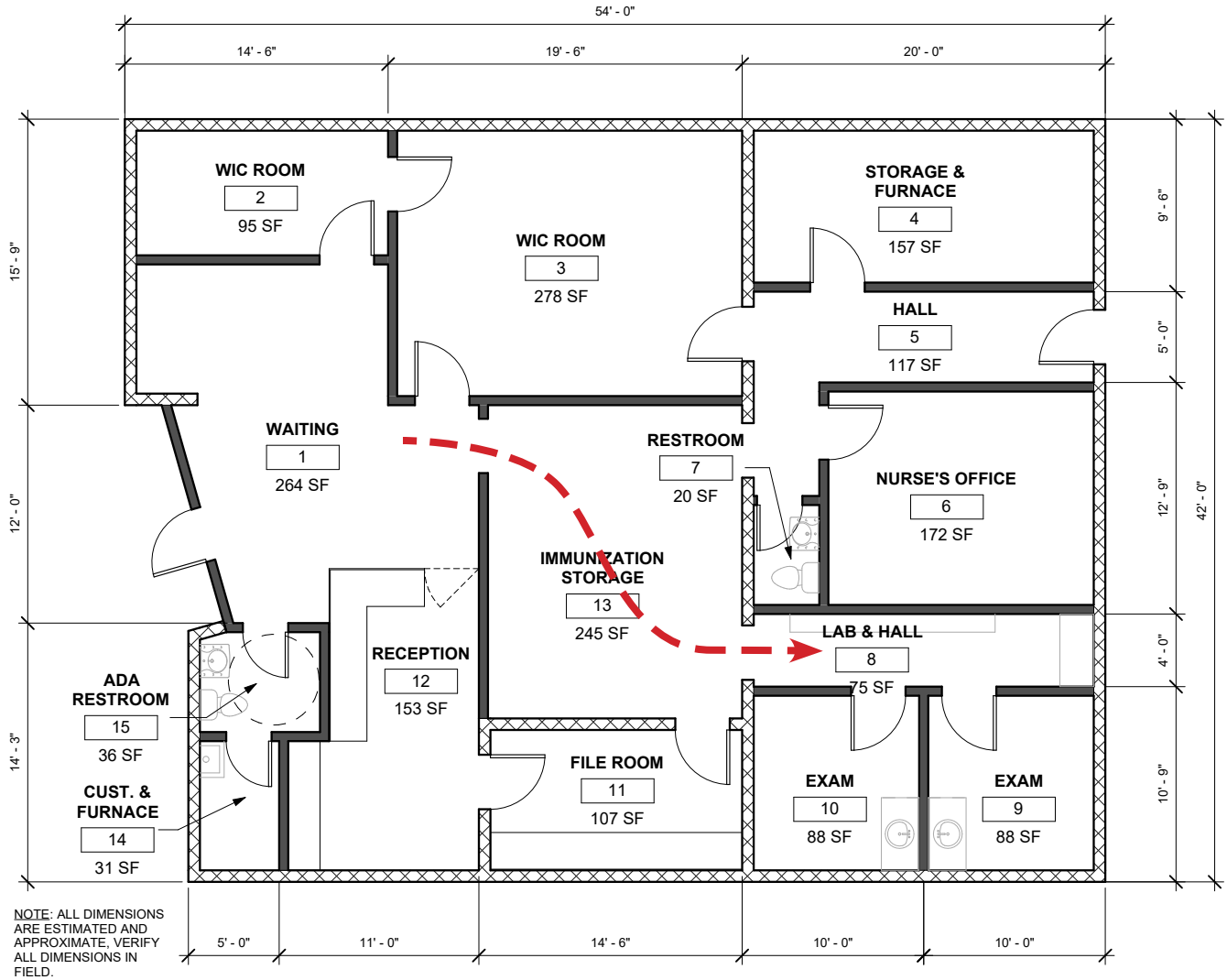
# PAYETTE OFFICE

## Building Square Footage = approximately 5000 sf

| Room # | Room Name | Existing Net Area | Comments | Recommended Area | Surplus or Deficit |
|---|---|---|---|---|---|
| 100 | ENTRANCE | 48 SF | | | |
| 101 | WAITING (includes circulation) | 578 SF | 6 chairs | | |
| 102 | RECEPTION | 168 SF | 2 workstations @ 64 sf each | 128 SF | +40 SF |
| 103 | FILE ROOM | 172 SF | | | |
| 104 | PARENTS AS TEACHERS | 147 SF | | 160 SF | -13 SF |
| 105 | KITCHEN BREAK ROOM | 231 SF | | | |
| 106 | CUSTODIAL | 49 SF | | | |
| 107 | STAFF RESTROOM | 66 SF | | | |
| 108 | PHARMACY | 39 SF | | | |
| 109 | NURSE | 28 SF | | 36 SF | -8 SF |
| 110 | NURSE | 28 SF | | 36 SF | -8 SF |
| 111 | EXIT | 48 SF | | | |
| 112 | RESTROOM | 36 SF | | | |
| 113 | STORAGE | 206 SF | | | |
| 114 | EXAM 3 | 105 SF | 4 total Exam Rooms | 120 SF | -15 SF |
| 115 | EXAM 4 | 110 SF | | 120 SF | -10 SF |
| 116 | WIC ROOM | 110 SF | 2 total WIC Rooms | 160 SF | -50 SF |
| 117 | WIC ROOM | 105 SF | | 160 SF | -55 SF |
| 118 | VOC REHAB | 110 SF | | 120 SF | -10 SF |
| 119 | CONFERENCE | 221 SF | ≈10’-6” x 21’-0” | 260 SF for 12 people | -39 SF |
| 120 | WOMEN’S | 99 SF | | | |
| 121 | MEN’S | 93 SF | | | |
| 122 | OFFICE | 118 SF | | 120 SF | -2 SF |
| 123 | OFFICE | 110 SF | | 120 SF | -10 SF |
| 124 | OFFICE | 110 SF | | 120 SF | -10 SF |
| 126 | VACCINES | 131 SF | | 120 SF | +11 SF |
| 127 | NURSE’S OFFICE | 110 SF | | 120 SF | -10 SF |
| 128 | CLINICIAN’S OFFICE | 110 SF | | 120 SF | -10 SF |
| 129 | EXAM 2 | 110 SF | | 120 SF | -10 SF |
| 130 | EXAM 1 | 102 SF | | 120 SF | -18 SF |
| 131 | MECHANICAL FURNACE<br>IT ELECTRICAL | 204 SF | | | |
| | Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | |

# WEISER OFFICE

All SWDH Services - Washington County
46 West Court St
Weiser, ID 83672



# WEISER OFFICE

## Building Square Footage = approximately 2200 sf

| Room # | Room Name | Existing Net Area | Comments | Recommended Area | Surplus or Deficit |
|---|---|---|---|---|---|
| 1 | WAITING (includes circulation) | 264 SF | 8 chairs | | |
| 2 | WIC ROOM | 95 SF | 2 total WIC Rooms | 160 SF | -65 SF |
| 3 | WIC ROOM | 278 SF | | 160 SF | +118 SF |
| 4 | STORAGE & FURNACE | 157 SF | | | |
| 5 | HALL | 117 SF | | | |
| 6 | NURSE'S OFFICE | 172 SF | | 120 SF | +52 SF |
| 7 | RESTROOM | 20 SF | | | |
| 8 | LAB & HALL | 75 SF | | | |
| 9 | EXAM | 88 SF | 2 total Exam Rooms | 120 SF | -32 SF |
| 10 | EXAM | 88 SF | | 120 SF | -32 SF |
| 11 | FILE ROOM | 107 SF | | | |
| 12 | RECEPTION | 153 SF | 1 workstation | 64 SF | +89 SF |
| 13 | IMMUNIZATION STORAGE | 245 SF | | | |
| 14 | CUST. & FURNACE | 31 SF | | | |
| 15 | ADA RESTROOM | 36 SF | | | |
| 19 | GARAGE | 517 SF | | | |
| | Conference Room | 0 SF | No conference room | 160 SF | -160 SF |
| | Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | |

# FACILITY SPACE ALLOCATION

The Weiser Office building layout poses several functional challenges. Modifications have been made over time, but reconfiguring the walls of the central core would greatly improve circulation and space use.

The centrally located Immunization Storage Room is inconvenient, as staff must escort patients through it to reach exam rooms. It contains refrigerated immunizations, environmental samples, and a work table, and though a moveable divider simulates a hallway, the layout is still inefficient.

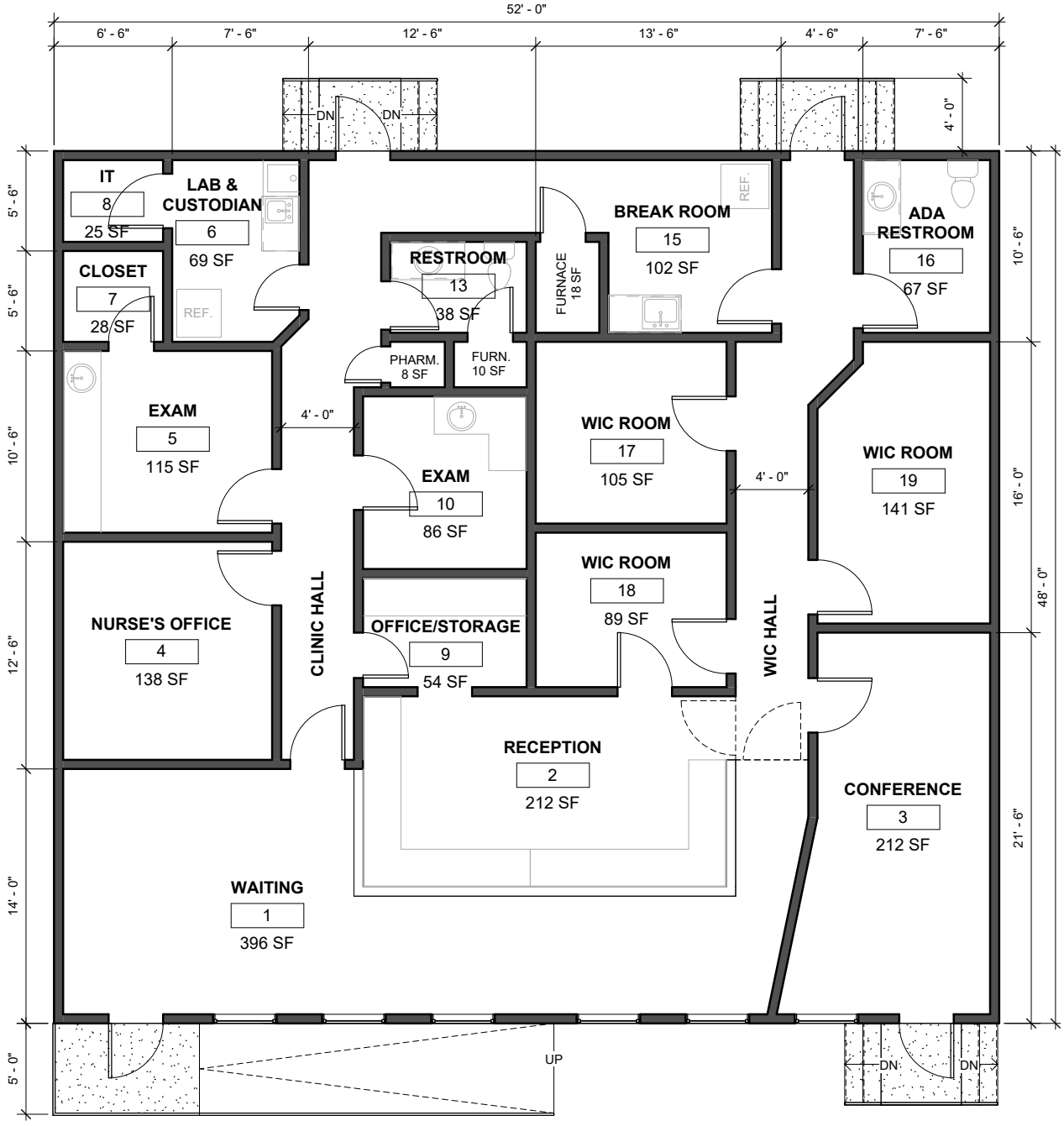
A narrow hallway outside the exam rooms doubles as the nurse's station, with a slim lab counter and supply storage. Some areas are tight, while others, like a WIC room and the nurse's office in the back, are oversized but awkwardly divided or poorly located.

The lobby is spacious yet underused and could be reconfigured for community classes. The Weiser office lacks functional meeting spaces equipped for hybrid meetings, such as TVs or microphones. The reception desk does not meet ADA standards for counter height or knee space and isn't directly visible from the entrance.

Despite its age and unusual layout, the building has charm and has a valuable downtown presence. With some floor plan reorganization, the space could be highly functional and beneficial to the community.

# EMMETT OFFICE

All SWDH Services - Gem County
1008 East Locust St
Emmett, ID 83617




NOTE: ALL DIMENSIONS ARE ESTIMATED AND APPROXIMATE, VERIFY ALL DIMENSIONS IN FIELD.

# EMMETT OFFICE

## Building Square Footage = approximately 2500 sf

| Room # | Room Name | Existing Net Area | Comments | Recommended Area | Surplus or Deficit |
|---|---|---|---|---|---|
| 1 | WAITING (incl. circulation) | 396 SF | 7 chairs | | |
| 2 | RECEPTION | 212 SF | 2 workstations @ 64 sf each | 128 SF | +84 SF |
| 3 | CONFERENCE | 212 SF | ≈9'-6" x 21'-0" | 260 SF for 12 people | -48 SF |
| 4 | NURSE'S OFFICE | 138 SF | | 120 SF | 18 SF |
| 5 | EXAM | 115 SF | 2 total Exam Rooms | 120 SF | -5 SF |
| 6 | LAB & CUSTODIAN | 69 SF | | | |
| 7 | CLOSET | 28 SF | | | |
| 8 | IT | 25 SF | | | |
| 9 | OFFICE/STORAGE | 54 SF | | | |
| 10 | EXAM | 86 SF | | 120 SF | -34 SF |
| 11 | PHARM. | 8 SF | | | |
| 12 | FURN. | 10 SF | | | |
| 13 | RESTROOM | 38 SF | | | |
| 14 | FURN. | 18 SF | | | |
| 15 | BREAK ROOM | 102 SF | | | |
| 16 | ADA RESTROOM | 67 SF | Not fully ADA | | |
| 17 | WIC ROOM | 105 SF | 3 total WIC Rooms | 160 SF | -55 SF |
| 18 | WIC ROOM | 89 SF | | 160 SF | -71 SF |
| 19 | WIC ROOM | 141 SF | | 160 SF | -19 SF |
| | Note: All dimensions are estimated and approximate, verify all dimensions in field. | | | | |

# FACILITY SPACE ALLOCATION

Located in the town of Emmett, the Emmett office building offers various health and community services, including clinical and WIC services. The office is organized with the Clinic services operating on the north side, and the WIC Services operating on the south side.

There are several ADA accessibility issues identified in the building. The reception desk is taller than the recommended height for ADA compliance and requires a lower, more accessible counter. The ADA restroom at the rear does not have compliant knee space below the sink. The entrance ramp meets ADA width standards but does not fulfill all International Building Code requirements.

According to 2021 IBC Chapter 10, Section 1012, ramp guardrails must not have openings larger than 4 inches, handrails are required on both sides, and edge protection must be present. The front door landing should be at least 60 x 60 inches. Replacement of the entrance ramp is advised. Installing a push-button door operator could also improve accessibility for individuals using wheelchairs or strollers.

The reception area currently extends into the waiting area, which reduces space at the main entrance and impacts movement through the waiting room. Modifying the reception desk to meet ADA standards and decreasing its size can increase circulation, especially for wheelchair and stroller users.

The ADA restroom is positioned at the back of the building, necessitating staff assistance for patient access. An ADA-compliant restroom that is accessed from the front waiting area would address this issue. The conference room does not have the proper IT resources required for hybrid meetings and events.

# NAMPA OFFICE

WIC Services Only - Canyon County
Idaho Hispanic Community Center (IH2C)
315 Stampede Dr
Nampa, ID 83687

Image: Google Street View, ©2025 Google, Image capture: Oct 2016

## FACILITY SPACE ALLOCATION

The Nampa WIC office is on the second floor of the Idaho Hispanic Community Center (IH2C). The space includes three cubicles, a small lab for weighing, measuring, and hemoglobin tests, and a waiting area. White noise is used for privacy. WIC families visit every three months. Additional family-friendly activities are needed for siblings during appointments.

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# HOMEDALE OFFICE

WIC Services Only - Owyhee County
Old Homedale Library
125 W Owyhee Ave
Homedale, ID 83628

Image: Google Street View, ©2025 Google, Image capture: Nov 2023

## FACILITY SPACE ALLOCATION

The Homedale Office operates in a reserved, shared space within the Old Homedale Library. As Owyhee County's only WIC site, it experiences high demand for services, mainly by appointment but also accepts walk-ins. Services are provided in a large, shared room where conversations can be overheard despite efforts to enhance confidentiality with white noise machines and privacy screens.

Note: The consultant team interviewed department heads and watched a staff-made video but did not tour this facility in person.

# FARMWAY OFFICE

WIC Services Only - Canyon County
Caldwell Housing Authority
22730 Farmway Rd #114
Caldwell, ID 83607


## FACILITY SPACE ALLOCATION

The Farmway Office is a WIC-only site sharing space with Terry Reilly and the Farmway Community Center. WIC services are provided mostly by appointment, with occasional walk-ins. The hallway leading to exam rooms is narrow, making it difficult to navigate with strollers. WIC appointments often occur in the waiting room due to limited space and the fact that they are mainly appointment based. Layout improvements, increased storage, and pest control are needed.

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# COUNCIL OFFICE

WIC Services Only - Adams County
Adams County Health Center (ACHC)
205 N Berkley St
Council, ID 83612

Image: Google Street View, ©2025 Google, Image capture: Sep 2024

## FACILITY SPACE ALLOCATION

The Council Office offers WIC-only services to Adams County and is SWDH's most distant site, located 104 miles (a 2-hour drive) from Caldwell. SWDH shares space there with the Adams County Health Center, operating on a limited schedule.

Note: The consultant team interviewed department heads and watched a staff-made video but did not tour this facility in person.

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# MARSING HUB

Clinic Services Only - Owyhee County
The Marsing Hub
205 8th Ave W
Marsing, ID 83639

Image: Google Street View, ©2025 Google, Image capture: Oct 2023

## FACILITY SPACE ALLOCATION

The Marsing School District converted its old middle school into "The Hub," a community center that offers education, health, and social services to all residents. The Hub is a circular building with perimeter rooms around a central meeting area. This space supports community needs such as preschool, adult education, food pantry and more. SWDH operates the school-based health center, offering clinical services to students within the Marsing School District as well as to members of the wider community. The clinic plays a vital role in meeting the healthcare needs of both students and residents in this rural area.

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# OVERALL DISTRICT WIDE SPACE CHALLENGES

### Community Meeting Spaces

Dedicated community meeting spaces at each SWDH-owned location with consistent IT infrastructure and SWDH branding for professional collaboration and public engagement.

Maximizing the use of the Caldwell Office community rooms and establishing clear reservation protocols for both SWDH uses and broader community uses. These community rooms could be a valuable community resource.

### IT Infrastructure

Inconsistent technology setups hinder hybrid meetings and telehealth capabilities. Standardizing conference room equipment and investing in reliable IT systems will enhance collaboration and service delivery.

Telehealth solutions could support better service delivery in remote areas.

### Storage

Many facilities suffer from inefficient storage solutions, leading to overcrowding in some divisions and underutilization in others. Centralizing and organizing materials—especially in WIC and Community Health—will improve accessibility and workflow.

### Space Efficiency

While some offices exceed recommended square footage, others fall short. Strategic reallocation, resizing, and reconfiguration could better align facilities with staffing needs and operational goals. This is particularly true for the Weiser and Emmett Offices. However, in the case of the Caldwell and Payette Offices, a full renovation to reduce office square footage is not cost effective. Renovations to meet the smaller standards may be costlier than retaining the current sizes.

### Maneuverability

Most clients are young families with children, diaper bags and strollers. It is difficult for many families to move through some of these locations. Improvements such as door operators, wider hallways, and kid-friendly activities for siblings during appointments would be helpful.

# CONCLUSION

The Southwest District Health (SWDH) Space Allocation Report provides a district-wide assessment of facility layouts, space utilization, and alignment with the State of Idaho Office Space Standards. Through site visits, staff interviews, and visual inspections, this report identifies both strengths and challenges across SWDH-owned and shared facilities.

As SWDH continues to grow and adapt to evolving public health demands, this report serves as a foundational tool for informed decision-making. Future evaluations incorporating staffing data, program expansion, and cost-benefit analyses will further refine space planning efforts. With thoughtful investment and strategic improvements, SWDH can ensure its facilities remain functional, welcoming, and responsive to the communities they serve.

2025

# Southwest District Health Demographic Report Summary

PREPARED FOR SOUTHWEST DISTRICT HEALTH

AUGUST 2025

# Contents

# Executive Summary

Southwest District Health (SWDH) serves six counties – Adams, Canyon, Gem, Owyhee, Payette, and Washington—encompassing a mix of rural and urban communities. As the second-largest health district in Idaho by population, SWDH is responsible for addressing diverse demographic, social, and economic conditions across its service area. This demographic report provides a comprehensive profile of current population trends, socioeconomic indicators, and long-term forecasts to support data-driven planning and service delivery.

## Population Growth and Forecasts

The District has experienced sustained population growth, adding more than 200,000 residents since 1970. Growth accelerated after 2000, particularly in Canyon and Owyhee Counties, reflecting regional in-migration and housing development. Looking ahead, forecasts for 2060 project a population ranging from approximately 472,000 (low) to 565,000 (high), with a mid-range estimate of 522,000.

- Opportunity: Strong population growth supports economic vitality and community development.
- Challenge: Rising demand will place pressure on health infrastructure, staffing, and equitable service access.

## Age Trends

Across the District, the population is aging. The 65+ age group is the fastest growing, with many counties experiencing double-digit increases over the past decade. At the same time, younger populations continue to expand in urbanizing areas.

- Opportunity: Expanding programs that engage older adults and promote aging-in-place strategies.
- Challenge: Meeting increased demand for chronic disease management, mobility assistance, and elder care while balancing the needs of growing child and young adult populations.

## Income and Poverty

Median household incomes have risen across the District, with some census tracts exceeding $100,000. However, significant variation remains, particularly between urban and rural areas. Poverty rates exceed 10% in every county, with Washington County reaching 15.3%.

- Opportunity: Rising incomes support a stronger tax base and greater community resources.
- Challenge: Persistent poverty and affordability pressures highlight the need for targeted, place-based service delivery.

## Race, Ethnicity, and Language Access

The District population is 23% Hispanic or Latino, with concentrations above 25% in Canyon and Owyhee Counties. While the majority of residents identify as White, the region is becoming increasingly diverse.

- Opportunity: Build on demographic diversity to expand partnerships and outreach strategies.
- Challenge: Ensuring culturally competent, linguistically accessible services across program areas.

## Veteran Status

Veterans make up a notable share of the adult population, ranging from 9% to nearly 11% depending on the county. Disability rates among veterans are higher than the general population, often exceeding one-third.

- Opportunity: Targeted programming can address veteran-specific health and support needs.
- Challenge: Access barriers persist for rural veterans and those with complex, service-connected conditions.

## Education and Workforce

Educational attainment has improved steadily, with significant increases in residents holding postsecondary degrees. However, some counties continue to report adults without a high school diploma.

- Opportunity: Higher education levels support health literacy and engagement in preventive care.
- Challenge: Gaps in baseline education levels may limit access to employment and health resources.

## Housing and Occupancy

Housing development has grown rapidly in certain counties, though vacancy rates have declined sharply, particularly in Canyon and Gem. Tight rental markets may contribute to housing insecurity and affordability challenges.

- Opportunity: Coordinating health and housing strategies to promote stability.
- Challenge: Housing stress may exacerbate health disparities, especially for low-income families and seniors.

## Conclusion

Demographic shifts across SWDH are uneven, reflecting the unique characteristics of each county. Population growth, aging trends, income disparities, and cultural diversity all carry significant implications for health planning. The District will need to balance opportunities created by a larger, more educated, and more diverse population with the challenges of poverty, housing instability, and aging-related health demands. Regular updates to demographic data and continued place-based strategies will be critical to ensuring that SWDH's facilities and services remain aligned with community needs over time.

## Southwest District Health Overview

Southwest District Health (SWDH) is one of seven (7) public health Districts in Idaho, serving a diverse and growing population across six (6) counties: Adams, Canyon, Gem, Owyhee, Payette, and Washington. These counties encompass both rural and urban areas, with varied geographic, demographic, and socioeconomic characteristics. SWDH is the second-largest health District in Idaho by total population, following Central District Health, which includes Ada County, the most populous in the state.

This Demographic Report is intended to provide a comprehensive, data-driven profile of the Southwest District Health service area. It compiles and analyzes population trends, forecasts, and key demographic indicators across all six (6) counties served by the District and is intended to support ongoing efforts to align public health infrastructure and programming with the changing needs of the communities served by SWDH.

Data in this report come primarily from the U.S. Census Bureau, including the Decennial Census (2020) and the American Community Survey (ACS) 5-Year Estimates (2019–2023). These sources provide insights into population growth, age distribution, race and ethnicity, income, poverty, education, veteran status, and housing trends.

This report is structured to provide:

- A high-level overview of regional trends affecting the entire District
- Detailed demographic summaries for each County
- Forecasts of future population growth to support long-term planning

Each County profile includes standardized indicators across population, age, income, poverty, education, housing, veteran status, and race/ethnicity. A glossary of terms with definitions can be found at the end of the report for reference.

## Population Trend

As of the 2020 Decennial Census, the total population of the Southwest District Health (SWDH) service area was 302,406 (U.S. Census Bureau, via TidyCensus, 2025). This reflects a net population increase of 202,398 people since 1970. While all counties in the District have grown overall during this 50-year period, Adams and Gem counties experienced periods of population decline between some decennial counts.

On average, the District's population has increased by approximately 40,480 people per decade, or 4,048 people per year since 1970. Over the more recent 20-year period (2000 to 2020), growth accelerated to an average of 55,555 people per decade, or 5,555 people per year. The percent change between decennial counts has ranged from a low of 5.06% (1990) to a high of 32.76% (2010).

Table: Southwest District Health, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 100,008 | - | - | - | - |
| **1980** | 131,872 | 31,864 | 31.86% | 3.19% | 3,186 |
| **1990** | 138,550 | 6,678 | 5.06% | 0.51% | 668 |
| **2000** | 191,297 | 52,747 | 38.07% | 3.81% | 5,275 |
| **2010** | 253,965 | 62,668 | 32.76% | 3.28% | 6,267 |
| **2020** | 302,406 | 48,441 | 19.07% | 1.91% | 4,844 |
| **Total Change** | 202,398 | - | - | - | - |
| **Recent Change** | 48,441 | - | - | - | - |
| **Average Change (50-years)** | - | 40,480 | 25.37% | 2.54% | 4,048 |
| **Average Recent Change (30 years)** | - | 55,555 | 25.92% | 2.59% | 5,555 |

*Note: See the References section for list of historical Census population records. Population values before 2000 were obtained from historical Census records not available through current online databases (i.e., non-database archives).*

Figure: Southwest District Health, Regional Context

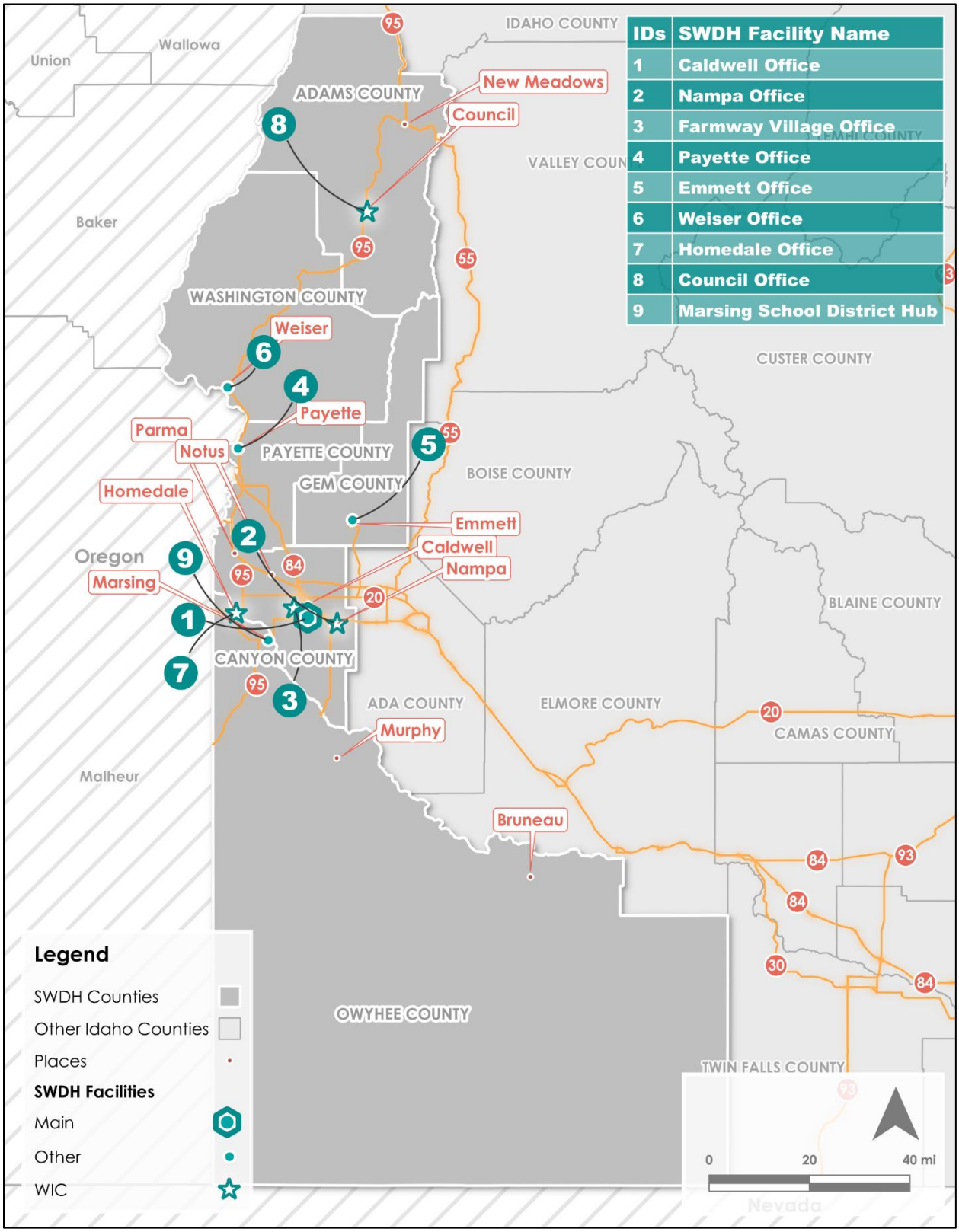


Figure: Southwest District Health, ACS Population by Block Group and Comparative City Populations

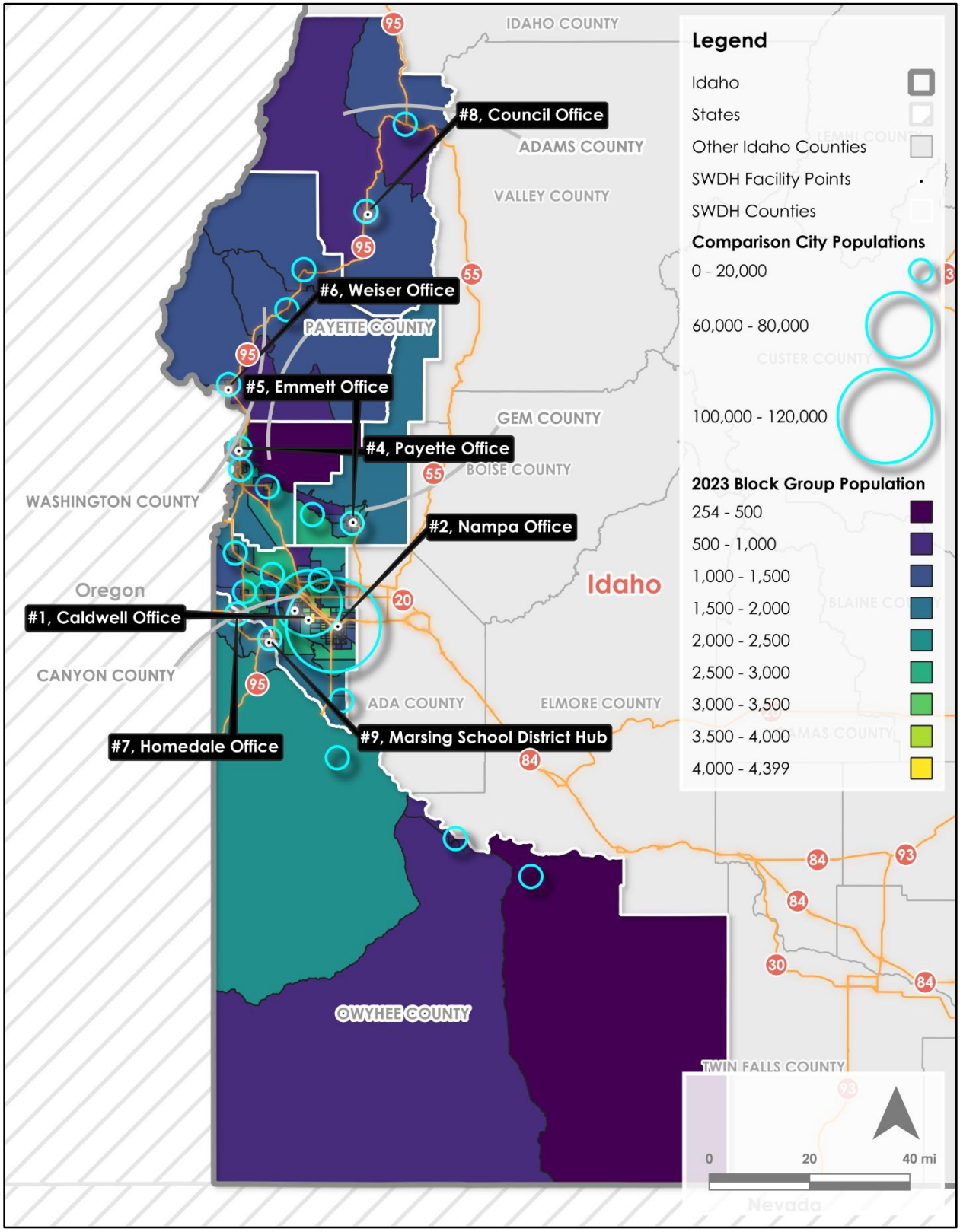
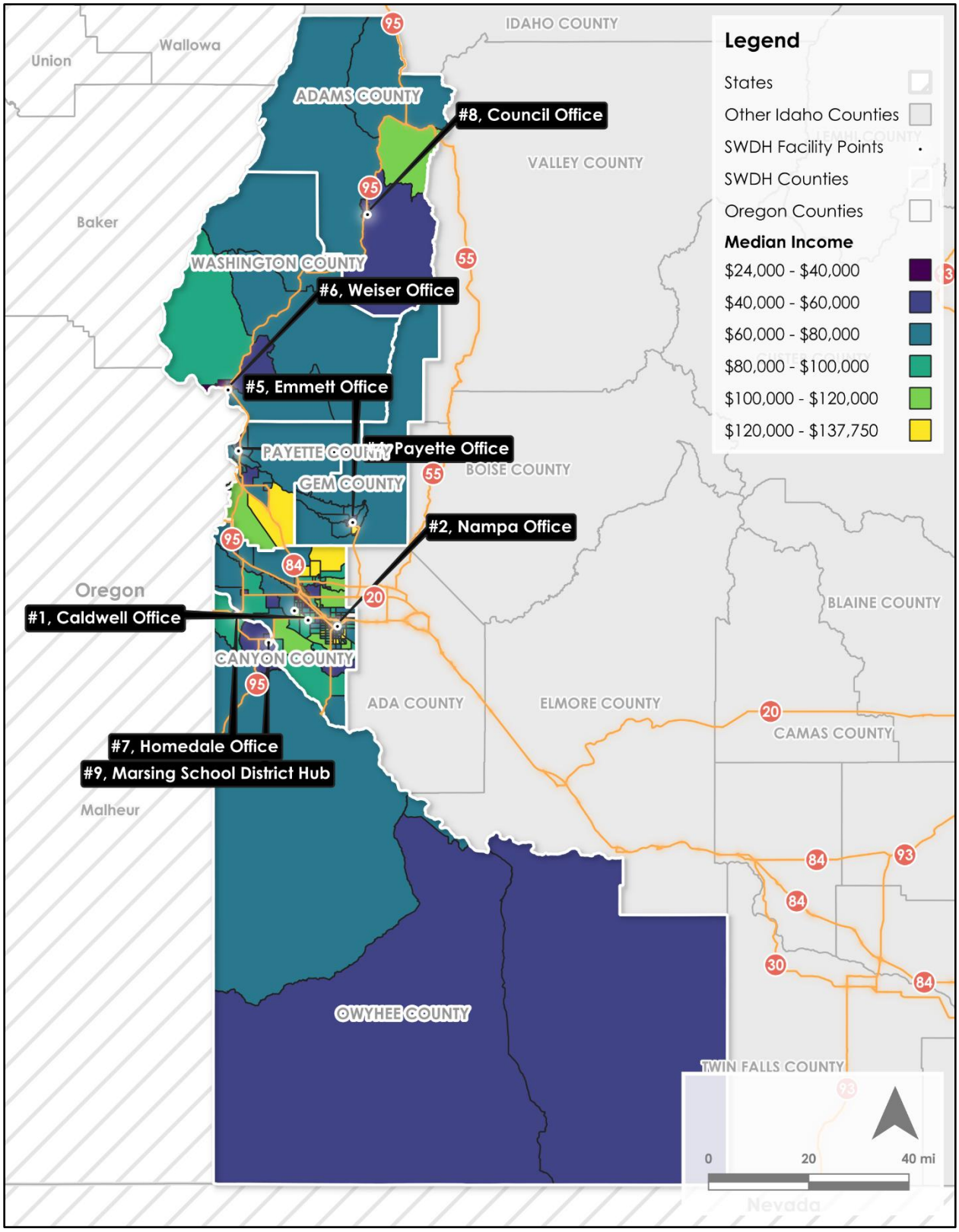


Figure: Southwest District Health, ACS Median Income by Block Group



## Income

Median household income across the Southwest District Health (SWDH) region reflects significant geographic variation, shaped by local economies, rurality, and proximity to urban centers. As shown in the preceding map, most of the District falls within the $60,000–$80,000 median income range (teal), though several counties include census tracts both above and below that range.

Notably, Canyon and Gem Counties display a mix of median income levels, with census tracts ranging from $40,000 to more than $100,000. This variation is likely driven by differences between urbanized areas such as Caldwell and Nampa and surrounding rural communities. In contrast, Owyhee County, which is geographically expansive and more isolated, contains large tracts in the lowest income range ($24,000–$40,000), while also including areas in the $60,000–$80,000 bracket. Washington and Payette Counties predominantly fall within the $60,000–$80,000 range, with some higher-income tracts in select areas.

Adams County, though smaller in population, exhibits a wide income range from $40,000 to more than $100,000, demonstrating the economic diversity even in less populous areas. Similarly, areas like Council and Weiser include tracts that exceed $100,000, indicating small pockets of higher-income households. These higher-income zones are exceptions rather than the rule, with only a few census tracts across the District falling in the top two income categories ($100,000–$120,000 and $120,000–$137,750).

Taken together, this income landscape underscores the importance of place-based strategies for service delivery. The presence of both high- and low-income communities within the same counties suggests that access to care, affordability, and resource targeting will need to be tailored at the sub-County level.

## Race and Ethnicity, Hispanic or Latino

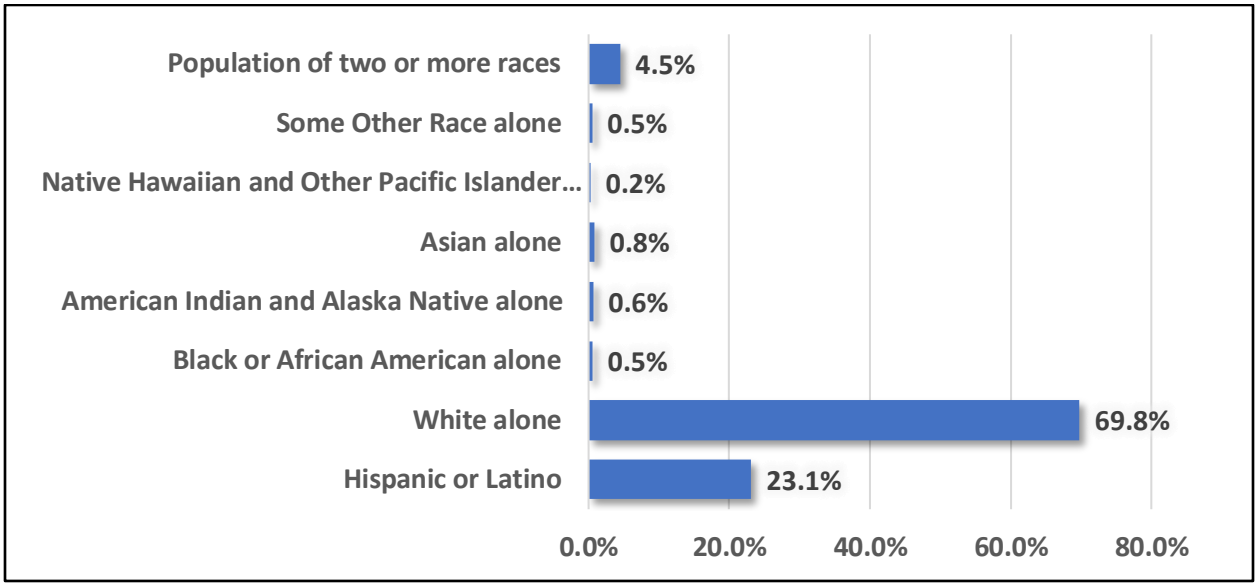
According to 2020 Decennial Census data (U.S. Census Bureau, 2025), most individuals in the Southwest District Health (SWDH) service area identified as belonging to a single race. A more detailed breakdown is provided below:

- **White (not Hispanic or Latino):** 69.8%
- **Hispanic or Latino (of any race):** 23.1%
- **Two or more races:** 4.5%

Within the SWDH service area, the proportion of individuals identifying as Hispanic or Latino ranged from 4.6% in Adams County to 26.5% in Owyhee County. Hispanic or Latino identity is classified by the U.S. Census Bureau as an **ethnicity**, not a race. Individuals may identify as both Hispanic or Latino and as any race.

See Appendix C: Table, Race and Ethnicity, Hispanic or Latino, or the County Summaries for more detailed breakdowns by jurisdiction.

Figure: Decennial 2020, Race and Ethnicity, Hispanic or Latino




*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

The U.S. Census Bureau provides several population estimate programs in addition to the official Decennial Census counts. The most prominent of these is the American Community Survey (ACS), which also includes detailed demographic, housing, social, and economic characteristics.

The ACS offers both 1-year and 5-year estimates. However, 1-year estimates are only available for geographies with populations of 65,000 or more, which excludes most counties in the Southwest District Health (SWDH) service area and the District as a whole (since SWDH is not a recognized Census geography).

By contrast, 5-year estimates are available for all geographies regardless of population size. These estimates are based on rolling averages, combining data collected over five years to provide a more reliable picture for smaller populations. While 5-year estimates are less current than 1-year data, they are more stable and better suited for analyzing trends over time, especially when comparing non-overlapping 5-year periods.

Throughout this report, references to ACS data by a single year (e.g., “2023”) refer to the most recent 5-year period available: 2019 to 2023. While some of these data are used to support population forecasts, most of it appears in the County Summaries. See the “Other Socioeconomic Indicators” section for additional demographic characteristics.

## Population Forecast

This report includes Low, Mid, and High population forecast scenarios for the Southwest District Health (SWDH) area, using 10-year increments from 2020 to 2060. Forecasts are trend-based, combining historical decennial Census counts with 5-year American Community Survey (ACS) estimates to identify past patterns of growth and change.

Each forecast scenario is based on aggregated estimates from the six counties within the District. The forecasting methodology incorporates:

- **Historical trends** (1970–2020 decennial Census)
- **Recent trends** (5-year estimates; comparisons between ACS 2013–2017 and 2018–2023)
- **Averaged trends** (an equal weighting of historical and recent trends)

See Appendix A for detailed methodology and County-level forecast tables.

**Forecast Scenarios:**

- **Low Scenario (2060)**: 472,457 people (+170,051 from 2020)
  This estimate is based primarily on long-term historical growth rates. It includes downward adjustment modifiers ("reduction modifiers") for counties with large populations—primarily Canyon County—to account for the likelihood that long-term growth may slow as infrastructure, land availability, or other constraints emerge in later decades.
- **Mid Scenario (2060):** 522,451 people (+220,045 from 2020)
  This scenario blends historical and recent growth rates to reflect a balanced projection. It includes upward adjustment modifiers in Canyon and Owyhee counties, which have shown significant acceleration in population growth over the past two decades due to increased housing development, in-migration, and proximity to fast-growing metropolitan areas.
- **High Scenario (2060**): 565,098 people (+262,692 from 2020)
  This estimate is based on recent high-growth trends extrapolated forward. It includes the same upward modifiers for Canyon and Owyhee counties as the mid scenario, further compounding the impact of recent growth patterns and assuming that these trends continue without major slowdowns.

**Note:** "Modifiers" refer to manual adjustments made to trend-based forecasts in order to account for observed shifts in growth not fully captured by long-term averages. For example, Canyon and Owyhee counties have experienced housing development booms and regional spillover growth from the Boise metropolitan area. No modifiers were applied to other counties, as their growth trends have remained stable or modest over time.

Figure: Southwest District Health Historical and Future Population Forecast

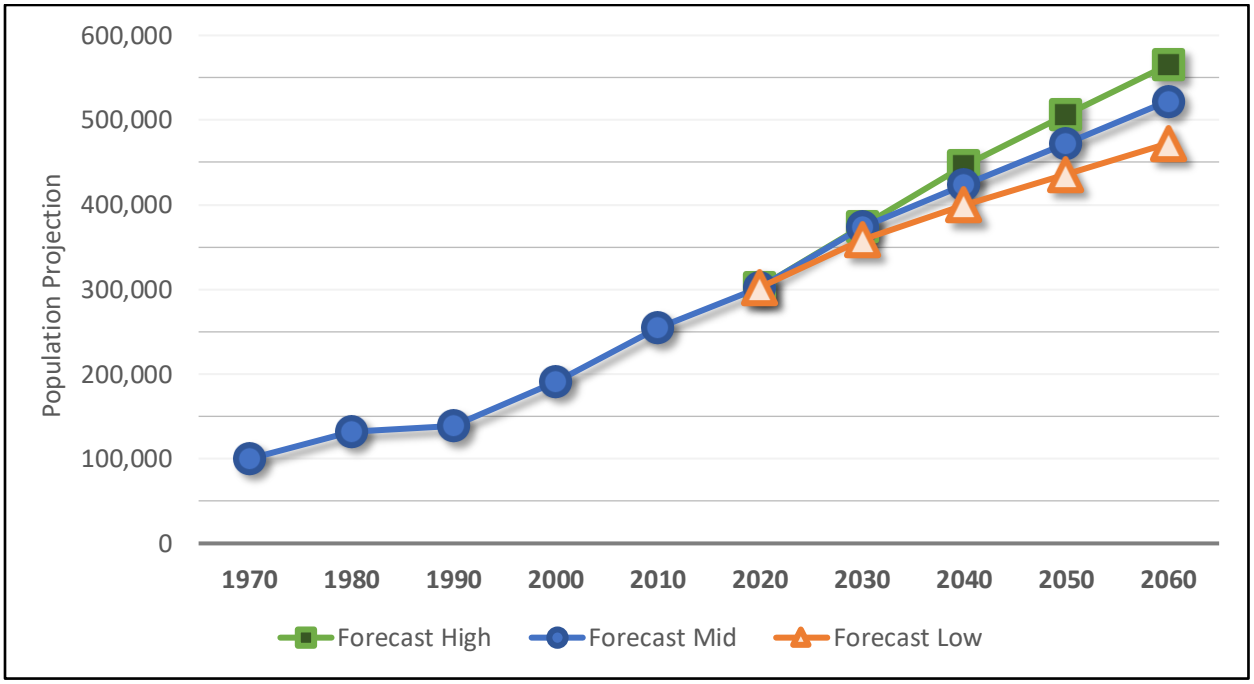



Table: Southwest District Health, Population Forecast

| Year | Low Forecast | Low % Change | Mid Forecast | Mid % Change | High Forecast | High % Change |
|---|---|---|---|---|---|---|
| 2020 | 302,406 | - | 302,406 | - | 302,406 | - |
| 2030 | 359,174 | 18.8% | 372,948 | 23.33% | 374,361 | 23.8% |
| 2040 | 399,199 | 11.1% | 422,782 | 13.36% | 446,315 | 19.2% |
| 2050 | 435,828 | 9.2% | 472,616 | 11.79% | 505,707 | 13.3% |
| 2060 | 472,457 | 8.4% | 522,451 | 10.54% | 565,098 | 11.7% |
| **Change** | **170,051** | - | **220,045** | - | **262,692** | - |

Population forecasting is influenced not only by historical growth patterns but also by external factors such as land availability, infrastructure capacity, economic trends, and utility services. This report uses trend-based forecasting, which relies on past population data to project future growth.

While no forecasting method is without limitations, trend analysis offers a practical advantage: it does not depend on detailed assumptions about variables like birth rates, death rates, or migration flows. It also avoids the need to model complex permitting and utility expansion data across multiple jurisdictions, data that are often inconsistent or unavailable.

For these reasons, a trend-based forecast provides a consistent and replicable foundation for planning. However, it should be regularly updated to account for emerging conditions or significant shifts in development, infrastructure, or population behavior. This aligns with public health and infrastructure planning best practices, which typically recommend a 5-year update cycle to ensure forecasts remain aligned with emerging conditions and data releases.

## Other Demographics Indicators

In addition to population estimates, ACS data provide valuable insights into socioeconomic characteristics that can inform targeted service delivery. This section presents 5-year ACS data on poverty rates and veteran status across the SWDH service area.

Due to the nature of survey-based estimates, and the considerable variation in geography, population size, and demographic composition between counties, data are not aggregated at the District level. Instead, a high-level summary is provided below, with County-specific details available in the following sections.

## Poverty

Poverty status in the American Community Survey (ACS) is based on household income over the past 12 months, compared to the federal poverty thresholds established by the U.S. Census Bureau. These thresholds vary by household size and composition and are used to determine whether individuals or families are considered to be living in poverty.

According to the most recent ACS 5-year estimates, all counties in the Southwest District Health (SWDH) service area have poverty rates exceeding 10%:

- The highest rate is in Washington County at 15.3%
- The lowest rate is in Canyon County at 10.1%

These differences may reflect a combination of factors, including access to social services, wage levels, and housing development trends. More detailed poverty characteristics by County can be found in the County Summary sections.

*Note: The U.S. Census Bureau's poverty thresholds are updated annually and vary based on family size and composition. For the most current thresholds, visit: https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html*

## Veteran Status

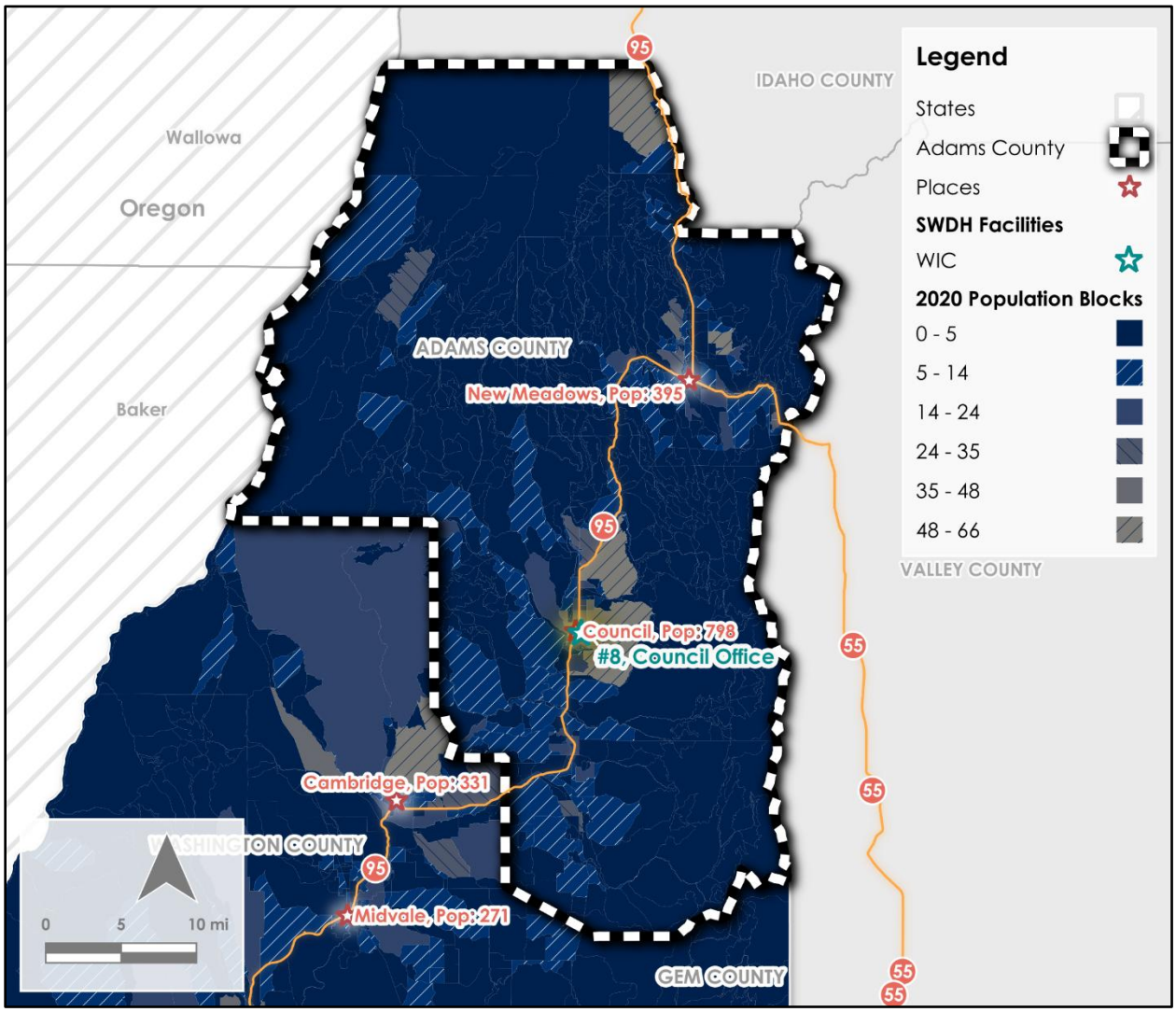
According to the latest 5-year ACS estimates (2019–2023), veteran status is reported for individuals aged 18 and older who have served in the U.S. Armed Forces, regardless of service period or discharge type.

- Adams County has the highest overall rate of military service at 10.8% (413 people).
- Canyon County, the most populous in the District, has the largest total number of veterans at 15,911 people, comprising 9.0% of its adult population.
- Across all counties, the majority of veterans are male, with male representation ranging from 83.5% to 94.7% of the veteran population.

Veterans also experience varying levels of poverty and disability:

- The percentage of veterans living in poverty ranges from 4.7% to 16.5% across counties.
- The share of veterans with disabilities ranges from 26.9% to 44.9%. The ACS defines disability status as having one or more of the following: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, or independent living difficulty (U.S. Census Bureau, 2024).

# Adams County Summary




*Adams County, 2020 Population Total by Census Blocks.*

## Population

Between 1970 and 2020, the population of Adams County increased by 1,502 people, reaching a total of 4,379 residents in 2020 (U.S. Census Bureau, 2020 Decennial Census). This reflects an average increase of approximately 300 people per decade, or 30 people per year over the 50-year period.

More recently, the County has experienced faster growth. Between 2000 and 2020, the population increased by an average of 452 people per decade, or approximately 45 people per year.

Table: Adams County, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 2,877 | - | - | - | - |
| **1980** | 3,347 | 470 | 16.34% | 1.63% | 47 |
| **1990** | 3,254 | (93) | -2.78% | -0.28% | (9) |
| **2000** | 3,476 | 222 | 6.82% | 0.68% | 22 |
| **2010** | 3,976 | 500 | 14.38% | 1.44% | 50 |
| **2020** | 4,379 | 403 | 10.14% | 1.01% | 40 |
| **Total Change** | 1,502 | - | - | - | - |
| **Recent Change** | 403 | - | - | - | - |
| **Average Change (50-years)** | - | 300 | 8.98% | 0.90% | 30 |
| **Average Recent Change (30 years)** | - | 452 | 12.26% | 1.23% | 45 |

*Note: 2000, 2010, and 2020 (U.S. Census Bureau, Via TidyCensus, 2025). See the References section for list of historical Census population records for 1980 (including 1970) and 1990.*

## Race and Ethnicity

According to the 2020 Decennial Census, Adams County had a total population of 4,379 residents. Of these, the vast majority—92.4%—identified as being of one race. The population was predominantly White (91.2%), with a smaller percentage identifying as two or more races (4.1%).

Approximately 3.5% of residents identified as Hispanic or Latino. The remaining population identified with other racial categories in small proportions.

Table: Adams County, 2020 Decennial Race and Ethnicity, Hispanic and Latino

| Description | Total | % of Total |
|---|---|---|
| **Total Population** | 4,379 | 100.0% |
| **Hispanic or Latino** | 152 | 3.5% |
| **Not Hispanic or Latino** | 4,227 | 96.5% |
| **Population of one race** | 4,048 | 92.4% |
| **White alone** | 3,992 | 91.2% |
| **Black or African American alone** | 3 | 0.1% |
| **American Indian and Alaska Native alone** | 27 | 0.6% |
| **Asian alone** | 8 | 0.2% |
| **Native Hawaiian and Other Pacific Islander alone** | - | 0.0% |
| **Some Other Race alone** | 18 | 0.4% |
| **Population of two or more races** | 179 | 4.1% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Age

Like much of the United States, Adams County is experiencing an aging population trend. According to the American Community Survey (ACS), the median age increased by 3.3 years from the 2009–2013 to the 2019–2023 5-year estimate periods. This represents a 6.5% increase in median age over the past decade.

The substantial growth in the senior population (60%) will likely increase demand for chronic disease care, mobility support, and aging-in-place services. Facility planning should consider accessible design, expanded home-based services, and partnerships for elder care.

Figure: Adams County, ACS Total Population by Age Groups (2019-2023)

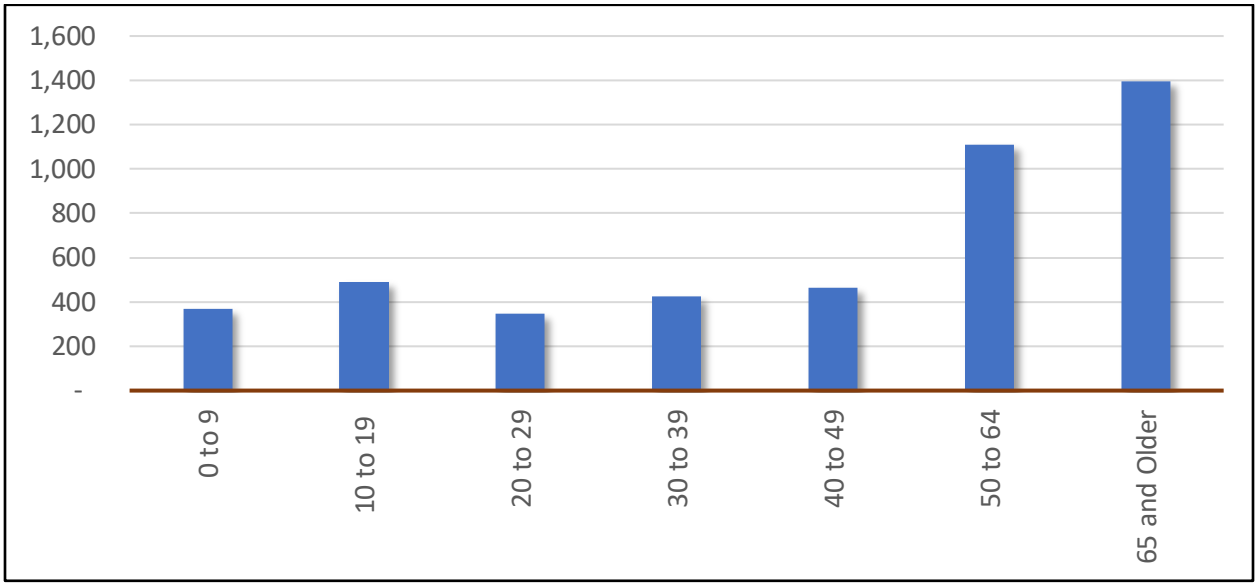



Figure: Adams County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)

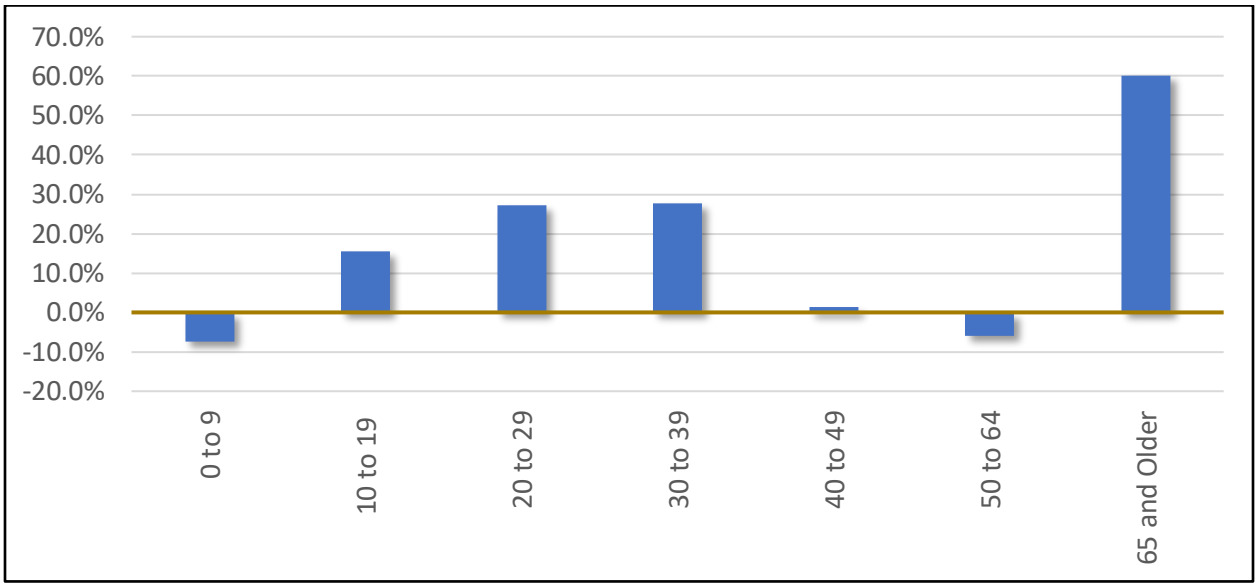


Table: Adams County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 0 to 9 | 399 | 359 | 369 | (30) | -7.5% |
| 10 to 19 | 426 | 497 | 492 | 66 | 15.5% |
| 20 to 29 | 271 | 232 | 345 | 74 | 27.3% |
| 30 to 39 | 332 | 366 | 424 | 92 | 27.7% |
| 40 to 49 | 458 | 347 | 464 | 6 | 1.3% |
| 50 to 64 | 1,178 | 1,090 | 1,108 | (70) | -5.9% |
| 65 and Older | 873 | 1,128 | 1,397 | 524 | 60.0% |
| Less than 18 | 747 | 737 | 788 | 41 | 5.5% |
| 18 and Older | 3,190 | 3,282 | 3,811 | 621 | 19.5% |
| Total Median Age | 51.0 | 54.2 | 54.3 | 3.3 | 6.5% |
| Total Median Age Male | 51.3 | 53.7 | 54.6 | 3.3 | 6.4% |
| Total Median Age Female | 50.5 | 54.4 | 53.6 | 3.1 | 6.1% |

## Housing and Occupancy

Between 2013 and 2023, Adams County experienced notable changes in household size and housing composition, based on American Community Survey (ACS) 5-year estimates.

- The average household size increased across all housing types:
  - Owner-occupied units: up by 14.8% (+0.34 persons per household)
  - Renter-occupied units: up by 7.5% (+0.16 persons per household)
  - All households (combined): up by 13.7% (+0.31 persons per household)

Even small increases in household size can affect how many new homes are needed. In rural areas like Adams County where housing construction tends to be slower, this can lead to challenges in meeting future housing demand.

Over the same period, the total number of housing units increased from 1,604 to 1,820 units, an addition of 216 units. However, the composition of occupied housing shifted:

- Owner-occupied units increased by 35.4% (+374 units)
- Renter-occupied units declined by 28.8% (–158 units)

Overall vacant housing units decreased substantially, with the total number of vacant units dropping by 70.9%. This trend suggests tightening housing availability, likely to be influenced by both demand-side pressures and aging housing inventory.

Declining renter-occupied housing (–28.8%) may limit options for young adults or low-income residents. a tightening vacancy rate (–70.9%) can contribute to housing insecurity or overcrowding. These changes could strain public health outreach, particularly for transient or housing-insecure populations.

Table: Adams County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.27 | 2.36 | 2.58 | 0.31 | 13.7% |
| Average Household Size: Owner | 2.30 | 2.24 | 2.64 | 0.34 | 14.8% |
| Average Household Size: Renter | 2.12 | 2.86 | 2.28 | 0.16 | 7.5% |

Table: Adams County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Units: Total | 1604 | 1763 | 1820 | 216 | 13.5% |
| Housing Units: Total Occupied | 1329 | 1699 | 1740 | 411 | 30.9% |
| Housing Units: Total Vacancy | 275 | 64 | 80 | (195) | -70.9% |
| % Vacancy | 17.1% | 3.6% | 4.4% | - | -12.7% |
| Owner-occupied housing units | 1056 | 1165 | 1430 | 374 | 35.4% |
| Renter-occupied housing units | 548 | 598 | 390 | (158) | -28.8% |
| % Owner Occupied | 65.8% | 66.1% | 78.6% | - | 12.7% |
| % Renter Occupied | 34.2% | 33.9% | 21.4% | - | -12.7% |

2025

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PREPARED FOR SOUTHWEST DISTRICT HEALTH

AUGUST 2025

# Contents

# Executive Summary

Southwest District Health (SWDH) serves six counties – Adams, Canyon, Gem, Owyhee, Payette, and Washington—encompassing a mix of rural and urban communities. As the second-largest health district in Idaho by population, SWDH is responsible for addressing diverse demographic, social, and economic conditions across its service area. This demographic report provides a comprehensive profile of current population trends, socioeconomic indicators, and long-term forecasts to support data-driven planning and service delivery.

## Population Growth and Forecasts

The District has experienced sustained population growth, adding more than 200,000 residents since 1970. Growth accelerated after 2000, particularly in Canyon and Owyhee Counties, reflecting regional in-migration and housing development. Looking ahead, forecasts for 2060 project a population ranging from approximately 472,000 (low) to 565,000 (high), with a mid-range estimate of 522,000.

- Opportunity: Strong population growth supports economic vitality and community development.
- Challenge: Rising demand will place pressure on health infrastructure, staffing, and equitable service access.

## Age Trends

Across the District, the population is aging. The 65+ age group is the fastest growing, with many counties experiencing double-digit increases over the past decade. At the same time, younger populations continue to expand in urbanizing areas.

- Opportunity: Expanding programs that engage older adults and promote aging-in-place strategies.
- Challenge: Meeting increased demand for chronic disease management, mobility assistance, and elder care while balancing the needs of growing child and young adult populations.

## Income and Poverty

Median household incomes have risen across the District, with some census tracts exceeding $100,000. However, significant variation remains, particularly between urban and rural areas. Poverty rates exceed 10% in every county, with Washington County reaching 15.3%.

- Opportunity: Rising incomes support a stronger tax base and greater community resources.
- Challenge: Persistent poverty and affordability pressures highlight the need for targeted, place-based service delivery.

## Race, Ethnicity, and Language Access

The District population is 23% Hispanic or Latino, with concentrations above 25% in Canyon and Owyhee Counties. While the majority of residents identify as White, the region is becoming increasingly diverse.

- Opportunity: Build on demographic diversity to expand partnerships and outreach strategies.
- Challenge: Ensuring culturally competent, linguistically accessible services across program areas.

## Veteran Status

Veterans make up a notable share of the adult population, ranging from 9% to nearly 11% depending on the county. Disability rates among veterans are higher than the general population, often exceeding one-third.

- Opportunity: Targeted programming can address veteran-specific health and support needs.
- Challenge: Access barriers persist for rural veterans and those with complex, service-connected conditions.

## Education and Workforce

Educational attainment has improved steadily, with significant increases in residents holding postsecondary degrees. However, some counties continue to report adults without a high school diploma.

- Opportunity: Higher education levels support health literacy and engagement in preventive care.
- Challenge: Gaps in baseline education levels may limit access to employment and health resources.

## Housing and Occupancy

Housing development has grown rapidly in certain counties, though vacancy rates have declined sharply, particularly in Canyon and Gem. Tight rental markets may contribute to housing insecurity and affordability challenges.

- Opportunity: Coordinating health and housing strategies to promote stability.
- Challenge: Housing stress may exacerbate health disparities, especially for low-income families and seniors.

## Conclusion

Demographic shifts across SWDH are uneven, reflecting the unique characteristics of each county. Population growth, aging trends, income disparities, and cultural diversity all carry significant implications for health planning. The District will need to balance opportunities created by a larger, more educated, and more diverse population with the challenges of poverty, housing instability, and aging-related health demands. Regular updates to demographic data and continued place-based strategies will be critical to ensuring that SWDH's facilities and services remain aligned with community needs over time.

## Southwest District Health Overview

Southwest District Health (SWDH) is one of seven (7) public health Districts in Idaho, serving a diverse and growing population across six (6) counties: Adams, Canyon, Gem, Owyhee, Payette, and Washington. These counties encompass both rural and urban areas, with varied geographic, demographic, and socioeconomic characteristics. SWDH is the second-largest health District in Idaho by total population, following Central District Health, which includes Ada County, the most populous in the state.

This Demographic Report is intended to provide a comprehensive, data-driven profile of the Southwest District Health service area. It compiles and analyzes population trends, forecasts, and key demographic indicators across all six (6) counties served by the District and is intended to support ongoing efforts to align public health infrastructure and programming with the changing needs of the communities served by SWDH.

Data in this report come primarily from the U.S. Census Bureau, including the Decennial Census (2020) and the American Community Survey (ACS) 5-Year Estimates (2019–2023). These sources provide insights into population growth, age distribution, race and ethnicity, income, poverty, education, veteran status, and housing trends.

This report is structured to provide:

- A high-level overview of regional trends affecting the entire District
- Detailed demographic summaries for each County
- Forecasts of future population growth to support long-term planning

Each County profile includes standardized indicators across population, age, income, poverty, education, housing, veteran status, and race/ethnicity. A glossary of terms with definitions can be found at the end of the report for reference.

## Population Trend

As of the 2020 Decennial Census, the total population of the Southwest District Health (SWDH) service area was 302,406 (U.S. Census Bureau, via TidyCensus, 2025). This reflects a net population increase of 202,398 people since 1970. While all counties in the District have grown overall during this 50-year period, Adams and Gem counties experienced periods of population decline between some decennial counts.

On average, the District's population has increased by approximately 40,480 people per decade, or 4,048 people per year since 1970. Over the more recent 20-year period (2000 to 2020), growth accelerated to an average of 55,555 people per decade, or 5,555 people per year. The percent change between decennial counts has ranged from a low of 5.06% (1990) to a high of 32.76% (2010).

Table: Southwest District Health, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 100,008 | - | - | - | - |
| **1980** | 131,872 | 31,864 | 31.86% | 3.19% | 3,186 |
| **1990** | 138,550 | 6,678 | 5.06% | 0.51% | 668 |
| **2000** | 191,297 | 52,747 | 38.07% | 3.81% | 5,275 |
| **2010** | 253,965 | 62,668 | 32.76% | 3.28% | 6,267 |
| **2020** | 302,406 | 48,441 | 19.07% | 1.91% | 4,844 |
| **Total Change** | 202,398 | - | - | - | - |
| **Recent Change** | 48,441 | - | - | - | - |
| **Average Change (50-years)** | - | 40,480 | 25.37% | 2.54% | 4,048 |
| **Average Recent Change (30 years)** | - | 55,555 | 25.92% | 2.59% | 5,555 |

*Note: See the References section for list of historical Census population records. Population values before 2000 were obtained from historical Census records not available through current online databases (i.e., non-database archives).*

Figure: Southwest District Health, Regional Context

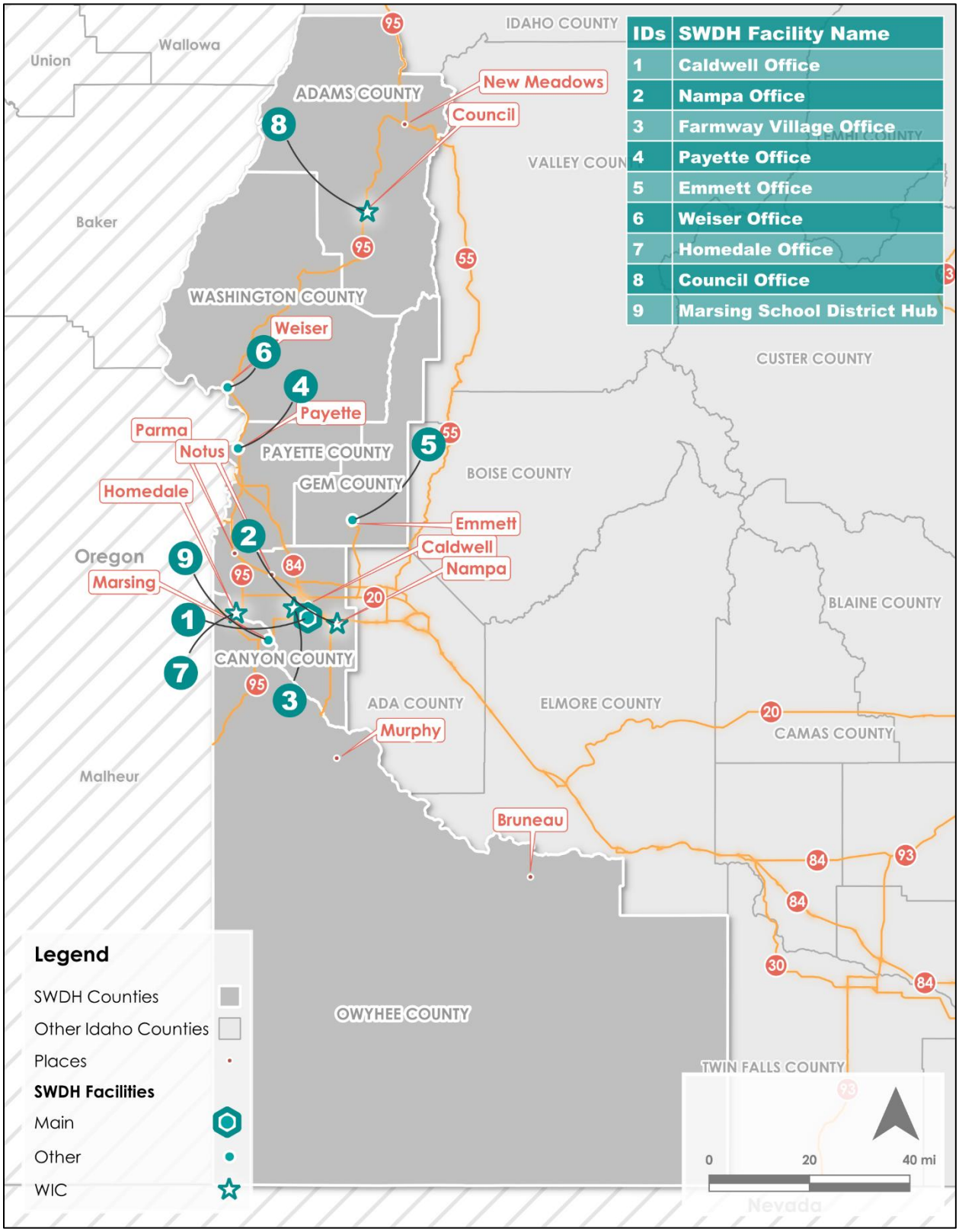


Figure: Southwest District Health, ACS Population by Block Group and Comparative City Populations

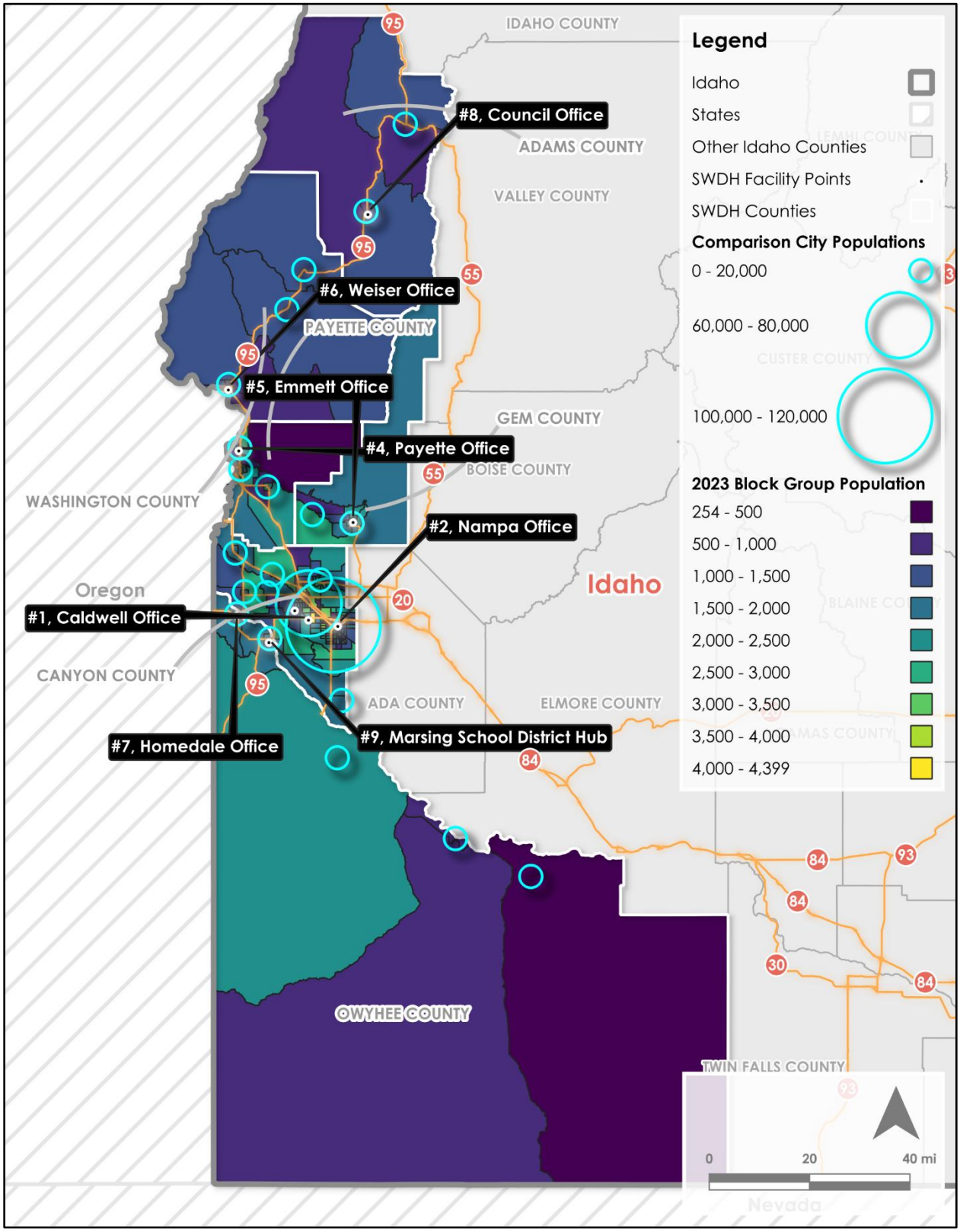
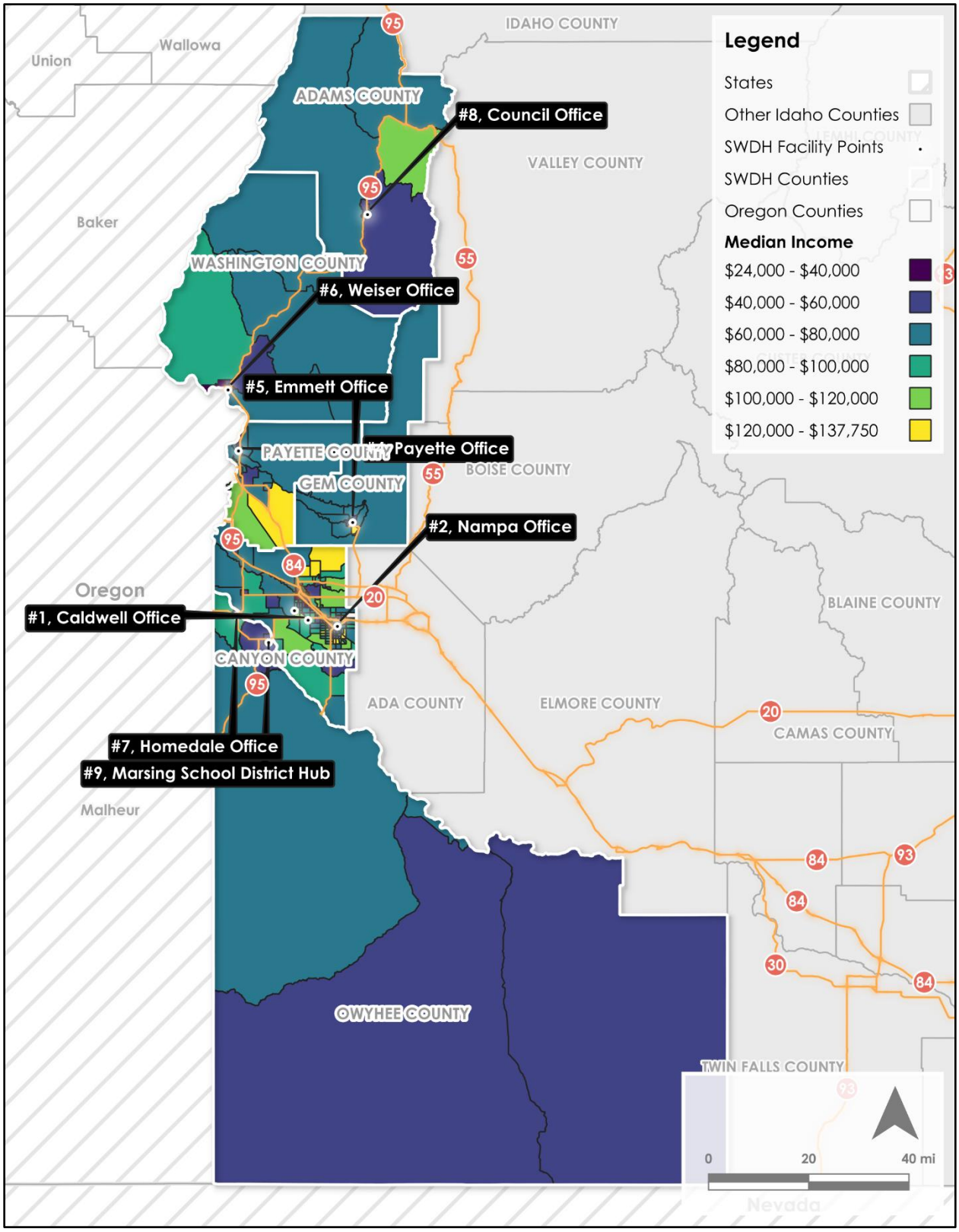


Figure: Southwest District Health, ACS Median Income by Block Group



## Income

Median household income across the Southwest District Health (SWDH) region reflects significant geographic variation, shaped by local economies, rurality, and proximity to urban centers. As shown in the preceding map, most of the District falls within the $60,000–$80,000 median income range (teal), though several counties include census tracts both above and below that range.

Notably, Canyon and Gem Counties display a mix of median income levels, with census tracts ranging from $40,000 to more than $100,000. This variation is likely driven by differences between urbanized areas such as Caldwell and Nampa and surrounding rural communities. In contrast, Owyhee County, which is geographically expansive and more isolated, contains large tracts in the lowest income range ($24,000–$40,000), while also including areas in the $60,000–$80,000 bracket. Washington and Payette Counties predominantly fall within the $60,000–$80,000 range, with some higher-income tracts in select areas.

Adams County, though smaller in population, exhibits a wide income range from $40,000 to more than $100,000, demonstrating the economic diversity even in less populous areas. Similarly, areas like Council and Weiser include tracts that exceed $100,000, indicating small pockets of higher-income households. These higher-income zones are exceptions rather than the rule, with only a few census tracts across the District falling in the top two income categories ($100,000–$120,000 and $120,000–$137,750).

Taken together, this income landscape underscores the importance of place-based strategies for service delivery. The presence of both high- and low-income communities within the same counties suggests that access to care, affordability, and resource targeting will need to be tailored at the sub-County level.

## Race and Ethnicity, Hispanic or Latino

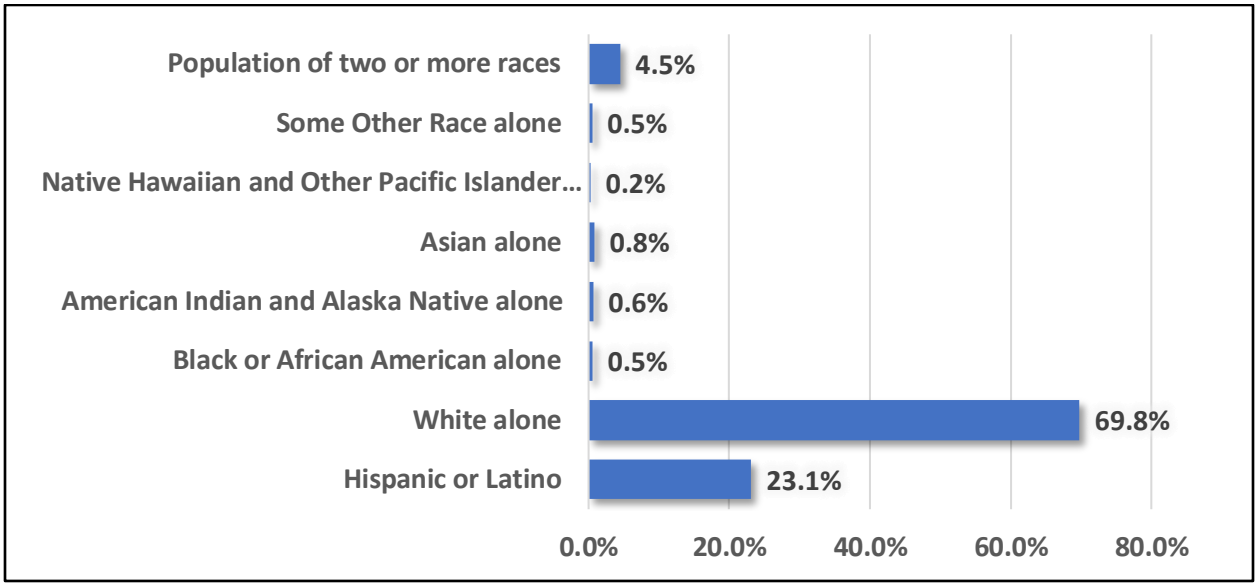
According to 2020 Decennial Census data (U.S. Census Bureau, 2025), most individuals in the Southwest District Health (SWDH) service area identified as belonging to a single race. A more detailed breakdown is provided below:

- **White (not Hispanic or Latino):** 69.8%
- **Hispanic or Latino (of any race):** 23.1%
- **Two or more races:** 4.5%

Within the SWDH service area, the proportion of individuals identifying as Hispanic or Latino ranged from 4.6% in Adams County to 26.5% in Owyhee County. Hispanic or Latino identity is classified by the U.S. Census Bureau as an **ethnicity**, not a race. Individuals may identify as both Hispanic or Latino and as any race.

See Appendix C: Table, Race and Ethnicity, Hispanic or Latino, or the County Summaries for more detailed breakdowns by jurisdiction.

Figure: Decennial 2020, Race and Ethnicity, Hispanic or Latino




*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

The U.S. Census Bureau provides several population estimate programs in addition to the official Decennial Census counts. The most prominent of these is the American Community Survey (ACS), which also includes detailed demographic, housing, social, and economic characteristics.

The ACS offers both 1-year and 5-year estimates. However, 1-year estimates are only available for geographies with populations of 65,000 or more, which excludes most counties in the Southwest District Health (SWDH) service area and the District as a whole (since SWDH is not a recognized Census geography).

By contrast, 5-year estimates are available for all geographies regardless of population size. These estimates are based on rolling averages, combining data collected over five years to provide a more reliable picture for smaller populations. While 5-year estimates are less current than 1-year data, they are more stable and better suited for analyzing trends over time, especially when comparing non-overlapping 5-year periods.

Throughout this report, references to ACS data by a single year (e.g., “2023”) refer to the most recent 5-year period available: 2019 to 2023. While some of these data are used to support population forecasts, most of it appears in the County Summaries. See the “Other Socioeconomic Indicators” section for additional demographic characteristics.

## Population Forecast

This report includes Low, Mid, and High population forecast scenarios for the Southwest District Health (SWDH) area, using 10-year increments from 2020 to 2060. Forecasts are trend-based, combining historical decennial Census counts with 5-year American Community Survey (ACS) estimates to identify past patterns of growth and change.

Each forecast scenario is based on aggregated estimates from the six counties within the District. The forecasting methodology incorporates:

- **Historical trends** (1970–2020 decennial Census)
- **Recent trends** (5-year estimates; comparisons between ACS 2013–2017 and 2018–2023)
- **Averaged trends** (an equal weighting of historical and recent trends)

See Appendix A for detailed methodology and County-level forecast tables.

**Forecast Scenarios:**

- **Low Scenario (2060)**: 472,457 people (+170,051 from 2020)
  This estimate is based primarily on long-term historical growth rates. It includes downward adjustment modifiers ("reduction modifiers") for counties with large populations—primarily Canyon County—to account for the likelihood that long-term growth may slow as infrastructure, land availability, or other constraints emerge in later decades.
- **Mid Scenario (2060):** 522,451 people (+220,045 from 2020)
  This scenario blends historical and recent growth rates to reflect a balanced projection. It includes upward adjustment modifiers in Canyon and Owyhee counties, which have shown significant acceleration in population growth over the past two decades due to increased housing development, in-migration, and proximity to fast-growing metropolitan areas.
- **High Scenario (2060**): 565,098 people (+262,692 from 2020)
  This estimate is based on recent high-growth trends extrapolated forward. It includes the same upward modifiers for Canyon and Owyhee counties as the mid scenario, further compounding the impact of recent growth patterns and assuming that these trends continue without major slowdowns.

**Note:** "Modifiers" refer to manual adjustments made to trend-based forecasts in order to account for observed shifts in growth not fully captured by long-term averages. For example, Canyon and Owyhee counties have experienced housing development booms and regional spillover growth from the Boise metropolitan area. No modifiers were applied to other counties, as their growth trends have remained stable or modest over time.

Figure: Southwest District Health Historical and Future Population Forecast

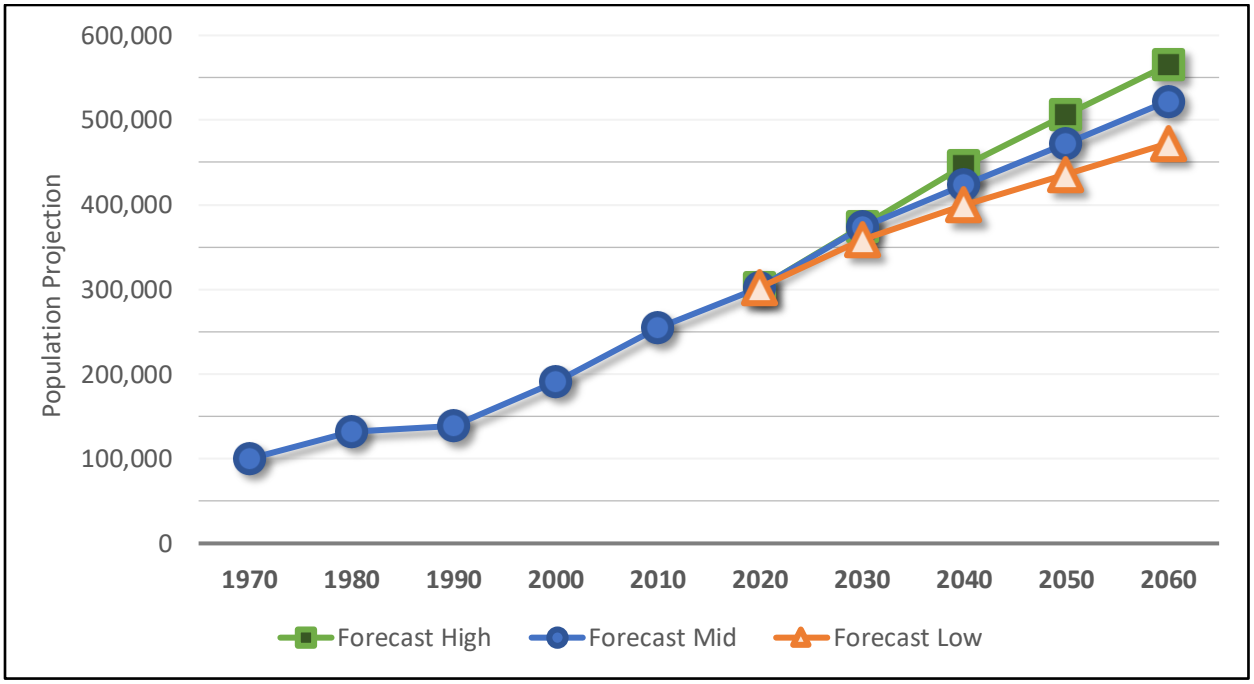



Table: Southwest District Health, Population Forecast

| Year | Low Forecast | Low % Change | Mid Forecast | Mid % Change | High Forecast | High % Change |
|---|---|---|---|---|---|---|
| 2020 | 302,406 | - | 302,406 | - | 302,406 | - |
| 2030 | 359,174 | 18.8% | 372,948 | 23.33% | 374,361 | 23.8% |
| 2040 | 399,199 | 11.1% | 422,782 | 13.36% | 446,315 | 19.2% |
| 2050 | 435,828 | 9.2% | 472,616 | 11.79% | 505,707 | 13.3% |
| 2060 | 472,457 | 8.4% | 522,451 | 10.54% | 565,098 | 11.7% |
| **Change** | **170,051** | - | **220,045** | - | **262,692** | - |

Population forecasting is influenced not only by historical growth patterns but also by external factors such as land availability, infrastructure capacity, economic trends, and utility services. This report uses trend-based forecasting, which relies on past population data to project future growth.

While no forecasting method is without limitations, trend analysis offers a practical advantage: it does not depend on detailed assumptions about variables like birth rates, death rates, or migration flows. It also avoids the need to model complex permitting and utility expansion data across multiple jurisdictions, data that are often inconsistent or unavailable.

For these reasons, a trend-based forecast provides a consistent and replicable foundation for planning. However, it should be regularly updated to account for emerging conditions or significant shifts in development, infrastructure, or population behavior. This aligns with public health and infrastructure planning best practices, which typically recommend a 5-year update cycle to ensure forecasts remain aligned with emerging conditions and data releases.

## Other Demographics Indicators

In addition to population estimates, ACS data provide valuable insights into socioeconomic characteristics that can inform targeted service delivery. This section presents 5-year ACS data on poverty rates and veteran status across the SWDH service area.

Due to the nature of survey-based estimates, and the considerable variation in geography, population size, and demographic composition between counties, data are not aggregated at the District level. Instead, a high-level summary is provided below, with County-specific details available in the following sections.

## Poverty

Poverty status in the American Community Survey (ACS) is based on household income over the past 12 months, compared to the federal poverty thresholds established by the U.S. Census Bureau. These thresholds vary by household size and composition and are used to determine whether individuals or families are considered to be living in poverty.

According to the most recent ACS 5-year estimates, all counties in the Southwest District Health (SWDH) service area have poverty rates exceeding 10%:

- The highest rate is in Washington County at 15.3%
- The lowest rate is in Canyon County at 10.1%

These differences may reflect a combination of factors, including access to social services, wage levels, and housing development trends. More detailed poverty characteristics by County can be found in the County Summary sections.

*Note: The U.S. Census Bureau's poverty thresholds are updated annually and vary based on family size and composition. For the most current thresholds, visit: https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html*

## Veteran Status

According to the latest 5-year ACS estimates (2019–2023), veteran status is reported for individuals aged 18 and older who have served in the U.S. Armed Forces, regardless of service period or discharge type.

- Adams County has the highest overall rate of military service at 10.8% (413 people).
- Canyon County, the most populous in the District, has the largest total number of veterans at 15,911 people, comprising 9.0% of its adult population.
- Across all counties, the majority of veterans are male, with male representation ranging from 83.5% to 94.7% of the veteran population.

Veterans also experience varying levels of poverty and disability:

- The percentage of veterans living in poverty ranges from 4.7% to 16.5% across counties.
- The share of veterans with disabilities ranges from 26.9% to 44.9%. The ACS defines disability status as having one or more of the following: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, or independent living difficulty (U.S. Census Bureau, 2024).

## Age

Like much of the United States, Adams County is experiencing an aging population trend. According to the American Community Survey (ACS), the median age increased by 3.3 years from the 2009–2013 to the 2019–2023 5-year estimate periods. This represents a 6.5% increase in median age over the past decade.

The substantial growth in the senior population (60%) will likely increase demand for chronic disease care, mobility support, and aging-in-place services. Facility planning should consider accessible design, expanded home-based services, and partnerships for elder care.

Figure: Adams County, ACS Total Population by Age Groups (2019-2023)

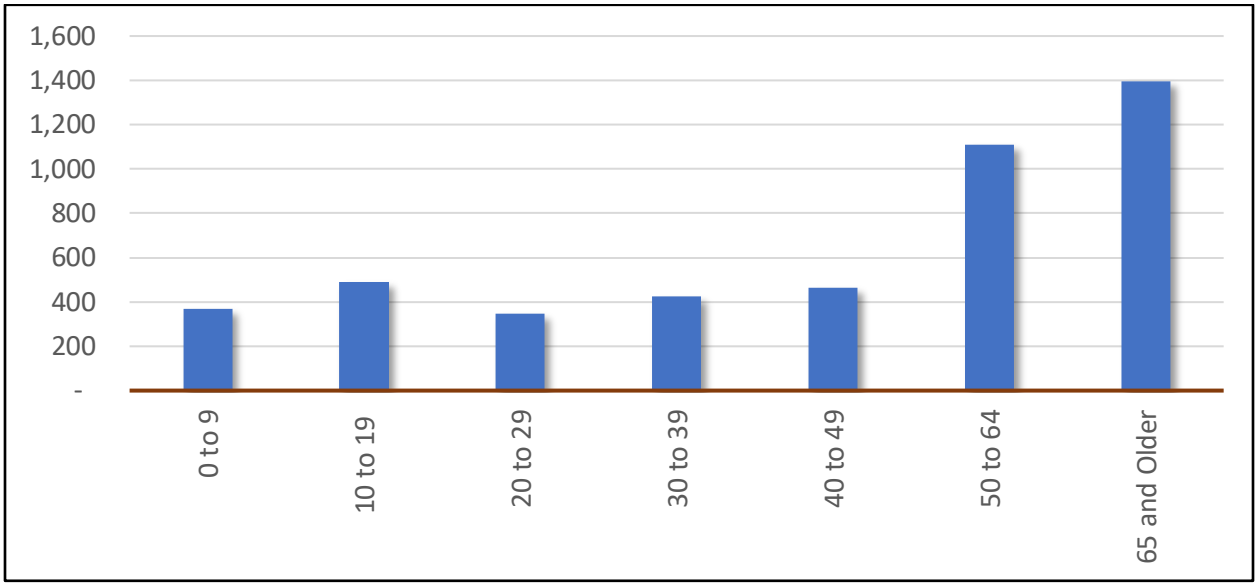



Figure: Adams County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)

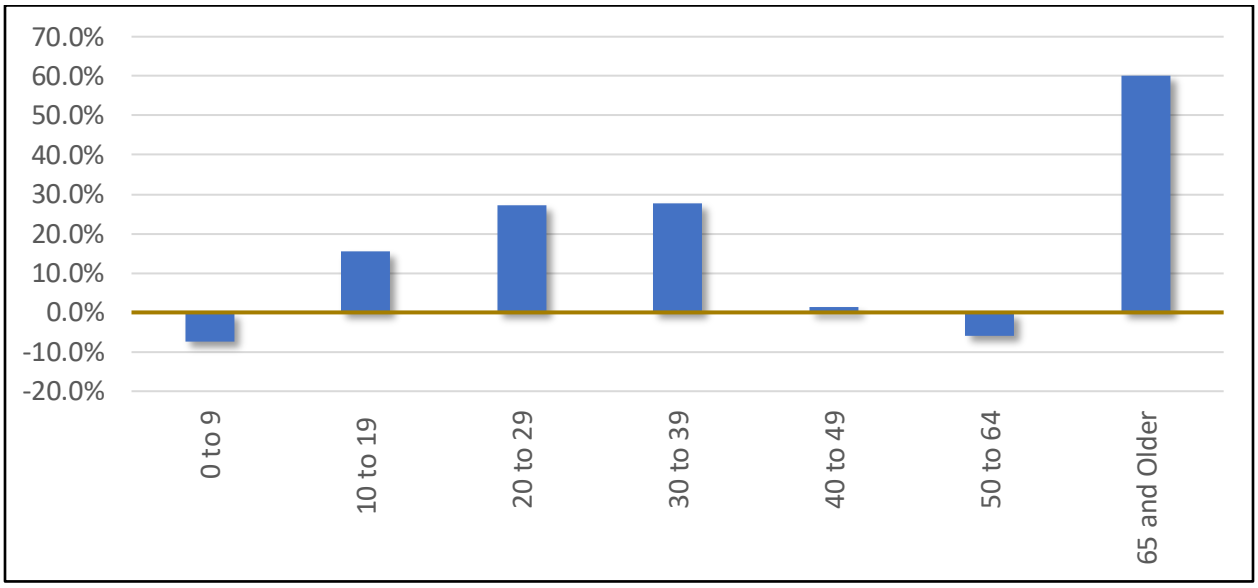


Table: Adams County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 0 to 9 | 399 | 359 | 369 | (30) | -7.5% |
| 10 to 19 | 426 | 497 | 492 | 66 | 15.5% |
| 20 to 29 | 271 | 232 | 345 | 74 | 27.3% |
| 30 to 39 | 332 | 366 | 424 | 92 | 27.7% |
| 40 to 49 | 458 | 347 | 464 | 6 | 1.3% |
| 50 to 64 | 1,178 | 1,090 | 1,108 | (70) | -5.9% |
| 65 and Older | 873 | 1,128 | 1,397 | 524 | 60.0% |
| Less than 18 | 747 | 737 | 788 | 41 | 5.5% |
| 18 and Older | 3,190 | 3,282 | 3,811 | 621 | 19.5% |
| Total Median Age | 51.0 | 54.2 | 54.3 | 3.3 | 6.5% |
| Total Median Age Male | 51.3 | 53.7 | 54.6 | 3.3 | 6.4% |
| Total Median Age Female | 50.5 | 54.4 | 53.6 | 3.1 | 6.1% |

## Housing and Occupancy

Between 2013 and 2023, Adams County experienced notable changes in household size and housing composition, based on American Community Survey (ACS) 5-year estimates.

- The average household size increased across all housing types:
  - Owner-occupied units: up by 14.8% (+0.34 persons per household)
  - Renter-occupied units: up by 7.5% (+0.16 persons per household)
  - All households (combined): up by 13.7% (+0.31 persons per household)

Even small increases in household size can affect how many new homes are needed. In rural areas like Adams County where housing construction tends to be slower, this can lead to challenges in meeting future housing demand.

Over the same period, the total number of housing units increased from 1,604 to 1,820 units, an addition of 216 units. However, the composition of occupied housing shifted:

- Owner-occupied units increased by 35.4% (+374 units)
- Renter-occupied units declined by 28.8% (–158 units)

Overall vacant housing units decreased substantially, with the total number of vacant units dropping by 70.9%. This trend suggests tightening housing availability, likely to be influenced by both demand-side pressures and aging housing inventory.

Declining renter-occupied housing (–28.8%) may limit options for young adults or low-income residents. a tightening vacancy rate (–70.9%) can contribute to housing insecurity or overcrowding. These changes could strain public health outreach, particularly for transient or housing-insecure populations.

Table: Adams County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.27 | 2.36 | 2.58 | 0.31 | 13.7% |
| Average Household Size: Owner | 2.30 | 2.24 | 2.64 | 0.34 | 14.8% |
| Average Household Size: Renter | 2.12 | 2.86 | 2.28 | 0.16 | 7.5% |

Table: Adams County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Units: Total | 1604 | 1763 | 1820 | 216 | 13.5% |
| Housing Units: Total Occupied | 1329 | 1699 | 1740 | 411 | 30.9% |
| Housing Units: Total Vacancy | 275 | 64 | 80 | (195) | -70.9% |
| % Vacancy | 17.1% | 3.6% | 4.4% | - | -12.7% |
| Owner-occupied housing units | 1056 | 1165 | 1430 | 374 | 35.4% |
| Renter-occupied housing units | 548 | 598 | 390 | (158) | -28.8% |
| % Owner Occupied | 65.8% | 66.1% | 78.6% | - | 12.7% |
| % Renter Occupied | 34.2% | 33.9% | 21.4% | - | -12.7% |

## Income

Between the 2009–2013 and 2019–2023 ACS 5-year periods, household income in Adams County increased across all income brackets above $50,000.

- The largest numeric increase was in the $50,000 to $75,000 income range, which grew by 158 households.
- The largest percentage increase occurred in the $200,000 or more income bracket, which increased by 459.3% over the ten-year period.

These changes suggest broad upward income mobility among County residents, especially in middle- and upper-income ranges, though affordability, cost of living, and fixed-income populations remain important considerations in rural counties.

While incomes have risen significantly, especially among middle- and upper-income households, rural affordability challenges remain. Public health planning should consider transportation, utility, and care costs that may outpace income gains, particularly for seniors and fixed-income residents.

Table: Adams County, ACS Change in Household Income Distribution (2013–2023)

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Less than $10,000 | 208 | 125 | 101 | (107) | -51.4% |
| $10,000 to $14,999 | 84 | 48 | 87 | 3 | 3.6% |
| $15,000 to $24,999 | 335 | 222 | 132 | (203) | -60.6% |
| $25,000 to $34,999 | 218 | 239 | 99 | (119) | -54.6% |
| $35,000 to $49,999 | 268 | 308 | 250 | (18) | -6.7% |
| $50,000 to $74,999 | 261 | 303 | 419 | 158 | 60.5% |
| $75,000 to $99,999 | 126 | 254 | 232 | 106 | 84.1% |
| $100,000 to $149,999 | 149 | 85 | 195 | 46 | 30.9% |
| $150,000 to $199,999 | 31 | 46 | 86 | 55 | 177.4% |
| $200,000 or more | 27 | 45 | 151 | 124 | 459.3% |
| Median income (dollars) | 35,434 | 45,319 | 59,286 | 23,852 | 67.3% |

Figure: Adams County, ACS Changes to Household Income by Total Households, 2013 to 2023

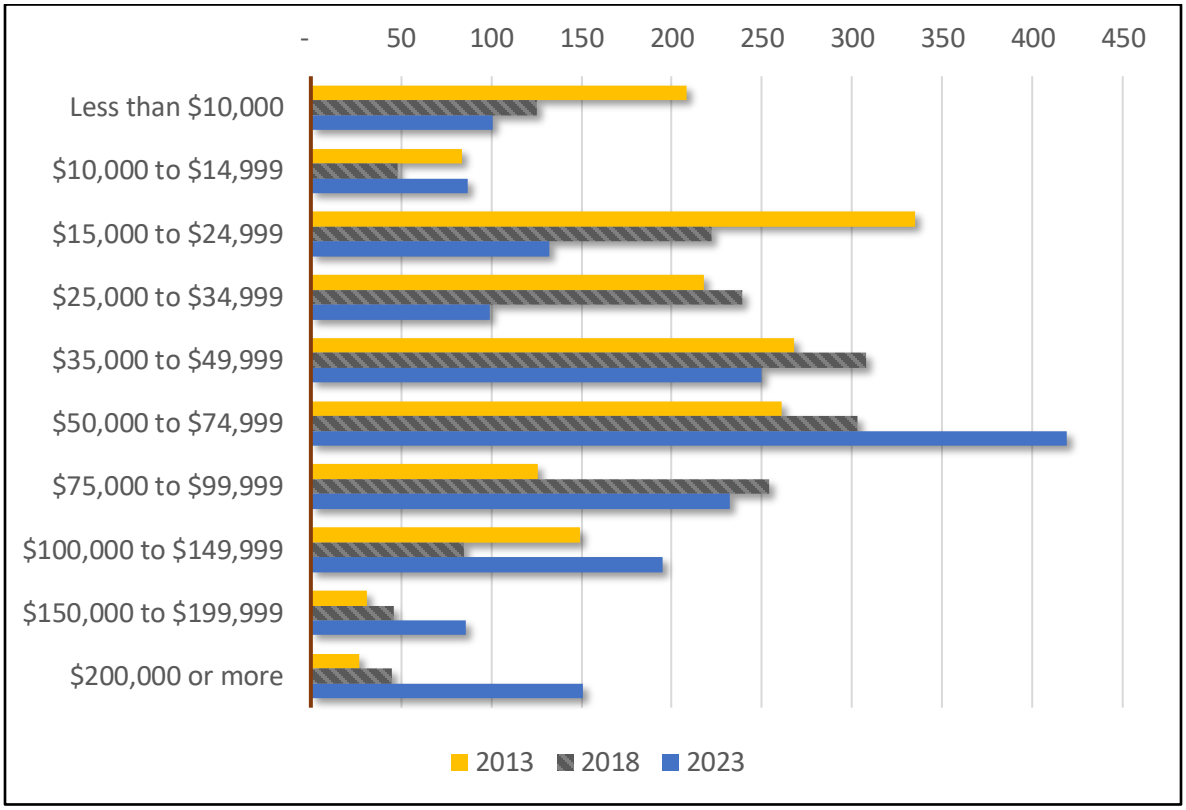
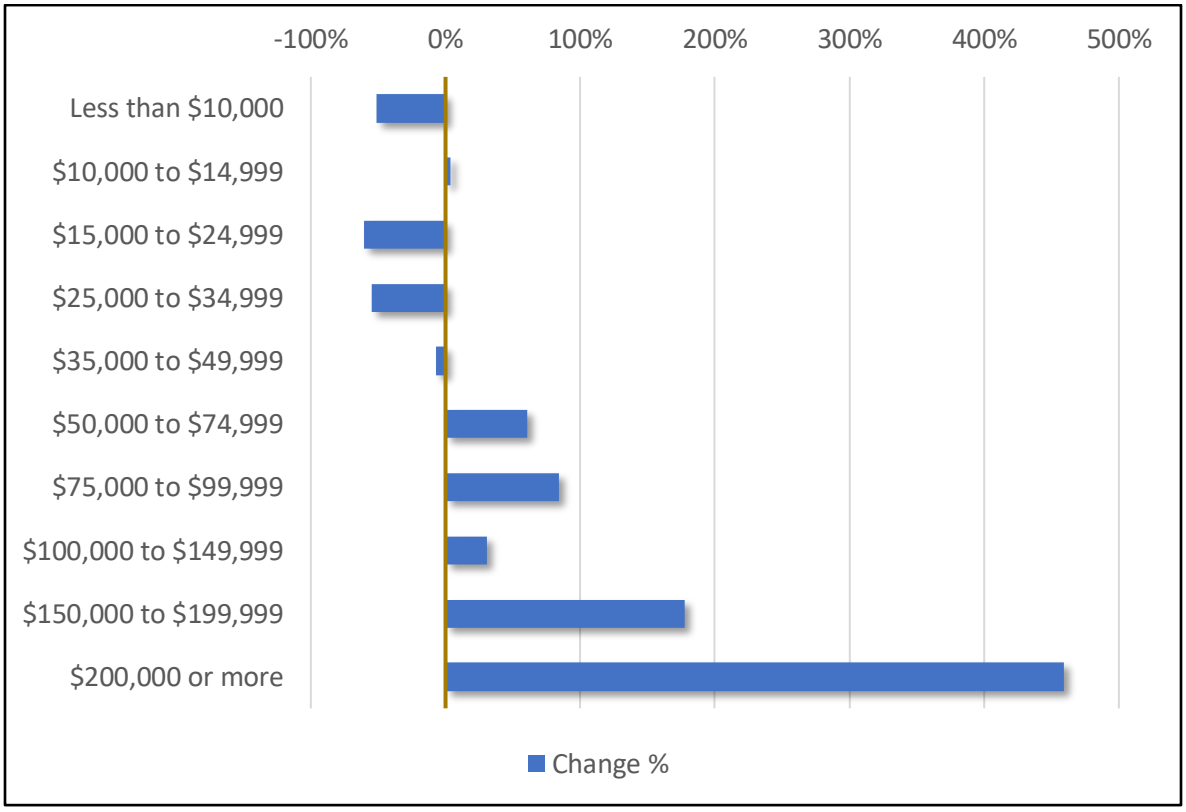



Figure: Adams County, ACS Changes to Household Income by %, 2013 to 2023



## Poverty Status

According to the latest 5-year ACS estimates (2019–2023), approximately 15.0% of Adams County residents live in poverty. Among those living in poverty:

- The largest share is in the 65 and older age group, followed by adults ages 35 to 64.
- The majority are White alone (87.3%), which reflects the County's overall racial composition.
- Most individuals in poverty are not in the labor force, including children, older adults, and others not currently working.

These trends suggest that poverty in Adams County disproportionately affects seniors and other non-working populations, which may require expanded access to social support, food security programs, and health services tailored to aging or fixed-income households. Wraparound services like nutrition support, housing stability, and low-cost care programs targeted at seniors and others outside the labor force will become a growing community need.

Figure: Adams County, ACS Poverty Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population** | 4,563 | 100.0% |
| **Total in Poverty Status** | 686 | 15.0% |
| **Under 18 years** | 101 | 14.7% |
| **18 to 34 years** | 114 | 16.6% |
| **35 to 64 years** | 226 | 32.9% |
| **65 years and over** | 245 | 35.7% |
| **White alone** | 599 | 87.3% |
| **Black or African American alone** | - | 0.0% |
| **American Indian and Alaska Native alone** | 19 | 2.8% |
| **Asian alone** | - | 0.0% |
| **Native Hawaiian and Other Pacific Islander alone** | - | 0.0% |
| **Some other race alone** | 12 | 1.7% |
| **Two or more races** | 56 | 8.2% |
| **Hispanic or Latino origin (of any race)** | 20 | |
| **White alone, not Hispanic or Latino** | 591 | |
| **Population 16 years and over** | 588 | 100.0% |
| **Worked full-time, year-round in the past 12 months** | 76 | 12.9% |
| **Worked part-time or part-year in the past 12 months** | 66 | 11.2% |
| **Did not work** | 446 | 75.9% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Veteran Status

As of the 2019–2023 American Community Survey (ACS) 5-year estimates, approximately 10.8% of Adams County residents are veterans. The majority of this group is aged 65 to 74, and most do not fall within Census-defined poverty income thresholds, indicating relatively stable income levels among veteran households.

Among residents with veteran status, approximately 26.9% report having a disability. This includes a range of difficulties such as ambulatory, cognitive, hearing, or self-care limitations, as defined by the U.S. Census Bureau.

These figures suggest that while many veterans in Adams County may have financial stability, disability-related needs remain a key area of concern, especially for aging populations.

Figure: Figure: Adams County, ACS Veteran Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population 18+** | 3,811 | 100.0% |
| **Population 18+ with Veteran Status** | 413 | 10.8% |
| **Male** | 383 | 92.7% |
| **Female** | 30 | 7.3% |
| **With any disability** | 111 | 26.9% |
| **Without a disability** | 302 | 73.1% |
| **18 to 34 years** | 19 | 4.6% |
| **35 to 54 years** | 68 | 16.5% |
| **55 to 64 years** | 93 | 22.5% |
| **65 to 74 years** | 159 | 38.5% |
| **75 years and over** | 74 | 17.9% |
| **Income in the past 12 months below poverty level** | 68 | 16.5% |
| **Income in the past 12 months at or above poverty level** | 345 | 83.5% |

## Education

Between the 2013 and 2023 ACS 5-year periods, educational attainment in Adams County increased across nearly all categories, reflecting a general trend toward higher education levels among adults aged 25 and older.

- The total population age 25 and older increased from 2,980 to 3,591, a gain of 611 people (20.5%).
- The number of residents with some college but no degree rose by 238 people (30.1%), and those with an Associate's Degree increased by 65 people (30.7%).
- Households with a Bachelor's Degree increased by 72 people (17.5%), and those with a graduate or professional degree rose by 40 people (16.6%).
- The number of adults with less than a high school diploma also increased by 39 people (18.1%), indicating that in-migration or generational persistence in lower educational attainment still affects a small portion of the population.

Overall:

- Residents with high school education or higher increased by 572 people (20.7%).
- Those with a Bachelor's Degree or higher grew by 112 people (17.2%).

These changes suggest increased educational access and attainment, but also highlight ongoing needs for adult education, GED preparation, and post-secondary pathways to support workforce development in rural settings.

Figure: Adams County, ACS Changes to Educational Attainment, 2013 to 2023

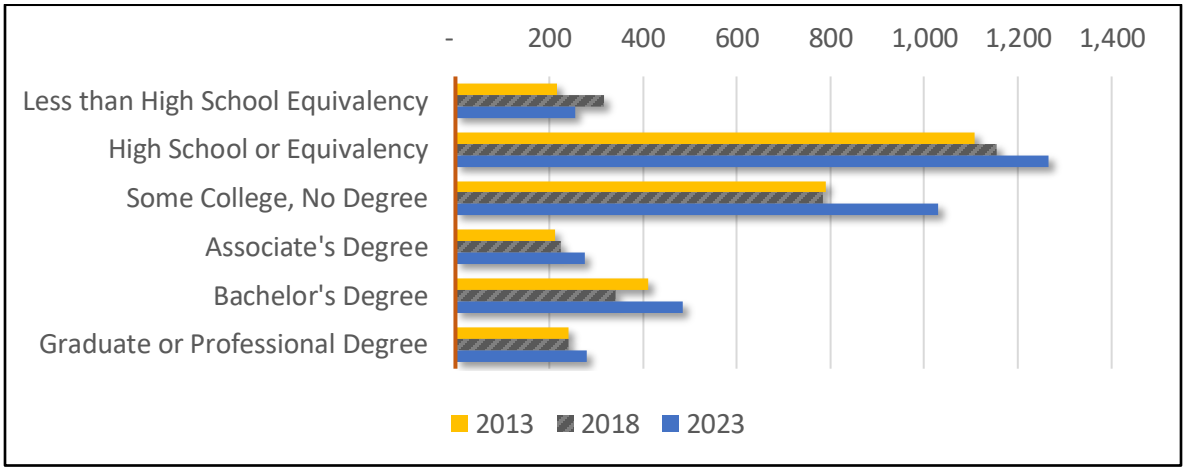


Figure: Adams County, ACS % Change to Educational Attainment, 2013 to 2023

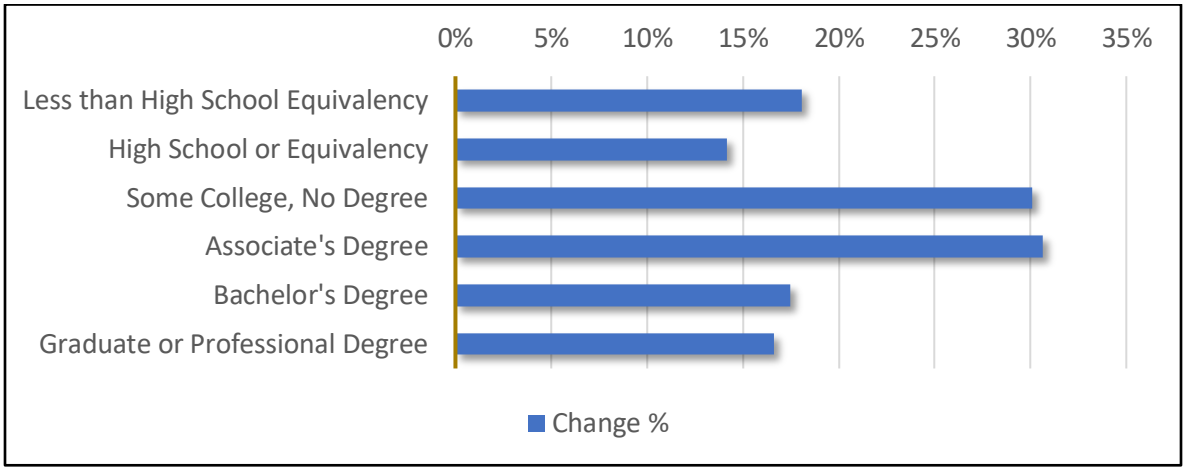
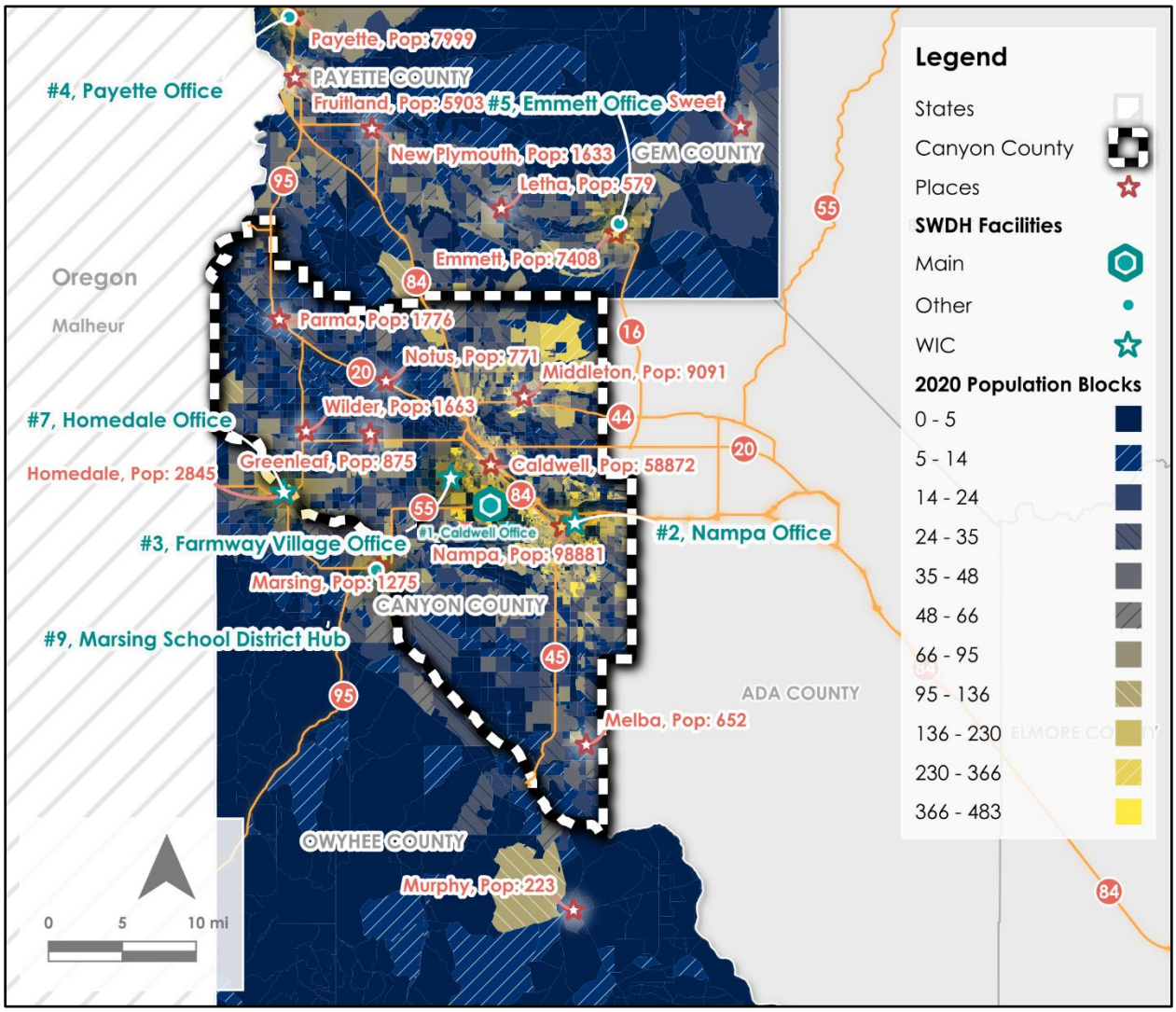
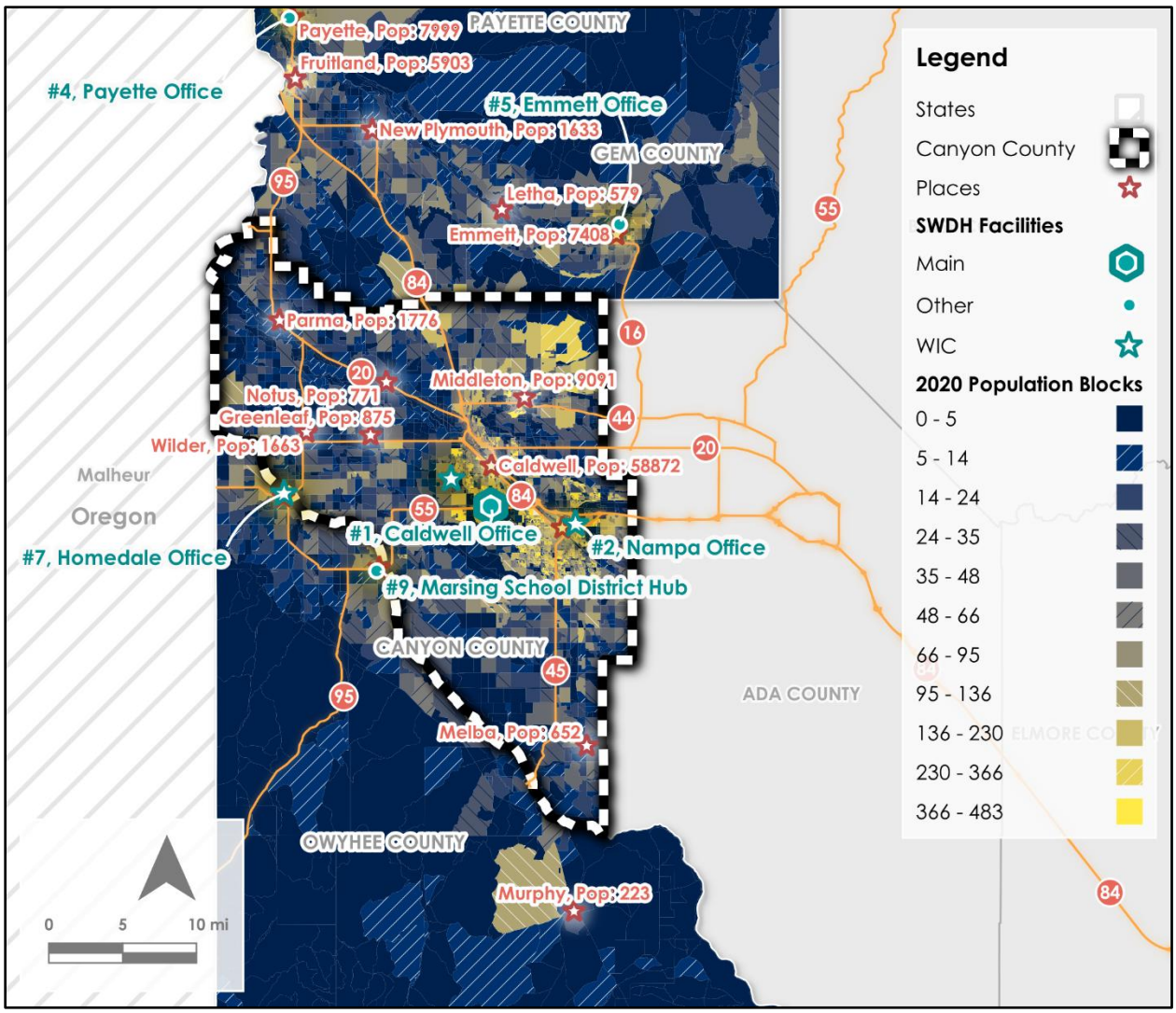



Table: Adams County, ACS Change in Educational Attainment 2013 to 2023

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Educational Attainment 25+ | 2,980 | 3,065 | 3,591 | 611 | 20.5% |
| Less than High School Equivalency | 216 | 318 | 255 | 39 | 18.1% |
| High School or Equivalency | 1,108 | 1,154 | 1,265 | 157 | 14.2% |
| Some College, No Degree | 791 | 784 | 1,029 | 238 | 30.1% |
| Associate's Degree | 212 | 225 | 277 | 65 | 30.7% |
| Bachelor's Degree | 412 | 342 | 484 | 72 | 17.5% |
| Graduate or Professional Degree | 241 | 242 | 281 | 40 | 16.6% |
| High School or Higher | 2,764 | 2,747 | 3,336 | 572 | 20.7% |
| Bachelor's Degree or Higher | 653 | 584 | 765 | 112 | 17.2% |
| Educational Attainment 25+ | 2,980 | 3,065 | 3,591 | 611 | 20.5% |

# Canyon County Summary






*Canyon County, 2020 Population Total by Census Blocks.*

## Population

Between 1970 and 2020, the population of Canyon County increased by 169,817 people, reaching a total of 231,105 residents in the 2020 Census. This represents an average 10-year increase of 33,963 people since 1970.

More recently, between 2000 and 2020, the population grew by 99,663 people, for an average 10-year increase of 49,832 people, or approximately 4,983 people per year. This trend reflects a period of accelerated growth compared to earlier decades.

This accelerated growth places increased demand on public health infrastructure, including clinical capacity, community-based prevention programs, and environmental health services such as water, sanitation, and food safety. As the largest and fastest-growing County in the District, Canyon County will likely continue to be a focal point for expanded facility investment and targeted outreach.

It is important to note that while the County as a whole has grown rapidly, population increases are concentrated in urban centers such as Caldwell and Nampa. This uneven distribution may require sub-County strategies to ensure rural residents retain access to health services amid ongoing urbanization.

Table: Canyon County, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 61,288 | - | - | - | - |
| **1980** | 83,756 | 22,468 | 36.66% | 3.67% | 2,247 |
| **1990** | 90,076 | 6,320 | 7.55% | 0.75% | 632 |
| **2000** | 131,441 | 41,365 | 45.92% | 4.59% | 4,137 |
| **2010** | 188,923 | 57,482 | 43.73% | 4.37% | 5,748 |
| **2020** | 231,105 | 42,182 | 22.33% | 2.23% | 4,218 |
| **Total Change** | 169,817 | - | - | - | - |
| **Recent Change** | 42,182 | - | - | - | - |
| **Average Change (50-years)** | - | 33,963 | 31.24% | 3.12% | 3,396 |
| **Average Recent Change (30 years)** | - | 49,832 | 33.03% | 3.30% | 4,983 |

*Note: 2000, 2010, and 2020 (U.S. Census Bureau, Via TidyCensus, 2025). See the References section for list of historical Census population records for 1980 (including 1970) and 1990.*

## Race and Ethnicity

According to the 2020 Decennial Census, Canyon County has one of the most racially and ethnically diverse populations in the SWDH service area, with a significantly higher percentage of Hispanic or Latino residents than most neighboring counties.

- Hispanic or Latino (of any race) residents make up 25.6% of the total population, one of the highest shares in the District. This is notably higher than the SWDH District average (23.1%) and the statewide average (approximately 13.5%), positioning Canyon County as a key area for focused bilingual and multicultural health outreach.
- The largest racial group is White alone, not Hispanic or Latino, representing 67.2% of the population.
- Two or more races account for 4.4%, followed by Asian alone (0.9%), Black or African American alone (0.6%), and American Indian and Alaska Native alone (0.5%).
- The category "Some other race alone," often associated with multiracial or underrepresented respondents, makes up 0.5%.

These demographic characteristics demonstrate the importance of culturally competent services and language access across public health outreach, education, and clinical care delivery in Canyon County. Given that over one in four residents identify as Hispanic or Latino, service delivery models, including public health education, chronic disease outreach, environmental health inspections, and other health district services should be linguistically accessible and culturally relevant. This includes providing materials in Spanish, ensuring interpreter access at clinics and during regulatory inspections, and partnering with trusted community-based organizations to strengthen engagement.

*Note: The U.S. Census Bureau treats Hispanic or Latino identity as an ethnicity, not a race. Individuals who identify as Hispanic or Latino may be of any race. For this reason, racial and ethnic percentages may overlap or not total 100% when combined.*

Table: Canyon County, 2020 Decennial Race and Ethnicity, Hispanic and Latino

| Description | Total | % of Total |
|---|---|---|
| **Total Population** | 231,105 | 100.0% |
| **Hispanic or Latino** | 59,166 | 25.6% |
| **Not Hispanic or Latino** | 171,939 | 74.4% |
| **Population of one race** | 161,745 | 70.0% |
| **White alone** | 155,401 | 67.2% |
| **Black or African American alone** | 1,455 | 0.6% |
| **American Indian and Alaska Native alone** | 1,176 | 0.5% |
| **Asian alone** | 1,973 | 0.9% |
| **Native Hawaiian and Other Pacific Islander alone** | 620 | 0.3% |
| **Some Other Race alone** | 1,120 | 0.5% |
| **Population of two or more races** | 10,194 | 4.4% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Age

Canyon County's population is aging like much of the U.S. and broader SWDH region. Between the 2009–2013 and 2019–2023 ACS 5-year periods, the median age increased by 8.7%, or 2.8 years, rising from 32.0 to 34.8 years.

The most significant growth occurred in the 65 and older age group, which increased by 13,001 people, a 59.7% rise over the ten-year period. By comparison:

- Adults aged 50 to 64 increased by 31.6% (+9,536 people).

These trends suggest strong generational growth across all adult age brackets, particularly among older adults, which has implications for future public health services, long-term care planning, chronic disease prevention, and community infrastructure for aging populations.

While older adults represent the fastest-growing demographic, Canyon County is also experiencing notable growth in young adult and child populations. This dual trend places pressure on both ends of the public health spectrum, requiring services for aging populations as well as maternal, child, and family health supports.

Figure: Canyon County, ACS Total Population by Age Groups (2019-2023)

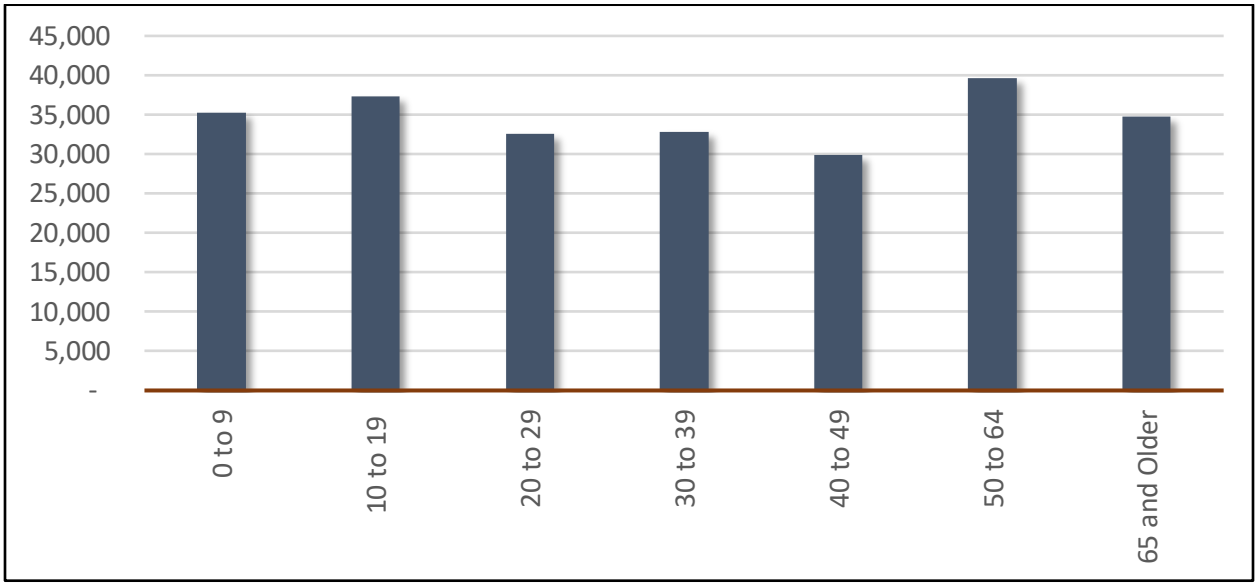


Figure: Canyon Change in Population Age Groups by % (2009-2013 to 2019-2023)

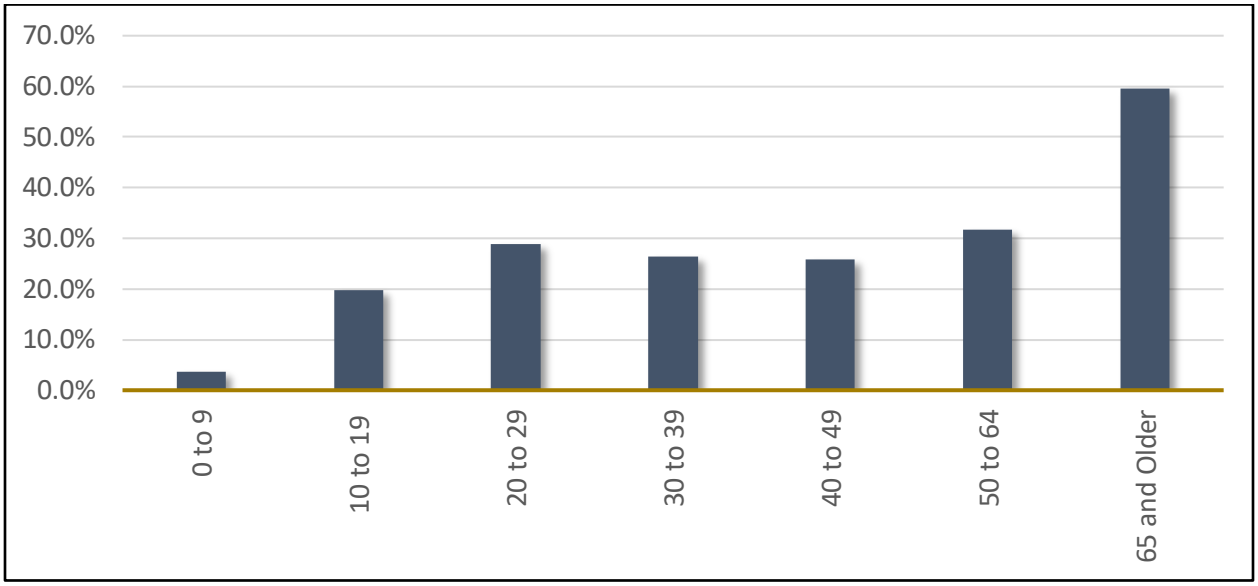



Table: Canyon County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 0 to 9 | 34,038 | 33,472 | 35,309 | 1,271 | 3.7% |
| 10 to 19 | 31,206 | 34,883 | 37,378 | 6,172 | 19.8% |
| 20 to 29 | 25,251 | 28,245 | 32,520 | 7,269 | 28.8% |
| 30 to 39 | 25,949 | 28,077 | 32,816 | 6,867 | 26.5% |
| 40 to 49 | 23,761 | 25,330 | 29,897 | 6,136 | 25.8% |
| 50 to 64 | 30,154 | 34,264 | 39,690 | 9,536 | 31.6% |
| 65 and Older | 21,794 | 27,959 | 34,795 | 13,001 | 59.7% |
| Less than 18 | 59,512 | 62,189 | 65,829 | 6,317 | 10.6% |
| 18 and Older | 132,641 | 150,041 | 176,576 | 43,935 | 33.1% |
| Total Median Age | 32.0 | 33.4 | 34.8 | 2.8 | 8.7% |
| Total Median Age Male | 31.0 | 32.5 | 34.1 | 3.1 | 10.0% |
| Total Median Age Female | 32.8 | 34.2 | 35.3 | 2.5 | 7.6% |

## Housing and Occupancy

Between 2013 and 2023, average household size in Canyon County declined across all tenure types. Owner-occupied units decreased by 0.05 people (-1.7%), renter-occupied units by 0.29 people (-9.7%), and all households overall by 0.11 people (-3.7%). Even modest reductions in household size can place increased pressure on housing demand, particularly in fast-growing counties.

During the same period, total housing units increased from 63,442 to 82,864, an increase of 30.6%. Owner-occupied units rose by 41.5% (+18,262 units), while renter-occupied units grew by 6.0% (+1,160 units). Owner-occupied units grew at a significantly faster pace than renter-occupied units (15x), potentially reducing the availability of affordable rental housing. This may pose access barriers for younger adults, seasonal workers, and others not in a position to purchase a home.

The overall vacancy rate declined from 9.7% to 3.3%, a 6.4 percentage point decrease, indicating high housing utilization and potential supply constraints. The steep drop in vacancy rates (from 9.7% to 3.3%) suggest a tightening housing market that may disproportionately affect renters, low-income families, and mobile populations. Limited rental availability can lead to housing instability, overcrowding, and longer commutes, all of which can contribute to negative health outcomes and reduced access to care.

Table: Canyon County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.98 | 2.95 | 2.87 | (0.11) | -3.7% |
| Average Household Size: Owner | 2.98 | 2.97 | 2.93 | (0.05) | -1.7% |
| Average Household Size: Renter | 2.99 | 2.91 | 2.70 | (0.29) | -9.7% |

Table: Canyon County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Units Total | 63,442 | 70,847 | 82,864 | 19,422 | 30.6% |
| Housing Units: Total Occupied | 57,287 | 67,044 | 80,145 | 22,858 | 39.9% |
| Housing Units: Total Vacancy | 6,155 | 3,803 | 2,719 | (3,436) | -55.8% |
| % Vacancy | 9.7% | 5.4% | 3.3% | -6.4% | -6.4% |
| Owner-occupied housing units | 43,959 | 48,290 | 62,221 | 18,262 | 41.5% |
| Renter-occupied housing units: | 19,483 | 22,557 | 20,643 | 1,160 | 6.0% |
| % Owner Occupied | 69.3% | 68.2% | 75.1% | 5.8% | 5.8% |
| % Renter Occupied | 30.7% | 31.8% | 24.9% | -5.8% | -5.8% |

## Income

Between the 2009–2013 and 2019–2023 ACS periods, household income in Canyon County shifted markedly upward, particularly in higher income brackets. The largest absolute growth occurred in the $100,000 to $149,999 range, which added 11,883 households, a 255.3% increase. The fastest relative growth was in the $200,000 or more category, which grew by 588.5% (+3,678 households). Over the same period, the County's median household income rose by 71.8%, increasing from $42,105 to $72,355. These trends likely reflect both regional in-migration and local economic development, as higher-income households relocate to the area and employment opportunities expand in urban centers like Caldwell and Nampa.

While these gains signal broad-based economic advancement, they also highlight the need to maintain access to affordable housing and health services for lower-income residents. The number of households earning under $35,000 declined sharply, raising concerns about cost-of-living pressures and potential barriers to care among those still in lower-income brackets. Part of the observed increases in wages and household income may also reflect the impact of inflation over time, which can raise nominal earnings without necessarily improving real purchasing power.

Table: Canyon County, ACS Change in Household Income Distribution (2013–2023)

| Income | 2013 | 2018 | 2023 | Change # 2013 - 2023 | | Change % 2013 - 2023 |
|---|---|---|---|---|---|---|
| Less than $10,000 | 4,976 | 4,788 | 2,518 | (2,458) | | -49.4% |
| $10,000 to $14,999 | 3,754 | 3,428 | 2,070 | (1,684) | | -44.9% |
| $15,000 to $24,999 | 8,533 | 6,993 | 5,106 | (3,427) | | -40.2% |
| $25,000 to $34,999 | 8,816 | 8,627 | 5,638 | (3,178) | | -36.0% |
| $35,000 to $49,999 | 11,091 | 12,142 | 10,219 | (872) | | -7.9% |
| $50,000 to $74,999 | 13,604 | 15,559 | 17,667 | 4,063 | | 29.9% |
| $75,000 to $99,999 | 6,470 | 8,370 | 12,993 | 6,523 | | 100.8% |
| $100,000 to $149,999 | 4,654 | 7,960 | 16,537 | 11,883 | | 255.3% |
| $150,000 to $199,999 | 919 | 1,748 | 5,813 | 4,894 | | 532.5% |
| $200,000 or more | 625 | 1,232 | 4,303 | 3,678 | | 588.5% |
| Median income (dollars) | 42,105 | 49,143 | 72,355 | 30,250 | | 71.8% |

Figure: Canyon County, ACS Changes to Household Income by Total Households, 2013 to 2023

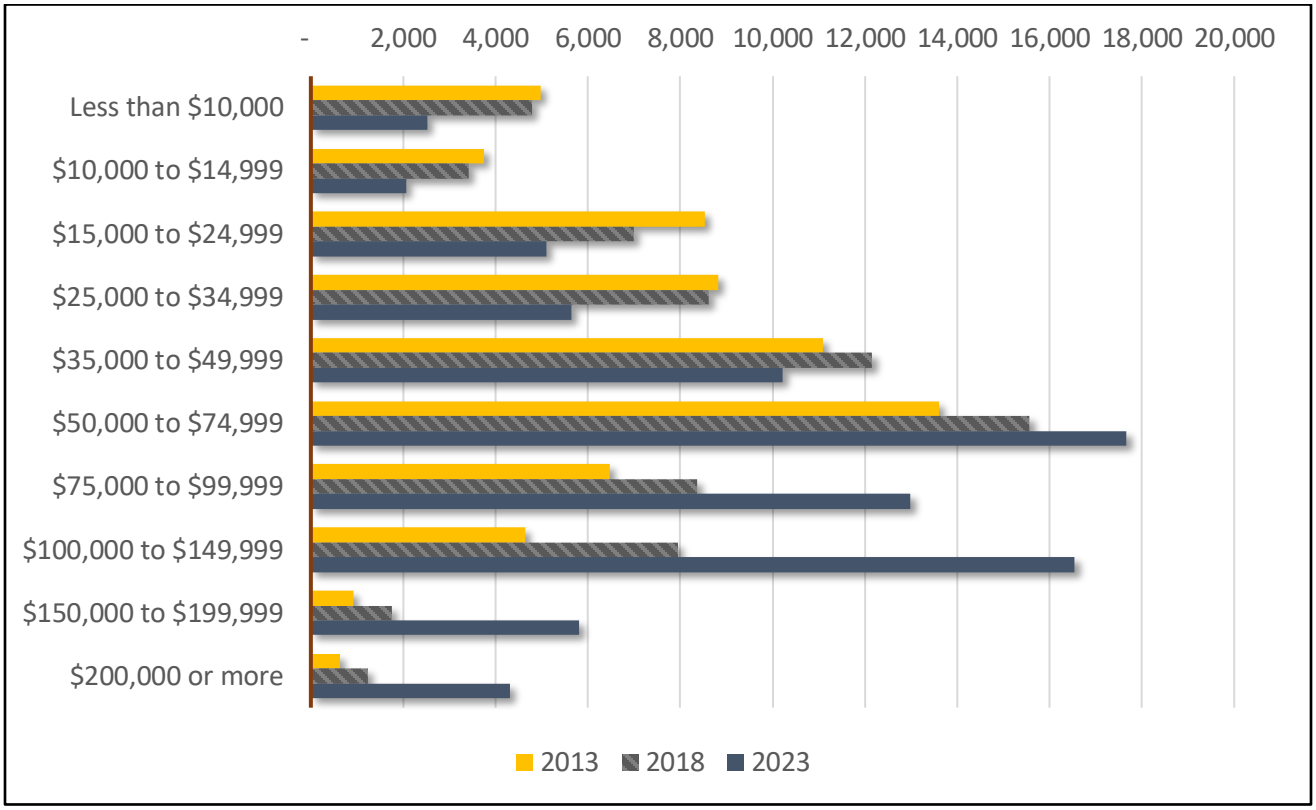
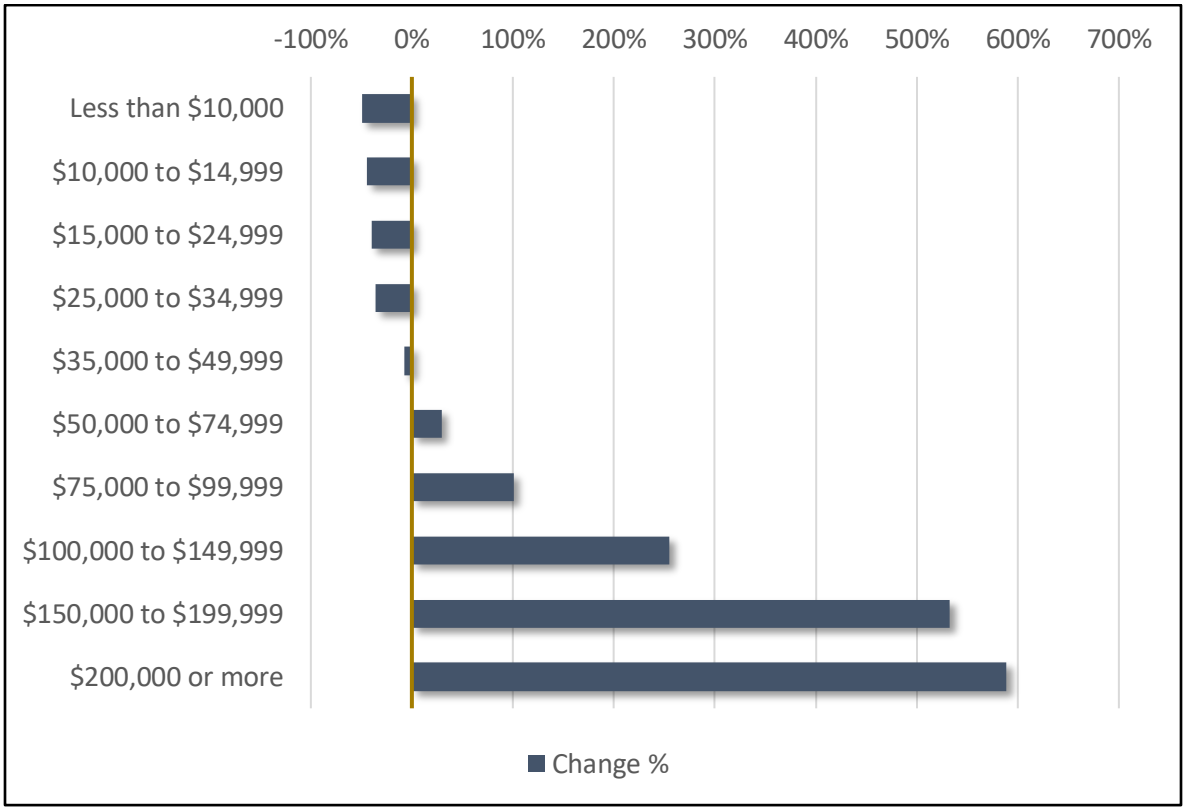



Figure: Canyon County, ACS Changes to Household Income by %, 2013 to 2023



## Poverty Status

According to the 2023 5-year American Community Survey (ACS), 10.1% of Canyon County's population is living below the federal poverty level. This represents a notable decline from 17.3% in 2013, reflecting both population growth and rising median incomes over the past decade.

The age distribution of those in poverty shows that children under 18 account for the largest share at 32.9%. Adults ages 18 to 64 make up **54.5%** of those in poverty, with roughly equal shares in the 18–34 (26.3%) and 35–64 (28.2%) ranges. Seniors aged 65 and older account for 12.6% of the poverty population.

In terms of labor force status, more than half (54.1%) of individuals age 16 and over in poverty did not work in the past year, which may include retirees, individuals with disabilities, caregivers, and others not in the workforce. A lower percentage, 35.4%, worked part-time or part-year, while only 10.5% worked full-time, year-round suggesting that many are underemployed or face unstable job conditions.

Racial and ethnic disparities are also evident. While 59.6% of those in poverty identify as White alone, 18.4% identify as some other race alone, and 17.0% report two or more races. Nearly 9,765 individuals in poverty (40.5%) identify as Hispanic or Latino, reflecting a significant need for culturally and linguistically appropriate outreach and services.

The data have direct implications for service delivery across SWDH's programs, including food access, maternal and child health, and preventive care. Targeted strategies will be essential to support vulnerable age groups, working poor families, and historically underserved communities, particularly as the cost of living and service demand continue to rise.

Figure: Canyon County, ACS Poverty Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population** | 237,994 | 100.0% |
| **Total in Poverty Status** | 24,145 | 10.1% |
| **Under 18 years** | 7,941 | 32.9% |
| **18 to 34 years** | 6,348 | 26.3% |
| **35 to 64 years** | 6,806 | 28.2% |
| **65 years and over** | 3,050 | 12.6% |
| **White alone** | 14,394 | 59.6% |
| **Black or African American alone** | 201 | 0.8% |
| **American Indian and Alaska Native alone** | 483 | 2.0% |
| **Asian alone** | 284 | 1.2% |
| **Native Hawaiian and Other Pacific Islander alone** | 240 | 1.0% |
| **Some other race alone** | 4,436 | 18.4% |
| **Two or more races** | 4,107 | 17.0% |
| **Hispanic or Latino origin (of any race)** | 9,765 | |
| **White alone, not Hispanic or Latino** | 12,532 | |
| **Population 16 years and over** | 17,023 | 100.0% |
| **Worked full-time, year-round in the past 12 months** | 1,789 | 10.5% |

| | | |
|---|---|---|
| **Worked part-time or part-year in the past 12 months** | 6,033 | 35.4% |
| **Did not work** | 9,201 | 54.1% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Veteran Status

According to the 2019–2023 ACS 5-year estimates, 9.0% of Canyon County's adult population (15,911 individuals age 18 and over) are veterans. The vast majority are male (92.7%), and the age distribution reflects a predominantly older population:

- 25.3% are ages 35–54,
- 22.9% are 55–64,
- 23.4% are 65–74, and
- 18.6% are 75 years or older.

Notably, 35.6% of veterans in Canyon County report at least one disability, compared to an estimated 14% disability rate in the general population, indicating that veterans are more than twice as likely to face functional limitations.

While only 5.1% of veterans fall below the federal poverty threshold, financial stability does not eliminate the need for accessible care, particularly for those living in rural areas or dealing with complex, service-connected conditions.

These data reinforce the importance of targeted health planning for older adults and veterans, particularly in the areas of accessible facilities, behavioral health supports, mobility assistance, and chronic disease management.

Figure: Canyon County, ACS Veteran Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population 18+** | 176,351 | 100.0% |
| **Population 18+ with Veteran Status** | 15,911 | 9.0% |
| **Male** | 14,751 | 92.7% |
| **Female** | 1,160 | 7.3% |
| **With any disability** | 5,669 | 35.6% |
| **Without a disability** | 10,093 | 63.4% |
| **18 to 34 years** | 1,552 | 9.8% |
| **35 to 54 years** | 4,033 | 25.3% |
| **55 to 64 years** | 3,643 | 22.9% |
| **65 to 74 years** | 3,716 | 23.4% |
| **75 years and over** | 2,967 | 18.6% |
| **Income in the past 12 months below poverty level** | 804 | 5.1% |
| **Income in the past 12 months at or above poverty level** | 14,958 | 94.0% |

## Education

Educational attainment in Canyon County increased significantly across nearly all categories between the 2009–2013 and 2019–2023 ACS 5-year periods. The most notable numeric increase was among residents with a high school diploma or equivalent, which rose by 10,047 individuals (+27.8%). Among postsecondary categories, the largest numeric gain occurred among those with a Bachelor's Degree, which increased by 11,190 people (+81.7%).

In terms of relative growth, the most rapid increase was in the graduate or professional degree category, which grew by 84.9% (+4,699 people). Other significant gains include:

- Associate's Degrees: +5,717 (+64.8%)
- Some college, no degree: +8,696 (+28.6%)

Meanwhile, the number of adults without a high school diploma declined modestly by 4.3% (–845 people) suggesting improved baseline education levels across the County.

Overall, the number of adults with at least a high school diploma increased by 42.7% (from 94,576 to 134,925), while the population with a Bachelor's Degree or higher grew by 82.6% (from 19,229 to 35,118).

This broad upward shift in educational attainment likely reflects both expanded access to higher education and in-migration of more highly educated individuals. These trends have important implications for public health: higher education levels are associated with improved health literacy, greater engagement in preventive care, and stronger socioeconomic outcomes. For Southwest District Health, these gains support the use of digital engagement tools, data-informed outreach, and tailored public health education, while also reinforcing the need to continue serving the roughly 18,896 residents who still lack a high school diploma.

Table: Canyon County, ACS Change in Educational Attainment 2013 to 2023

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Educational Attainment 25+ | 114,317 | 129,864 | 153,821 | 39,504 | 34.6% |
| Less than High School Equivalency | 19,741 | 19,989 | 18,896 | (845) | -4.3% |
| High School or Equivalency | 36,080 | 41,573 | 46,127 | 10,047 | 27.8% |
| Some College, No Degree | 30,450 | 34,389 | 39,146 | 8,696 | 28.6% |
| Associate's Degree | 8,817 | 10,172 | 14,534 | 5,717 | 64.8% |
| Bachelor's Degree | 13,692 | 16,763 | 24,882 | 11,190 | 81.7% |
| Graduate or Professional Degree | 5,537 | 6,978 | 10,236 | 4,699 | 84.9% |
| High School or Higher | 94,576 | 109,875 | 134,925 | 40,349 | 42.7% |
| Bachelor's Degree or Higher | 19,229 | 23,741 | 35,118 | 15,889 | 82.6% |
| Educational Attainment 25+ | 114,317 | 129,864 | 153,821 | 39,504 | 34.6% |

Figure: Canyon County, ACS Changes to Educational Attainment, 2013 to 2023

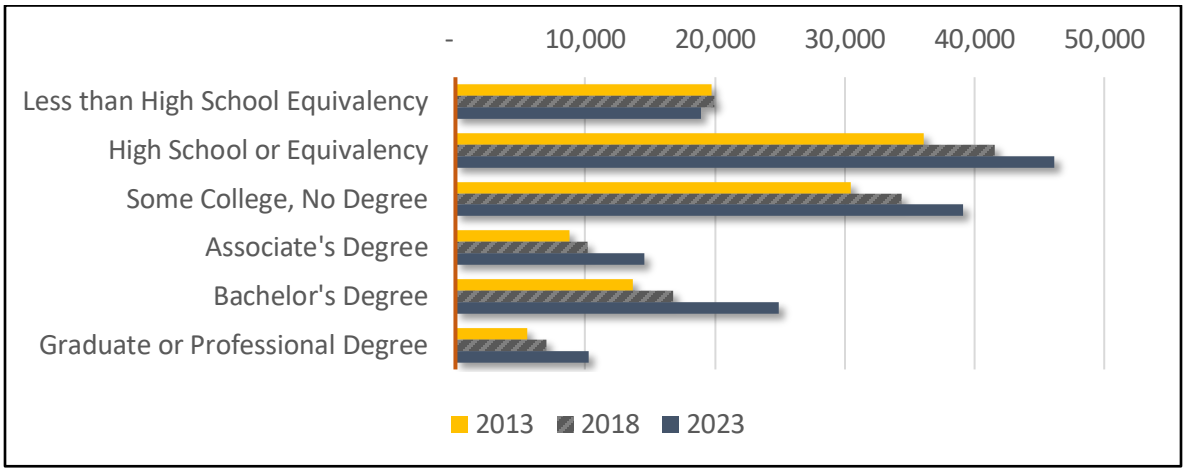
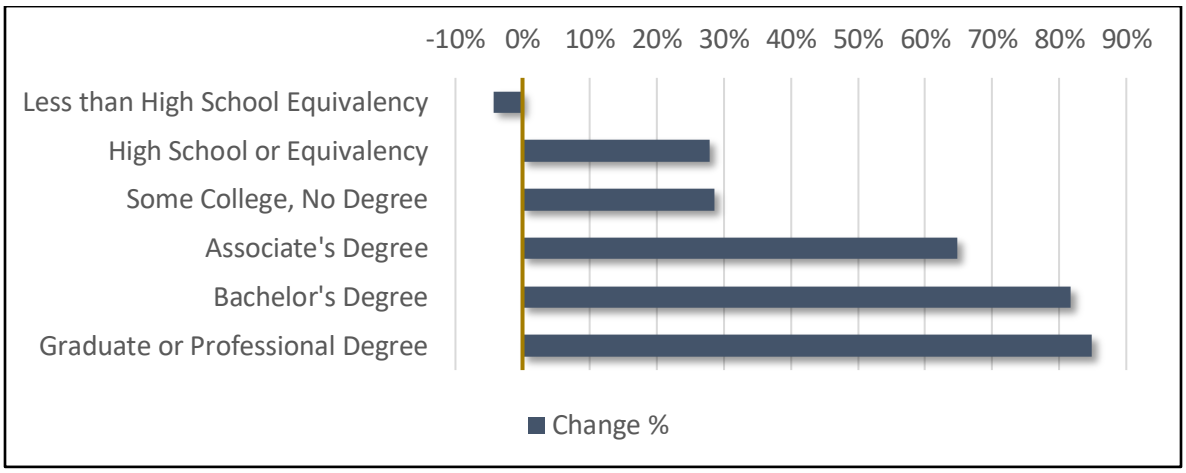
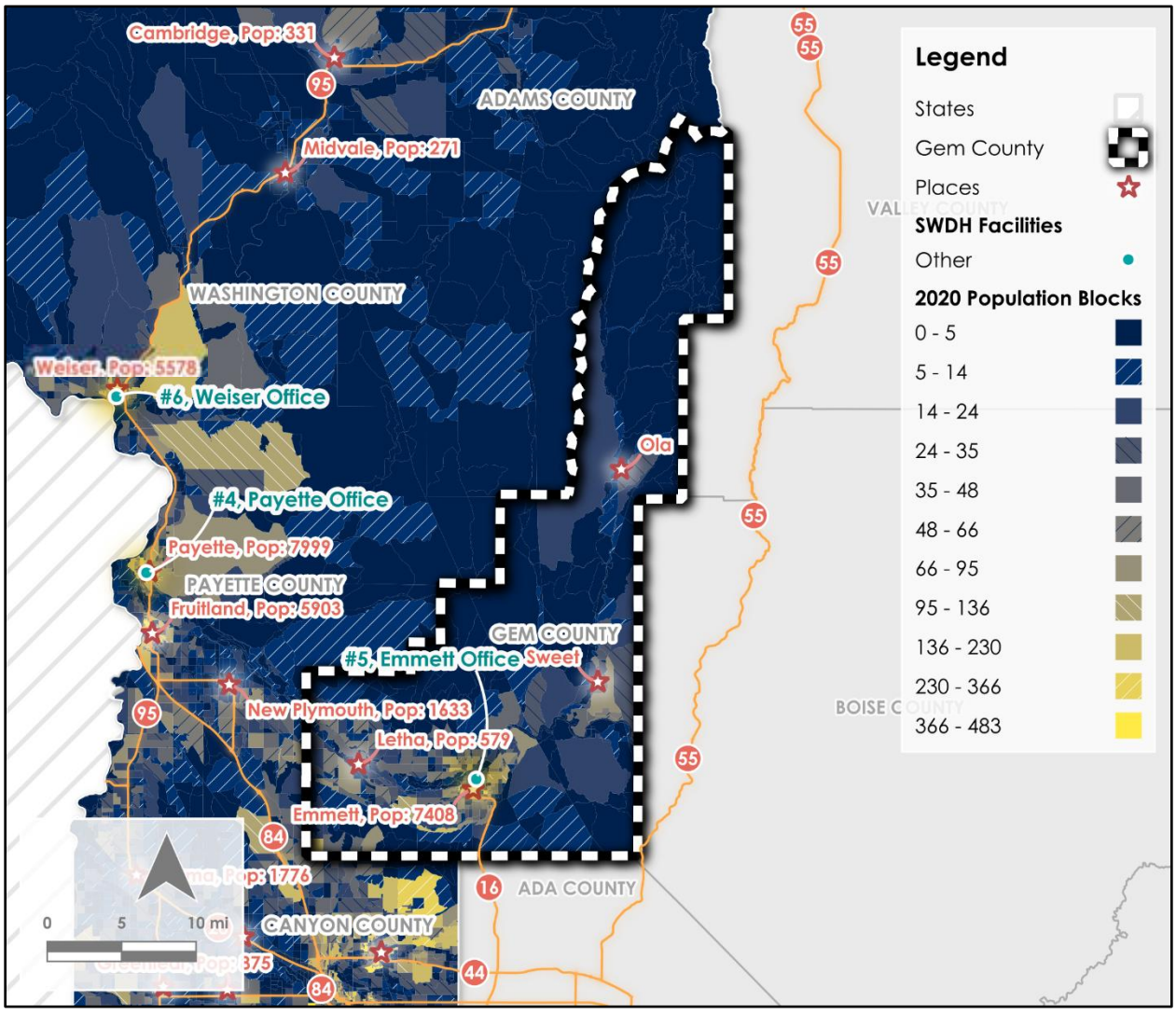



Figure: Canyon County, ACS % Change to Educational Attainment, 2013 to 2023



## Gem County Summary




*Gem County, 2020 Population Total by Census Blocks.*

## Population

Between 1970 and 2020, Gem County's population increased by 9,736 people, reaching a total of 19,123 residents by the 2020 Decennial Census. This reflects an average 10-year population gain of approximately 1,947 people over the 50-year period. More recently, from 2000 to 2020, the population grew by 3,942 people, averaging 1,971 people per decade or about 197 residents per year.

Although the pace of growth has varied from decade to decade, Gem County has experienced steady long-term population increases, particularly over the past 30 years. For Southwest District Health, this consistent upward trend, coupled with the County's rural geography, suggests the need for sustained investment in public health infrastructure, including clinics, environmental health services, and mobile or satellite access points. As Gem County continues to grow incrementally, future planning should focus on balancing capacity with cost-effective service delivery models that ensure equitable access for both in-town and outlying populations.

Table: Gem County, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 9,387 | - | - | - | - |
| **1980** | 11,972 | 2,585 | 27.54% | 2.75% | 259 |
| **1990** | 11,844 | (128) | -1.07% | -0.11% | (13) |
| **2000** | 15,181 | 3,337 | 28.17% | 2.82% | 334 |
| **2010** | 16,719 | 1,538 | 10.13% | 1.01% | 154 |
| **2020** | 19,123 | 2,404 | 14.38% | 1.44% | 240 |
| **Total Change** | 9,736 | - | - | - | - |
| **Recent Change** | 2,404 | - | - | - | - |
| **Average Change (50-years)** | - | 1,947 | 15.83% | 1.58% | 195 |
| **Average Recent Change (30 years)** | - | 1,971 | 12.25% | 1.23% | 197 |

*Note: 2000, 2010, and 2020 (U.S. Census Bureau, Via TidyCensus, 2025). See the References section for list of historical Census population records for 1980 (including 1970) and 1990.*

## Race and Ethnicity

According to the 2020 Decennial Census, 86.3% of Gem County residents identified as one race, with the vast majority identifying as White alone (84.4%). Individuals identifying as Hispanic or Latino made up 9.0% of the total population (1,722 people), while those reporting two or more races comprised 4.7%. All other racial groups, such as Asian, Black or African American, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander, each accounted for less than 1% of the population.

While Gem County has less racial and ethnic diversity than the SWDH region as a whole, the 9.0% Hispanic or Latino population remains a key consideration for public health planning. Culturally responsive programming, including bilingual materials, interpreter services, and outreach through trusted community organizations, will continue to be important for promoting health access, chronic disease prevention, and family health programs.

*Note: The U.S. Census Bureau treats Hispanic or Latino as an ethnicity, not a race. Individuals who identify as Hispanic or Latino may be of any race.*

Table: Gem County, 2020 Decennial Race and Ethnicity, Hispanic and Latino

| Description | Total | % of Total |
|---|---|---|
| | | |
| **Total Population** | 19,123 | 100.0% |
| **Hispanic or Latino** | 1,722 | 9.0% |
| **Not Hispanic or Latino** | 17,401 | 91.0% |
| **Population of one race** | 16,500 | 86.3% |
| **White alone** | 16,132 | 84.4% |
| **Black or African American alone** | 29 | 0.2% |
| **American Indian and Alaska Native alone** | 124 | 0.6% |
| **Asian alone** | 99 | 0.5% |
| **Native Hawaiian and Other Pacific Islander alone** | 20 | 0.1% |
| **Some Other Race alone** | 96 | 0.5% |
| **Population of two or more races** | 901 | 4.7% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Age

Gem County is following the national trend of population aging, though growth is also evident in several younger adult cohorts. Between the 2009–2013 and 2019–2023 ACS 5-year periods, the median age increased slightly from 42.7 to 42.8 years (+0.1 years). This small overall shift masks broader movement within specific age groups.

The most significant increase occurred among residents age 65 and older, which grew by 1,261 people (+38.8%). Several other adult age groups also experienced significant growth:

- **20 to 29 years**: +569 people (+38.7%)
- **40 to 49 years:** +309 people (+15.5%)
- **30 to 39 years**: +276 people (+14.6%)

Younger age groups showed more moderate increases:

- **0 to 9 years**: +181 people (+8.8%)
- **10 to 19 years:** +252 people (+10.5%)

The population under the age of 18 grew by 13.1%, while the adult population (18+) increased by 20.4%, indicating that growth is occurring across multiple generations. The median age for males rose from 40.0 to 42.2 years (+5.5%), while the median age for females declined slightly from 45.3 to 43.9 years (–3.1%).

These patterns suggest growing demand for both senior-focused services, such as chronic disease management, mobility support, and aging-in-place programming, and family and workforce supports, including behavioral health, maternal and child health services, and preventive care. Planning for the future should take generational trends into account to ensure all age groups can access suitable care across the County.

Table: Gem County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 0 to 9 | 2,057 | 1,780 | 2,238 | 181 | 8.8% |
| 10 to 19 | 2,404 | 2,509 | 2,656 | 252 | 10.5% |
| 20 to 29 | 1,471 | 1,834 | 2,040 | 569 | 38.7% |
| 30 to 39 | 1,887 | 1,371 | 2,163 | 276 | 14.6% |
| 40 to 49 | 1,999 | 2,132 | 2,308 | 309 | 15.5% |
| 50 to 64 | 3,653 | 3,799 | 3,937 | 284 | 7.8% |
| 65 and Older | 3,251 | 3,627 | 4,512 | 1,261 | 38.8% |
| Less than 18 | 3,924 | 3,983 | 4,440 | 516 | 13.1% |
| 18 and Older | 12,798 | 13,069 | 15,414 | 2,616 | 20.4% |
| Total Median Age | 42.7 | 45.1 | 42.8 | 0.1 | 0.2% |
| Total Median Age Male | 40.0 | 43.8 | 42.2 | 2.2 | 5.5% |
| Total Median Age Female | 45.3 | 45.8 | 43.9 | (1.4) | -3.1% |

Figure: Gem County, ACS Total Population by Age Groups (2019-2023)

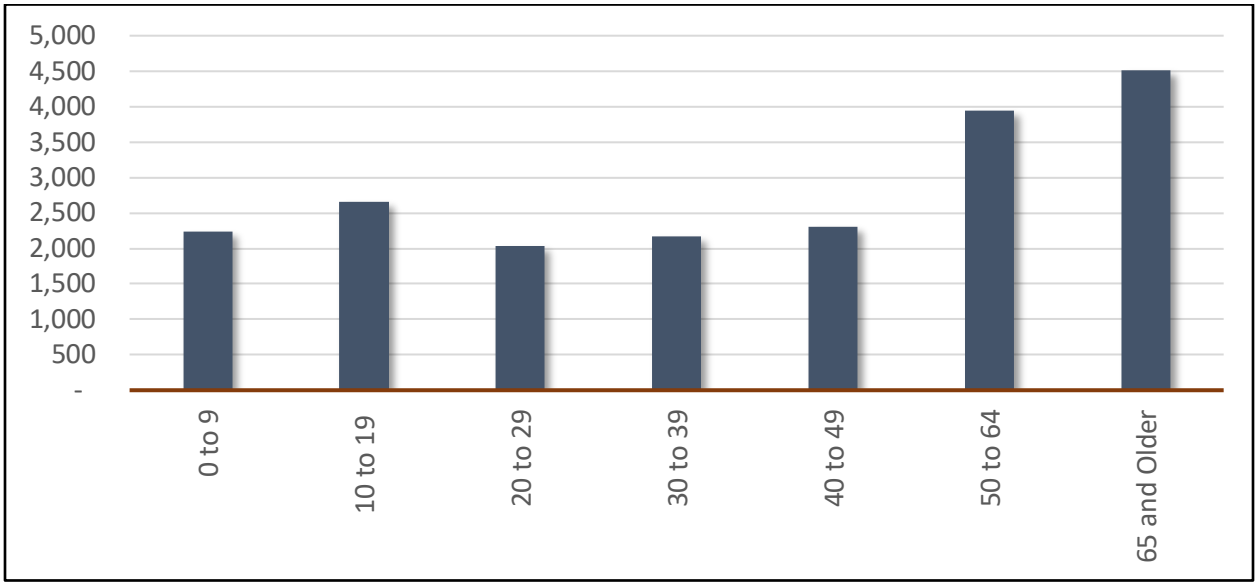
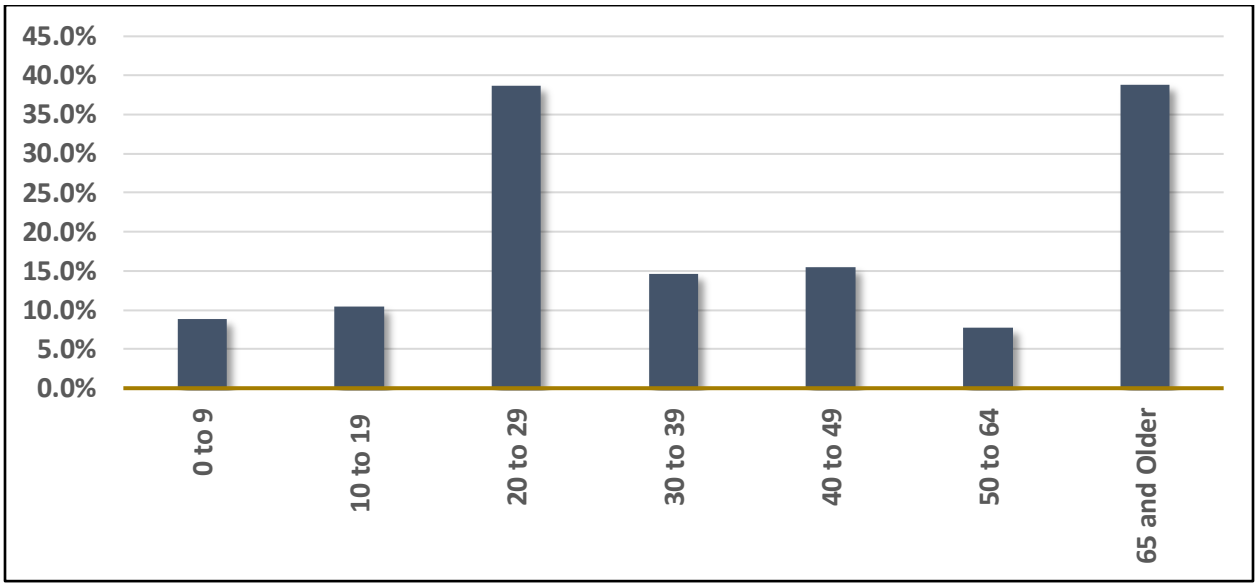



Figure: Gem County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



## Housing and Occupancy

Between 2013 and 2023, Gem County saw moderate growth in both household size and total housing units. The average household size increased slightly across all categories, with owner-occupied units growing by 0.04 people (+1.6%), renter-occupied units by 0.03 people (+1.0%), and overall household size rising from 2.62 to 2.65 (+1.1%).

Total housing units increased by 1,083 units (+17.1%), growing from 6,323 to 7,406. Occupied units rose even more sharply by 1,452 units (+26.1%) reflecting reduced vacancy and increased demand. Owner-occupied housing rose significantly, adding 957 units (+20.3%), while renter-occupied housing grew more modestly, increasing by 126 units (+7.8%). As a result, owner-occupied housing now accounts for 76.6% of all occupied units, up from 74.6% in 2013.

The vacancy rate dropped sharply, from 11.9% to 5.2%, a 6.7 percentage point decline, indicating a tightening housing market. Even modest increases in household size can compound housing pressures in rural areas like Gem County, where development may be constrained by infrastructure capacity, land availability, or regulatory factors.

From a public health standpoint, declining vacancy and limited rental growth may increase housing stress for lower-income families, younger adults, and older residents on fixed incomes. These conditions can influence health outcomes through overcrowding, unstable housing, and reduced access to preventive care, factors that may need to be considered in facility siting, outreach, and community resource planning.

Table: Gem County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.62 | 2.57 | 2.65 | 0.03 | 1.1% |
| Average Household Size: Owner | 2.52 | 2.73 | 2.56 | 0.04 | 1.6% |
| Average Household Size: Renter | 2.90 | 2.13 | 2.93 | 0.03 | 1.0% |

Table: Gem County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Units Total | 6,323 | 6,583 | 7,406 | 1,083 | 17.1% |
| Housing Units: Total Occupied | 5,572 | 5,885 | 7,024 | 1,452 | 26.1% |
| Housing Units: Total Vacancy | 751 | 698 | 382 | (369) | -49.1% |
| % Vacancy | 11.9% | 10.6% | 5.2% | -6.7% | -6.7% |
| Owner-occupied housing units | 4,715 | 4,836 | 5,672 | 957 | 20.3% |
| Renter-occupied housing units: | 1,608 | 1,747 | 1,734 | 126 | 7.8% |
| % Owner Occupied | 74.6% | 73.5% | 76.6% | 2.0% | 2.0% |
| % Renter Occupied | 25.4% | 26.5% | 23.4% | -2.0% | -2.0% |

## Income

Between the 2009–2013 and 2019–2023 ACS 5-year periods, household income in Gem County increased significantly, particularly among higher-income households. The number of households earning $200,000 or more grew by 466, a 1,294.4% increase, marking the most dramatic relative gain among all income brackets. Strong growth also occurred in the $150,000–$199,999 (+231.0%), $100,000–$149,999 (+103.0%), and $50,000–$74,999 (+56.6%) ranges.

In contrast, the number of households earning less than $50,000 declined across all brackets, including a 51.5% decrease among those earning less than $10,000. Overall, the median household income rose by 49.1%, from $44,432 to $66,245.

This upward trend likely reflects rising wages, housing market dynamics, and the in-migration of higher-income households. While these shifts suggest overall economic growth, they may also signal increasing income stratification. This trend has implications for service planning: as the lower-income population contracts but does not disappear, it becomes especially important to maintain access to affordable care, housing-linked outreach, and programs that address the needs of residents on fixed or limited incomes.

Table: Gem County, ACS Change in Household Income Distribution (2013–2023)

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Less than $10,000 | 679 | 523 | 329 | (350) | -51.5% |
| $10,000 to $14,999 | 282 | 477 | 215 | (67) | -23.8% |
| $15,000 to $24,999 | 880 | 913 | 532 | (348) | -39.5% |
| $25,000 to $34,999 | 711 | 614 | 507 | (204) | -28.7% |
| $35,000 to $49,999 | 1,153 | 1,296 | 934 | (219) | -19.0% |
| $50,000 to $74,999 | 1,121 | 1,520 | 1,756 | 635 | 56.6% |
| $75,000 to $99,999 | 767 | 580 | 1,020 | 253 | 33.0% |
| $100,000 to $149,999 | 536 | 448 | 1,088 | 552 | 103.0% |
| $150,000 to $199,999 | 158 | 143 | 523 | 365 | 231.0% |
| $200,000 or more | 36 | 69 | 502 | 466 | 1294.4% |
| Median income (dollars) | 44,432 | 43,001 | 66,245 | 21,813 | 49.1% |

Figure: Gem County, ACS Changes to Household Income by Total Households, 2013 to 2023

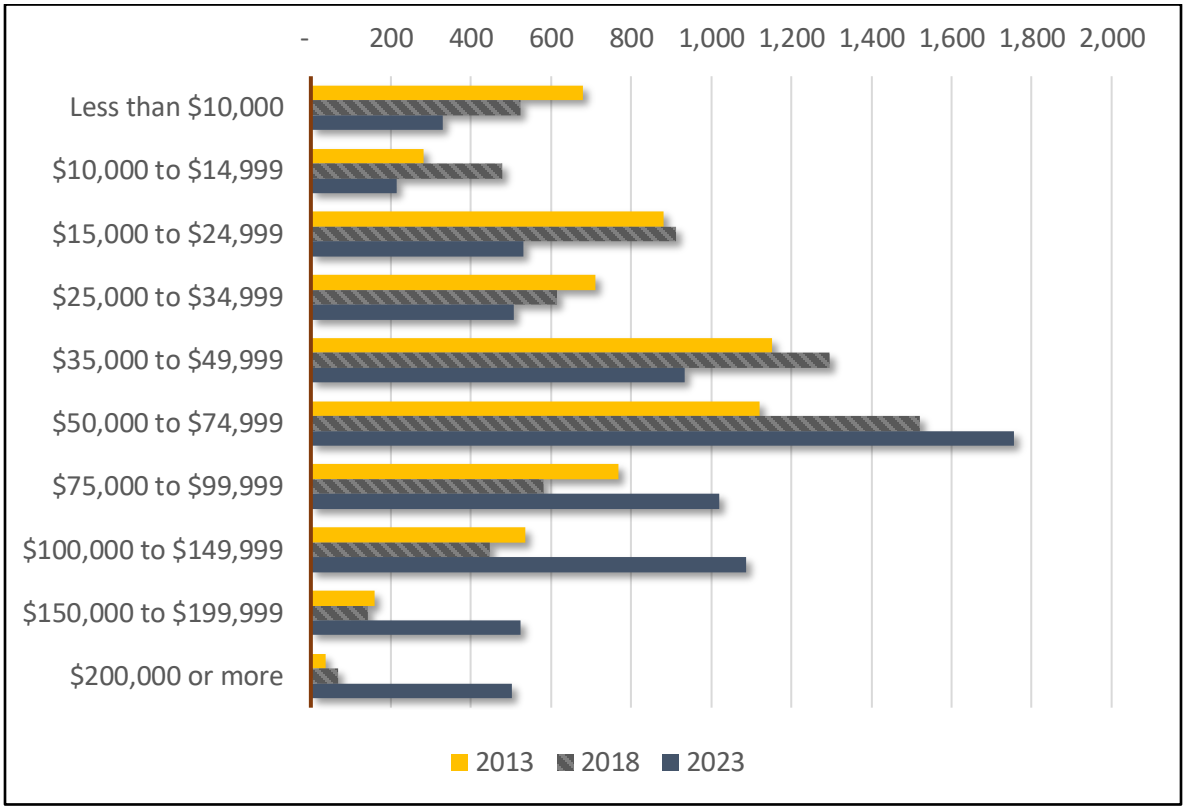
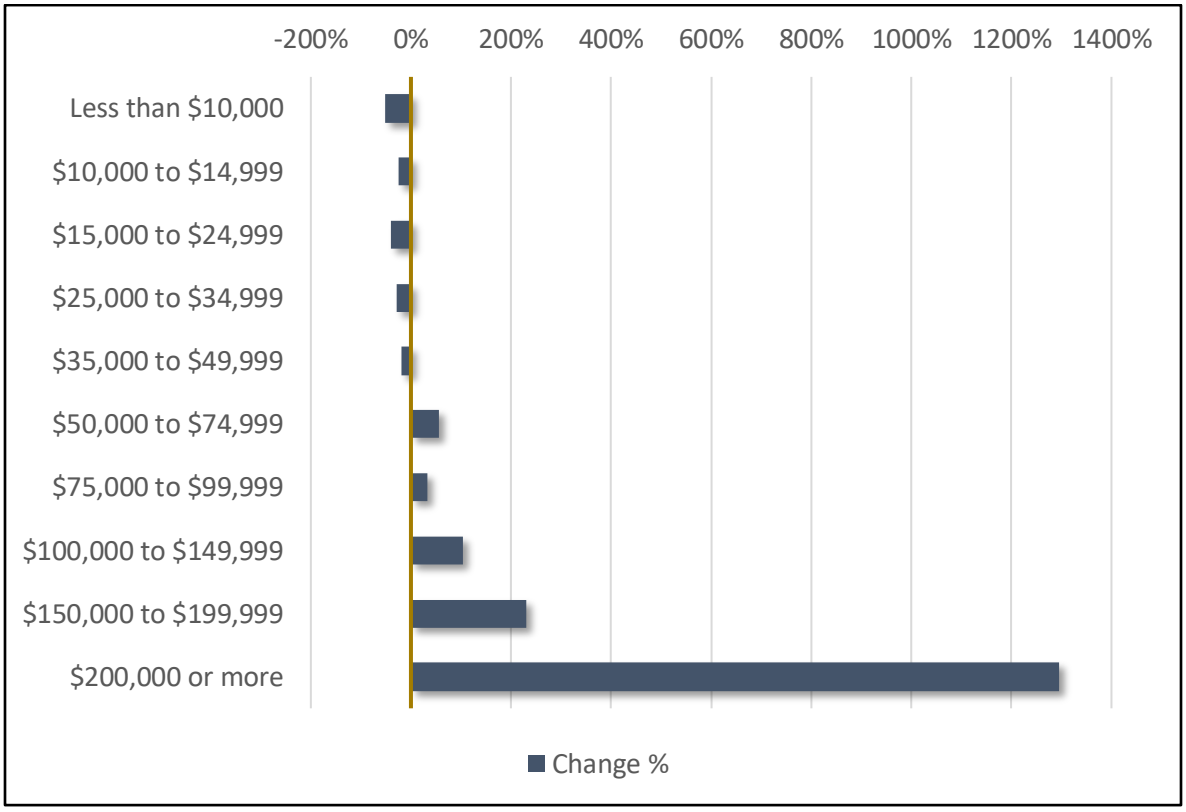



Figure: Gem County, ACS Changes to Household Income by %, 2013 to 2023



## Poverty

According to the 2019–2023 ACS 5-year estimates, 10.4% of Gem County residents (2,013 people) live below the federal poverty threshold.

Age Distribution of Individuals in Poverty:

- 27.7% are under age 18 (557 individuals)
- 19.4% are ages 18 to 34 (390 individuals)
- 28.9% are ages 35 to 64 (581 individuals)
- 24.1% are age 65 or older (485 individuals)

This distribution shows that more than half of those in poverty are working-age adults, with a significant portion being children and seniors, groups that often rely on public programs, fixed incomes, or caregiver support.

Racial and Ethnic Distribution:

- 77.0% identify as White alone
- 12.8% identify as two or more races
- 10.2% identify as some other race alone
- 18.9% identify as Hispanic or Latino (any race)

While most individuals in poverty identify as White, Hispanic or Latino residents are overrepresented relative to their total share of the County population. This demonstrates the need for culturally and linguistically appropriate public health services, particularly in clinical access and nutrition or behavioral health outreach.

Employment Status of Individuals in Poverty (Age 16+):

- 59.5% did not work in the past year (900 individuals)
- 28.3% worked part-time or part-year (428 individuals)
- 12.2% worked full-time, year-round (185 individuals)

These figures suggest that the majority of people in poverty are either not in the labor force (due to age, disability, or caregiving) or are underemployed. This has important implications in bridging access gaps for low-wage earners and uninsured individuals, including through partnerships, referrals, and social determinants-based care coordination.

Figure: Gem County, ACS Poverty Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population** | 19,292 | 100.0% |
| **Total in Poverty Status** | 2,013 | 10.4% |
| **Under 18 years** | 557 | 27.7% |
| **18 to 34 years** | 390 | 19.4% |
| **35 to 64 years** | 581 | 28.9% |
| **65 years and over** | 485 | 24.1% |
| **White alone** | 1,550 | 77.0% |
| **Black or African American alone** | 0 | 0.0% |
| **American Indian and Alaska Native alone** | 0 | .0.0% |
| **Asian alone** | 0 | 0.0% |
| **Native Hawaiian and Other Pacific Islander alone** | 0 | 0.0% |
| **Some other race alone** | 205 | 10.2% |
| **Two or more races** | 258 | 12.8% |
| **Hispanic or Latino origin (of any race)** | 381 | |
| **White alone, not Hispanic or Latino** | 1,438 | |
| **Population 16 years and over** | 1,513 | 100.0% |
| **Worked full-time, year-round in the past 12 months** | 185 | 12.2% |
| **Worked part-time or part-year in the past 12 months** | 428 | 28.3% |
| **Did not work** | 900 | 59.5% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Veteran Status

According to the 2019–2023 ACS estimates, 9.5% of Gem County's adult population (1,464 individuals) identify as having veteran status. The majority are male (83.5%), while 16.5% are female, a growing demographic that may have unique healthcare and service needs.

The largest share of veterans (29.6%) are ages 65 to 74, reflecting the aging trend seen across Idaho and the U.S. More than half of veterans in the County are aged 65 or older. In addition, 29.0% of veterans report having at least one disability, which may include hearing, mobility, vision, or self-care limitations.

Most veterans in Gem County do not fall within Census-defined poverty income ranges, with only 6.4% living below the federal poverty threshold, suggesting a relatively stable income base for this group. However, aging and disability status may still create barriers to healthcare access, transportation, or independent living.

These data demonstrate the importance of ensuring that local health services, mobility assistance, and veteran support programs are accessible, physically navigable, and appropriately staffed to meet the needs of an older, and increasingly disabled, veteran population.

Figure: Gem County, ACS Veteran Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population 18+** | 15,414 | 100.0% |
| **Population 18+ with Veteran Status** | 1,464 | 9.5% |
| **Male** | 1,223 | 83.5% |
| **Female** | 241 | 16.5% |
| **With any disability** | 425 | 29.0% |
| **Without a disability** | 1,013 | 69.2% |
| **18 to 34 years** | 62 | 4.2% |
| **35 to 54 years** | 244 | 16.7% |
| **55 to 64 years** | 391 | 26.7% |
| **65 to 74 years** | 433 | 29.6% |
| **75 years and over** | 334 | 22.8% |
| **Income in the past 12 months below poverty level** | 94 | 6.4% |
| **Income in the past 12 months at or above poverty level** | 1,344 | 91.8% |

## Education

According to the 2019–2023 ACS 5-year estimates, educational attainment among Gem County residents has increased across nearly all categories since the 2009–2013 period.

- The largest numerical gain occurred among those with a Bachelor's Degree, which increased by 1,067 people (79.0%).
- The largest percentage gain was among those with a graduate or professional degree, rising by 212 people (44.2%).
- Individuals with some college but no degree also increased significantly, adding 780 people (24.4%).
- Those with an Associate's Degree increased by 130 people (19.5%).
- The number of residents with less than a high school equivalency declined slightly by 57 people (–3.6%).

Overall, the number of individuals with at least a high school diploma or equivalent rose by 2,396 people (+23.9%), while those with a Bachelor's Degree or higher increased by 1,279 people (+69.9%).

This broad upward trend reflects a changing workforce profile and may be tied to in-migration, access to higher education, or broader regional development. These gains may support increased use of preventive health services, digital communication tools, and self-guided care management. However, with more than 1,500 adults still lacking a high school diploma, foundational health literacy and system navigation remain important priorities for inclusive service delivery and outreach.

Table: Gem County, ACS Change in Educational Attainment 2013 to 2023

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Educational Attainment 25+ | 11,615 | 11,784 | 13,954 | 2,339 | 20.1% |
| Less than High School Equivalency | 1,586 | 1,425 | 1,529 | (57) | -3.6% |
| High School or Equivalency | 4,340 | 4,621 | 4,547 | 207 | 4.8% |
| Some College, No Degree | 3,191 | 2,726 | 3,971 | 780 | 24.4% |
| Associate's Degree | 668 | 1,263 | 798 | 130 | 19.5% |
| Bachelor's Degree | 1,350 | 1,186 | 2,417 | 1,067 | 79.0% |
| Graduate or Professional Degree | 480 | 563 | 692 | 212 | 44.2% |
| High School or Higher | 10,029 | 10,359 | 12,425 | 2,396 | 23.9% |
| Bachelor's Degree or Higher | 1,830 | 1,749 | 3,109 | 1,279 | 69.9% |
| Educational Attainment 25+ | 11,615 | 11,784 | 13,954 | 2,339 | 20.1% |

Figure: Gem County, ACS Changes to Educational Attainment, 2013 to 2023

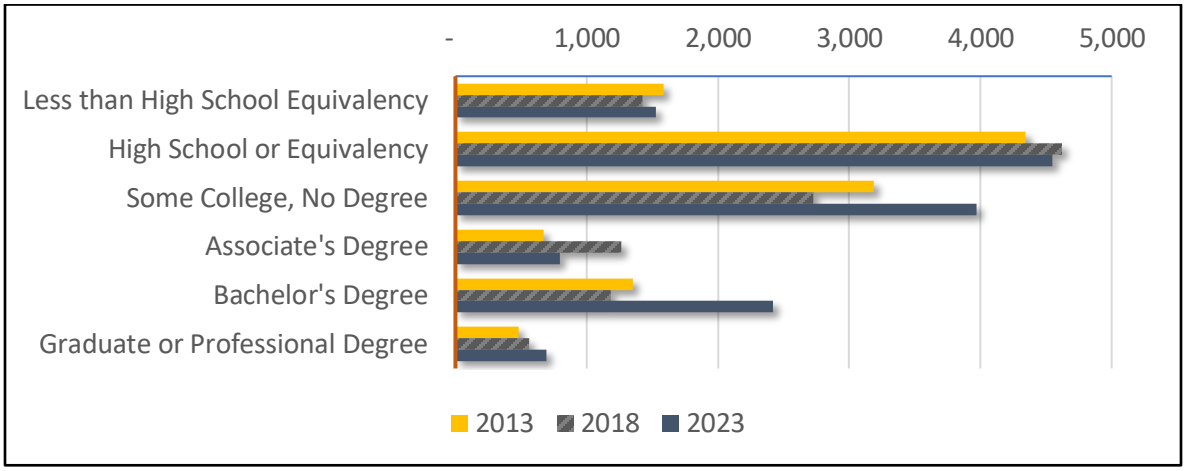
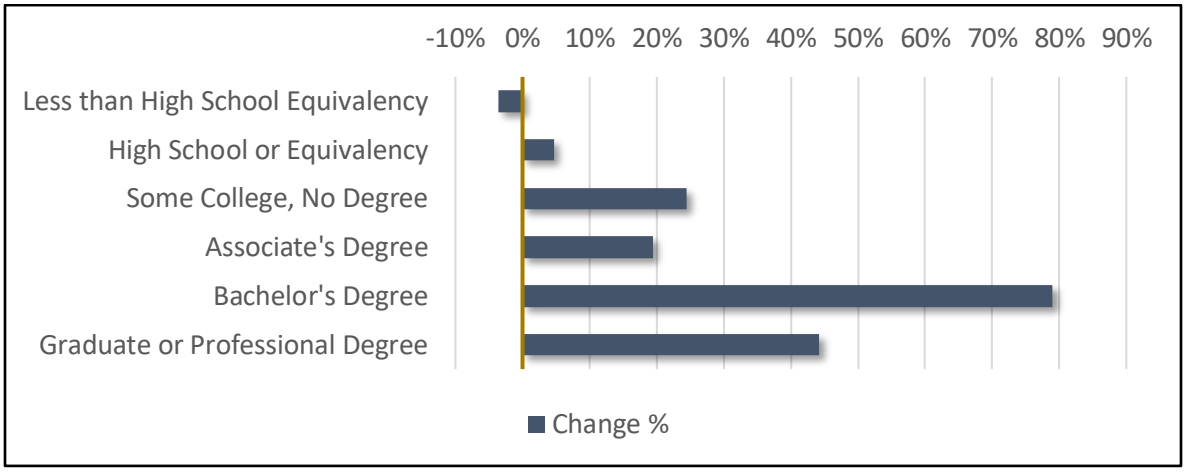
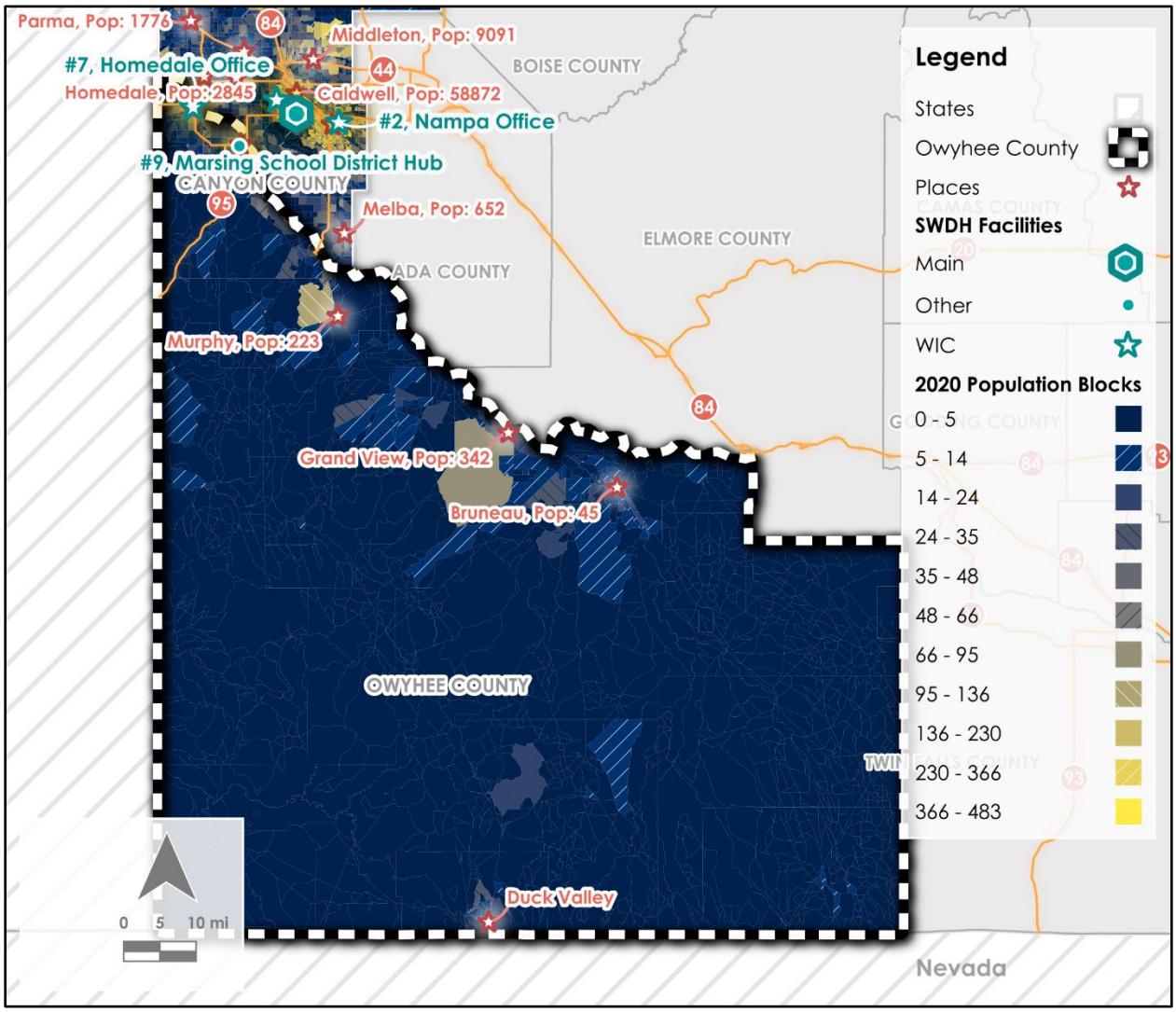



Figure: Gem County, ACS % Change to Educational Attainment, 2013 to 2023



# Owyhee County Summary




*Owyhee County, 2020 Population Total by Census Blocks.*

## Population

Between 1970 and 2020, the population of Owyhee County increased by 5,491 people, reaching a total of 11,913 residents by the 2020 Decennial Census. This reflects an average 10-year increase of 1,098 people over the 50-year period.

More recently, between 2000 and 2020, the County added 1,269 residents, averaging 635 people per decade or roughly 63 people per year, a notably slower growth rate than in earlier decades.

This pattern of moderate and tapering growth carries important implications for long-term planning. While a slower pace may ease short-term service pressures, it can also make infrastructure investment and staffing more difficult to scale cost-effectively, especially in a geographically large and rural County like Owyhee.

These trends underscore the need for place-based strategies that maintain fiscal responsibility while ensuring all residents, including those in lower-density areas, have access to essential public health services across the District.

Table: Owyhee County, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 6,422 | - | - | - | - |
| **1980** | 8272 | 1,850 | 28.81% | 2.88% | 185 |
| **1990** | 8,392 | 120 | 1.45% | 0.15% | 12 |
| **2000** | 10,644 | 2,252 | 26.84% | 2.68% | 225 |
| **2010** | 11,526 | 882 | 8.29% | 0.83% | 88 |
| **2020** | 11,913 | 387 | 3.36% | 0.34% | 39 |
| **Total Change** | 5,491 | - | - | - | - |
| **Recent Change** | 387 | - | - | - | - |
| **Average Change (50-years)** | - | 1,098 | 13.75% | 1.37% | 110 |
| **Average Recent Change (30 years)** | - | 635 | 5.82% | 0.58% | 63 |

*Note: 2000, 2010, and 2020 (U.S. Census Bureau, Via TidyCensus, 2025). See the References section for list of historical Census population records for 1980 (including 1970) and 1990.*

## Race and Ethnicity

According to the 2020 Decennial Census, Owyhee County had a total population of 11,913 people. The majority of residents (67.7%) identified as White alone, while 3.5% identified as two or more races and 3.1% as American Indian and Alaska Native alone. Other racial identities included:

- Asian alone: 0.4% (42 people)
- Black or African American alone: 0.2% (28 people)
- Native Hawaiian and Other Pacific Islander alone: 0.1% (8 people)
- Some Other Race alone: 0.6% (68 people)

A total of 72.0% of residents identified as one race.

In terms of ethnicity, 24.5% of the population (2,915 people) identified as Hispanic or Latino, while 75.5% (8,998) identified as **not** Hispanic or Latino.

This relatively high proportion of Hispanic or Latino residents, particularly when compared to other SWDH counties, has important implications for public health planning. Culturally and linguistically appropriate services will be essential to ensure access to care. Facility design, staffing, outreach materials, and health promotion strategies should account for language preferences, health-seeking behaviors, and trust-building needs within diverse communities. These efforts will support more effective service delivery across the County.

Table: Owyhee County, 2020 Decennial Race and Ethnicity, Hispanic and Latino

| Description | Total | % of Total |
|---|---|---|
| **Total Population** | 11,913 | 100.0% |
| **Hispanic or Latino** | 2,915 | 24.5% |
| **Not Hispanic or Latino** | 8,998 | 75.5% |
| **Population of one race** | 8,580 | 72.0% |
| **White alone** | 8,060 | 67.7% |
| **Black or African American alone** | 28 | 0.2% |
| **American Indian and Alaska Native alone** | 374 | 3.1% |
| **Asian alone** | 42 | 0.4% |
| **Native Hawaiian and Other Pacific Islander alone** | 8 | 0.1% |
| **Some Other Race alone** | 68 | 0.6% |
| **Population of two or more races** | 418 | 3.5% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Age

Like much of the U.S. and the broader Southwest District Health service area, Owyhee County is experiencing population aging. According to the 2019–2023 ACS 5-year estimates, the median age increased by 6.4% over the past decade rising from 36.0 years in 2013 to 38.3 years in 2023. While this mirrors national trends, it also has specific local implications for healthcare delivery, workforce support, housing needs, and long-term community planning.

Key population shifts from 2013 to 2023 include:

- A 41.0% increase in residents age 65 and older (+683 individuals), bringing the total to 2,347 people.
- A 12.3% increase in adults age 18 and over (+1,012 people).
- A 6.2% decline in the under-18 population (–202 people).

Other notable trends include:

- Growth among young adults: +12.4% in the 20–29 group and +6.5% in the 30–39 group.
- A sharp decline in children ages 0–9 (–10.7%, or –187 people), the steepest drop among all cohorts.

This shifting age structure reflects a maturing population, with increased demand for aging-related services such as chronic disease management, mobility assistance, and caregiver support. At the same time, the decline in younger residents may impact school enrollment, early childhood programming, and future workforce pipelines.

While the overall trend points toward an aging population, modest growth among younger adults may suggest that some individuals or families are relocating to Owyhee County for its relative housing affordability and then commuting to jobs in nearby Ada or Canyon counties. Though not confirmed by available data, this pattern, if present, could influence local transportation needs, housing demand, and community service planning.

For SWDH, these trends reinforce the importance of age-responsive service planning, including mobile and home-based care models, health promotion targeting older adults, and cross-sector coordination to sustain intergenerational support systems.

Table: Owyhee County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 0 to 9 | 1,740 | 1,682 | 1,553 | (187) | -10.7% |
| 10 to 19 | 1,823 | 1,650 | 1,820 | (3) | -0.2% |
| 20 to 29 | 1,272 | 1,314 | 1,430 | 158 | 12.4% |
| 30 to 39 | 1,477 | 1,289 | 1,573 | 96 | 6.5% |
| 40 to 49 | 1,333 | 1,347 | 1,312 | (21) | -1.6% |
| 50 to 64 | 2,165 | 2,164 | 2,249 | 84 | 3.9% |
| 65 and Older | 1,664 | 2,009 | 2,347 | 683 | 41.0% |
| Less than 18 | 3,270 | 3,026 | 3,068 | (202) | -6.2% |

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 18 and Older | 8,204 | 8,429 | 9,216 | 1,012 | 12.3% |
| Total Median Age | 36.0 | 38.4 | 38.3 | 2.3 | 6.4% |
| Total Median Age Male | 35.3 | 38.2 | 37.7 | 2.4 | 6.8% |
| Total Median Age Female | 37.7 | 38.5 | 39.2 | 1.5 | 4.0% |

Figure: Owyhee County, ACS Total Population by Age Groups (2019-2023)

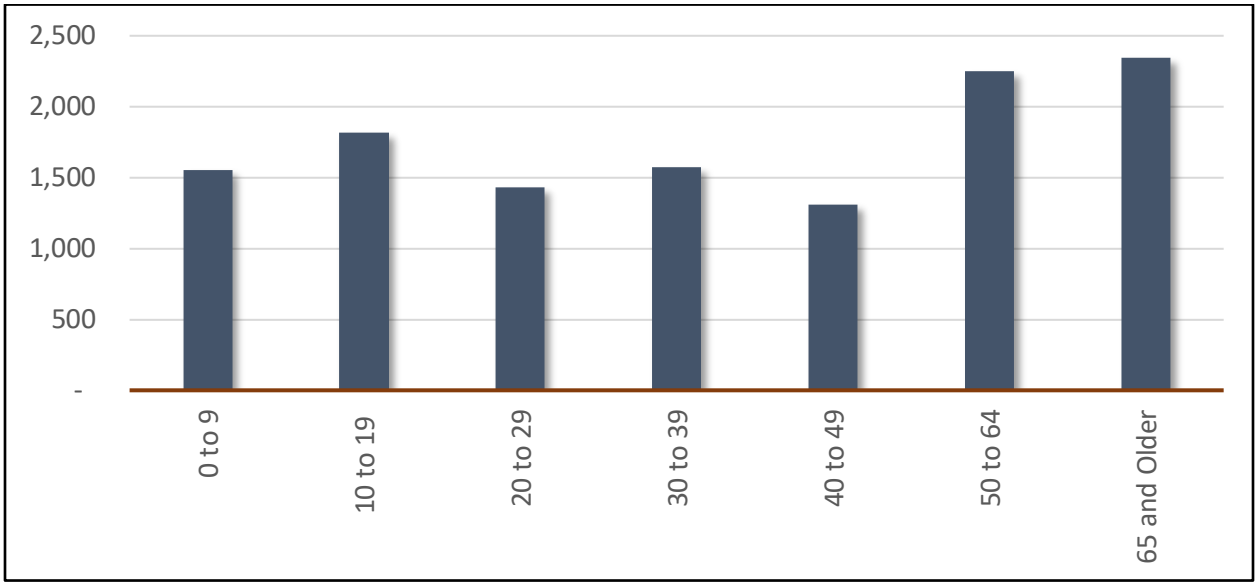
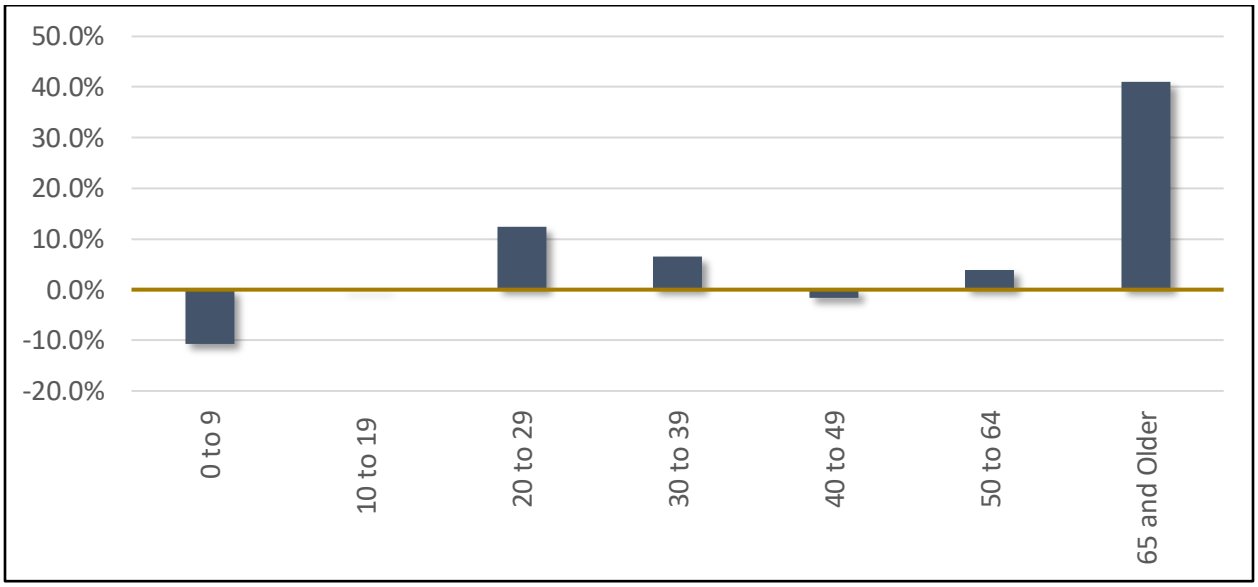



Figure: Owyhee County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



## Housing and Occupancy

Between 2013 and 2023, Owyhee County experienced notable shifts in housing characteristics. While total housing stock increased modestly, occupancy patterns and household size trended in different directions.

- Average household size declined overall by 1.7% (–0.05 persons).
- Owner-occupied households increased by 1.4% (+0.04 persons)
- Renter-occupied households decreased by 8.1% (–0.24 persons)
- Total housing units increased from 3,911 to 4,248, a gain of 337 units (+8.6%).
- Owner-occupied units rose by 500 (+19.9%), while renter-occupied units fell by 163 (–11.6%).

The number of vacant units dropped significantly, from 852 to 555 (–34.9%), and the vacancy rate fell from 21.8% to 13.1%, an 8.7 percentage point decrease.

These shifts suggest that new housing development has primarily benefited owner-occupiers, with relatively little growth—or even contraction—in the rental market. As vacancy rates decline and household sizes shift, rural housing pressures may intensify, especially for renters and younger or lower-income households.

From a public health perspective, tight housing markets can lead to overcrowding, stress-related health impacts, or longer travel distances to care. These trends point to the value of incorporating housing access, affordability, and environmental health factors into planning and coordination efforts, potentially in partnership with housing authorities, city/County planning departments, and aging services providers.

Table: Owyhee County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.90 | 2.66 | 2.85 | (0.05) | -1.7% |
| Average Household Size: Owner | 2.87 | 2.67 | 2.91 | 0.04 | 1.4% |
| Average Household Size: Renter | 2.95 | 2.65 | 2.71 | (0.24) | -8.1% |

Table: Owyhee County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Units All | 3,911 | 4,250 | 4,248 | 337 | 8.6% |
| Housing Units: Total Occupied | 3,059 | 3,623 | 3,693 | 634 | 20.7% |
| Housing Units: Total Vacancy | 852 | 627 | 555 | (297) | -34.9% |
| % Vacancy | 21.8% | 14.8% | 13.1% | -8.7% | -8.7% |
| Owner-occupied housing units | 2,511 | 3,000 | 3,011 | 500 | 19.9% |
| Renter-occupied housing units: | 1,400 | 1,250 | 1,237 | (163) | -11.6% |
| % Owner Occupied | 64.2% | 70.6% | 70.9% | 6.7% | 6.7% |
| % Renter Occupied | 35.8% | 29.4% | 29.1% | -6.7% | -6.7% |

## Income

Between the 2009–2013 and 2019–2023 ACS periods, household income in Owyhee County shifted markedly upward, particularly for households earning above $35,000.

- The largest numeric increase occurred in the $100,000 to $149,999 income group, which grew by 521 households (263.1%).
- The fastest percentage growth was in the $200,000 or more category, which increased by 386.2% (+112 households).
- Other substantial gains included:
- $75,000 to $99,999: +431 households (+132.6%)
- $150,000 to $199,999: +64 households (+182.9%)

In contrast, all income brackets below $35,000 experienced declines, including a 58.3% drop in households earning $10,000 to $14,999 and a 41.5% drop in the $25,000 to $34,999 bracket. These shifts point to rising household earnings and a changing economic profile for the County.

The median household income increased by 85.8%, rising from $32,175 in 2013 to $59,773 in 2023.

While these trends suggest growing affluence in portions of the population, likely due to wage growth, in-migration, or expanding employment sectors, they may also create affordability gaps for residents on fixed or lower incomes. It will be important to monitor how these income dynamics influence access to care, housing stability, and eligibility for public health programs, particularly as cost of living pressures continue to rise.

Table: Owyhee County, ACS Change in Household Income Distribution (2013–2023)

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Less than $10,000 | 356 | 254 | 164 | (192) | -53.9% |
| $10,000 to $14,999 | 446 | 267 | 186 | (260) | -58.3% |
| $15,000 to $24,999 | 555 | 729 | 349 | (206) | -37.1% |
| $25,000 to $34,999 | 735 | 577 | 430 | (305) | -41.5% |
| $35,000 to $49,999 | 600 | 654 | 630 | 30 | 5.0% |
| $50,000 to $74,999 | 632 | 800 | 774 | 142 | 22.5% |
| $75,000 to $99,999 | 325 | 379 | 756 | 431 | 132.6% |
| $100,000 to $149,999 | 198 | 386 | 719 | 521 | 263.1% |
| $150,000 to $199,999 | 35 | 59 | 99 | 64 | 182.9% |
| $200,000 or more | 29 | 145 | 141 | 112 | 386.2% |
| Median income (dollars) | 32,175 | 40,430 | 59,773 | 27,598 | 85.8% |

Figure: Owyhee County, ACS Changes to Household Income by Total Households, 2013 to 2023

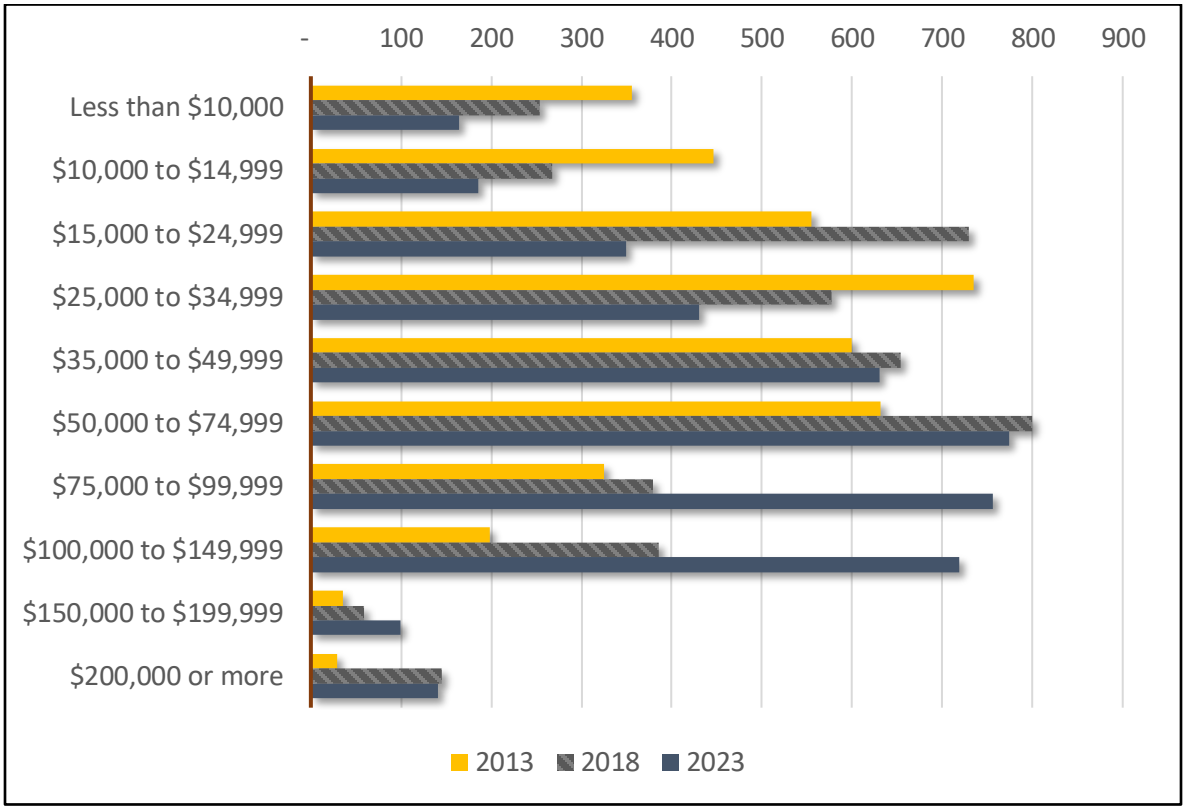
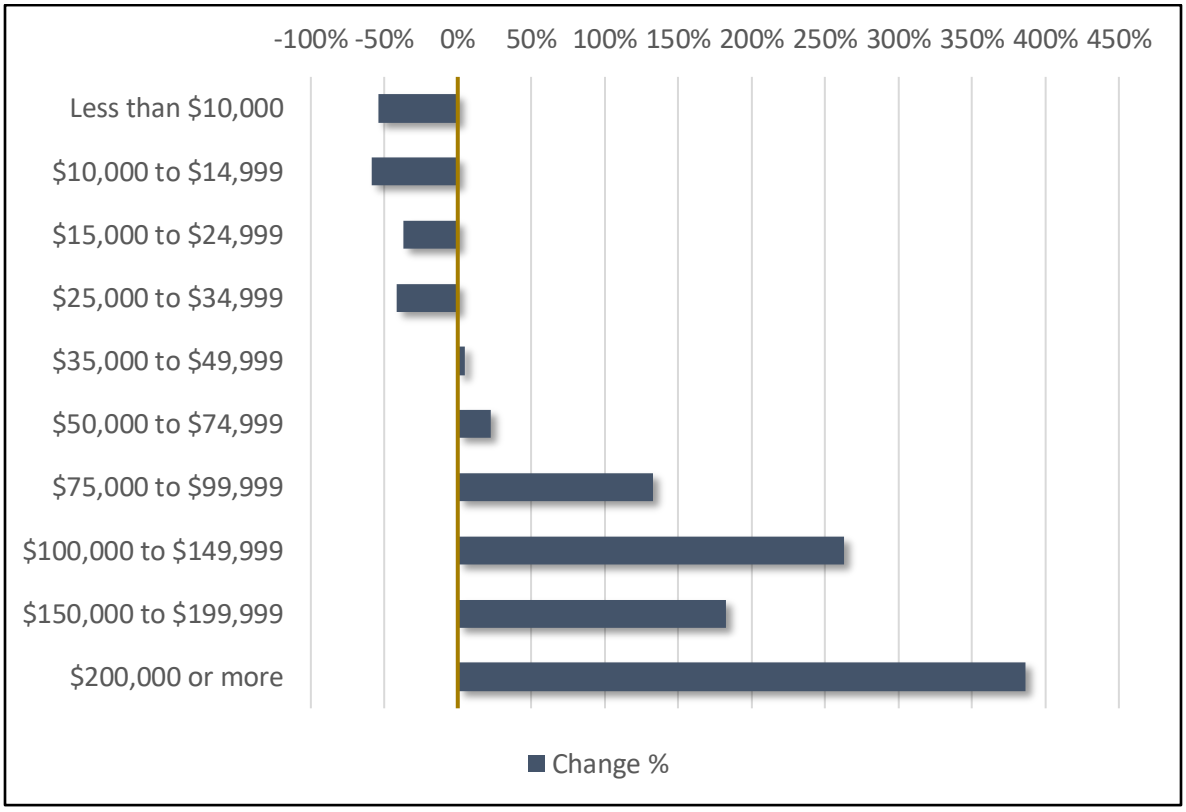



Figure: Owyhee County, ACS Changes to Household Income by %, 2013 to 2023



## Poverty Status

According to the latest 5-year ACS estimates (2019–2023), approximately 13.4% of Owyhee County residents (1,620 individuals) live below the federal poverty threshold.

Age Distribution:

- Children under 18 represent the largest group in poverty, making up 36.5% of all individuals in poverty.
- Young adults (18 to 34) account for 26.9%, while the 35 to 64 age group comprises 24.9%.
- Seniors (65+) make up 11.7% of those in poverty.

This age distribution reflects a significant burden among children and working-age adults.

Race and Ethnicity:

- White alone residents comprise the largest group in poverty by count (1,044 individuals or 64.4%).
- Hispanic or Latino residents represent 697 individuals, a share that exceeds their proportion of the overall population (24.5%).
- Additional groups include:
    - American Indian/Alaska Native: 162 people (10.0%)
    - Some other race alone: 254 people (15.7%)
    - Two or more races: 150 people (9.3%)

This distribution points to the importance of equitable access to health services, culturally responsive outreach, and income-sensitive program design across racial and ethnic lines.

Workforce Status (Among Adults in Poverty):

- 13.4% worked full-time, year-round
- 29.8% worked part-time or part-year
- 56.8% did not work, a group likely to include children, seniors, caregivers, or those with employment barriers

These figures highlight the complex nature of poverty in the County, where even working individuals may face economic hardship. For SWDH, this highlights the value of integrated care models, referral systems, and outreach efforts that connect low-income residents to preventive care, housing support, and nutrition programs.

Figure: Owyhee County, ACS Poverty Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population** | 12,121 | 100.0% |
| **Total in Poverty Status** | 1,620 | 13.4% |
| **Under 18 years** | 592 | 36.5% |
| **18 to 34 years** | 435 | 26.9% |
| **35 to 64 years** | 403 | 24.9% |
| **65 years and over** | 190 | 11.7% |
| **White alone** | 1,044 | 64.4% |
| **Black or African American alone** | - | 0.0% |
| **American Indian and Alaska Native alone** | 162 | 10.0% |
| **Asian alone** | 10 | 0.6% |
| **Native Hawaiian and Other Pacific Islander alone** | - | 0.0% |
| **Some other race alone** | 254 | 15.7% |
| **Two or more races** | 150 | 9.3% |
| **Hispanic or Latino origin (of any race)** | 697 | |
| **White alone, not Hispanic or Latino** | 744 | |
| **Population 16 years and over** | 1,059 | 100.0% |
| **Worked full-time, year-round in the past 12 months** | 142 | 13.4% |
| **Worked part-time or part-year in the past 12 months** | 316 | 29.8% |
| **Did not work** | 601 | 56.8% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Veteran Status

According to the 2019–2023 ACS estimates, 7.4% of Owyhee County's adult population (684 individuals) report veteran status.

Key characteristics of this population include:

- **Gender composition:**
  Veterans are predominantly male (87.1%), with women making up 12.9%—a growing demographic with distinct service needs.
- **Age profile:**
  The largest share of veterans (27.3%) are between ages 65 and 74, with an additional 26.5% age 75 and over. This reflects national trends of an aging veteran population and signals increasing demand for geriatric care and age-appropriate services.
- **Disability status:**
  Approximately 34.9% of veterans report one or more disabilities, including hearing, vision, cognitive, or ambulatory challenges. This rate is higher than the general adult population and may intersect with aging-related health issues.
- **Economic status:**
  The vast majority (95.3%) of veterans have incomes at or above the federal poverty level, suggesting relative financial stability among this group.

These findings point to the importance of planning for accessible, veteran-friendly health services, especially in areas such as mobility support, chronic disease management, behavioral health, and home-based care.

Figure: Figure: Owyhee County, ACS Veteran Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population 18+** | 9,186 | 100.0% |
| **Population 18+ with Veteran Status** | 684 | 7.4% |
| **Male** | 596 | 87.1% |
| **Female** | 88 | 12.9% |
| **With any disability** | 239 | 34.9% |
| **Without a disability** | 445 | 65.1% |
| **18 to 34 years** | 45 | 6.6% |
| **35 to 54 years** | 236 | 34.5% |
| **55 to 64 years** | 35 | 5.1% |
| **65 to 74 years** | 187 | 27.3% |
| **75 years and over** | 181 | 26.5% |
| **Income in the past 12 months below poverty level** | 32 | 4.7% |
| **Income in the past 12 months at or above poverty level** | 652 | 95.3% |

## Education

Educational attainment levels in Owyhee County improved across most categories between the 2009–2013 and 2019–2023 ACS periods, reflecting a gradual shift toward higher levels of formal education among adults.

Key trends include:

- High School or Equivalency remains the most common level of education and grew by 315 individuals (+11.3%).
- The Graduate or Professional Degree category experienced the largest percentage increase, rising by 237.7% (+252 individuals).
- Bachelor's degrees also grew substantially, increasing by 280 individuals (+57.6%).

While most gains occurred in higher attainment categories, the number of adults with less than a high school diploma also rose slightly (+47 individuals or +2.6%), indicating persistent educational barriers for a small segment of the population.

Cumulative gains:

- The number of adults with at least a high school diploma increased by 915 people (+16.7%).
- Those with a Bachelor's Degree or higher rose by 532 people (+89.9%).

These changes likely reflect a combination of improved access to higher education and in-migration of more highly educated residents, which can have positive implications for workforce capacity, health literacy, and digital health engagement.

At the same time, the modest growth in the population with low educational attainment suggests the continued need for adult education programs, GED outreach, and public health communication strategies that account for limited literacy or language access, particularly in rural communities.

Table: Owyhee County, ACS Change in Educational Attainment 2013 to 2023

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Educational Attainment 25+ | 7,255 | 7,436 | 8,217 | 962 | 13.3% |
| Less than High School Equivalency | 1,783 | 1,856 | 1,830 | 47 | 2.6% |
| High School or Equivalency | 2,788 | 2,552 | 3,103 | 315 | 11.3% |
| Some College, No Degree | 1,644 | 1,611 | 1,682 | 38 | 2.3% |
| Associate's Degree | 448 | 584 | 478 | 30 | 6.7% |
| Bachelor's Degree | 486 | 648 | 766 | 280 | 57.6% |
| Graduate or Professional Degree | 106 | 185 | 358 | 252 | 237.7% |
| High School or Higher | 5,472 | 5,580 | 6,387 | 915 | 16.7% |
| Bachelor's Degree or Higher | 592 | 833 | 1,124 | 532 | 89.9% |
| Educational Attainment 25+ | 7,255 | 7,436 | 8,217 | 962 | 13.3% |

Figure: Owyhee County, ACS Changes to Educational Attainment, 2013 to 2023

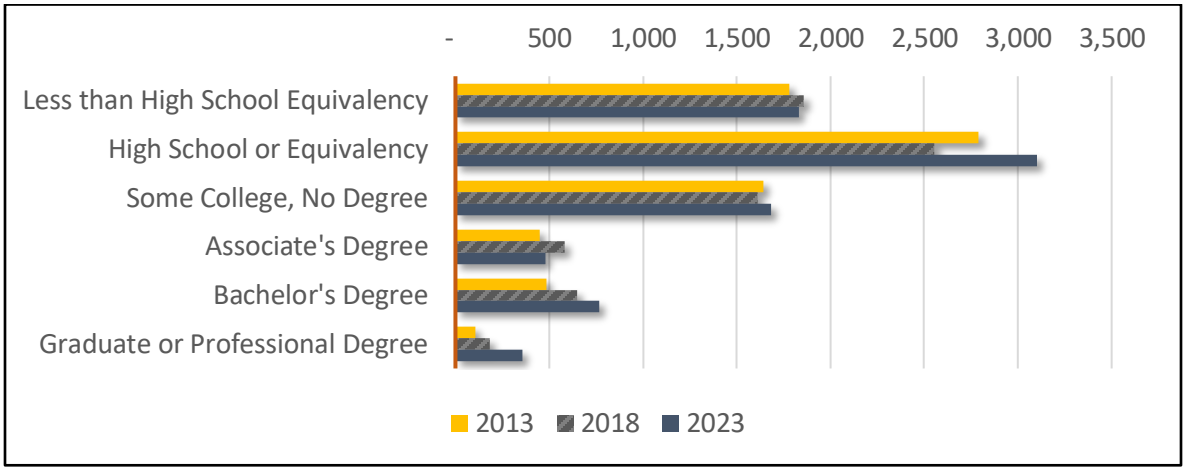
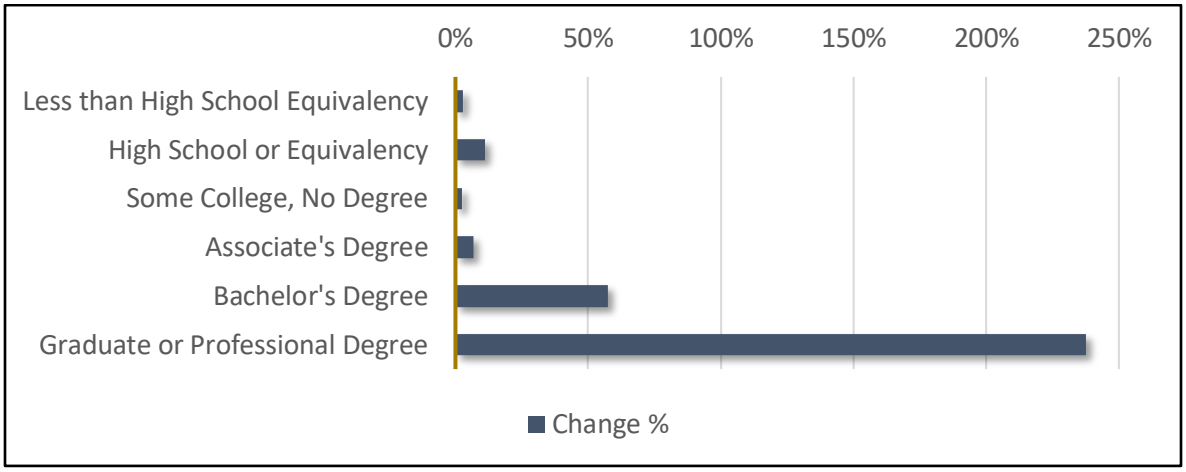
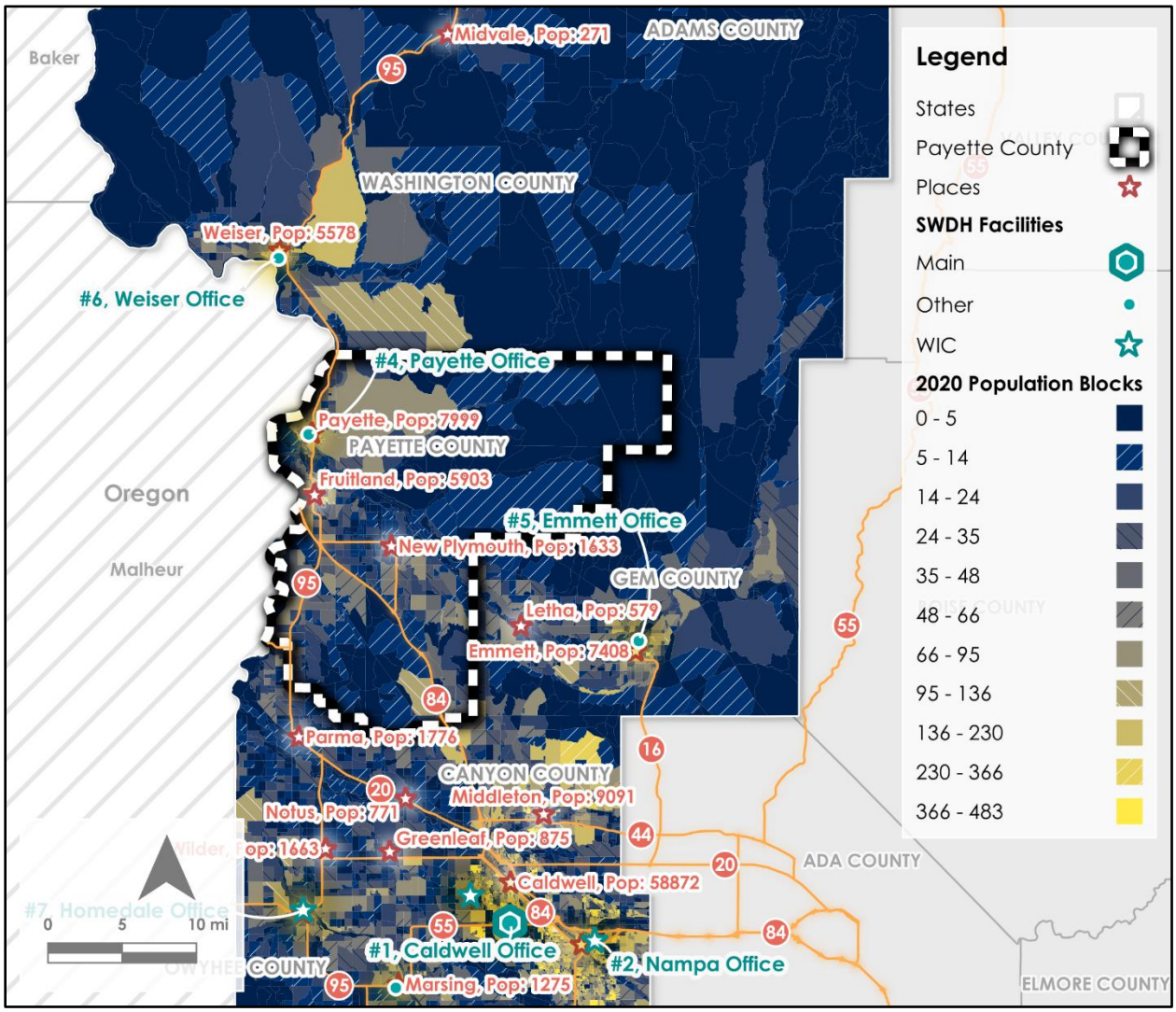



Figure: Owyhee, ACS % Change to Educational Attainment, 2013 to 2023



# Payette County Summary




*Payette County, 2020 Population Total by Census Blocks.*

## Population

Between 1970 and 2020, the population of Payette County grew by 12,985 people, reaching a total of 25,386 residents by the 2020 Decennial Census. This represents an average growth of approximately 2,597 people per decade over the 50-year period.

More recently, the County has continued to grow at a slower but steady rate. From 2000 to 2020, the population increased by 4,808 people, averaging 2,404 new residents per decade, or about 240 people per year.

These trends reflect a long-term pattern of moderate and consistent growth, which has important implications for infrastructure planning, housing availability, and health and human services delivery. Maintaining service scalability, particularly in fast-growing population centers or newly developing subdivisions, will be essential to meeting future demand without overextending resources. Gradual population increases may also support more stable budgeting and phased facility improvements when compared to rapid-growth counties elsewhere in the region.

Table: Payette County, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 12,401 | - | - | - | - |
| **1980** | 15,722 | 3,321 | 26.78% | 2.68% | 332 |
| **1990** | 16,434 | 712 | 4.53% | 0.45% | 71 |
| **2000** | 20,578 | 4,144 | 25.22% | 2.52% | 414 |
| **2010** | 22,623 | 2,045 | 9.94% | 0.99% | 205 |
| **2020** | 25,386 | 2,763 | 12.21% | 1.22% | 276 |
| **Total Change** | 12,985 | - | - | - | - |
| **Recent Change** | 2,763 | - | - | - | - |
| **Average Change (50-years)** | - | 2,597 | 15.74% | 1.57% | 260 |
| **Average Recent Change (30 years)** | - | 2,404 | 11.08% | 1.11% | 240 |

*Note: 2000, 2010, and 2020 (U.S. Census Bureau, Via TidyCensus, 2025). See the References section for list of historical Census population records for 1980 (including 1970) and 1990.*

## Race and Ethnicity

According to the 2020 Decennial Census, 78.1% of Payette County residents identified as being of one race, a distribution consistent with broader patterns across the Southwest District Health region.

Key racial and ethnic demographics include:

- White alone individuals comprised the majority, at 75.8% of the population.
- Hispanic or Latino residents represented the second-largest group, accounting for 16.8% of the population.
- Two or more races were reported by 5.1% of residents.

All other single-race groups each made up less than 1% of the population, including:

- Black or African American (0.2%)
- American Indian and Alaska Native (0.6%)
- Asian (0.8%)
- Native Hawaiian and Other Pacific Islander (0.1%)
- Some other race alone (0.5%)

While Payette County remains predominantly White, the growing Hispanic or Latino population plays a central role in shaping the County's cultural and community identity. This demographic diversity has clear implications for public health strategy, including the need for bilingual materials, culturally responsive services, and targeted outreach efforts that address potential barriers to care.

Focusing on language access, trust-building, and addressing the needs of underserved populations is key to ensuring services are effective and reach those who need them most.

Table: Payette County, 2020 Decennial Race and Ethnicity, Hispanic and Latino

| Description | Total | % of Total |
|---|---|---|
| **Total Population** | 25,386 | 100.0% |
| **Hispanic or Latino** | 4,268 | 16.8% |
| **Not Hispanic or Latino** | 21,118 | 83.2% |
| **Population of one race** | 19,826 | 78.1% |
| **White alone** | 19,240 | 75.8% |
| **Black or African American alone** | 52 | 0.2% |
| **American Indian and Alaska Native alone** | 163 | 0.6% |
| **Asian alone** | 207 | 0.8% |
| **Native Hawaiian and Other Pacific Islander alone** | 31 | 0.1% |
| **Some Other Race alone** | 133 | 0.5% |
| **Population of two or more races** | 1,292 | 5.1% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Age

Payette County is experiencing a gradual aging of its population. Between the 2009–2013 and 2019–2023 ACS 5-year periods, the median age increased from 38.1 to 38.8 years—a 1.8% rise. While this shift is more modest than in other counties within the Southwest District Health region, it continues a consistent trend toward an older demographic profile.

**Additional insights:**

- The 65 and older population grew by 1,510 individuals, a 42.7% increase, making it the fastest-growing age group in the County.
- Among working-age adults, the 30 to 39 cohort expanded by 29.7% (+732 people), suggesting growth in young professional households or families with school-aged children.
- In contrast, the 40 to 49 cohort declined by 4.7%, which may reflect out-migration or demographic replacement.
- The under-18 population increased slightly by 6.2%, signaling relative stability in younger age groups.

This evolving age structure has direct implications for public health planning and infrastructure. As older residents represent a larger share of the population, demand will grow for services such as geriatric care, chronic disease management, home-based support, and mobility-friendly facilities. At the same time, the presence of younger families presents the ongoing need for maternal and child health programs, preventive services, and family-centered care.

These dual dynamics reinforce the importance of age-inclusive service design, flexible delivery models, and intergenerational planning to ensure good health for all and sustainability across all life stages.

Table: Payette County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| 0 to 9 | 3,234 | 3,272 | 3,633 | 399 | 12.3% |
| 10 to 19 | 3,560 | 3,401 | 3,853 | 293 | 8.2% |
| 20 to 29 | 2,605 | 2,629 | 2,704 | 99 | 3.8% |
| 30 to 39 | 2,467 | 2,235 | 3,199 | 732 | 29.7% |
| 40 to 49 | 3,128 | 3,170 | 2,981 | (147) | -4.7% |
| 50 to 64 | 4,097 | 4,337 | 4,772 | 675 | 16.5% |
| 65 and Older | 3,538 | 3,997 | 5,048 | 1,510 | 42.7% |
| Less than 18 | 6,329 | 6,216 | 6,719 | 390 | 6.2% |
| 18 and Older | 16,300 | 16,825 | 19,471 | 3,171 | 19.5% |
| Total Median Age | 38.1 | 39.9 | 38.8 | 0.7 | 1.8% |
| Total Median Age Male | 36.2 | 37.9 | 37.9 | 1.7 | 4.7% |
| Total Median Age Female | 38.8 | 40.6 | 40.1 | 1.3 | 3.4% |

Figure: Payette County, ACS Total Population by Age Groups (2019-2023)

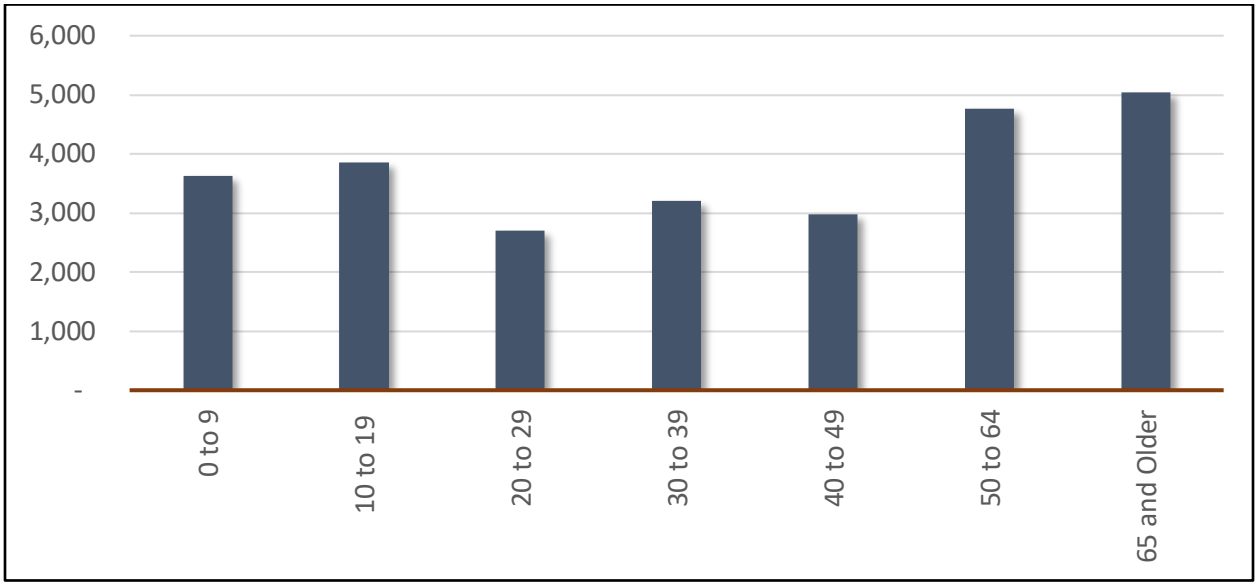
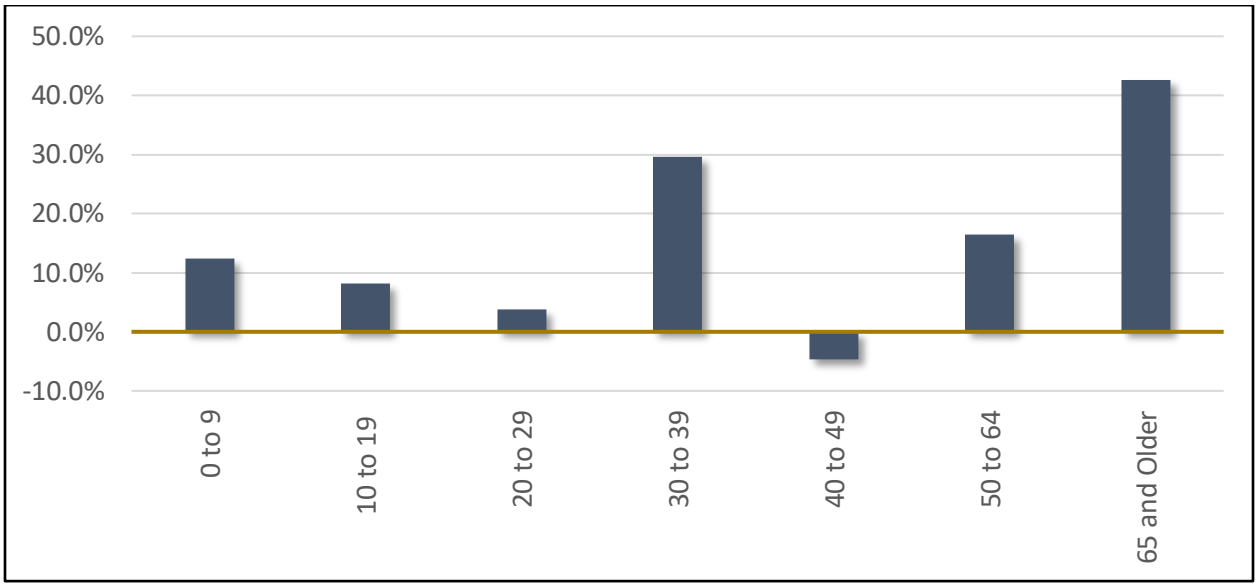



Figure: Payette County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



## Housing and Occupancy

Between 2013 and 2023, Payette County experienced steady housing growth alongside minor shifts in household composition.

- Average household size declined slightly overall (–1.8%, or –0.05 persons per household), driven primarily by a decrease in renter-occupied household size (–9.6%). In contrast, owner-occupied household size increased modestly by 1.1%.
- The total housing stock grew by 17.7%, with an increase of 1,425 units (from 8,056 to 9,481). Meanwhile, occupied housing units rose 25.5%, outpacing new supply—an early indicator of increasing demand.

A particularly notable trend is the sharp drop in vacancy:

- The number of vacant units declined by 46.4%, and the vacancy rate fell from 10.9% to just 4.9%, signaling a tightening housing market.

During the same period:

- Owner-occupied housing increased by 1,053 units (+17.5%)
- Renter-occupied units grew by 372 units (+18.2%), maintaining a stable 25.5% share.

These dynamics point to growing housing demand that exceeds supply, particularly in the rental market. The declining vacancy rate suggests reduced availability, a concern for low-income residents, older adults on fixed incomes, young families, and seasonal or mobile workers.

From a public health perspective, limited housing supply may increase risk factors such as overcrowding, housing instability, and delayed or foregone medical care, especially for vulnerable groups. These trends reinforce the need for place-based service planning, mobile clinic deployment, and strengthened partnerships to reach populations impacted by cost and access barriers in the housing market.

Table: Payette County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.79 | 2.61 | 2.74 | (0.05) | -1.8% |
| Average Household Size: Owner | 2.81 | 2.67 | 2.84 | 0.03 | 1.1% |
| Average Household Size: Renter | 2.72 | 2.46 | 2.46 | (0.26) | -9.6% |

Table: Payette County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Tenure by Educational Attainment All | 8,056 | 8,768 | 9,481 | 1,425 | 17.7% |
| Housing Units: Total Occupied | 7,181 | 8,187 | 9,012 | 1,831 | 25.5% |
| Housing Units: Total Vacancy | 875 | 581 | 469 | (406) | -46.4% |
| % Vacancy | 10.9% | 6.6% | 4.9% | -5.9% | -5.9% |
| Owner-occupied housing units | 6,010 | 6,368 | 7,063 | 1,053 | 17.5% |
| Renter-occupied housing units: | 2,046 | 2,400 | 2,418 | 372 | 18.2% |
| % Owner Occupied | 74.6% | 72.6% | 74.5% | -0.1% | -0.1% |
| % Renter Occupied | 25.4% | 27.4% | 25.5% | 0.1% | 0.1% |

## Income

Between the 2009–2013 and 2019–2023 ACS 5-year periods, household income in Payette County rose significantly, especially among middle- and higher-income brackets. The median household income increased by 50.6%, rising from $43,649 to $65,723 over the decade.

**Key income shifts include:**

- The $100,000 to $149,999 bracket added the most households, growing by 1,090.
- The $200,000 or more bracket experienced the largest relative growth, increasing by 519.5% (+426 households).
- Other notable increases occurred in:
    - $75,000 to $99,999: +767 households (142.0%)
    - $150,000 to $199,999: +305 households (133.8%)

Meanwhile, income brackets below $35,000 all saw declines:

- $10,000 to $14,999: –77.1%
- $15,000 to $24,999: –42.2%
- $25,000 to $34,999: –21.6%

These changes reflect regional wage growth, new in-migration, and broader economic development, but also signal a growing income divide. The shrinking number of households in lower income brackets suggests rising costs of living and potential displacement of vulnerable residents, especially renters and seniors on fixed incomes.

This evolving income landscape has clear implications:

- **Higher median incomes** may improve access to care and insurance coverage for many residents.
- However, **affordability pressures** may increase need for subsidized services, food assistance, or targeted outreach to those left behind by income growth.
- **Planning for geographic distribution** in service access, especially in rural areas or among non-homeowners, will remain critical as economic gains are not evenly distributed.

Table: Payette County, ACS Change in Household Income Distribution (2013–2023)

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Less than $10,000 | 723 | 489 | 448 | (275) | -38.0% |
| $10,000 to $14,999 | 669 | 424 | 153 | (516) | -77.1% |
| $15,000 to $24,999 | 943 | 940 | 545 | (398) | -42.2% |
| $25,000 to $34,999 | 929 | 920 | 728 | (201) | -21.6% |
| $35,000 to $49,999 | 1,333 | 1,583 | 1,452 | 119 | 8.9% |
| $50,000 to $74,999 | 2,041 | 1,726 | 2,149 | 108 | 5.3% |
| $75,000 to $99,999 | 540 | 1,029 | 1,307 | 767 | 142.0% |
| $100,000 to $149,999 | 568 | 1,248 | 1,658 | 1,090 | 191.9% |
| $150,000 to $199,999 | 228 | 142 | 533 | 305 | 133.8% |
| $200,000 or more | 82 | 267 | 508 | 426 | 519.5% |
| Median income (dollars) | 43,649 | 50,289 | 65,723 | 22,074 | 50.6% |

Figure: Payette County, ACS Changes to Household Income by Total Households, 2013 to 2023

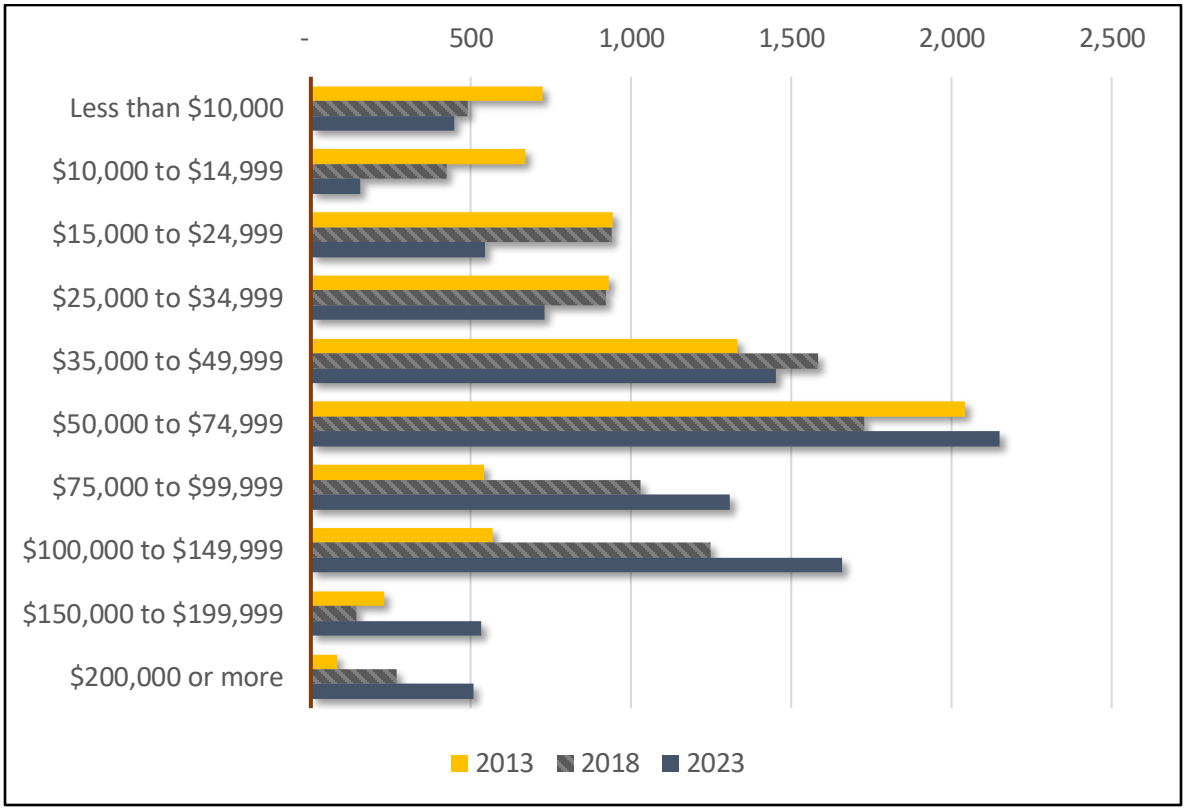
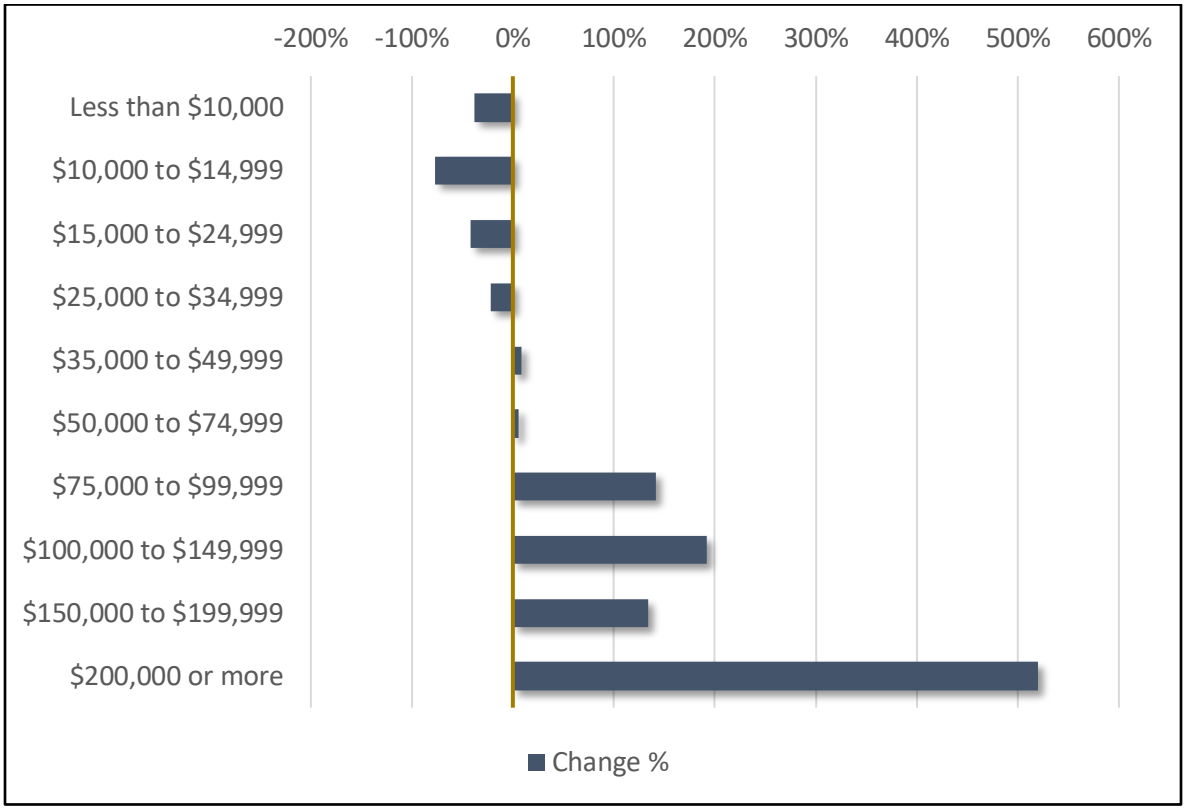


Figure: Payette County, ACS Changes to Household Income by %, 2013 to 2023



## Poverty Status

According to the 2019–2023 ACS 5-year estimates, 9.0% of Payette County residents (2,332 people) live below the federal poverty threshold.

**Age Distribution:**

- Children under 18 make up the largest share of the poverty population (32.5%), underscoring the importance of affordable youth-centered support programs.
- Adults ages 18 to 64 account for more than half of those in poverty:
    - 18–34 years: 23.0%
    - 35–64 years: 28.3%
- Seniors (65+) comprise 16.2%, which may reflect fixed incomes and limited access to supplemental resources.

**Racial and Ethnic Characteristics:**

- The majority of individuals in poverty (81.2%) identify as White alone.
- Individuals reporting two or more races account for 12.9%, and “some other race” represents 5.6%.
- Hispanic or Latino residents make up 10.2% of those in poverty, a figure that warrants attention in outreach and translation planning.

**Employment Status (16+ in poverty):**

- 58.6% did not work in the past year, including children, older adults, and people with disabilities.
- 33.0% worked part-time or part-year, while just 8.3% worked full-time year-round, suggesting a high rate of underemployment among working-age adults in poverty.

These data reflect a persistent rural poverty pattern, where job access, transportation, and service availability may limit household stability despite a relatively low cost of living. Implications may include:

- Expanded outreach to children, families, and seniors remains critical.
- Service models should account for low workforce participation, ensuring that non-employed residents, especially in remote areas, can still access care.
- As poverty disproportionately affects non-working and underemployed populations, access to basic needs, preventive health, and affordable services remains a key challenge and planning priority.

Figure: Payette County, ACS Poverty Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population** | 25,864 | 100.0% |
| **Total in Poverty Status** | 2,332 | 9.0% |
| **Under 18 years** | 758 | 32.5% |
| **18 to 34 years** | 536 | 23.0% |
| **35 to 64 years** | 660 | 28.3% |
| **65 years and over** | 378 | 16.2% |
| **White alone** | 1,894 | 81.2% |
| **Black or African American alone** | - | 0.0% |
| **American Indian and Alaska Native alone** | 6 | 0.3% |
| **Asian alone** | - | 0.0% |
| **Native Hawaiian and Other Pacific Islander alone** | - | 0.0% |
| **Some other race alone** | 131 | 5.6% |
| **Two or more races** | 301 | 12.9% |
| **Hispanic or Latino origin (of any race)** | 237 | |
| **White alone, not Hispanic or Latino** | 1,822 | |
| **Population 16 years and over** | 1,581 | 100.0% |
| **Worked full-time, year-round in the past 12 months** | 132 | 8.3% |
| **Worked part-time or part-year in the past 12 months** | 522 | 33.0% |
| **Did not work** | 927 | 58.6% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Veteran Status

According to the 2019–2023 ACS 5-year estimates, 10.4% of Payette County's adult population (2,019 individuals) are veterans. This group is predominantly male (85.6%) and aging, with more than half age 65 or older.

- The largest veteran subgroup (29.6%) is aged 75 and over, followed by those aged 65–74 (21.9%), reflecting broader national trends in the aging veteran population.
- Nearly one-third (32.2%) of veterans in Payette County report having at least one disability.
- While only 9.9% of veterans live below the poverty line, suggesting relative economic stability, many may still face access barriers tied to fixed incomes, mobility limitations, or rural geography.

The demographic profile of Payette County's veterans reinforces the need for:

- Accessible, age-friendly, and ADA-compliant health facilities.
- Integrated care models that address physical limitations, chronic condition management, and coordination across health and social service providers.
- Proactive outreach and transportation support, particularly for those in more remote areas who may be underserved despite financial stability.
- Strengthened collaboration with veteran service organizations to connect residents with local and federal benefits, peer support programs, and targeted behavioral health services.

As the veteran population continues to age, investments in wraparound support systems, including home-based care, mobility services, and mental health access, will be increasingly vital for this high-needs, high-priority group.

Figure: Payette County, ACS Veteran Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population 18+** | 19,459 | 100.0% |
| **Population 18+ with Veteran Status** | 2,019 | 10.4% |
| **Male** | 1,729 | 85.6% |
| **Female** | 290 | 14.4% |
| **With any disability** | 650 | 32.2% |
| **Without a disability** | 1,348 | 66.8% |
| **18 to 34 years** | 84 | 4.2% |
| **35 to 54 years** | 504 | 25.0% |
| **55 to 64 years** | 390 | 19.3% |
| **65 to 74 years** | 443 | 21.9% |
| **75 years and over** | 598 | 29.6% |
| **Income in the past 12 months below poverty level** | 200 | 9.9% |
| **Income in the past 12 months at or above poverty level** | 1,798 | 89.1% |

## Education

Between the 2009–2013 and 2019–2023 ACS periods, educational attainment in Payette County improved across nearly all categories. The number of residents with post-secondary degrees rose substantially, indicating both rising educational attainment among existing residents and potential in-migration of more highly educated individuals.

The largest gains were seen among those with a Bachelor's Degree or higher:

- Bachelor's degrees increased by 805 individuals, a 50.0% rise.
- Graduate or professional degrees grew by 277 people, or 36.8%.
- Associate's Degrees rose by 464 individuals, an increase of 36.5%.

Those with some college but no degree also grew by 722 individuals (20.6%), while those with a high school diploma or equivalency increased by 627 people (12.1%). These gains reflect consistent progress across foundational and intermediate education levels.

However, the number of residents with less than a high school diploma also increased slightly—by 222 people or 10.5%, highlighting persistent gaps in educational access or completion.

Cumulatively:

- Residents with a high school diploma or higher increased by 2,895 people (23.5%).
- Those with a Bachelor's Degree or higher grew by 1,082 people (45.8%).

These shifts suggest an evolving educational profile with implications for workforce development, economic resilience, and public health literacy. While educational attainment is rising overall, the modest increase in those lacking a high school diploma reinforces the need for continued adult education, skill-building programs, and targeted outreach to ensure inclusive access to opportunity and services.

Table: Payette County, ACS Change in Educational Attainment 2013 to 2023

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Educational Attainment 25+ | 14,422 | 15,025 | 17,539 | 3,117 | 21.6% |
| Less than High School Equivalency | 2,112 | 2,252 | 2,334 | 222 | 10.5% |
| High School or Equivalency | 5,168 | 5,059 | 5,795 | 627 | 12.1% |
| Some College, No Degree | 3,509 | 4,254 | 4,231 | 722 | 20.6% |
| Associate's Degree | 1,272 | 1,322 | 1,736 | 464 | 36.5% |
| Bachelor's Degree | 1,609 | 1,588 | 2,414 | 805 | 50.0% |
| Graduate or Professional Degree | 752 | 550 | 1,029 | 277 | 36.8% |
| High School or Higher | 12,310 | 12,773 | 15,205 | 2,895 | 23.5% |
| Bachelor's Degree or Higher | 2,361 | 2,138 | 3,443 | 1,082 | 45.8% |
| Educational Attainment 25+ | 14,422 | 15,025 | 17,539 | 3,117 | 21.6% |

Figure: Payette County, ACS Changes to Educational Attainment, 2013 to 2023

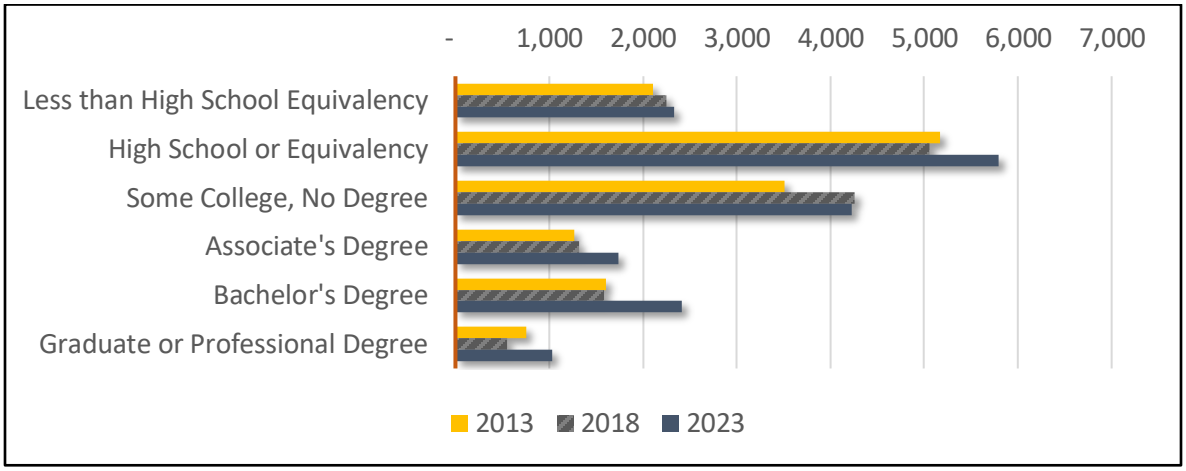
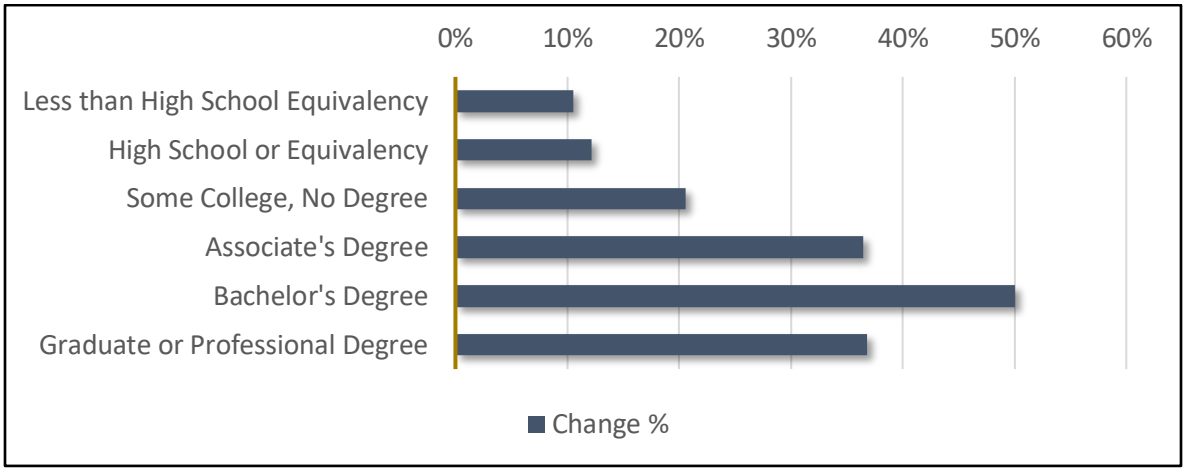
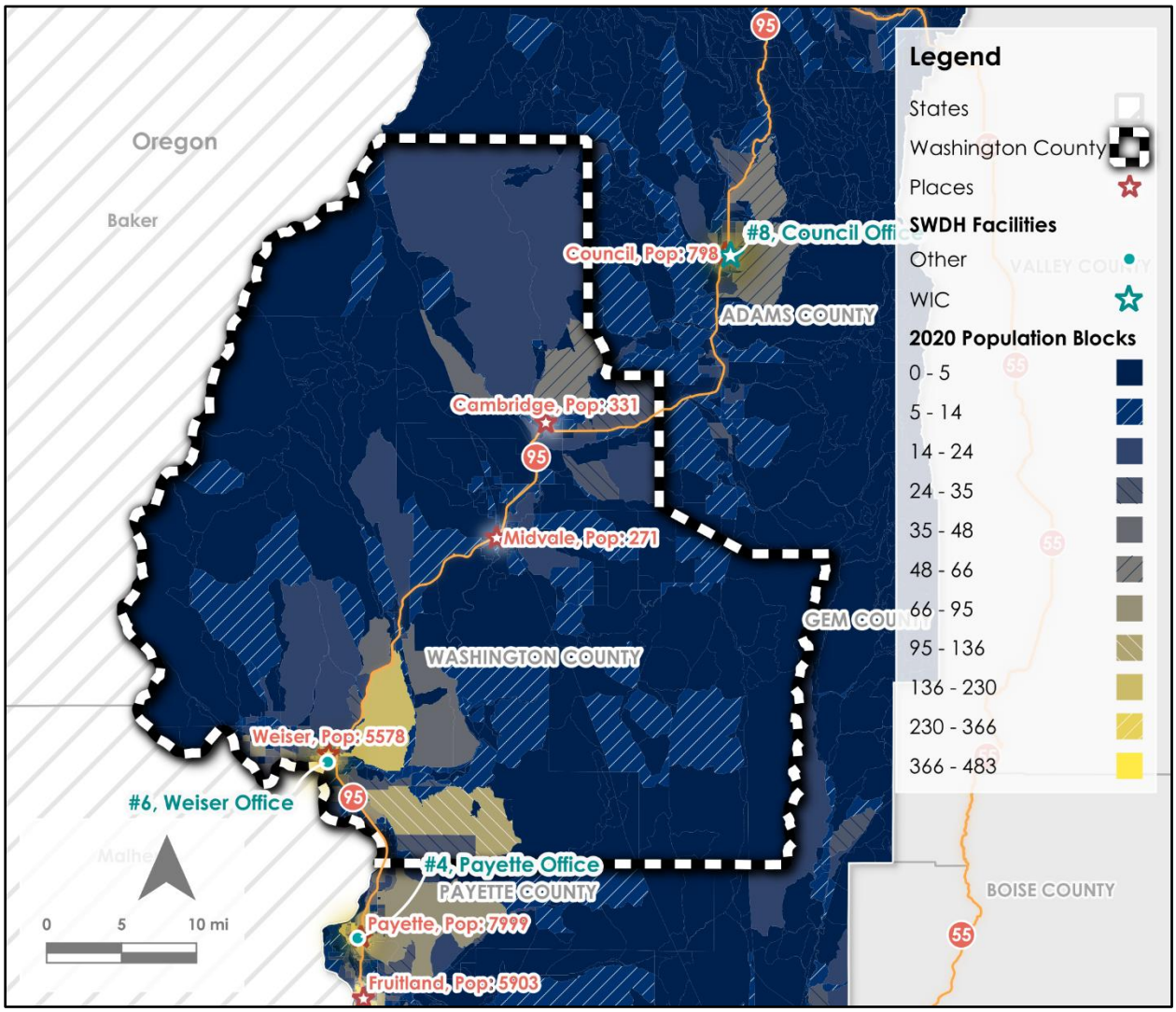



Figure: Payette County, ACS % Change to Educational Attainment, 2013 to 2023



# Washington County Summary




*Washington County, 2020 Population Total by Census Blocks.*

## Population

Between 1970 and 2020, Washington County added 2,867 residents, growing from 7,633 to 10,500 people. This reflects a long-term average growth of 573 people per decade over the past 50 years. Population change has not been uniform, with a slight decline during the 1980s followed by stronger growth into the early 2000s.

More recently, between 2000 and 2020, the population increased by 523 people, an average of 262 residents per decade, or about 26 per year.

- 1970 population: 7,633
- 2020 population: 10,500
- Recent 20-year change (2000–2020): +523 residents
- Average 10-year growth (1970–2020): +573 people

While growth has been relatively modest compared to other counties in the Southwest District Health region, the trend remains positive. This slow but steady increase points to a stable rural population with low turnover and limited in-migration. For facility and service planning, it suggests a continued focus on maintaining core service delivery and infrastructure rather than large-scale expansion. However, aging facilities and modest growth may continue to pose obstacles to providing accessible and well-distributed public health resources throughout the County.

Table: Washington County, Decennial Census Populations

| Year | Population | Change Over Previous (10 yr.) | % Change (10 Yr.) | Year Over Year % Change | # Change Year over Year |
|---|---|---|---|---|---|
| **1970** | 7,633 | - | - | - | - |
| **1980** | 8803 | 1,170 | 15.33% | 1.53% | 117 |
| **1990** | 8,550 | (253) | -2.87% | -0.29% | (25) |
| **2000** | 9,977 | 1,427 | 16.69% | 1.67% | 143 |
| **2010** | 10,198 | 221 | 2.22% | 0.22% | 22 |
| **2020** | 10,500 | 302 | 2.96% | 0.30% | 30 |
| **Total Change** | 2,867 | - | - | - | - |
| **Recent Change** | 302 | - | - | - | - |
| **Average Change (50-years)** | - | 573 | 6.86% | 0.69% | 57 |
| **Average Recent Change (30 years)** | - | 262 | 2.59% | 0.26% | 26 |

*Note: 2000, 2010, and 2020 (U.S. Census Bureau, Via TidyCensus, 2025). See the References section for list of historical Census population records for 1980 (including 1970) and 1990.*

## Race and Ethnicity

According to the 2020 Decennial Census, Washington County is predominantly White, though there is a modest but important Hispanic or Latino population.

- White alone accounted for 77.3% of the County's population.
- Hispanic or Latino (of any race) made up 15.8%.
- Those identifying as two or more races represented 4.6% of the population.
- All other single-race categories (e.g., Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander) each comprised less than 1%.

These figures highlight a primarily homogenous population with a growing Hispanic or Latino community. Continued attention to culturally and linguistically appropriate services remains important for effective public health outreach.

Table: Washington County, 2020 Decennial Race and Ethnicity, Hispanic and Latino

| Description | Total | % of Total |
|---|---|---|
| **Total Population** | 10,500 | 100.0% |
| **Hispanic or Latino** | 1,662 | 15.8% |
| **Not Hispanic or Latino** | 8,838 | 84.2% |
| **Population of one race** | 8,350 | 79.5% |
| **White alone** | 8,118 | 77.3% |
| **Black or African American alone** | 17 | 0.2% |
| **American Indian and Alaska Native alone** | 74 | 0.7% |
| **Asian alone** | 81 | 0.8% |
| **Native Hawaiian and Other Pacific Islander alone** | 7 | 0.1% |
| **Some Other Race alone** | 53 | 0.5% |
| **Population of two or more races** | 488 | 4.6% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Age

Washington County is experiencing a steady but moderate aging trend. Between the 2009–2013 and 2019–2023 ACS 5-year periods, the County's median age rose from 44.3 to 44.6 years, a slight increase of 0.7%. While this rate of change is slower than in many nearby counties, it signals a demographic shift with long-term planning implications.

Population changes by age group show distinct generational movement:

- The 65 and older population increased by 717 people (+34.6%), making it the fastest-growing age group.
- Adults aged 30 to 39 grew by 213 people (+18.7%), indicating growth among younger working-age adults.
- In contrast, the 50 to 64 cohort declined by 260 people (–11.3%), and the 40 to 49 group decreased by 111 people (–9.9%), suggesting a tapering population in older middle-age brackets.
- The 10 to 19 age group also declined by 9.2%, while the 0 to 9 population increased by 19.2%, hinting at recent growth among young families.

Overall, the population age 18 and older increased by 9.4% (+726 people), while the number of residents under 18 remained relatively stable.

These shifts indicate growing needs for senior-focused services and infrastructure, such as mobility supports, chronic disease care, and social engagement, alongside continued investments in family and workforce supports for younger age groups. Planning efforts should balance these dual demands to ensure service accessibility across generations.

Table: Washington County, ACS Change in Population Age Groups

| Age | 2013 | 2018 | 2023 | Change # 2013-2023 | Change % 2013-2023 |
|---|---|---|---|---|---|
| 0 to 9 | 1,105 | 1,315 | 1,317 | 212 | 19.2% |
| 10 to 19 | 1,514 | 1,256 | 1,374 | (140) | -9.2% |
| 20 to 29 | 853 | 899 | 994 | 141 | 16.5% |
| 30 to 39 | 1,137 | 935 | 1,350 | 213 | 18.7% |
| 40 to 49 | 1,116 | 1,081 | 1,005 | (111) | -9.9% |
| 50 to 64 | 2,296 | 2,128 | 2,036 | (260) | -11.3% |
| 65 and Older | 2,073 | 2,411 | 2,790 | 717 | 34.6% |
| Less than 18 | 2,396 | 2,345 | 2,442 | 46 | 1.9% |
| 18 and Older | 7,698 | 7,680 | 8,424 | 726 | 9.4% |
| Total Median Age | 44.3 | 45.4 | 44.6 | 0.3 | 0.7% |
| Total Median Age Male | 41.9 | 43.9 | 42.7 | 0.8 | 1.9% |
| Total Median Age Female | 45.7 | 46.8 | 45.6 | (0.1) | -0.2% |

Figure: Washington County, ACS Total Population by Age Groups (2019-2023)

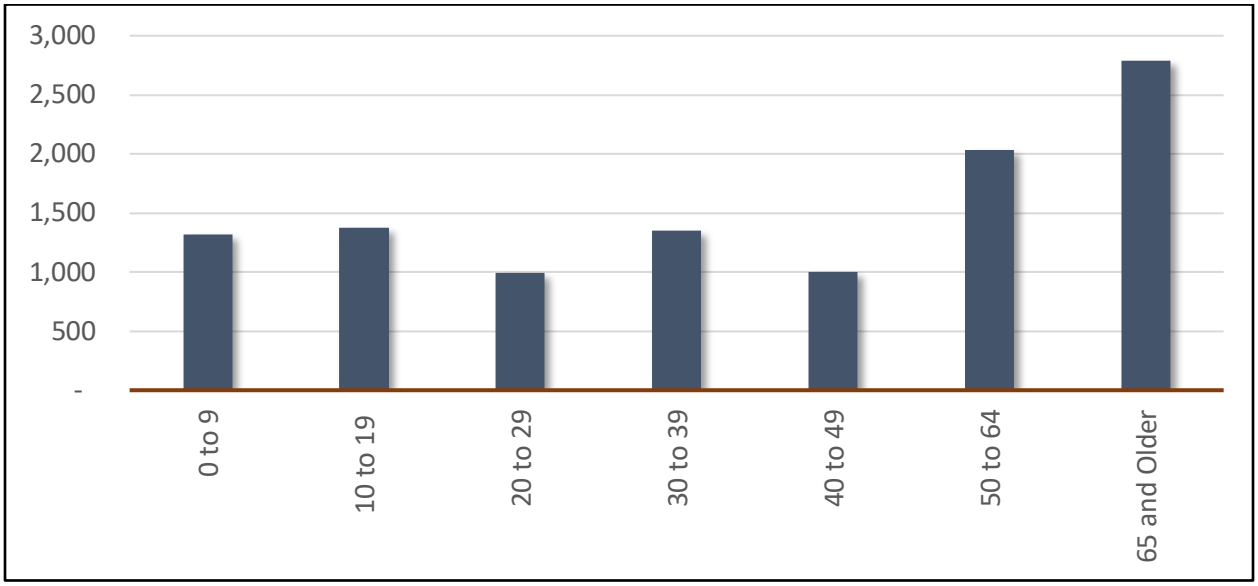
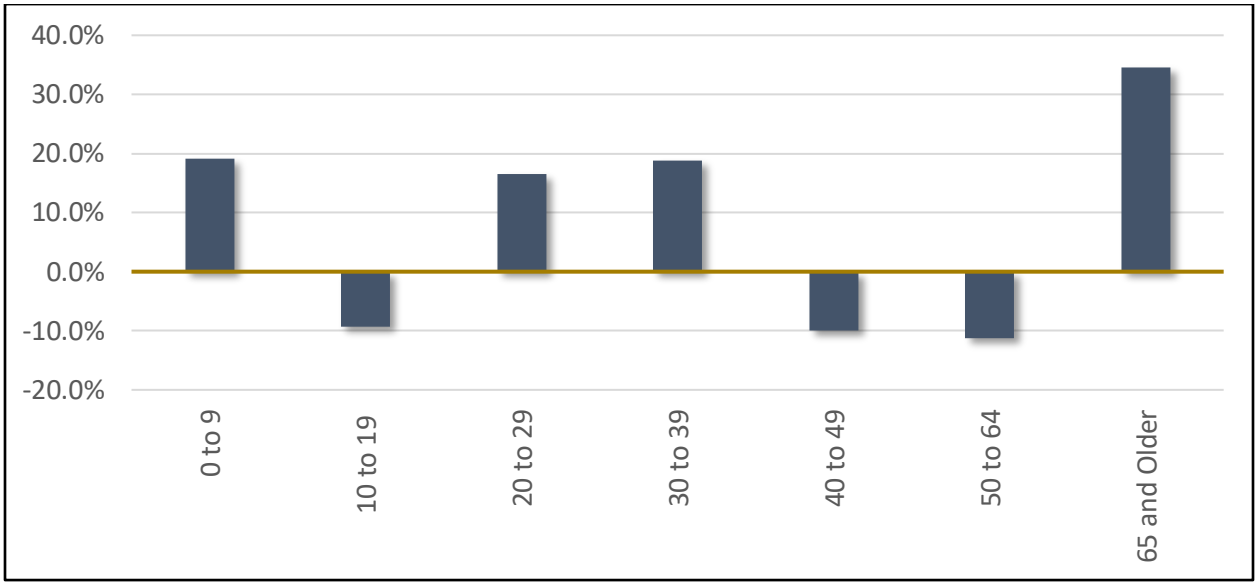



Figure: Washington County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



## Housing and Occupancy

Between 2013 and 2023, average household size in Washington County increased modestly across all housing types. Owner-occupied households grew by 4.3% (+0.11 persons), renter-occupied households rose by 2.5% (+0.06 persons), and the overall average household size increased by 3.6% (+0.09 persons).

During the same period, total housing units increased from 3,938 to 4,089, reflecting a modest 3.8% increase. However, the composition of occupied housing shifted noticeably: owner-occupied units declined slightly by 0.3% (–10 units), while renter-occupied units grew significantly by 17.3% (+161 units). The overall vacancy rate fell by 2.5 percentage points, from 14.7% to 12.2%, signaling a tighter housing market.

These changes may reflect broader shifts in affordability, mobility, and household composition. For Southwest District Health, these patterns point to the growing importance of flexible, community-based service models that can adapt to housing-related barriers. As the mix of housing tenure and density evolves, planning should continue to emphasize access for all, ensuring that services remain responsive to both long-term residents and more transient or housing-insecure populations.

Table: Washington County, ACS Change in Household Size

| Household Size | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Average Household Size: All | 2.52 | 2.46 | 2.61 | 0.09 | 3.6% |
| Average Household Size: Owner | 2.57 | 2.48 | 2.68 | 0.11 | 4.3% |
| Average Household Size: Renter | 2.36 | 2.42 | 2.42 | 0.06 | 2.5% |

Table: Washington County, ACS Change in Housing

| Housing | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Housing Tenure by Educational Attainment All | 3,938 | 4,018 | 4,089 | 151 | 3.8% |
| Housing Units: Total Occupied | 3,360 | 3,404 | 3,592 | 232 | 6.9% |
| Housing Units: Total Vacancy | 578 | 614 | 497 | (81) | -14.0% |
| % Vacancy | 14.7% | 15.3% | 12.2% | -2.5% | -2.5% |
| Owner-occupied housing units | 3,006 | 2,824 | 2,996 | (10) | -0.3% |
| Renter-occupied housing units: | 932 | 1,194 | 1,093 | 161 | 17.3% |
| % Owner Occupied | 76.3% | 70.3% | 73.3% | -3.1% | -3.1% |
| % Renter Occupied | 23.7% | 29.7% | 26.7% | 3.1% | 3.1% |

## Income

Between the 2009–2013 and 2019–2023 ACS periods, household income in Washington County increased notably across all income brackets above $50,000.

- The largest increase in total households occurred in the $100,000 to $149,999 range, which grew by 305 households.
- The largest percentage increase was in the $150,000 to $199,999 group, which rose by 235.8%, reflecting a substantial upward shift in mid-to-upper income households.
- Median household income rose from $37,453 to $53,608, a 43.1% increase over the decade.

These trends suggest rising household earnings across the County, which may reflect broader economic growth, increased wages, or in-migration of higher-income households. While this may strengthen the local tax base and spending power, it may also widen affordability gaps for lower-income residents. It also has potential implications for housing affordability, service needs, and access to essential resources for lower-income residents.

Table: Washington County, ACS Change in Household Income Distribution (2013–2023)

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Less than $10,000 | 373 | 333 | 237 | (136) | -36.5% |
| $10,000 to $14,999 | 315 | 255 | 235 | (80) | -25.4% |
| $15,000 to $24,999 | 585 | 620 | 439 | (146) | -25.0% |
| $25,000 to $34,999 | 538 | 666 | 380 | (158) | -29.4% |
| $35,000 to $49,999 | 672 | 651 | 627 | (45) | -6.7% |
| $50,000 to $74,999 | 733 | 720 | 883 | 150 | 20.5% |
| $75,000 to $99,999 | 387 | 274 | 458 | 71 | 18.3% |
| $100,000 to $149,999 | 170 | 386 | 475 | 305 | 179.4% |
| $150,000 to $199,999 | 53 | 59 | 178 | 125 | 235.8% |
| $200,000 or more | 112 | 54 | 177 | 65 | 58.0% |
| Median income (dollars) | 37,453 | 37,206 | 53,608 | 16,155 | 43.1% |

Figure: Washinton County, ACS Changes to Household Income by Total Households, 2013 to 2023

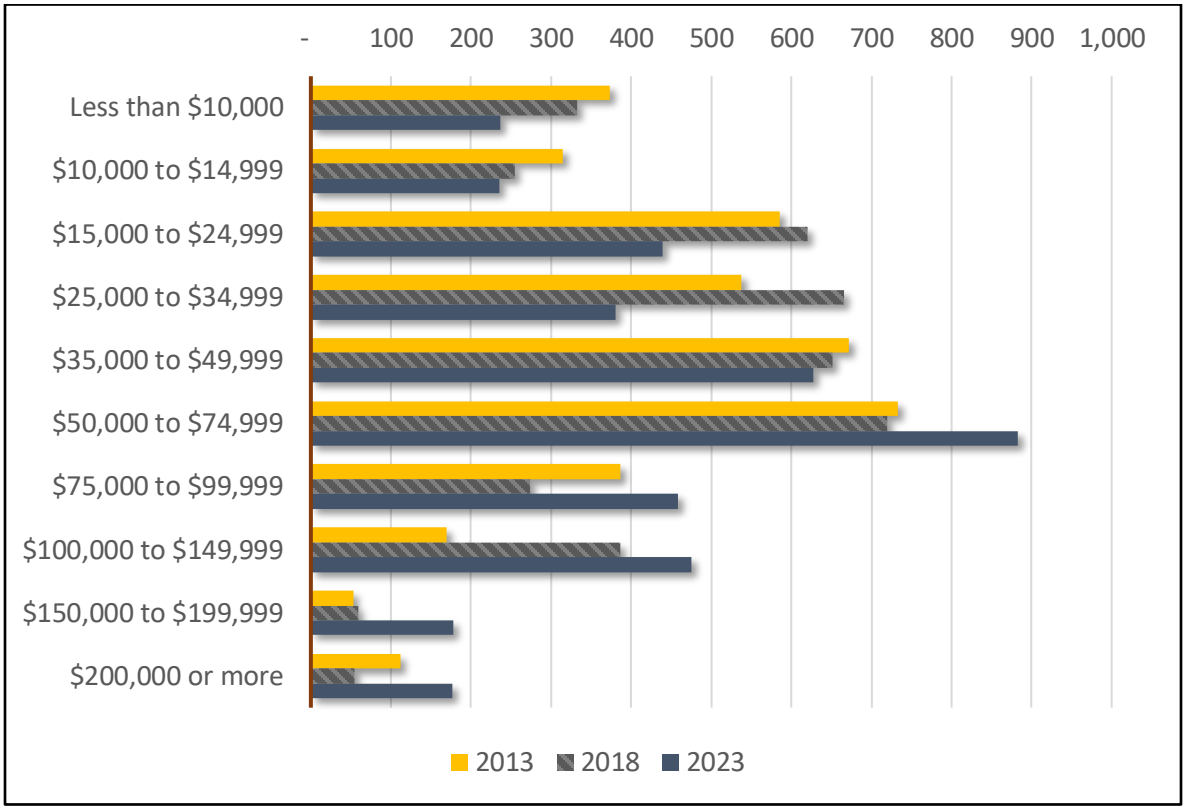
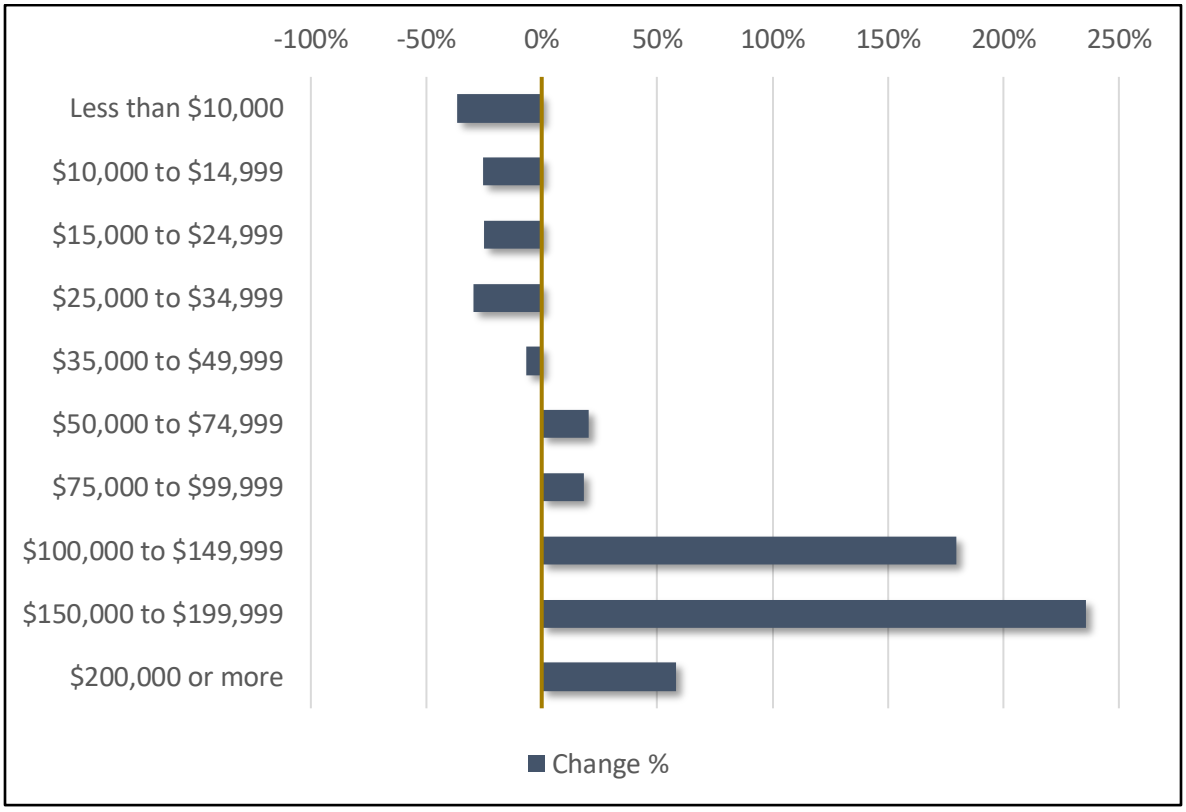



Figure: Washington County, ACS Changes to Household Income by %, 2013 to 2023



### Poverty Status

According to the 2019–2023 American Community Survey estimates, approximately 15.3% of Washington County residents—roughly 1,640 individuals—live below the federal poverty threshold.

Children and working-age adults make up the majority of this population:

- 27.6% of those in poverty are under the age of 18,
- 23.0% are aged 18 to 34, and
- 25.7% are between 35 and 64 years old.
- Seniors aged 65 and older represent 23.6% of those in poverty.

Most individuals in poverty identified as White alone (76.4%), which generally reflects the County's broader racial makeup. Hispanic or Latino individuals made up 430 of those in poverty, underscoring the importance of culturally inclusive services.

These figures reflect common rural poverty dynamics, where limited job access, transportation barriers, and service gaps can disproportionately affect children, seniors, and underemployed adults. As a result, community strategies that strengthen wraparound services, improve access to care, and support working families remain critical to addressing persistent poverty across the County.

Figure: Washington County, ACS Poverty Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population** | 10,685 | 100.0% |
| **Total in Poverty Status** | 1,640 | 15.3% |
| **Under 18 years** | 453 | 27.6% |
| **18 to 34 years** | 378 | 23.0% |
| **35 to 64 years** | 422 | 25.7% |
| **65 years and over** | 387 | 23.6% |
| **White alone** | 1,253 | 76.4% |
| **Black or African American alone** | - | 0.0% |
| **American Indian and Alaska Native alone** | - | 0.0% |
| **Asian alone** | 6 | 0.4% |
| **Native Hawaiian and Other Pacific Islander alone** | - | 0.0% |
| **Some other race alone** | 236 | 14.4% |
| **Two or more races** | 145 | 8.8% |
| **Hispanic or Latino origin (of any race)** | 430 | |
| **White alone, not Hispanic or Latino** | 1,178 | |
| **Population 16 years and over** | 1,204 | 100.0% |
| **Worked full-time, year-round in the past 12 months** | 130 | 10.8% |
| **Worked part-time or part-year in the past 12 months** | 185 | 15.4% |
| **Did not work** | 889 | 73.8% |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Veteran Status

According to the 2019–2023 American Community Survey estimates, veterans make up 8.7% of Washington County's adult population, approximately 730 individuals. This group is overwhelmingly male (94.7%) and predominantly older, with:

- 31.5% aged 65 to 74,
- 31.2% aged 75 and over.

While most veterans in the County live above the poverty threshold (90.7%), a small subset (9.3%) still fall below the poverty line. Additionally, nearly half of all veterans (44.9%) report having at least one disability. This rate is notably higher than that of the general adult population and emphasizes the need for health, mobility, and support services that address both service-related and age-related limitations.

As Washington County's veteran population continues to age, planning efforts should consider strategies to ensure continued access to accessible facilities, coordinated care, and programs tailored to meet the physical and economic needs of older veterans.

Figure: Figure: Washington County, ACS Veteran Status, 2019-2023

| Description | Estimate | % of Group |
|---|---|---|
| **Total Population 18+** | 8,411 | 100.0% |
| **Population 18+ with Veteran Status** | 730 | 8.7% |
| **Male** | 691 | 94.7% |
| **Female** | 39 | 5.3% |
| **With any disability** | 328 | 44.9% |
| **Without a disability** | 402 | 55.1% |
| **18 to 34 years** | 27 | 3.7% |
| **35 to 54 years** | 124 | 17.0% |
| **55 to 64 years** | 121 | 16.6% |
| **65 to 74 years** | 230 | 31.5% |
| **75 years and over** | 228 | 31.2% |
| **Income in the past 12 months below poverty level** | 68 | 9.3% |
| **Income in the past 12 months at or above poverty level** | 662 | 90.7% |

## Education

Educational attainment levels in Washington County have improved overall between the 2009–2013 and 2019–2023 ACS periods. The most notable shift is the 33.8% decrease in residents without a high school diploma or equivalency, reflecting stronger baseline education levels across the adult population.

The largest numeric gain occurred among those with an Associate's Degree, which more than doubled, rising by 471 individuals (a 108.0% increase). Smaller but meaningful increases were also seen in the number of residents with Bachelor's and Graduate or Professional Degrees.

These changes suggest growing access to post-secondary education and may indicate long-term benefits for workforce readiness, health literacy, and earning potential. For Southwest District Health, these trends support the continued development of education-based health interventions and messaging strategies that align with a moderately advancing educational profile.

Table: Washington County, ACS Change in Educational Attainment 2013 to 2023

| Age | 2013 | 2018 | 2023 | Change # 2013 - 2023 | Change % 2013 - 2023 |
|---|---|---|---|---|---|
| Educational Attainment 25+ | 7,139 | 7,059 | 7,622 | 483 | 6.8% |
| Less than High School Equivalency | 1,298 | 998 | 859 | (439) | -33.8% |
| High School or Equivalency | 2,167 | 2,576 | 2,308 | 141 | 6.5% |
| Some College, No Degree | 2,043 | 2,015 | 2,097 | 54 | 2.6% |
| Associate's Degree | 436 | 427 | 907 | 471 | 108.0% |
| Bachelor's Degree | 831 | 681 | 962 | 131 | 15.8% |
| Graduate or Professional Degree | 364 | 362 | 489 | 125 | 34.3% |
| High School or Higher | 5,841 | 6,061 | 6,763 | 922 | 15.8% |
| Bachelor's Degree or Higher | 1,195 | 1,043 | 1,451 | 256 | 21.4% |
| Educational Attainment 25+ | 7,139 | 7,059 | 7,622 | 483 | 6.8% |

Figure: Washington County, ACS Changes to Educational Attainment, 2013 to 2023

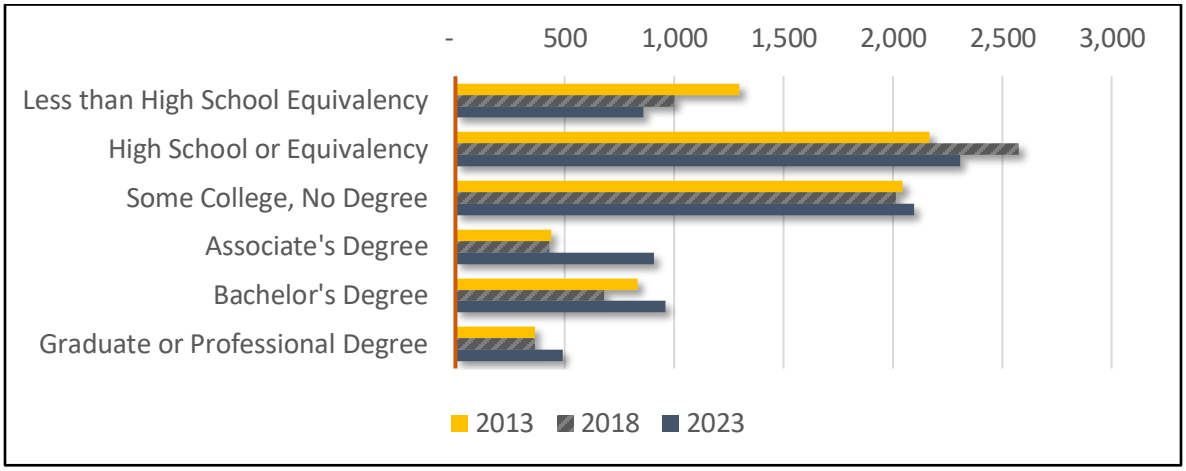
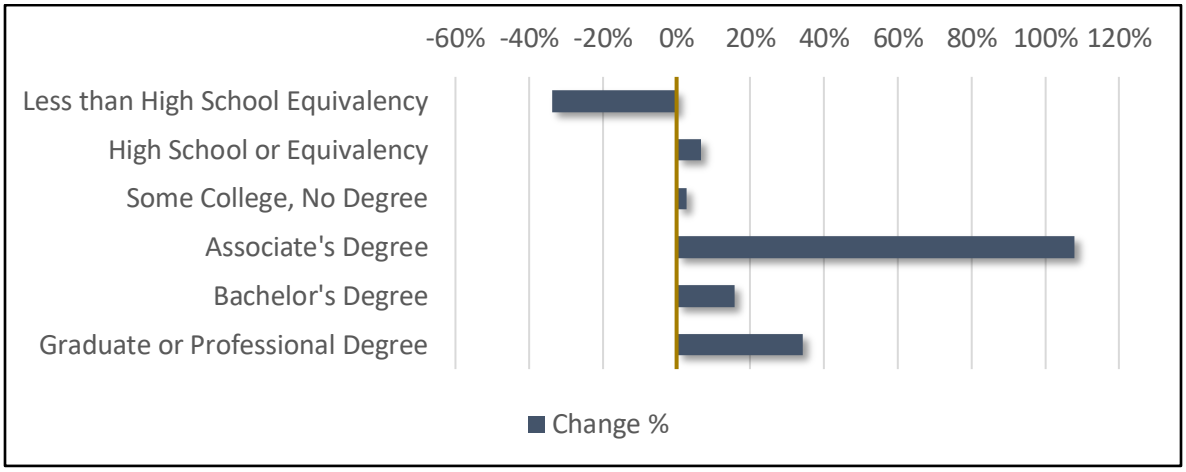



Figure: Washington County, ACS % Change to Educational Attainment, 2013 to 2023



## Conclusion

The demographic landscape of the Southwest District Health (SWDH) service area is experiencing sustained growth, increasing diversity, and shifting age and income structures. As of the 2020 Census, the region reached a population of over 300,000 people across six counties, with projections estimating continued expansion through 2060. This growth, particularly in Canyon and Owyhee counties, is shaped by rising in-migration, increased housing development, and regional spillover from urban centers like Boise.

**Key regional themes include:**

- **Population Growth and Forecasting:** Every County within the District has grown over the past several decades, though the pace and patterns of growth vary significantly. Forecast scenarios anticipate a total population between 470,000 and 565,000 by 2060. These projections should inform long-term health infrastructure planning, emergency preparedness, and workforce development.
- **Aging Population**: All counties are seeing a rise in residents aged 65 and older. In counties like Adams and Gem, older adults now represent over one-quarter of the total population. This trend points to an increasing need for aging-related services, such as chronic disease management, long-term care, transportation access, and home-based support. The District's most recent Community Health Needs Assessment (CHNA) identified access to care, including dental and vision services, as a priority across all counties in the 10-county region. These needs are especially critical for aging populations, as oral health and vision care play a key role in maintaining independence, preventing secondary health issues, and supporting overall quality of life.
- **Income and Poverty Trends:** Median household income has increased across the District, particularly in higher-income brackets. However, poverty persists, especially among children, seniors, and non-working populations. Several counties report poverty rates above 15% and working-age poverty remains substantial where labor force participation is low. These disparities demonstrate the need for targeted interventions to address food insecurity, affordable housing, and access to care.
- **Veteran and Disability Status:** The veteran population, especially those over age 65, faces disproportionately high disability rates across all counties. While most veterans are not living in poverty, disability-related health needs are considerable. The District should consider how public health services can better support physical access, mobility, and specialized care for aging veterans.
- **Educational Attainment and Workforce Implications**: Most counties experienced gains in post-secondary education, but a portion of the population continues to lack high school equivalency. This suggests a continued role for GED access, workforce training programs, and support for adult learners. Higher education levels are associated with improved health outcomes, reinforcing education as a social determinant of health.
- **Housing Dynamics and Household Composition:** Household sizes are increasing in rural counties and shrinking in urban ones, while vacancy rates are declining across the board. Rising housing demand, coupled with tight availability, could constrain access to affordable housing and affect service delivery models, particularly where populations are aging in place.

Taking these together, these demographic shifts point to emerging priorities for SWDH and its partners:

- **Prepare for Aging Service Demands**: Expand access to behavioral health, mobility, and chronic disease support for seniors.
- **Address Persistent Poverty:** Tailor outreach and interventions for non-working populations, low-income families, and children.
- **Adapt Infrastructure for Growth**: Coordinate with cities and counties to align public health facilities, workforce capacity, and housing patterns.
- **Support Education and Workforce Readiness**: Collaborate with local institutions to promote health literacy and job training programs.
- **Monitor Trends and Update Frequently**: Maintain a 5-year cycle for demographic updates to ensure accurate, relevant planning inputs.

This report is designed to inform strategic planning and guide long-term investments in public health infrastructure and programming. By proactively adapting to the evolving needs of its communities, SWDH can continue to fulfill its mission while maximizing the impact of public health investments. Understanding who lives in the District, where, how, and under what conditions, will remain essential to achieving long-term health access and service delivery sustainability.

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# Glossary

**Absolute Growth**
The actual numeric increase (or decrease) in a value over time. For example, if the number of households earning $100,000–$149,999 grows from 4,658 to 16,541, the absolute growth is 11,883 households.

**ACS (American Community Survey):**
An ongoing survey conducted by the U.S. Census Bureau that collects detailed demographic, economic, housing, and social data. The report primarily uses 5-year estimates, which are averages collected over five years to provide reliable data for smaller geographic areas.

**Block Group:**
A geographic unit used by the U.S. Census Bureau, typically containing between 600 and 3,000 people. It is smaller than a census tract and used for analyzing localized data (e.g., income or population density).

**5-Year Estimate:**
A statistical average based on five years of ACS data. These estimates are more reliable for rural or low-population areas than 1-year estimates and help identify trends over time.

**Census (Decennial Census):**
A nationwide population count conducted every 10 years by the U.S. Census Bureau. The 2020 Census is the most recent official headcount referenced in the report.

**Census Tract:**
A small, relatively permanent statistical subdivision of a County used by the U.S. Census Bureau to report data. Tracts typically contain between 1,200 and 8,000 people and are used for regional comparisons.

**Disability (ACS Definition):**
A broad classification used in Census data that includes difficulties with hearing, vision, cognition, walking or mobility, self-care, and independent living.

**Hispanic or Latino (Ethnicity):**
An ethnic category used by the U.S. Census Bureau to describe people of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. People identifying as Hispanic or Latino may belong to any racial group.

**Household Size (Average):**
The average number of people living in a housing unit. Changes in household size can affect housing demand and service delivery needs.

**Housing Unit:**
A house, apartment, mobile home, or group of rooms intended for occupancy as separate living quarters.

**Infrastructure Capacity:**
The extent to which systems such as roads, water, sewer, broadband, and public facilities can support current and future populations.

**In-Migration:**
The movement of people into a region from another location. This can influence population growth and demand for services.

**Labor Force Participation:**
The proportion of the population that is either working or actively seeking work. Low participation can affect poverty levels and economic development.

**Median Age:**
The midpoint of the population's age distribution—half the population is younger than this age, and half is older.

**Median Household Income:**
The middle value of household incomes in a given area. Half of households earn more than this amount, and half earn less. It reflects general economic well-being.

**Modifier (Forecasting):**
An adjustment applied to a trend-based population forecast to reflect recent changes in growth patterns that aren't fully captured by historical averages.

**Occupied Housing Unit:**
A housing unit that is the usual place of residence for one or more people. Includes both owner-occupied and renter-occupied homes.

**Owner-Occupied Housing:**
Housing units where the occupant owns the home, either outright or with a mortgage.

**Population Forecast (Low, Mid, High):**
Projections estimating how much the population may grow over time. "Low" assumes slower growth, "Mid" reflects balanced trends, and "High" assumes continued acceleration.

**Poverty Threshold:**
The income level set by the federal government to determine poverty status. It varies by household size and composition. Individuals or families earning below this threshold are considered to be living in poverty.

**Race:**
A self-identified category in Census data that includes White, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and “Some Other Race.” Individuals may also identify as being of two or more races.

**Relative Growth**

The percentage change in a value over time, showing how much something has increased or decreased in proportion to its original size. For example, if a group increases from 625 to 4,303 households, the relative growth is 588.5%.

**Renter-Occupied Housing:**
Housing units where the occupant pays rent to live in the home.

**Rolling Average:**
A method of averaging data over a moving time window (e.g., 5 years). Used in ACS estimates to smooth out short-term fluctuations in small population areas.

**Trend Analysis:**
A method of examining past data to predict future patterns or needs. Often used for population and housing projections.

**Trend-Based Forecast:**
A projection model that uses historical data to estimate future growth. It does not account for policy changes, birth/death rates, or migration beyond past patterns.

**Underemployment:**
When individuals work fewer hours than desired or are overqualified for their current job. This can still result in economic hardship even if individuals are employed.

**Veteran (ACS Definition):**
An individual age 18 or older who has served in the U.S. Armed Forces, regardless of service period, duration, or discharge type.

**Vacancy Rate:**
The percentage of housing units that are unoccupied at the time of the survey. A declining vacancy rate can signal increased housing demand or limited supply.

**Wraparound Services:**
Comprehensive support services (e.g., transportation, mental health, housing assistance) provided alongside core healthcare or social services, particularly for high-need populations.

# Appendices

## Appendix A: Historical Populations and Trends

| County | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total Population |
|---|---|---|---|---|---|---|---|
| **1970** | 2,877 | 61,288 | 9,387 | 6,422 | 12,401 | 7,633 | **100,008** |
| **1980** | 3,347 | 83,756 | 11,972 | 8,272 | 15,722 | 8,803 | **131,872** |
| **1990** | 3,254 | 90,076 | 11,844 | 8,392 | 16,434 | 8,550 | **138,550** |
| **2000** | 3,476 | 131,441 | 15,181 | 10,644 | 20,578 | 9,977 | **191,297** |
| **2010** | 3,976 | 188,923 | 16,719 | 11,526 | 22,623 | 10,198 | **253,965** |
| **2020** | 4,379 | 231,105 | 19,123 | 11,913 | 25,386 | 10,500 | **302,406** |
| **2013** | 3,937 | 192,153 | 16,722 | 11,474 | 22,629 | 10,094 | **257,009** |
| **2018** | 4,019 | 212,230 | 17,052 | 11,455 | 23,041 | 10,025 | **277,822** |
| **2023** | 4,599 | 242,405 | 19,854 | 12,284 | 26,190 | 10,866 | **316,198** |
| **Change # 1970-2020** | 1,502 | 169,817 | 9,736 | 5,491 | 12,985 | 2,867 | **202,398** |
| **Change % 1970-2020** | 52.2% | 277.1% | 103.7% | 85.5% | 104.7% | 37.6% | **202.4%** |
| **Avg Dec. Change / 10 year** | 300 | 33,963 | 1,947 | 1,098 | 2,597 | 573 | **40,480** |
| **Change #, 2013 to 2018** | 82 | 20,077 | 330 | (19) | 412 | (69) | **20,813** |
| **Change %, 2013 to 2018** | 2.1% | 10.4% | 2.0% | -0.2% | 1.8% | -0.7% | **8.1%** |
| **Change #, 2018 to 2023** | 580 | 30,175 | 2,802 | 829 | 3,149 | 841 | **38,376** |
| **Change %, 2018 to 2023** | 14.4% | 14.2% | 16.4% | 7.2% | 13.7% | 8.4% | **13.8%** |
| **Change #, 2013 to 2023** | 662 | 50,252 | 3,132 | 810 | 3,561 | 772 | **59,189** |
| **Change %, 2013 to 2023** | 16.8% | 26.2% | 18.7% | 7.1% | 15.7% | 7.6% | **23.0%** |
| **10-year Historical Trend** | **300** | **33,963** | **1,947** | **1,098** | **2,597** | **573** | **40,480** |
| **10-year Recent Trend** | **662** | **50,252** | **3,132** | **810** | **3,561** | **772** | **59,189** |
| **10-year Average Trend** | **481** | **42,108** | **2,540** | **954** | **3,079** | **673** | **49,834** |

*Notes: 1970, 1980, 1990, 2000, 2010, and 2020 are decennial values. 2013, 2018, an 2023 are 5-year ACS values.*

## Appendix B: Population Forecast by County

### Low Population Forecast by County

| Year | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total |
|---|---|---|---|---|---|---|---|
| **2020** | 4,379 | 231,105 | 19,123 | 11,913 | 25,386 | 10,500 | **302,406** |
| **2030** | 4,679 | 281,357 | 21,070 | 13,011 | 27,983 | 11,073 | **359,174** |
| **2040** | 4,980 | 315,320 | 22,823 | 14,109 | 30,320 | 11,647 | **399,199** |
| **2050** | 5,280 | 345,887 | 24,575 | 15,208 | 32,658 | 12,220 | **435,828** |
| **2060** | 5,581 | 376,455 | 26,328 | 16,306 | 34,995 | 12,794 | **472,457** |

### Mid Population Forecast by County

| Year | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total |
|---|---|---|---|---|---|---|---|
| **2020** | 4,379 | 231,105 | 19,123 | 11,913 | 25,386 | 10,500 | **302,406** |
| **2030** | 4,860 | 293,920 | 21,663 | 12,867 | 28,465 | 11,173 | **372,948** |
| **2040** | 5,341 | 336,028 | 24,202 | 13,821 | 31,544 | 11,845 | **422,782** |
| **2050** | 5,823 | 378,135 | 26,742 | 14,775 | 34,623 | 12,518 | **472,616** |
| **2060** | 6,304 | 420,243 | 29,281 | 15,729 | 37,702 | 13,191 | **522,451** |

### High Population Forecast by County

| Year | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total |
|---|---|---|---|---|---|---|---|
| **2020** | 4,379 | 231,105 | 19,123 | 11,913 | 25,386 | 10,500 | **302,406** |
| **2030** | 5,041 | 293,920 | 22,255 | 12,926 | 28,947 | 11,272 | **374,361** |
| **2040** | 5,703 | 356,735 | 25,387 | 13,938 | 32,508 | 12,044 | **446,315** |
| **2050** | 6,365 | 406,987 | 28,519 | 14,951 | 36,069 | 12,816 | **505,707** |
| **2060** | 7,027 | 457,239 | 31,651 | 15,963 | 39,630 | 13,588 | **565,098** |

## Appendix C: Historical Census Housing Units

| County | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total Values |
|---|---|---|---|---|---|---|---|
| housing total, 2000 | 1,982 | 47,965 | 5,888 | 4,452 | 7,949 | 4,138 | 72,374 |
| housing total, 2010 | 2,636 | 69,409 | 7,099 | 4,781 | 8,945 | 4,529 | 97,399 |
| housing total, 2020 | 2,642 | 81,013 | 7,563 | 4,719 | 9,684 | 4,514 | 110,135 |
| **Change, 2000 to 2020** | **660** | **33,048** | **1,675** | **267** | **1,735** | **376** | **37,761** |
| housing occupied, 2000 | 1,421 | 45,018 | 5,539 | 3,710 | 7,371 | 3,762 | 66,821 |
| housing occupied, 2010 | 1,748 | 63,604 | 6,495 | 4,076 | 8,262 | 4,034 | 88,219 |
| housing occupied, 2020 | 1,927 | 77,829 | 7,199 | 4,232 | 9,223 | 4,087 | 104,497 |
| **Change, 2000 to 2020** | **506** | **32,811** | **1,660** | **522** | **1,852** | **325** | **37,676** |
| housing vacant, 2000 | 561 | 2,947 | 349 | 742 | 578 | 376 | 5,553 |
| housing vacant, 2010 | 888 | 5,805 | 604 | 705 | 683 | 495 | 9,180 |
| housing vacant, 2020 | 715 | 3,184 | 364 | 487 | 461 | 427 | 5,638 |
| **Change, 2000 to 2020** | **154** | **237** | **15** | **(255)** | **(117)** | **51** | **85** |

## Appendix D: Decennial 2020 Race and Ethnicity, Hispanic or Latino

| County | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total Population | % of Total Population |
|---|---|---|---|---|---|---|---|---|
| Total Population | 4,379 | 231,105 | 19,123 | 11,913 | 25,386 | 10,500 | 302,406 | **100.0%** |
| Hispanic or Latino | 152 | 59,166 | 1,722 | 2,915 | 4,268 | 1,662 | 69,885 | **23.1%** |
| Not Hispanic or Latino | 4,227 | 171,939 | 17,401 | 8,998 | 21,118 | 8,838 | 232,521 | **76.9%** |
| Population of one race | 4,048 | 161,745 | 16,500 | 8,580 | 19,826 | 8,350 | 219,049 | **72.4%** |
| White alone | 3,992 | 155,401 | 16,132 | 8,060 | 19,240 | 8,118 | 210,943 | **69.8%** |
| Black or African American alone | 3 | 1,455 | 29 | 28 | 52 | 17 | 1,584 | **0.5%** |
| American Indian and Alaska Native alone | 27 | 1,176 | 124 | 374 | 163 | 74 | 1,938 | **0.6%** |
| Asian alone | 8 | 1,973 | 99 | 42 | 207 | 81 | 2,410 | **0.8%** |
| Native Hawaiian and Other Pacific Islander alone | - | 620 | 20 | 8 | 31 | 7 | 686 | **0.2%** |
| Some Other Race alone | 18 | 1,120 | 96 | 68 | 133 | 53 | 1,488 | **0.5%** |
| Population of two or more races | 179 | 10,194 | 901 | 418 | 1,292 | 488 | 13,472 | **4.5%** |

*Note: Population totals are either Hispanic or Latino, White, another race, or two or more races to equal 100% of the population.*

## Appendix E: ACS 2019-2023, Workforce by County

Economic/Jobs

| Description | Adams | Canyon | Gem | Owyhee | Payette | Washington | Total |
|---|---|---|---|---|---|---|---|
| **Total Workforce** | 1,760 | 114,357 | 8,886 | 5,224 | 11,153 | 3,934 | 145,314 |
| **Ag, forestry, fishing and hunting, and mining:** | 230 | 3,790 | 475 | 862 | 1,016 | 407 | 6,780 |
| **Construction** | 259 | 13,425 | 1,420 | 781 | 944 | 329 | 17,158 |
| **Manufacturing** | 64 | 11,880 | 779 | 351 | 1,566 | 545 | 15,185 |
| **Wholesale trade** | 58 | 2,552 | 269 | 130 | 257 | 149 | 3,415 |
| **Retail trade** | 330 | 12,965 | 917 | 685 | 701 | 318 | 15,916 |
| **Trans and warehousing, and util:** | 103 | 7,268 | 442 | 226 | 927 | 210 | 9,176 |
| **Information** | 27 | 1,820 | 43 | 41 | 133 | 92 | 2,156 |
| **Finance and ins, and real estate, and rental and leasing:** | 31 | 6,374 | 284 | 182 | 260 | 95 | 7,226 |
| **Prof, sci, and mgmt, and admin, and waste mgmt services:** | 101 | 10,924 | 775 | 257 | 824 | 150 | 13,031 |
| **Edu services, and health care and social assistance:** | 253 | 23,607 | 1,911 | 909 | 2,646 | 925 | 30,251 |
| **Arts, ent, and rec, and accom and food services:** | 157 | 8,426 | 616 | 358 | 466 | 281 | 10,304 |
| **Other services, except public administration** | 35 | 6,209 | 609 | 260 | 539 | 156 | 7,808 |
| **Public administration** | 112 | 5,117 | 346 | 182 | 874 | 277 | 6,908 |

| Director Approvals - July 22 - August 19, 2025 | | |
|---|---|---|
| **Date** | **Item** | **Other** |
| 22-Jul-25 | YouthROC Subgrant to Nampa | $220,000 |
| 22-Jul-25 | YouthROC Subgrant to Nampa | $50,000 |
| 22-Jul-25 | Submitted grant application to Grants.gov | Proposed opioid training and support to rural EMS |
| 22-Jul-25 | Recognition bonus | $1,000 |
| 23-Jul-25 | Change in supervision for NV | |
| 23-Jul-25 | Change in supervision for TD | |
| 23-Jul-25 | Change in supervision for AM | |
| 23-Jul-25 | Public Health Preparedness Cooperative Agreement Subgrant | $402,839 |
| 24-Jul-25 | PO ad design services | $760 |
| 24-Jul-25 | PO annual subscription renewal - Weiser Signal American | $65 |
| 24-Jul-25 | PO replacement computer + accessories | $2,326 |
| 25-Jul-25 | PO Platt electric - facility maintenance | $1,500 |
| 25-Jul-25 | P-card statement (KW) - travel reimbursement | $211 |
| 25-Jul-25 | Cancer Prevention & Control Programs Subgrant | $19,366 |
| 28-Jul-25 | Change in supervision for LM | |
| 28-Jul-25 | Change in supervision for BH | |
| 28-Jul-25 | Purdue Settlement Participation Form (re: opioid settlement) | |
| 28-Jul-25 | PO copy paper & USB adapter | $31.79 |
| 29-Jul-25 | Luma Security Access Request - HR & Payroll roles for MH | |
| 29-Jul-25 | PO Zupas - Treasure Valley public information officers meeting | $909 |
| 30-Jul-25 | Lease agreement (48 mon) - Quadient Leasing - mailing scale | $3,427 |
| 30-Jul-25 | P-card statement (KW) - 988 bumber stickers | $156 |
| 30-Jul-25 | Funding agreement - UWTV - Idaho Oregon Health Atlas | $32,000 |
| 3-Aug-25 | Timesheets for direct reports | |
| 5-Aug-25 | Recruitment bonus - extremely hard-to-fill possion RD | $2,400 |
| 5-Aug-25 | MOA - Central District Health - CatchMyBreath Scantron purchase | $1,190 (D3 share) |
| 5-Aug-25 | MOU - State Hospital West (CatchMyBreath education) | |
| 5-Aug-25 | SPO PAT home visiting supplies | $600 |
| 5-Aug-25 | MOU - limited service, employee SJF | |
| 6-Aug-25 | Invoice - Adams County monthly contribution | $4,956 |
| 6-Aug-25 | Invoice - Canyon County monthly contribution | $204,403 |
| 6-Aug-25 | Invoice - Gem County monthly contribution (July) | $16,664 |
| 6-Aug-25 | Invoice - Gem County monthly contribution (July) | $16,664 |
| 6-Aug-25 | Invoice - Owyhee County monthly contribution | $9,101 |
| 6-Aug-25 | Invoice - Payette County monthly contribution | $20,660 |
| 6-Aug-25 | Invoice - Washington County monthly contribution | $8,215 |
| 7-Aug-25 | P-card statement (ME) - FB meta boosts | $29 |
| 7-Aug-25 | TB Control and Directly Observed Therapy Subgrant, Amd 1 | $12,016 |
| 8-Aug-25 | PO NFP training materials | $6,596 |
| 8-Aug-25 | Change of supervisor for JD | |
| 8-Aug-25 | Change of supervisor for CA | |
| 8-Aug-25 | Telecommuting agreement for VM | |
| 8-Aug-25 | Contract with IdahoSports.com | $9,900 |
| 11-Aug-25 | Recruitment of vacant Office Specialist 2 position (DO) | |
| 12-Aug-25 | MOU - Canyon Springs High School (INDEPTH curricula) | |
| 13-Aug-25 | Telecommuting agreement for BG | |
| 13-Aug-25 | MOU - Nampa School District (INDEPTH curricula) | |
| 13-Aug-25 | PO staff bravo - pullover | $44.53 |
| 14-Aug-25 | P-card statement (ME) - Mail Chimp subscription (SPO) | $180 |
| 15-Aug-25 | Timesheets for direct reports | |
| 19-Aug-25 | P-card statement (KW) - Carpenters | $358 |
| 19-Aug-25 | Change in FTE Status | |
| 19-Aug-25 | Contract with Becky Wolery | $646 |
| 19-Aug-25 | Disease Investigation and Reporting to BCDP - Subgrant, Amd. 5 | $-3,260 (from $390,001 (5yr period)) |

AUGUST 19, 2025

# SWDH PENDING GRANT APPLICATIONS

| Board of Health Report - Grant Applications in Progress | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| Pending | Reg 10 EPA Thriving Communities | District 3 residents that are installing or replacing a waste water system | 1-Oct-25 | 30-Sep-27 | $338,089 | $238,390 | $55,600 | $293,990 | 15% | No | | No |
| Brief proposed scope of work: Collect 300 water samples from wells, test for contaminates, evaluate results, & inform future water quality initiatives in District 3 | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| Pending | Rural Communities Opioid Response-Overdose Response HRSA-25-010 | Payette County | 1-Oct-25 | 30-Sep-26 | $267,719 | $182,859 | $49,940 | $232,799 | 15% | No | | No |
| Brief proposed scope of work: Diversion Program for SUD that is arrested. | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| In Process | Bayer Education Fund | WIC Clients | 1-Oct-25 | 30-Sep-26 | Not determined yet | Unk | Unk | Unk | 15% | No | | No |
| Brief proposed scope of work: Nutrition Education WIC | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| Pending | Opioid Funds City of Nampa | 18-24 year olds in Nampa | 10/1/2025 | 9/30/2026 | $25,000 | - | - | $25,000 | 15% | No | | Nampa residents |
| Brief proposed scope of work: 100 hours of counselling for uninsured individuals with mental health and/or SUD | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| In Process | Idaho Youth Assessment Ctrs | 12-17 year olds | 10/1/2025 | 9/30/2029 | Not yet determined | Unk | | | 15% | No | | No |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | YouthROC (SAMHSA) | | | | about $500,000 | | | | | | | |
| Brief proposed scope of work: Continuation of YouthROC; Youth assessment and treatment for mental health issues | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| In Process | Idaho Rural Health Access Grant | Adults | 10/1/2025 | 9/30/2026 | $35,000 | $20,000 | $15,000 | $35,000 | 15% | | | |
| Brief proposed scope of work: Increase access to primary health care in rural SWDH locations | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| Pending | First Responder Comprehensiv e Addiction and Recovery Act (FR-CARA) (SAMHSA) | All ages, rural community not yet identified | 10/1/2025 | 9/30/2029 | $585,676 | $140,982 | $444,694 | $585,676 | 15% | No | | No |
| Continue community and first responder education for overdose response and distribution of overdose response kits | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| In Process | Forever Idaho - Idaho Community Foundation | WICHC board | 10/1/2025 | 9/30/2026 | $10,000 | - | $10,000 | $10,000 | 15% | | | No |
| Brief proposed scope of work: WICHC gen operating and strategic planning | | | | | | | | | | | | |
| **STATUS** | **Description ALN Name** | **Target Population** | **Expected Effective Date** | **Expected Expiration Date** | **Requested Funding Amount** | **Perso-nnel Funding** | **Operat-ing Funding** | **Perso-nnel & Operat-ing** | **Allow-able Indirect %** | **Match Rqd** | **Match $** | **Restric-tions** |
| In Process | Forever Idaho - Idaho Community Foundation | Youth 12-17 | 10/1/2025 | 9/30/2026 | $10,000 | - | $10,000 | $10,000 | 15% | | | No |
| Brief proposed scope of work: YouthROC support for mental health assessments of youth (supplement subgrant for assessments) | | | | | | | | | | | | |

AUGUST 19, 2025

# SWDH AGREEMENTS

| Board of Health Report - Agreements | | | | | | |
|---|---|---|---|---|---|---|
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Division of Occupational & Professional Licenses | Government | Services Agreement | $100/inspection | District Dollars (Indirect) | 4/14/2025 | N/A |
| DIVISION SCOPE OF WORK<br>1. The Division will conduct annual building inspections of the Public Health Districts' facilities. These inspections will be conducted in substantial accord with the codes adopted in Idaho Code 39-4109, 39-4116, 39-9701, 54-1001, 54-2601, and 54-5001, with any amendments adopted by the Division boards in Idaho Administrative Rule Chapters 24.39.10, 24.39.20, 24.39.30, and 24.39.70.<br>2. When performing its services, the Division will notify the relevant Public Health District of the results of the annual inspection within 60 calendar days of inspection completion. Those results will include identifying any violations or non-complying installations and will sufficiently identify corrections that are necessary to comply with relevant adopted codes.<br>3. The Division will be available during regular business days and hours to respond to inspection-related questions. The Division will schedule as staff availability allows, however, frequency will be no less than usual. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| State Controllers Office | Government | Services Agreement | $60,361 (variable year-to-year) | District Dollars (Indirect) | 3/1/2024 | 6/30/2029 |

3.1.1 The State Controller will process payroll for the PHDs using the State Controller's regular procedures for state agency payroll. Such procedures shall include:
a. Processing payroll on a biweekly basis, with a Sunday through Saturday workweek and pay issued in arrears by one (1) pay period.
b. Issuing payroll using direct deposit, unless a PHD employee is exempted from direct deposit by the State Controller. The PHDs shall ensure that all PHD employees not exempted are participating in direct deposit under the terms of the State Controller's Mandatory Direct Deposit Policy.
c. The PHDs shall utilize the existing deduction structure of the State Controller, including retirement and health benefit deduction coding. This may exclude the social security deductions.
3.2 Leave Use and Accrual. The State Controller will maintain leave balances for PHD employees using Luma. The PHDs shall be solely responsible for ensuring PHD employees code leave taken and time worked in accordance with the policies of the PHDs, Idaho law, and procedures and codes established by the State Controller. Leave balances will be maintained as follows:
3.2.1 Current Balances. Sick leave, vacation leave and compensatory leave balances accrued by PHD employees prior to March 1, 2022, will continue to carry forward after such date. All such accrued leave balances have been accepted by the PHDs for use by its employees after March 1, 2022, in accordance with this Agreement.
3.2.2 Sick Leave. Sick leave for eligible PHD officers and employees will accrue at the same rate and under the same conditions as is provided in Idaho Code sections 59-1605 and 67-5333 for non-classified state employees, with the following exceptions:
a. Reinstatement of sick leave credits in the event a PHD employee returns to PHD employment within 3 years of separation under Idaho Code 67-5333(1)(c), is allowed among the PHDs. If a PHD employee returns to state employment before February 28, 2025, sick leave balances accrued before March 1, 2022 may be reinstated. State agencies are not permitted to accept the transfer of sick leave credits accrued by PHD employees after March 1, 2022.
b. PHD employees may donate, or transfer sick and vacation leave from one employee to another to the same extent and under the same conditions a non- classified state employee may donate or transfer sick and vacation leave; however, such a donation or transfer may only be made between and among eligible PHD employees. State agencies are not permitted to accept the donation or transfer of sick or vacation leave from a PHD or its employee.
c. PHDs and their employees may participate in the sick leave account maintained by the Public Employee Retirement System of Idaho (PERSI) and the unused sick leave benefit upon retirement as provided in Idaho Code section 67- 5333(2), as permitted and under terms and conditions established by PERSI.
3.2.3 Vacation Leave. Vacation leave for eligible PHD officers and employees will accrue at the same rate and under the same conditions as is provided in Idaho Code sections 59- 1606 and 67-5334 for non-classified state employees. The PHDs warrant the State Controller that the Fair Labor Standards Act (FLSA) classifications of its employees that have been provided are correct. The donation and transfer of vacation leave may only be made between and among eligible PHD employees under the same conditions and limitations set forth in Section 3.2.2 b.
3.2.4 Compensatory Time. PHD officers and employees will receive cash or accrue compensatory time for overtime work at the same rates and under the same conditions as is provided in Idaho Code section 59-1607 for non-classified employees. The parties recognize that a PHD employee's classification under the provisions of the FLSA determines the method and amount of compensation for overtime worked. The PHDs warrant the State Controller that the FLSA classifications of its employees that have been provided are correct.
a. Paying cash compensation for overtime work for eligible PHD employees during unusual or emergency situations or disasters under Idaho Code sections 59-1607(5) and (7) does not require prior approval from the State Board of Examiners, unless state funds appropriated by the Legislature are used to pay such compensation, or otherwise required by law.
3.2.5 PHD Leave Policies. On or before March 1, 2022, the PHDs shall establish and provide to the State Controller written policies and procedures for the payout, transfer, and use of sick leave, vacation leave, and compensatory time upon separation from employment within the parameters of Idaho statutes and this Agreement. It is the responsibility of the PHDs to provide significant updates to leave policies as they occur.
3.2.6 Credited State Service (CSS) Hours. As of March 1, 2022, PHD employees will no longer accrue CSS under Idaho Code sections 67-5332 and 59-1604. PHD employees may continue to earn credited service for continued employment with a PHD, under terms and conditions established by the PHDs, and which may be substantially equivalent to Idaho Code for state employees, PHD credited service may be used for the purposes of determining the accrual of vacation leave, sick leave, and other applicable purposes consistent with this Agreement and Idaho Code to include PERSI.
3.3 Earnings Codes and Time Worked. The State Controller will maintain, through the use of Luma, earnings codes for time worked by PHD employees. The PHDs shall be solely responsible for ensuring PHD employees code their time worked in accordance with the policies of the PHDs, Idaho law, and the procedures and codes established by the State Controller.

3.5 Payroll Deduction Processing.
3.5.1 The State Controller will process the following payroll deductions for the PHDs in accordance with the State Controller's procedures for such deductions as if the PHDs were an agency of the State of Idaho during the term of this Agreement:
a. Public Employee Retirement System of Idaho (PERSI) employer and employee deductions, including the PERSI unused sick leave deduction, as applicable.
b. Tax deferred retirement plan employee deductions as established by PERSI (PERSI Choice 401(k)) and the State Legislature for state employees (457 Deferred Compensation). The deductions are calculated based on the PHD employee's voluntary participation in one or more of those plans;
c. Office of Group Insurance health, dental and life insurance deductions. The deduction rates are those established by the State Department of Administrations for State of Idaho employees;
d. Office of Group Insurance flexible spending account deductions. The deduction rates are those established by the State Department of Administration for State of Idaho employees;
e. Workers compensation insurance deductions;
f. Unemployment insurance deductions;
g. Voluntary deductions approved the State Controller; and,
h. Garnishments and other deductions as required by law.
3.5.2 Notice of Garnishments. In the event a PHD is served a notice of garnishment from any court of competent jurisdiction for garnishment of any obligation owning to any PHD employee (wages, salary, payment for service), the PHD shall immediately provide the State Controller, without delay, the notice of garnishment and all papers served concurrently with the notice, including any fee provided for garnishment, so the State Controller can properly answer and return such warrant.
3.6 Payroll Taxes and Governmental Deductions. The State Controller will process payroll and tax deductions under the PHDs individual EINs as established after March 1, 2022. For calendar year 2023, the state controller will provide W-2s under the state EIN and PHD EINs for all PHD employees. From calendar year 2024 forward, the State Controller will provide single W-2s for all PHD employees under the PHD individual EINs.
3.6.1 Social Security Coverage. At the time of this Agreement, the State Controller is working with the PHDs to establish their continued participation in social security coverage under the Social Security Act. Deductions for social security for one or more of the PHDs may change as a result of each PHDs desire to continue coverage.
3.7 Employee and Employer IRS Forms. At the completing of each calendar year, the State Controller will prepare W-2 and 1095C forms through the conclusion of the Final State Pay period for each Calendar Year this Agreement is in effect, and until this Agreement is terminated or expired. The forms shall be prepared and made available to the PHDs with reasonably sufficient time to allow the PHDs to transmit its forms using its own Employer Identification Number to the Internal Revenue Service before the legally required deadlines, but no later than the time the State prepares its own forms for transmittal. The State Controller shall provide communication and notice to the PHDs leading up to final preparation of the forms required by the section.
4. Accounting Services.
4.1 Accounts with the State of Idaho, Office of the Treasurer. During the term of this Agreement, the PHDs shall maintain an account or accounts at the State of Idaho, Office of the Treasurer with sufficient funds to process payroll and to issue payments and warrants contemplated by this Agreement. The State Controller shall maintain records of deposits and distributions from such account(s) using the same processes and procedures used for State of Idaho accounts at the Office of the Treasurer.
4.2 Luma and Web-based Applications. The PHDs shall follow all State Controller policies and procedures concerning the security access to the State Controller's accounting systems and shall abide by all statewide accounting policies regarding its use, including, but not limited to, policies for financial reporting of transactions, reconciliation, encumbrances, and use of purchase cards.
4.3 IRS 1099 MISC and NEC Reporting. At the completing of each calendar year, the State Controller will prepare 1099 Miscellaneous and Non-Employee Compensation reporting for the PHDs for each Calendar Year this Agreement is in effect, and until this Agreement is terminated or expired. The forms shall be prepared and made available to the PHDs with reasonably sufficient time to allow the PHDs to transmit its forms under its own federal tax identification number(s) to the Internal Revenue Service before the legally required deadlines, but no later than the time the State prepares its own forms for transmittal. The State Controller shall provide communication and notice to the PHDs leading up to final preparation of the forms required by the section. Upon the termination of this Agreement, the PHDs will continue to have access to review, approve, or revise its financial reporting for a reasonable period, but not less than the State Controller's retention period for such records.
4.4 Closing Summary of Accounts. Upon the termination of this Agreement, the State Controller will provide the PHDs with a summary of accounts and balances as of the date of termination. The PHDs and the State Controller will meet and confer concerning any discrepancies between PHDs' records and the State Controller's records. If additional

reconciliation or records are requested by the PHDs, the State Controller will provide a time and cost estimate for any such services.
4.5 P-Cards. In the event the PHDs intend to continue the utilization of the purchase card (P-Card) agreement offered to state agencies through the Department of Administration, the PHDs shall independently contract for that service with the Department of Administration. The PHDs shall abide by the State Controller's statewide policies regarding reporting and reconciling P-Card transactions on the current STARS system and the Luma financial system once implemented, the same as an agency of the state.
4.6 Annual Comprehensive Financial Report. Both parties acknowledge that the PHDs are not required to be included in the State of Idaho's fiscal year-end Annual Comprehensive Financial Report (ACFR). As such, the PHDs will not be required to submit closing packages at fiscal year-end.
4.7 Travel Reimbursements. The PHDs will have access to use the full functionality of the Luma module (XM) used by state agencies for reporting and reimbursement of employee business related travel, including meal per diem, mileage, lodging, and other allowable travel reimbursement items. The PHDs understand that the Luma module (XM) for business related travel will be configured to the meal per diem rates, mileage and allowable travel expenses as allowed by the Statewide Travel Policy and Procedures approved by the Idaho State Board of Examiners.
5. Billing for Services.
5.1 From the effective date of this Agreement until June 30, 2026, the PHDs will continue to pay each year the annual amounts calculated for their allocated share of costs under the State of Idaho's Statewide Cost Allocation Plan provided under Idaho Code section 67-353, for the services provided under this Agreement. The PHDs will continue to receive notice of their annual costs from the State Division of Financial Management and shall pay said amounts in the same manner and time as if they were a state agency.
5.2 The State Controller will be seeking approval of a new cost recovery model for its new Luma system by the Idaho State Legislature. The new cost recovery model will be designed to recover only the costs of operating the new system, which are not known at the time of executing this Agreement. Beginning July 1, 2026, the cost of services provided by the State Controller under the terms of this Agreement will be calculated under the new cost recovery model approved by the State Legislature for state agencies. The PHDs shall receive adequate notice of such cost and shall pay said amounts in the same manner and time as if they were a state agency.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Department of Environmental Quality | Government | MOU | N/A | Subgrant, District Dollars, & Fee Revenue | 4/22/2021 | N/A |

1. The DEQ and the Districts will work cooperatively in the preparation of rules, standards, technical policies, or guidelines in those program areas where joint responsibilities exist.
2. The DEQ will send draft documents outlined in Item 1 to the Districts for a thirty (30) day, when feasible, review and comment period prior to any formal public process.
3. The Districts will forward to the DEQ proposed draft changes to rules, standards, technical policies or guidelines following the procedures outlined in Item 2 above. This is in addition to the district board procedures for adoption of regulations as set forth in Idaho Code § 39-416.
4. The DEQ, or the Districts, will provide copies to each other of final rules, standards, technical policies, or guidelines adopted. This procedure is in addition to the requirements of the Administrative Procedures Act. Also, the DEQ will provide specific direction to the Districts regarding the implementation of DEQ final rules, standards, technical policies, and guideline changes for programs delegated to the Districts. This direction will be provided to the Districts in a timely manner.
5. The Districts, if requesting a formal interpretation of rules or guidance, will submit the request to the appropriate DEQ Bureau Chief. The Bureau Chief, in coordination with the Attorney General's office as appropriate, will draft a response and share that with the Districts. For those interpretations with statewide applicability, the DEQ Bureau Chief will ensure that the response is in a memo form and can be posted online in keeping with Executive Order 2020-02. This does not include normal day to day communications between the Health Districts and DEQ staff regarding implementation of the rules.
6. Upon initiation of an appeal of a District decision regarding a DEQ-delegated program, the District should notify the DEQ state office program contact of the administrative appeal for the DEQ's evaluation to ensure consistent application of the DEQ rules. The DEQ, when appropriate, will provide interpretation of the DEQ rules to the District for consistency.

4.3 Coordinating Enforcement Actions
1. The Districts will take appropriate and timely enforcement actions as outlined within the specific protocols in this MOU. The DEQ may initiate enforcement actions after an enforcement referral package is received from the Districts.
2. The DEQ reserves the right to initiate enforcement actions if DEQ determines, after consultation with the Districts, that enforcement is necessary to protect public health and the environment. The DEQ will coordinate with the Districts in the event the DEQ determines it necessary to take such enforcement action.
3. The DEQ may request the Attorney General's Office provide legal consultation to the District's legal counsel when the District is preparing for cases in district court.
4. The DEQ will provide revisions of enforcement referral package templates, as appropriate, for subsurface sewage and non-municipal solid waste programs.

4.4 Management of Complaints
This section outlines the actions the DEQ and the Districts will take when receiving complaints that are the responsibility of the other agency.
1. Complaints, which are the responsibility of the other agency, will be referred to the other agency within one working day. Either agency, upon receiving a telephoned complaint, will refer the caller to the appropriate agency. Written complaints will be forwarded to the appropriate agency by fax, e-mail or mail and include the complainant's contact information whenever possible.
2. In referring complaints, one agency will not commit the other agency to any particular action.
3. If the agency referring a complaint requests notification of what actions were taken by the other agency, that agency will provide the information to the referring agency.
4. The DEQ may request that the Districts provide initial support for complaints generated in remote areas.

4.5 Consultations and Technical Assistance
This section defines when the agencies will provide technical assistance and consultation.
1. Each agency, within its resource limitations, will provide consultations, training, and technical assistance to the other upon request.
2. The DEQ will inform the Districts of pertinent training courses and vice versa, such as courses related to drinking water systems, subsurface sewage, solid waste, wastewater land application, hazardous wastes, septage, ground water quality, surface water quality, and source water protection.
3. The Districts will work with the DEQ to develop and present training courses of mutual interest.

| Agreement Partner | Type of Partner (Non-profit, For- | Type of Agreement | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|

| | profit, Government) | (MOU, MOA, BAA) | | | | |
|---|---|---|---|---|---|---|
| Idaho Association of Public Health District Directors | Government | MAA | NA | Situation Dependent | 4/5/2023 | NA |

This agreement has been developed to address both emergency and non-emergency needs where one district requests resource aids from one or more other districts.
This agreement shall constitute a joint exercise of powers authorized pursuant to Idaho Code §67-2328. The District Director will contact other District Directors by phone to make the initial request, followed by an e-mail request. Should the Director not be available, the Management Assistant will be contacted by phone. Based upon the urgency or the request, the requesting Director may use StateComm to request the other District be "Paged Out".
A District, through a mutual agreement with another District, may provide services for that District in isolated areas that are more accessible to it. Compensation for services and enforcement responsibilities would be addressed in the agreement.
II. RESPONSE TO REQUEST
The District Director receiving the request will respond to the requesting Director using the protocols outlined above.
The District Director receiving a request shall determine if the Health District has equipment and personnel available lo respond to the request. Every effort shall be made to provide assistance to the requesting District. In the event the needed equipment and/or personnel arc not available, the requesting District will be notified. Each District Director must assess the needs of their own District first before consideration of providing aid to another District. If, in the course of an event in a host District, the responding District may withdraw aid to a host District if events unfold which requires resources to be brought back to the responding District. Each Responding District agrees to provide services during a declared disaster or emergency situation without compensation for an initial response period of up to 72 hours including travel time to the Host District's assigned work station, if required. After the initial response period, the Host District shall reimburse the Responding District for the actual costs incurred during the time that services are provided, in accordance with the Responding District's fiscal policies. The Host District shall reimburse the Responding District for all operational costs associated with the request for assistance, such as wages, mileage, meals, supplies, lodging, etc.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Idaho Association of Public Health District Directors | Government | Interagency Agreement | NA | NA | 4/1/2022 | NA |

Health districts agree they will transfer and accept transfer of accrued balances through SCO's personnel system of sick and vacation leave upon transfer within three days of separation of an employee from one public health district (PHD) to another PHD. No other balances of any form of leave (accrued compensatory time-off, accrued on-call time, etc.) shall be eligible for transfer from one PHD to another PHD.
Each PHD agrees to voluntarily allow employees of their PHD to transfer and accept transfer of sick and vacation leave for the purpose of leave donation where an employee with a qualifying medical condition needs donated leave. Such donations will follow SCO procedures and guidance regarding leave donation.
Each PHD agrees they will assume financial liability for all leave transfers.
If an employee of a PHD leaves employment for a period of less than three years and then is reinstated in the same or another PHD, their sick leave balance will be reinstated.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Department of Health and Welfare | Government | MOU | NA | Subgrants, District Dollars, Fee Revenue | 3/22/2022 | NA |

4. General Program Agreements

4.1 General Principles

This section sets forth that communication and coordination on various topics is critical to promoting, protecting, and improving the health of the public.

The Districts and DHW will convene in periodic joint meetings, as appropriate, to ensure statewide consistency in all assigned programs.

DHW will notify the Districts of all public meetings and hearings pertaining to assigned programs when needed, with the expectation that the Districts will participate.

Districts and DHW will notify DHW each other of policy changes, staffing changes, and capacity restraints that impact the ability to fully execute protocols A, B, and C.

4.2 Rules, Standards, Technical Policies, and Guidelines

Whenever feasible, DHW and the Districts will work cooperatively in the preparation of rules, standards, and to the extent possible, technical policies or guidelines in those program areas where joint responsibilities exist.

DHW will send draft documents outlined in Item 1 to the Districts for a thirty (30) day, when feasible, review and comment period prior to any formal public process.

The Districts will forward to DHW proposed draft changes to rules, standards, technical policies or guidelines following the procedures outlined in Item 2 above. This is in addition to the district board procedures for adoption of regulations as set forth in Idaho Code § 39-416.

DHW will provide copies of final rules, standards, technical policies, or guidelines adopted. This procedure is in addition to the requirements of the Administrative Procedures Act. Also, the DHW will provide specific direction to the Districts regarding the implementation of DHW final rules, standards, technical policies, and guideline changes for programs delegated to the Districts. This direction will be provided to the Districts in a timely manner.

The Districts, if requesting a formal interpretation of rules or guidance, will submit the request to the appropriate DHW programmatic Bureau Chief. The Bureau Chief, in coordination with the Attorney General's office as appropriate, will draft a response and share that with the Districts. For those interpretations with statewide applicability, the DHW Bureau Chief will ensure that the response is in a memo form and can be posted online in keeping with Executive Order 2020-02. This does not include normal day to day communications between the Districts and DHW staff regarding implementation of the rules or assigned programs.

Upon initiation of an appeal of a District decision regarding an assigned program, the District should notify the DHW state program contact of the administrative appeal for DHW's evaluation to ensure consistent application of the DHW rules. DHW, when appropriate, will provide interpretation of the DHW rules to the District for consistency.

4.3 Coordinating Enforcement Compliance Actions

The Districts will take appropriate and timely enforcement actions for each programmatic area.

DHW reserves the right to initiate enforcement actions if DHW determines, after consultations with the Districts, that enforcement is necessary to preserve and protect the public health. DHW will coordinate with the Districts in the event DHW determines it necessary to take such enforcement action.

DHW may request the Attorney General's Office provide legal consultation to the District's legal counsel when necessary.

4.4 Management of Complaints

This section outlines the actions DHW and the Districts will take when receiving complaints that are the responsibility of the other agency.

Complaints, which are the responsibility of the other agency, will be referred to the other agency within one (1) working day. Either agency, upon receiving a telephoned complaint, will refer the call to the appropriate agency. Written complaints will be forwarded to the appropriate agency by fax, email, or mail and include the complainants contact information whenever possible.

In referring complaints, one agency will not commit the other agency to any particular action.

If the agency referring a complaint requests notification of what actions were taken by the other agency, that agency will provide the information to the referring agency.

4.5 Consultations and Technical Assistance

This section defines when the agencies will provide technical assistance and consultation.
Each agency will provide consultations, training and technical assistance to the other upon request or when needed.
At the Districts' request, DHW may deploy state-level staff as needed to ensure full execution of responsibilities described in protocols A, B, and C.
DHW and the Districts will inform each other of pertinent training and education courses pertaining to the assigned programs.
DHW and the Districts will work collaboratively to develop and present training courses of mutual interest and need.

4.6 Sharing and Dissemination of Information
This section defines procedures for information sharing between agencies and to the public.
Agency Information Sharing
DHW will assist the Districts in joint program communications, including the development of information or educational materials, as necessary.
The Districts will make requests to DHW for the areas in which communication support to community members or stakeholders is needed.
DHW and the Districts will inform each other of correspondence received from other state and/or federal agencies which concern activities related to the assigned programs. This could include other state of Idaho agencies or agencies representing other states.
DHW and the Districts shall exchange data as specified in subgrants, contracts and/or protocols of this MOU.
Information to the Public
Risk communication is an important public health aspect of sharing and disseminating information related to the protection of public health. DHW may seek assistance from the Districts to help deliver prepared critical public health messages.

4.7 Coordination of Programs
Representatives of the Districts will work with appropriate representatives of DHW when problems of mutual concern arise for which no agreement has been detailed in this document to determine a course of action.
In addition to this MOU, the Districts and DHW will coordinate activities as specified in subgrants and contracts, as appropriate.
Routine program meetings and discussions are desirable and expected for both the Districts and DHW.
Districts will share this MOU with appropriate agency staff.

5. Protocols for Specific Programs
The roles and responsibility of DHW and the Districts, and the mutually agreed upon assignment of authority from DHW to the Districts, with respect to specific programs are set forth in the following listed Protocols that incorporated, as a part of the MOU:
Communicable Disease Control
Food Safety and Inspection
Public Swimming Pool Inspection

This MOU shall be executed by the DHW Division of Public Health Administrator and the Public Health District Directors and replaces any prior memorandum or agreement related to the coordination of public health action and the exchange of information in the assigned program areas, excluding program-specific sub-grants. The terms of this agreement shall be on-going unless otherwise revoked by any one of the signatory agencies following thirty (30) days written notice from the DHW Division of Public Health Administrator or the Chairman of the Idaho Association of Public Health District Directors. This agreement may be amended or extended through mutual written agreement of the parties. This agreement, when accepted by each agency, will be effective on the date of the DHW Division of Public Health Administrator's signature.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Department of Human Resources | Government | MOA | Cost dependent on training | Situation Dependent | 12/2/2024 | NA |

DHR Training Programs. DHR will provide access to the PHDs to register and attend the following DHR training programs:
• Crucial Conversations for Mastering Dialogue®
• Crucial Conversations for Accountability ®
• Crucial Conversations for Add-On®
• Getting Things Done®

Costs and Billing for Services. PHDs will pay for DHR training programs based on the attached fee schedule (See Attachment A). The program fees listed in Attachment A do not include the cost of class materials or the Certified Public Manager (CPM) Program participation fees. CPM participation is allowable under this Agreement, but subject to the CPM application, approval, and program fee requirements.

| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
|---|---|---|---|---|---|---|
| Office of Group Insurance | Government | Services Agreement | NA | All revenue sources contributed to OGI employee benefits | 3/1/2022 | until terminated |

OGI will procure and maintain the types of group insurance, group annuity, and health care service coverage set forth below, for the officers and employees of Contracting Employer:

- Medical (includes prescription drug coverage, vision and Employee Assistance Program) Dental
- Flexible Spending Accounts
- Basic Life (including Accidental Death & Dismemberment) Voluntary Term Life

The policies of Group Insurance provided under this Agreement will be identical to those policies provided by OGI to active State of Idaho employees.
Costs and Payment
On or before the fifth (5th) day of each month, Contracting Employer shall pay OGI for Contracting Employer's premiums, surcharges and administrative contributions set fo1th below. The Contracting Employer shall pay premiums, surcharges, and administrative contributions in advance for the following month. The Contracting Employer shall submit stabilization reserve payments upon the initiation of pa1ticipation in the Group Insurance and upon resumption of participation following the exclusion period set fo1th in section 5(c)(ii) of this Agreement. Medical (includes prescription drug coverage, vision and Employee Assistance Program) Dental, Flexible Spending Accounts, Basic Life (including Accidental Death & Dismemberment) Voluntary Term Life.

| **Agreement Partner** | **Type of Partner (Non-profit, For-** | **Type of Agreement** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| | **profit, Government)** | **(MOU, MOA, BAA)** | | | | |
| Nampa Family Justice Center | non-profit | MOU | NA | Subgrant | 7/1/2024 | NA |
| Southwest District Health (SWDH) is a current MOU partner providing funding for teen assessment and mentoring services in Canyon County. SWDH developed the Southwest Youth Collaborative to help connect youth at risk of entering foster care or the criminal justice system to mental health providers and case managers who work to minimize risk factors and enhance protective factors. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Youth Rising | non-profit | MOU | NA | NA | 1/1/2024 | NA |
| MOU between YouthROC and youth Rising programs outlining agreed upon referral pathways for youth accessing the Youth Rising Drop In Center. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Central District Health | Government | Interagency Agreement | NA | NA | 3/28/2025 | NA |
| CDH will provide PAT services in eastern Owyhee County and eastern Adams County | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Crisis Intervention Collaborative | Agency Collaborative | MOU | NA | NA | 4/12/2024 | 4/30/2027 |

The Parties agree to work cooperatively to:
1. Improve how health care and criminal justice systems respond to people with mental illness and/or addiction.
2. Decrease the proportion of people with behavioral health concerns in the county jail.
3. Decrease incarceration and/or criminalization of people with behavioral health illness.
4. Decrease behavioral health calls for law enforcement officers.
5. Increase safety and security for all consumers, law enforcement, and community members.
6. Enhance law enforcement knowledge about and increase skills in their interactions with people experiencing behavioral health concerns.
7. Enhance the relationships between law enforcement departments and behavioral health providers and community agencies.
8. Participate in evaluation of the Parties CITC goals and outcome measures.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Women, Infant and Children (WIC) | Government | MOU | NA | Subgrant | 3/1/2025 | 3/1/2028 |
| The information shared between programs will be used for the purpose of program referral and potential enrollment for NFP, PAT and WIC | | | | | | |

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Michelle Mothersill (CRP) | Individual | MOU | NA | State grant | 6/16/2025 | NA |
| MOU outlines the responsibilities of IDHW and panel member, reporting procedure if data is breached. | | | | | | |

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Lori Rainboth (CRP) | Individual | MOU | NA | State Pass Through | 4/13/2023 | NA |
| MOU outlines the responsibilities of IDHW and panel member, reporting procedure if data is breached. | | | | | | |

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Abby Levario (CRP) | Individual | MOU | NA | State Pass Through | 6/17/2025 | NA |

| | | | | | | |
|---|---|---|---|---|---|---|
| MOU outlines the responsibilities of IDHW and panel member, reporting procedure if data is breached. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Jeannie Strohmeyer (CRP) | Individual | MOU | NA | State Pass Through | 6/19/2025 | NA |
| MOU outlines the responsibilities of IDHW and panel member, reporting procedure if data is breached. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Elisha Horrock(CRP) | Individual | MOU | NA | State Pass Through | 6/25/2025 | NA |
| MOU outlines the responsibilities of IDHW and panel member, reporting procedure if data is breached. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Tiffany Ruiz (CRP) | Individual | MOU | NA | State Pass Through | 6/25/2025 | NA |
| MOU outlines the responsibilities of IDHW and panel member, reporting procedure if data is breached. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| St. Luke's Health System | Non-profit | Lease Agreement | $11,262.50/month | Lease Agreement | 7/11/2023 | 7/10/2028 |
| Lease agreement with St. Luke's (building owner) at 308 E Hawaii Avenue for the youth crisis center. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |

| | | | | | | |
|---|---|---|---|---|---|---|
| PLB Acquisitions LLC | For profit | Lease Agreement | $5,056.96/month | Lease Agreement | 12/20/2023 | 12/19/2028 |

Lease agreement with PLB Acquisitions LLC (building owner) at 524 Cleveland Blvd #160 in Caldwell for the adult crisis center.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Northwest Nazarene University | Non-profit | MOU | NA | NA | 1/1/2022 | NA |

I. MUTUAL RESPONSIBILITIES:
A. The FACILITY will accept STUDENTS selected by the PROGRAM for a period of clinical education experiences. The nature of the experiences shall be individually arranged by the clinical education coordinator of the FACILITY within the stated philosophies and objectives of the PROGRAM and the FACILITY.

B. The rules and regulations of the FACILITY shall be applicable to the assigned STUDENT.

C. The PROGRAM and FACILITY do not consider the STUDENT an employee of the FACILITY, but a STUDENT in the clinical education phase of the STUDENT'S professional education.

D. The PROGRAM maintains the privilege to visit the FACILITY before, during, and after the internship period.

E. The PROGRAM and the FACILITY will comply with the Family Educational Rights and Privacy Act (Buckley Amendment) in maintaining student records, restricting access to student records to those employees of the PROGRAM and the FACILITY as needed to meet obligations and duties related to student experiences. Neither the PROGRAM nor the FACILITY will release any information about any student(s) or any student clinical affiliation to parties not associated with this agreement without prior written permission of student(s) involved.

III. FACILITY RESPONSIBILITIES
A. Provide for, and to be primarily responsible for, the care of all patients. At all times the ultimate responsibility for patient care shall be that of the FACILITY. Any patient may be withdrawn by FACILITY or FACILITY'S authorized designee from STUDENT assignment for good cause.

B. Provide clinical education experiences as stated in objectives and philosophy of the PROGRAM and supervision appropriate to the academic and clinical level of the assigned STUDENTS where deemed necessary and appropriate.

C. Provide the physical facilities and other equipment necessary for the clinical education experiences.

D. Designate the liaison representative to the PROGRAM.

E. Request the PROGRAM to withdraw a STUDENT from assigned clinical education experiences when the STUDENT'S clinical performance is unsatisfactory or the STUDENT'S behavior is disruptive or detrimental to the FACILITY and/or patients.

F. Complete all forms requested by the PROGRAM, such as general information forms, evaluation reports, etc.

G. Not discriminate against any STUDENT applicant because of race, creed, sex, pregnancy, national origin, age, veteran status, and disability except as it prevents the ability to perform essential role functions.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Idaho Home Visiting Program (previously known as MIECHV) | Government | Data Agreement | NA | NA | | |

This Data Use Agreement establishes an agreement between the Idaho public health districts as local implementing agencies of evidence-based home visiting programs and the Idaho Department of Health and Welfare (IDHW) for the acquisition of data and information related to Evidence Based Home Visiting (EBHV) programs supported by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Patrick Lewis | Individual | MOU | $0 | Federal Grant | 5/12/2025 | 1/16/2026 |

Scholarship to support professional development.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Lifeways, Inc., Nampa Family Justice Center, WICAP, Advocates Against Family | For profit, non-profit, non-profit, non-profit | BAA | NA | NA | 1/6/2023 | NA |

| | | | | | | |
|---|---|---|---|---|---|---|
| Violence, Boys & Girls Club of Nampa | | | | | | |
| BAA for YouthROC Program: Purpose and Intent. Business Associate has agreed to perform certain services for or on behalf of Covered Entity, which services may involve the creation, maintenance, use, transmission or disclosure of Protected Health Information within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, 45 C.F.R. parts 160 and 164, as they shall be amended ("the Privacy and Security Rules"). This Agreement supplements the parties' agreement for services and is intended and shall be interpreted so as to satisfy the requirements for business associate contracts as set forth in the federal HITECH Act §§ 13401 and 13404, and the Privacy and Security Rules, including 45 C.F.R. §§ 164.314, .410, and .504(e), as they shall be amended. Business Associate hereby agrees to comply with applicable provisions of the HITECH Act, its implementing regulations, and the Privacy and Security Rules as they shall be amended, and to assist Covered Entity with its compliance, as explained below. In addition, Business Associate agrees to comply with applicable provisions in 42 C.F.R. part 2, to the extent that those requirements are more restrictive than the HIPAA Privacy and Security Rules. | | | | | | |
| **Agreement Partner** | **Type of Partner (Non-profit, For-profit, Government)** | **Type of Agreement (MOU, MOA, BAA)** | **Cost for Service** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Valor Health | Non-Profit | MOA | NA | NA | 11/16/2021 | NA |

This Memorandum of Agreement between Southwest District Health (hereinafter referred to as SWDH), 1008 E. Locust, Emmett ID 83617 and Walter Knox Memorial dba Valor Health (hereinafter referred to as Valor), 1202 E. Locust Street, Emmett ID 83617, enters into a cooperative agreement to maintain safe biological supplies. SWDH has a supply of vaccine that requires stable refrigeration and/or freezer temperatures, as outlined below. Valor has a generator source of electricity for use during power or mechanical failure and can maintain adequate freezer and refrigeration temperatures for vaccine storage.

General Agreement:
1. The term of this agreement shall be as long as there is a need for safe vaccine storage in the event of a power outage at SWDH.
2. It is understood and agreed that the parties hereto may revise or modify this agreement by written amendments whenever the same shall be agreed upon.
3. Both parties reserve the right to te1minate the agreement for any reason within thirty (30) days written notice sent by certified mail or hand delivered to the addresses set forth above.

Valor agrees to:
1. Store vaccine from SWDH at a safe temperature until power is restored at the SWDH building. Safe temperatures are 35 to 46 degrees Fahrenheit for refrigerated vaccines and 5 degrees Fahrenheit or colder for frozen vaccines, (i.e. MMR , varicella, herpes zoster vaccine).
2. Provide the name of the individual(s) or department in order to arrange storage. The contact person(s) or department and phone number is as follows:
Primary Contact: Pharmacy Department (208) 365-3561 extension 3244 (Regular Business Hours) Secondary Contacts: Charge Nurse at (208) 901-3280 or (208) 901-3287 (After-Hours)
3. Valor will not charge SWDH for this public health service
4. Valor is not responsible for the replacement of lost or damaged vaccine.

Southwest District Health agrees to:
1. Package vaccine in clear plastic Ziploc bags to allow for easy identification of the contents. Bags will be taped shut and labeled for either freezer or refrigerator storage.
2. Provide a complete list of the vaccine inventory and name(s) and phone number(s) of SWDH staff to contact regarding the vaccine.
3. Transport the vaccine to and from the medical center.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| St. Luke's Health System | Non-Profit | MOA | NA | NA | 12/7/2023 | 12/7/2026 |

This MEMORANDUM OF UNDERSTANDING FOR CLOSED POINT OF DISPENSING ("MOU"),
effective as of September 1, 2023, Is entered into by and among Southwest District Health, Central District Health and South Central District Health (each a "Public Health District" and collectively, the "Public Health Districts"), and ST. LUKE'S HEALTH SYSTEM, LTD., an Idaho nonprofit corporation ("COMMUNITY PARTNER").

I. Background. In the event of a public health emergency, local public health departments use community locations known as points of dispensing ("POD") to dispense and administer medical countermeasures ("MCMs") such as vaccines, antiviral drugs, and chemical antidotes. "Open PODs" are used to dispense and administer MCMs to the public. "Closed PODs" are managed by organizations to dispense and administer MCMs to an organization's own populations, such as the organization's employees, family members of employees, or clients/patients.

II. Purpose. COMMUNITY PARTNER Is Idaho's largest health system and the state's largest private employer. In the event of a public health emergency, COMMUNITY PARTNER and the Public Health Districts desire lo collaborate to meet community health needs. This collaboration may include the Public Health Districts using COMMUNITY PARTNER as a Closed POD for the treatment, prophylaxis and/or vaccination of Identified target populations.

Ill. Request for Assistance. In the event of a public-health-emergency-requiring-mass treatment, prophylaxis and/or vaccination within a Public Health District, the District Director may request that COMMUNITY PARTNER serve as a Closed POD by contacting one of the contacts listed below and referencing this MOU. The District Director will Inform COMMUNITY PARTNER of the Intended target population for the proposed Closed POD. If COMMUNITY PARTNER is willing and able to serve as a Closed POD during the public health emergency, COMMUNITY PARTNER and the Public Health District will work together to properly define and quantify the intended target population.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Saint Alphonsus | Non-Profit | MOU | NA | NA | 2/9/2024 | 2/9/2027 |

This agreement is for the purpose of coordinating the treatment, prophylaxis and/or vaccination of citizens in the event of a public health emergency or communicable disease outbreak .

Situations
Typically, Southwest District Health and Central District Health Public Health Districts (hereto referred to as local public health) have established and maintained Points of Dispensing (PODs) for the purpose of coordinating the treatment, prophylaxis and/or vaccination of citizens in the event of a public health emergency or communicable disease outbreak. This MOU establishes that the Saint Alphonsus Health System (hereto referred to as Health System), an Idaho nonprofit corporation, will partner with local public health in accomplishing this goal through one or more of the following means, as applicable based on the event:

• Each Medical Facility (as identified by the Health System) may conduct a "Closed POD" for treatment, prophylaxis and/or vaccination of staff and their family members
• Each Medical Facility (as identified by the Health System) may provide treatment, prophylaxis and/or vaccination to inpatients
• Each Medical Facility (as identified by the Health System) may dispense treatment, prophylaxis, and/or vaccination to outpatients via outpatient clinics, affiliated urgent care centers, and/or emergency departments

Request for Assistance
In an event requiring mass treatment, prophylaxis and/or vaccination within the local public health jurisdiction(s), the District Director will request assistance from the Health System referencing this Memorandum of Understanding (MOU). The Health System will provide assistance to the extent possible.

Supplies Provided
The local public health district(s) will provide medications, vaccines, and other medical supplies (henceforth referred to as Supplies) made available through the State of Idaho,

the Strategic National Stockpile, or the District(s) within the scope and jurisdiction of the District(s). Other medical supplies may include items necessary for dispensing of medication or vaccine, personal protective equipment, or other supplies.

To the extent possible, local public health will rely on the established system wide distribution apparatus in place supporting Saint Alphonsus Health System from their

Boise campus. Supplies will be distributed by the District to representatives of the Saint Alphonsus Health System, in accordance with the District Emergency Operations Plan.

Dispensing or Distribution of Supplies
Supplies provided by local public health must be dispensed or distributed in accordance with event specific Terms of Use. These Terms of Use will be drawn up by local public health at the time of the event, based upon guidance received from the Administration for Strategic Preparedness and Response (ASPR), the Centers for Disease Control and Prevention (CDC), and/or the State of Idaho. The Health System must agree in writing to these Terms of Use prior to receipt of any Supplies.

Return of Supplies
The Health System agrees to return unused Supplies at the end of the event at the request of local public health.

Effective Date and Expiration
In witness thereof, the parties have caused this agreement to be executed. Said agreement will become effective and operative upon the date of the fixing of the last signature hereto and will remain in place for three (3) years from the effective date.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Zwygart John & Associates CPAs, LLC | For Profit | Engagement Letter | $11,500 | Allocated | 7/7/2025 | 6/30/2026 |

Zwygart John CPAs will: 1.) audit the financial statements of SWDH activities and the aggregate remaining fund information of SWDH as of June 30, 2025 and 2.) audit the entity's compliance over major federal award programs for period ending June 30, 2025.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Access Point | For Profit | MOU | NA | NA | 8/13/2024 | NA |

The Memorandum of Understanding (MOU) is created to provide shared information collaboratively amongst the parties in the case conferencing team. Each agency will share information, consistent with applicable confidentiality restrictions, in order to provide the others with information believed to be potentially relevant and useful to others. This MOU is to provide oversight and accountability to ensure integrated work amongst parties is kept confidential.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Nurse Family Partnership | Non-Profit | MOU/MOA | $25,272 | Federal subgrant | 7/1/2024 | 6/30/2027 |

A. Network Partner will make best efforts to implement the Program with Fidelity to the Model and will undertake the steps described in Exhibit E, Network Partner Responsibilities, attached and incorporated herein, to do so.

B. Network Partner shall notify NFP within three (3) business days of learning of funding decisions that may materially affect Network Partner's delivery of the Program and/or impact Clients' ability to complete the Program.

C. Network Partner will take all appropriate steps to maintain Client confidentiality and obtain any necessary written Client consents for data analysis or disclosure of protected health information, in accordance with applicable federal and state laws, including, but not limited to, authorizations, data use agreements, business associate agreements, as necessary.

D. Network Partner assumes responsibility for knowledge of and compliance with the State Nurse Practice Act of its state, state laws, regulations, and licensing requirements pertaining to nursing practice and state laws and regulations pertaining to mandatory reporting.

E. Network Partner's Nurse Home Visitors, Program Supervisors, and Administrators shall complete all required NFP Education. Nurse Home Visitors and Program Supervisors who leave the Program for two (2) years or longer and then return must attend NFP Education before visiting Clients and resuming Program delivery. Network Partner shall ensure that Nurse Home Visitors are able to provide care to Clients in a manner consistent with the NFP E-Guidelines.

F. When requested by NFP, Network Partner will make reasonable efforts to collect additional data and/or participate in Research intended to improve the NFP model or implementation of the model. The decision as to whether to participate in such Research is, however, entirely up to Network Partner.

G. To avoid becoming involved in Research that conflicts with implementing the Program with Fidelity to the Model, Network Partner shall request NFP's permission prior to participating in any Research that is (1) initiated by a party other than NFP and (2) that involves Program staff or explicitly targets the families that are enrolled in the Program. NFP shall review and approve or disapprove Network Partner's request for participation in such Research on a timely basis and shall not unreasonably withhold such approval.

H. Network Partner will inform NFP of Network Partner proposals to publish or present NFP-related information in research reports, books, book chapters, peer-reviewed journal articles, and at academic or professional conferences. Results of the Program herein outlined may be published by Network Partner, or jointly by Network Partner and NFP, always giving due credit to the Parties involved and recognizing the rights of the individuals doing the work.

I. Network Partner is authorized to reproduce certain published materials specified below and used in the implementation of the Program so long as (1) this Agreement is in effect,
(2) Network Partner uses the reproductions solely for Program implementation, and
(3) Network Partner does not sell or otherwise distribute the reproductions to any third party not involved in Network Partner's implementation of the Program.
1. The published materials covered by this authorization are delivered to Nurse Home Visitors as part of the NFP education materials in sets referred to as the E Guidelines. These are available electronically/digitally in the online eGuidelines system.
2. The published materials bear notices indicating copyright by any of the following:
a) University of Colorado

b) University of Colorado Health Sciences Center
c) University of Colorado at Denver and Health Sciences Center
d) Nurse-Family Partnership
3. NFP has the right to grant permission to reproduce materials specified above and that bear the University of Colorado copyright notice under the terms of a Memorandum of Understanding ("MOU") dated March 31, 2003, between the University of Colorado Health Sciences Center, now known as University of Colorado at Denver and Health Sciences Center, and NFP. The MOU gives NFP an exclusive, perpetual, royalty-free right and license to use copyrighted materials and other materials used in the Program for the purpose of implementing the Program to serve low-income, first-time mothers and their families.
4. The corresponding Spanish-language versions of these materials are also covered by this authorization.
5. Network Partner may not authorize any other entity to reproduce the materials without prior written permission from NFP.

J. NFP represents to Network Partner and Network Partner understands and agrees that all Proprietary Property and all associated intellectual property rights are owned exclusively by NFP and its licensors. Network Partner shall use the Proprietary Property solely for carrying out Network Partner's obligations under this Agreement and shall not share the Proprietary Property with third parties or modify any Proprietary Property without the prior express written permission of NFP. Network Partner may not duplicate, distribute, or provide access to the Proprietary Property to any individual or organization, except as authorized by this Agreement. Network Partner may allow only trained, NFP authorized users to access the NFP DCS. Network Partner shall retrieve all Proprietary Property from departing employees. Duties of confidentiality and use of the Proprietary Property under this Agreement shall not expire.

K. Maintenance, Protection and Promotion of the Nurse-Family Partnership® Program. Network Partner agrees to use all reasonable means to protect, encourage and promote the Nurse-Family Partnership name and Program. NFP and Network Partner have a mutual responsibility to support and promote each other, as each of the Party's activities reflect on the national image of Nurse-Family Partnership and on the image of Nurse Family Partnership in the state in which the Network Partner is located. Network Partner shall take all reasonable actions necessary to incorporate the Nurse-Family Partnership Marks and name into any Network Partner material associated with the Program. In all marketing materials related to the Program, Network Partner shall take all reasonable actions to use the Nurse-Family Partnership name and make its Program readily recognizable to the public as an integral part of the Nurse-Family Partnership.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Nurse Family Partnership | Non-Profit | BAA | NA | NA | 7/1/2024 | 6/30/2027 |

Both Parties are committed to complying with the Standards for Privacy and Security of Individually Identifiable Health Information (the "Privacy & Security Regulations") promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as it is updated, amended, or revised, including the requirement under 45 CFR §164.502(e)(2) to enter into a Business Associate Agreement with business associates who are subcontractors.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Youth Rising | Non-Profit | MOU | NA | NA | 1/1/2024 | NA |

This Memorandum of Understanding for Screening and Referral Services ("Memorandum") is a collaboration between Youth Rising Center (Youth Rising) and Youth Resource & Opportunity Collaborative (YouthROC) for the provision of screening and referral services for youths and/or their families. The Memorandum begins January 1, 2024 and shall automatically renew from year to year unless terminated by either party with thirty (30) days written notice prior to the end of the Memorandum's term.
The goal of this collaboration is to provide youth and their families with brief screening and referral to supportive services and preventative strategies that align with the vision and mission of early intervention. The respective services will be tailored to address each youth's individual needs and the family's specific needs.
The objectives are as follows:
Identify the behavioral health needs of youth (10-17 years old, specific to YouthROC's servicing age range; 11-18 years old, specific to Youth Rising's service age range) at a prevention and early intervention point.
Divert youth from justice-involved systems into community-based treatment and supports.
Divert youth from child welfare involved systems into community-based treatment and supports.
Maintain a referral process to ensure that youth screened for additional needs by Youth Rising are referred to YouthROC for further screening, assessment, and connection to community supports through case management services.
Maintain collaborative relationships with YouthROC to assist youth and their families with additional services, supports, and/or treatment needs.
Provide services to the family based on data driven decisions gathered from screening and assessments, as appropriate.
The scope of services for the Youth Rising Center (Youth Rising) will be limited to the following:
Youth Rising will provide evidence-based screening for eligible youth.
Youth Rising will make referrals to YouthROC through the findhelpidaho.org system, or directly to an on-site co-located YouthROC provider, based off screening results within an established timeline.
Youth Rising will complete an ROI and refer eligible youth to YouthROC for specialized services and treatment within the organization's expertise. Specifically, YouthROC will provide additional screening (as necessary), assessment and case management services for the youth and family.
Youth Rising will provide a safe environment for youth and their families with access to supportive needs such as computer use, crisis intervention services, and collaboration for collateral needs.
Youth Rising will provide peer-to-peer support services for the youth and their family to ensure connection to YouthROC and other support outlined in their individualized care plan.
YouthROC will provide a designated contact to Youth Rising for follow-up regarding service coordination for the youth and/or family. Personal Health Information (PHI) will not be shared or released to YouthROC staff.
YouthROC will provide a designated contact for a "warm handoff" to coordinate services for the referred youth and families.
YouthROC will co-locate at the Youth Rising Center as appropriate for assessments, case management and other services on an agreed upon basis.
The scope of services in this Memorandum may change as necessary and appropriate with written notice.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Purdue Opioids Implementation Administrator | N/A | Settlement Agreement | NA | NA | 28 Jul 25 | NA |

Participation and Release Form

The governmental entity identified above ("Governmental Entity"), in order to obtain and in consideration for the benefits provided to the Governmental Entity pursuant to that certain Governmental Entity & Shareholder Direct Settlement Agreement accompanying this participation form (the "Agreement")1, and acting through the undersigned authorized official, hereby elects to participate in the Agreement, grant the releases set forth below, and agrees as follows.

1. The Governmental Entity is aware of and has reviewed the Agreement, and agrees that by executing this Participation and Release Form, the Governmental Entity elects to participate in the Agreement and become a Participating Subdivision as provided therein.

2. The Governmental Entity shall promptly after the Effective Date, and prior to the filing of the Consent Judgment, dismiss with prejudice any Shareholder Released Claims and Released Claims that it has filed. With respect to any Shareholder Released Claims and Released Claims pending in In re National Prescription Opiate Litigation, MDL No. 2804, the Governmental Entity authorizes the Plaintiffs' Executive Committee to execute and file on behalf of the Governmental Entity a Stipulation of Dismissal with Prejudice substantially in the form found at https://nationalopioidsettlement.com.

3. The Governmental Entity agrees to the terms of the Agreement pertaining to Participating Subdivisions as defined therein.

4. By agreeing to the terms of the Agreement and becoming a Releasor, the Governmental Entity is entitled to the benefits provided therein, including, if applicable, monetary payments beginning following the Effective Date.

5. The Governmental Entity agrees to use any monies it receives through the Agreement solely for the purposes provided therein.

6. The Governmental Entity submits to the jurisdiction of the court in the Governmental Entity's state where the Consent Judgment is filed for purposes limited to that court's role as and to the extent provided in, and for resolving disputes to the extent provided in, the Agreement. The Governmental Entity likewise agrees to arbitrate before the National Arbitration Panel as provided in, and for resolving disputes to the extent otherwise provided in, the Agreement.

7. The Governmental Entity has the right to enforce the Agreement as provided therein.

8. The Governmental Entity, as a Participating Subdivision, hereby becomes a Releasor for all purposes in the Agreement, including without limitation all provisions of Article 10 (Release), and along with all departments, agencies, divisions, boards, commissions, districts, instrumentalities of any kind and attorneys, and any person in his or her official capacity whether elected or appointed to serve any of the foregoing and any agency, person, or other entity claiming by or through any of the foregoing, and any other entity identified in the definition of Subdivision Releasor, to the maximum extent of its authority, for good and valuable consideration, the adequacy of which is hereby confirmed, the Shareholder Released Parties and Released Parties are, as of the Effective Date, hereby released and forever discharged by the Governmental Entity and its Subdivision Releasors from: any and all Causes of Action, including, without limitation, any Estate Cause of Action and any claims that the Governmental Entity or its Subdivision Releasors would have presently or in the future been legally entitled to assert in its own right (whether individually or collectively), notwithstanding section 1542 of the California Civil Code or any law of any jurisdiction that is similar, comparable or equivalent thereto (which shall conclusively be deemed waived), whether existing or hereinafter arising, in each case, (A) directly or indirectly based on, arising out of, or in any way relating to or concerning, in whole or in part, (i) the Debtors, as such Entities existed prior to or after the Petition Date, and their Affiliates, (ii) the Estates, (iii) the Chapter 11 Cases, or (iv) Covered Conduct and (B) as to which any conduct, omission or liability of any Debtor or any Estate is the legal cause or is otherwise a legally relevant factor (each such release, as it pertains to the Shareholder Released Parties, the "Shareholder Released Claims", and as it pertains to the Released Parties other than the Shareholder Released Parties, the "Released Claims"). For the avoidance of doubt and without limiting the foregoing: the Shareholder Released Claims and Released Claims include any Cause of Action that has been or may be asserted against any Shareholder Released Party or Released Party by the Governmental Entity or its Subdivision Releasors (whether or not such party has brought such action or proceeding) in any federal, state, or local action or proceeding (whether judicial, arbitral, or administrative) (A) directly or indirectly based on, arising out of, or in any way relating to or concerning, in whole or in part, (i) the Debtors, as such Entities existed prior to or after the Petition Date, and their Affiliates, (ii) the Estates, (iii) the Chapter 11 Cases, or (iv) Covered Conduct and (B) as to which any conduct, omission or liability of any Debtor or any Estate is the legal cause or is otherwise a legally relevant factor.

9. As a Releasor, the Governmental Entity hereby absolutely, unconditionally, and irrevocably covenants not to bring, file, or claim, or to cause, assist or permit to be brought, filed, or claimed, or to otherwise seek to establish liability for any Shareholder Released Claims or Released Claims against any Shareholder Released Party or Released Party in any forum whatsoever, subject in all respects to Section 9.02 of the Master Settlement Agreement. The releases provided for herein (including the term "Shareholder Released Claims" and "Released Claims") are intended by the Governmental Entity and its Subdivision Releasors to be broad and shall be interpreted so as to give the Shareholder Released Parties and Released Parties the broadest possible release of any liability relating in any way to Shareholder Released Claims and Released Claims and extend to the full extent of the power of the Governmental Entity to release claims. The Agreement shall be a complete bar to any Shareholder Released Claim and Released Claims.

10. To the maximum extent of the Governmental Entity's power, the Shareholder Released Parties and the Released Parties are, as of the Effective Date, hereby released and discharged from any and all Shareholder Released Claims and Released Claims of the Subdivision Releasors.
11. The Governmental Entity hereby takes on all rights and obligations of a Participating Subdivision as set forth in the Agreement.
12. In connection with the releases provided for in the Agreement, each Governmental Entity expressly waives, releases, and forever discharges any and all provisions, rights, and benefits conferred by any law of any state or territory of the United States or other jurisdiction, or principle of common law, which is similar, comparable, or equivalent to § 1542 of the California Civil Code, which reads:
General Release; extent. A general release does not extend to claims that the creditor or releasing party does not know or suspect to exist in his or her favor at the time of executing the release that, if known by him or her, would have materially affected his or her settlement with the debtor or released party.
A Releasor may hereafter discover facts other than or different from those which it knows, believes, or assumes to be true with respect to the Shareholder Released Claims or such other Claims released pursuant to this release, but each Governmental Entity hereby expressly waives and fully, finally, and forever settles, releases and discharges, upon the Effective Date, any and all Shareholder Released Claims or such other Claims released pursuant to this release that may exist as of such date but which Releasors do not know or suspect to exist, whether through ignorance, oversight, error, negligence or through no fault whatsoever, and which, if known, would materially affect the Governmental Entities' decision to participate in the Agreement.
13. Nothing herein is intended to modify in any way the terms of the Agreement, to which Governmental Entity hereby agrees. To the extent any portion of this Participation and Release Form not relating to the release of, or bar against, liability is interpreted differently from the Agreement in any respect, the Agreement controls.
14. Notwithstanding anything to the contrary herein or in the Agreement, (x) nothing herein shall (A) release any Excluded Claims or (B) be construed to impair in any way the rights and obligations of any Person under the Agreement; and (y) the Releases set forth herein shall be subject to being deemed void to the extent set forth in Section 9.02 of the Master Settlement Agreement.
I have all necessary power and authorization to execute this Participation and Release Form on behalf of the Governmental Entity.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Quadient Leasing USA | For profit | Lease agreement | $3,426.20 | Indirect | 30Jul25 | 30Jul27 |
| iX-3 Series Base w/5lb Integrated Weigh Platform, Moistener & Catch Tray | | | | | | |

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Canyon Springs High School | Government | MOU | $0 | N/A | 8/12/25 | 6/30/2026 |

**SWDH** agrees to perform the following:
Facilitate four INDEPTH lessons on a recurring basis during the last two weeks of each month. Lessons will be held at **Canyon Springs High School** on **Thursdays** and **Fridays** beginning **September 2025** from **2-3pm**. Classes will cover the following topics:

- What nicotine is and how it affects the developing brain
- Reasons why young people might start using nicotine/tobacco

- Health effects of nicotine on the body
- Strategies to manage stress and resources on how to quit nicotine/tobacco use
- Provide pre/post survey questions to **Canyon Springs High School** before the start of the first class for their review and approval to administer to students.
- Maintain confidentiality of all personal information obtained from parent/guardian(s) and youth attending the program.
- Provide **Canyon Springs High School** with attendance numbers for each week of completed classes.
- Provide students who complete the intervention program with certificates to show to **Canyon Springs High School** staff (to verify completion of class).
- Provide **Canyon Springs High School** with reports summarizing survey data from completed classes.

Primary point of contact for SWDH will be:
**Name:** Lee'Erin Brooks
**Email**: lee'erin.brooks@swdh.id.gov **Phone**: 208-606-2888

**Canyon Springs High School** agrees to perform the following:

- Notify students and parents/guardians of when and where to attend the intervention program.
- Provide SWDH with a list of students attending their first intervention class by the close of business on the **Monday before their first class** the following week.
- Provide SWDH with parent/guardian information for each student attending the intervention program during the referral process.
- Provide a classroom-like setting that includes internet access, chairs, student desks or equivalent, and a projector/screen with HDMI/USB-C connections at **Canyon Springs High School** for SWDH to facilitate intervention classes each week.
- Ensure that no more than 12 students are assigned to a class at a time, any exceptions must be approved by the primary point of contact for SWDH.
- Primary point of contact for **Canyon Springs High School** will be: Name: Alex Flemmer

Email: aflemmer@caldwellschools.org Phone:208-455-3325

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Nampa School District | Government | MOU | $0 | N/A | 8/13/2025 | 6/30/2026 |

**SWDH** agrees to perform the following:
Facilitate four intervention lessons the first **two weeks** of each month beginning September 2025 to **Nampa School District.** High School students will be taught INDEPTH on **Wednesdays** from **4:00-5:30** pm at **Nampa High School** and Middle School students will be taught OUR Healthy Futures on **Thursdays** from **4:00-5:30** pm at **South Middle School.** Classes will cover the following topics:

- What nicotine is and how it affects the developing brain
- Reasons why young people might start using nicotine/tobacco
- Health effects of nicotine on the body
- Strategies to manage stress and resources on how to quit nicotine/tobacco use
- Provide pre/post survey questions to **Nampa School District** before the start of the first class for their review and approval to administer to students.
- Provide **Nampa School District** with attendance rosters for each week of completed classes.
- Provide students who complete intervention program with certificates to provide to **Nampa School District** staff (to verify completion of class).
- Provide **Nampa School District** with reports summarizing survey data from completed classes.

Primary point of contact for SWDH will be: Name: Lee'Erin Brooks
Email: lee'erin.brooks@swdh.id.gov

Phone: 208.606.2888

**Nampa School District** agrees to perform the following:

- Notify students and parents/guardians of when and where to attend intervention program.
- Provide SWDH with a list of students attending their first intervention class by the close of business on the **Monday** before their first class the following week.
- Provide SWDH with parent/guardian information for each student attending the intervention program during the referral process.
- Provide a classroom-like setting that includes internet access, chairs, student desks or equivalent, and a projector/screen with HDMI/USB-C connections at **Nampa School District** for SWDH to facilitate intervention classes each week.
- Ensure that no more than 12 students are assigned to a class at a time, any exceptions must be approved by the primary point of contact for SWDH.

Primary point of contact for **Nampa School District** will be:
Name: Steve LaBau
Email: slabau@nsdl3 l.org Phone: 208-468-4600

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| Central District Health | Government | MOA | $1,189 | MF | 15Aug25 | 30Jun26 |

MOA between CDH and SWDH for data collection and analysis scantron system for Catch My Breath program.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| State Hospital West | Government | MOU | $0 | MF | 16Jul25 | 16Jul28 |

Updated MOU to change programming from Catch My Breath to a shorter vape prevention presentation due to the environment and needs of State Hospital West and the youth they serve.

Southwest District Health agrees to perform the following:

1. Deliver an educational program with interactive activities that covers vape prevention of nicotine and THC substances. The program will be 45-60 minutes long and will cover the following topics:

a. Consequences of using nicotine and THC
b. Differences bet\veen nicotine and THC substances
c. What is in e-liquids
d. Signs of addiction and the addiction cycle
e. Developing a stress management plan

State Hospital West agrees to perform the following:

a) Provide a maximum count of thirty-five (35) youth per class for any nicotine and THC vape prevention education taught by Southwest District Health staff.
b) Assign at least one staff member to be present in the room for the duration of the program

alongside
Southwest District Health staff.
c) Administer surveys to participating students. If staff are unable to deliver the survey before the scheduled class, extra time will be allotted (15 min.) to the session for Southwest District Health staff to administer the surveys.

| Agreement Partner | Type of Partner (Non-profit, For-profit, Government) | Type of Agreement (MOU, MOA, BAA) | Cost for Service | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|---|---|
| United Way of Treasure Valley | Non-profit | Funding Agreement | $32,000 | Local partners | 30Jul25 | 30Jun26 |
| UWTV will serve as the fiduciary agent for the Idaho Oregon Health Atlas. | | | | | | |

AUGUST 19, 2025

# SWDH REVENUE  CONTRACTS AND GRANTS

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.268 Immunization Cooperative Agreement | All | 7/1/2024 | 6/30/2025 | $82,305.70 | $49,383.42 | $32,922.28 | NA | NA | 24.95 | No | No | No |

I. GENERAL REQUIREMENTS

A. This Subgrant is funded by the Immunization and Vaccines for Children 93.268 awarded upon receipt of the Notice of Award (NOA) through the Centers for Disease Control and Prevention (CDC) with a total award amount as indicated on the NOA and state general funds.

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

C. Reserved.

D. The Subgrantee must adhere to the following:

1. Reserved

2. 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.

3. Federal Awardee Performance and Integrity Information System (FAPIIS) Disclosure:

Consistent with 45 CFR 75.113, the Subgrantee must disclose, within ten (10) business days of discovery, in writing to the Department and the 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 CDC and to the HHS OIG at the following addresses:

a. Centers for Disease Control and Prevention, Office of Grants Services; Freda Johnson, Grants Management Officer/Specialist; Centers for Disease Control and Prevention; Infectious Disease Services Branch; 2939 Flowers Road, MS TV2; Atlanta, GA 30341; Fax: 770-488-2640 (Include <Mandatory Grant Disclosures= in subject line); Email: WWE2@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. The current Immunization Program Operational Manual that will be provided upon request.

2. The current Vaccines for Children Operations Guide that will be provided upon request.

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.

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. This Subgrant'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. 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]".

b. Publications – "The project described was supported 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]".

c. 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]”.
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. Reserved

II. SUBGRANT SERVICES AND ACTIVITIES
A. The Subgrantee must provide a Subgrant Planning Worksheet detailing the specific number of staff for each training and education activity and the specific number of instances of each Subgrantee specific activity. The Subgrantee may request revisions to the Subgrant Planning Worksheet numbers by submitting a written explanation detailing the change and the circumstances requiring the change, and by submitting a revised Planning Worksheet showing the entire work plan including the proposed changes for Department approval.
B. Subgrantee Staff Training and Education
1. The Subgrantee must send staff, including the immunization coordinator, or otherwise participate in the:
a. Immunization Subgrant Meeting by the end of the Subgrant period. The names(s) and number of attendees must be reported to the Department through the Immunization Health District Specific SharePoint Site within thirty (80) calendar days of the training.
b. Annual Shot Smarts Immunization Conferences by the end of the Subgrant period. The name(s) and number of attendees must be reported to the Department through the Immunization Health District Specific SharePoint Site within thirty (30) calendar days of the conference.
c. Booster Shots Workshop by the end of the Subgrant period. The name(s) and number of attendees must be reported to the Department through the Immunization Health District Specific SharePoint Site within thirty (80) calendar days of the conference.
d. Regional Vaccine for Children (VFC) Coordinator Training by the end of the Subgrant period. The name(s) and number of attendees must be reported to the Department through the Immunization Health District Specific SharePoint Site within thirty (30) calendar days of the training.
C. District Specific Activities
1. The Subgrantee must conduct activities (marketing, promotion, education, and/or other services) as identified in the Department approved Subgrant Planning Worksheet. All activities must be in direct support of increasing immunization rates in Idaho. Efforts involving recommendations for vaccination must follow the guidance of the CDC's Advisory Committee on Immunization Practices (ACIP).
a. The Subgrantee must include at least one (1) activity participating in Human Papillomavirus (HPV) Free Idaho Month. The activity must be in direct support of increasing HPV immunization rates in Idaho. Efforts involving recommendations for vaccination must follow the guidance of the CDC's ACIP.
b. The Subgrantee must provide support and assistance to healthcare providers enrolled in a routine vaccine program with the Department (i.e., the Vaccines for Children program), as needed. Support and assistance may include immunization recommendations, the immunization schedule, vaccine storage and handling, vaccine redistribution, and other immunization related topics as appropriate.
c. The Subgrantee must conduct an on-site provider follow-up visit with new healthcare providers, as assigned by the Department (no more than four [4]), within thirty (30) business days of being assigned. The Subgrantee must assess the new provider's general knowledge of immunization including: the program, the schedule, recommendations, administration, storage and handling, and other immunization related topics as appropriate.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public Water Regulatory Inspections : The purpose of this contract is to provide services for public water system supervision. | public water systems with 15 connections or serving 25 people or more 60 days out of the year | 7/1/2025 | 5/30/2027 | $269,330.72 | $190,120.76 | $79,209.96 | $269,330.72 | NA | 24.95 | No | No | No |

Personnel Requirements.
a. Required Staff. The PHD must provide and identify a designated staff person in a personnel class equivalent to DEQ Analyst 2 or Analyst 3 (Environmental Health Specialist 2 or Environmental Health Specialist, Senior) to administer and implement the public drinking water program pursuant to this CONTRACT. When the PHD is unable to hire at the Environmental Health Specialist 2 level, they may under fill the vacancy with an Environmental Health Specialist 1 as long as that staff member is operating under the oversight of an Environmental Health Specialist 2 or higher. The position may only be filled by an Environmental Health Specialist 1 for a period not to exceed 12 months. Vacant drinking water staff positions shall be filled within 180 calendar days.
The PHD shall provide a backup environmental health specialist, meeting the same personnel class equivalency requirements stated above, for this position to administer and implement the public drinking water program pursuant to this CONTRACT.
b. Vacant Staff Positions. If a PHD designated drinking water staff position is vacant for 180 calendar days, DEQ shall consider this a material breach of the CONTRACT.

c. Staff Training. DEQ REGIONAL OFFICE and DEQ STATE OFFICE staff will assist in new staff training, which includes completing new inspector training, reviewing Safe Drinking Water Information System (SDWIS) procedure documents, and following DEQ training outlines. For backup positions, training shall be provided utilizing existing PHD staff with assistance from DEQ REGIONAL or STATE OFFICE staff as needed.

Recognition and Resolution of Contamination.

Timely recognition, notification to the PWS and DEQ, and resolution of contamination at PWSs regulated by the PHD are the highest priorities under this CONTRACT. The PHD will coordinate with the DEQ REGIONAL OFFICE and follow established DEQ STATE OFFICE procedures for addressing E.coli positive results; maximum contaminant level (MCL) violations for E. coli, chemicals, or radionuclides; action level exceedances for lead and copper; and short-term health advisory events when directed by the DEQ STATE OFFICE.

DEQ STATE OFFICE approved procedures are accessible through the internal PWS Switchboard under the Rules Switchboard and approved templates are on the internal PWS Switchboard under Templates. These documents are also available in DEQ's electronic document management system (EDMS).

a. Procedures for Acute Events. The PHD shall have written internal procedures to manage contamination events applicable to both the primary PHD staff and back-up PHD staff.

b. Microbiological Contamination. Certified drinking water laboratories are required to immediately inform the PHD that oversees a PWS by telephone when test results indicate the presence of microbiological contaminants. If notification from the laboratory to the PHD does not occur within the appropriate timeframe the PHD shall provide the DEQ STATE OFFICE information on the event including notification timelines, contaminant information, and the laboratory that failed for meet the notification requirements. After receiving notification from the laboratory, the PHD shall perform the following:

i. Make immediate telephone contact with the PWS owner/operator or back-up operator upon learning of a positive result to ensure a timely response by the owner/operator or back-up operator. If telephone contact is unsuccessful, the PHD shall utilize any other means necessary to ensure contact is made and document in writing/an email to the owner/operator or back-up operator the contact attempts that were made. The DEQ REGIONAL OFFICE contract manager shall be copied on the emails described above.

ii. For PWSs required to have a licensed operator, PHD staff shall document in writing/an email when a licensed operator is unavailable as required and a back-up operator has not been identified. The DEQ REGIONAL OFFICE contract manager shall be copied on the emails described above.

iii. In accordance with the Revised Total Coliform Rule and the Ground Water Rule, all repeat samples and triggered source water samples are required to be taken within 24 hours of notification of positive results as required by IDAPA 58.01.08.100. The PHD on a case-by-case basis, may allow the PWS owner or operator additional time beyond the 24 hour timeframe as necessary based on weekends and holidays as outlined in 40 CFR § 141.858. Any extension of time shall follow established procedures and be documented using the template on the internal PWS Switchboard "Approval for Delaying Repeat Total Coliform Sampling" and filed in the EDMS. iv. If the water system operator/owner does not take the repeat samples following an E.coli present routine sample as required, the PHD shall assess an acute event and have the system follow all acute event requirements and post public notification as expeditiously as possible, but no later than 24 hours, and the PHD shall notify the DEQ STATE OFFICE and REGIONAL OFFICE.

v. Waiving repeat samples is not allowed by rule. Neither the PHD nor DEQ can waive repeat monitoring requirements in accordance with 40 CFR § 141.858(a)(1). The PHD shall contact the DEQ STATE OFFICE with any questions about this requirement.

vi. Assist with determining cause and directing the water system to correct the problem, including scheduling and conducting a Level 2 Assessment in response to an E.coli MCL violation in accordance with the Revised Total Coliform Rule. Staff shall request assistance from the DEQ REGIONAL OFFICE when needed.

vii. PHD staff is not required to conduct Level 2 Assessments not associated with an E.coli violation.

viii. Ensure public notification is provided in accordance with IDAPA 58.01.08.150. SECTION C.15.g. of the CONTRACT.

ix. Weekend E.coli positive samples: If a routine sample is present/positive for E.coli and the PWS is unable to take repeat samples such as due to weekend laboratory availability, the PHD shall notify the DEQ REGIONAL OFFICE as soon as practical and require a Tier 1 Public Notification until repeat sample results are obtained.

x. Communicate within 24 hours to the DEQ REGIONAL OFFICE any E.coli positive sample result.

xi. Report E.coli MCL events to the DEQ STATE OFFICE using the "E.coli MCL Form" on the DW Internal Switchboard.

c. Chemical/Radiological Contamination. If notification from the laboratory to the PHD does not occur within the appropriate timeframe the PHD shall provide the DEQ STATE OFFICE information on the event including notification timelines, contaminant information, and the laboratory that failed to meet the notification requirements. After receiving notification from the laboratory, the PHD shall perform the following:

i. Follow the DEQ procedures outlined in the "MCL AL – Follow-up procedures for a Chemical/Radiological MCL/AL Event" on the DW Internal Switchboard. The PHD shall contact the DEQ STATE OFFICE with any questions.

ii. Nitrate. If the water system operator/owner does not take the confirmation sample or post public notification following a nitrate or nitrite MCL exceedance as required by 40 CFR § 141.23(f)(2), the PHD shall assess an acute event and have the system follow all acute event requirements and post public notification as expeditiously as possible, but no later than 24 hours, and the PHD shall notify the DEQ REGIONAL OFFICE.

d. Unregulated Contaminants. EPA published short-term advisories for certain unregulated contaminants. On a case-by-case basis as provided by 40 CFR § 141.202(a) Table 1, (9), DEQ determined that a Tier 1 notification is necessary for manganese, chlorpyrifos, microcystin, and cylindrospermopsin. The PHD staff shall follow DEQ polices and directives for short-term health advisories and work with the DEQ REGIONAL OFFICE and STATE OFFICE if a short-term advisory is exceeded.

3. Data and Record Management. The PHD shall only be responsible for data entry in subject areas where training, support, or procedure documents are available from DEQ. The procedure documents shall be followed by the PHD staff to identify what minimum data entry tasks are required.

a. Authorized Staff. Only authorized staff employed by the PHD may access the Safe Drinking Water Information System (SDWIS) and supporting software programs such as DEQ's EDMS. PHD staff, contractors, or third parties without a username and a password provided by DEQ are not authorized to access these programs.

i. Passwords Are Confidential—The PHD and its staff members are responsible for keeping passwords confidential.

ii. Unauthorized Use—The PHD and its staff members are responsible for any loss or damage resulting from the use of the usernames and passwords by any unauthorized staff member or third party attributed to their accounts.

iii. Termination of Individual Access—DEQ reserves the right to terminate access to the SDWIS database and supporting tools if DEQ finds that (a) the PHD and/or its staff members have shared password(s) or (b) PHD use is detrimental to SDWIS and supporting tools, or to other users.

b. Data Entry. The PHD shall be responsible for entering data into SDWIS for the PWS under its jurisdiction. Support staff such as administrative assistants/clerical staff may enter data for sample results, inventory, and legal entities if instructions and oversight are provided by the designated PHD drinking water staff. All other data entry, violation determinations, public notification requirements, and schedule entry, SDWIS Bridge work or maintenance must be completed by an Environmental Health Specialist.
c. Data Entry and Management Timelines—The following tasks must be completed by the PHD within the specified time frames unless otherwise directed by the DEQ Decision Support Analyst.
i. Positive bacteria results will be entered within 5 business days from the date of PHD's receipt. All other sample entry shall be within 10 business days from the date of receipt of laboratory sample results. Lead and copper result entry is based upon the date when all required samples are received from the laboratory.
ii. Inventory changes, such as population or connections, shall be entered within 5 business days of notification or discovery of inventory change.
iii. Increased monitoring frequency schedules in SDWIS shall be completed within 5 business days of the determination or within the timeframe determined through collaboration with the DEQ STATE OFFICE rule lead and must be completed by an Environmental Health Specialist.
iv. Public notification will be updated with a Performed Date within 5 business days of receipt of the notification or, if received prior to SDWIS generating the corresponding violation, enter the public notification at the time of violation verification.
v. SDWIS Bridge: Positive Sample Analytical Result for the Revised Total Coliform Rule (RTCR) and Ground Water Rule (GWR). Positive results shall be addressed within 5 business days of sample result data entry, which includes appropriate repeat and triggered source water schedules, and all accompanying schedule activities, standard responses, and PN schedules. SDWIS Bridge processing shall be completed no later than 10 business days after receipt of sample results.
vi. Address candidate violations in the timeframe as directed by the DEQ Decision Support Analyst and address deleted or rejected violations as directed by DEQ STATE OFFICE staff.
vii. Legal entity changes shall be completed within 10 business days of the date of receipt of the notification/request to add/remove/modify address, phone number, e-mail or personnel information.
viii. Compliance schedules will be updated with an Achieved Date within 5 business days of receipt of notification that it was completed such as for a Level 1 or Level 2 assessment, a corrections of a sanitary survey significant deficiency, or an addressed Level 1 or Level 2 sanitary defect.
ix. All other data entry items must be completed by the PHD no later than 30 business days from the date of receipt.
d. Data and Record Consistency. The records entered in the DEQ EDMS shall be consistent with information maintained in SDWIS and procedures outlined in the Drinking Water Filing Index (EMDS 2009ABP2).
e. SDWIS Modules. The PHD is responsible for maintaining current inventory information, site visit information, points of contact, sample results, monitoring schedules, compliance determinations, and information in the enforcement module as follows:
i. Inventory module. The PHD shall be responsible for maintaining current inventory information, which includes: basic information, population served, service connection(s), treatment plant information, PWS facilities and sample points, related points of contact(s), geographic area(s), service area(s), regulating agencies, and PWS facility flows.
ii. Site visit module. The PHD shall enter a sanitary survey or assessment site visit information into SDWIS within 30 calendar days after the site visit. All significant deficiencies shall be documented in SDWIS as identified in the Site Visits Procedures document. Level 1 or Level 2 Assessments shall be entered and maintained in SDWIS. Sanitary defects shall be entered in accordance with the site visit procedures documents.
iii. Points of contact/legal entities. The PHD shall maintain information on the people and organizations associated with the PWSs in their jurisdiction. All legal entity contacts need to be kept current in accordance with the Legal Entities Procedures document (EDMS # 2012AME28).
iv. Sample results. The PHD shall be responsible for daily review, during standard work weeks (Monday through Friday), by the Environmental Health Specialist and timely data entry of sample results into SDWIS as identified in SECTION C.3.c. and C.5.a. of the CONTRACT. Sample results must be assigned to the correct monitoring period. Any sample assigned to a previous monitoring period must be reported to and approved by the DEQ Decision Support Analyst to ensure compliance is properly evaluated by SDWIS.
v. Sample schedules. The PHD Environmental Health Specialist shall make rule-conforming and timely monitoring frequency decisions and maintain all monitoring schedules.
Changes to monitoring requirements and frequencies must be documented in writing to the PWS and maintained in the DEQ EDMS. Such information shall include but not be limited to entry or modification of the following: sample schedules, facility analyte levels (FANLs), lead and copper treatment and any optimization milestones.
vi. Compliance reports. The PHD shall run designated compliance reports consistent with a detailed schedule outlined in the SDWIS Calendar located on the internal Switchboard (an approximate schedule is provided in Table 1). All candidate violations shall be investigated to determine validity, with data being corrected or entered as needed to ensure data integrity is maintained. All candidate violations determined as invalid shall be addressed through data entry or correction so they are no longer identified on the compliance report. If the PHD compliance officer does not understand the reason a violation for a PWS appears on a compliance report, they shall contact the DEQ Decision Support Analyst.
vii. Compliance determinations. The PHD is responsible for managing the following in a timely manner: maintaining the SDWIS Bridge by addressing positive sample results for the RTCR and the GWR, including the migration of assessment schedules; addressing all preliminary violations and correcting data entry related to rejecting or deleting preliminary violations; adding specific and complete comments for all violations that are rejected or deleted; and assigning standard responses as outlined in the SDWIS procedure documents.
viii. Compliance and enforcement information. The PHD is responsible for adding or maintaining the following information: applying the appropriate addressing action (SOX code) when a system has returned to compliance; Tier 1 and Tier 2 public notification schedules; and compliance schedules. Questions regarding whether a violation can be returned to compliance shall be directed to the DEQ STATE OFFICE Compliance and Enforcement Supervisor. The PHD shall add and maintain sanitary survey significant deficiencies, sanitary defects from assessments, fecal-contaminated sources, and notification between wholesale and purchasers when there are RTCR positive samples.
4. Quality Assurance/Quality Control Tool (QA/QC Tool). SDWIS is a compliance tool designed to assist drinking water professionals in making timely and accurate public health decisions. SDWIS performance is directly related to the quality of data entered by users. To maintain high data quality, DEQ provides a SDWIS QA/QC tool, which is modified to add or remove reports as needed. The SDWIS QA/QC tool identifies items that need to be corrected and updated and contains detailed correction instructions. Level 1 and Level 2 QA/QC reports are prioritized based upon public health related information. Level 3 is based upon EPA's grant withholding criteria and other levels are informational for managing data integrity and/or workload.
a. Priority QA/QC reports. No less than once per month, the PHD shall use the SDWIS QA/QC tool to review the current number of deficiencies. The PHD shall maintain the total number of Level 1 and Level 2 QA results combined to no more than 2 deficiencies that are over 30 calendar days on the QA report, unless approved in writing by the DEQ Decision Support Analyst.
5. Record Management using the DEQ EDMS. The PHD shall add and maintain final copies of all drinking water-related documents into the DEQ EDMS, consistent with locations, naming conventions, container organization, and procedures outlined in the Drinking Water Filing Index (EMDS 2009ABP2) and the training provided by DEQ. When an electronic document is registered into the DEQ EDMS, it

then constitutes the file of record for that action and/or decision and will not need to be maintained in hard copy format unless DEQ policy requires hard copies, such as for enforcement cases. If documents generated prior to July 1, 2013 are electronically registered into the DEQ EDMS, they then constitute the file of record for that action or decision and do not need to be maintained in hard copy format.

a. Timelines for entry into the DEQ EDMS. All documents received and generated pertaining to a water system under PHD jurisdiction shall be registered into the DEQ EDMS within 15 calendar days of either receipt or generation, whichever comes first. The list of drinking water-related document types shall include relevant correspondence, including e-mails; sample results; inspection reports; photographs and logs; monitoring determinations, including monitoring waivers; and file notes. b. Restrictions using the DEQ EDMS. The PHD shall restrict their DEQ EDMS activity to only Drinking Water Bureau record types and only to those PWSs for which they have been delegated PWS program oversight responsibility.

6. Technology Standards. The PHD accesses SDWIS and the DEQ EDMS through DEQ's firewall using a web browser. SDWIS was designed for specific web-interface requirements. SDWIS functionality is maintained by a contractor for EPA. The PHD must ensure internet and software capabilities are maintained to ensure PHD staff has reliable access to SDWIS, the DEQ EDMS, and supporting applications. DEQ reserves the right to change any IP address at any time to meet operational or security needs.

a. The PHD shall ensure PHD staff has reliable access to SDWIS, the DEQ EDMS, and supporting applications sufficient to perform the work of this CONTRACT, including internet and browser compatibilities. SDWIS shall be used in the Chrome internet browser.

b. The PHD shall communicate any technological or security concerns with SDWIS or the DEQ EDMS with the DEQ Decision Support Analyst as soon as possible.

c. DEQ maintains lists of PHD Internet Protocol (IP) addresses. The PHD must notify the Decision Support Analyst no later than 2 business days prior to changing IP addresses of staff using SDWIS and the DEQ EDMS to ensure they maintain access to SDWIS and the DEQ EDMS.

d. If a PHD staff member changes their password such that it requires a sync to regain their DEQ access, the PHD staff member must call the ITS Service Desk at 208-605-4000 to request help. When calling the Service Desk, ask that the tech review page 16 of the DEQ SoS for guidance.

e. PHD staff members shall forward the Decision Support Analyst the ITS email ticket with the ticket number for all incidents or requests submitted to ITS related to the PHD's business needs related to this contract.

f. If a PHD staff member does not receive a response on an ITS ticket involving any business needs related to this contract, within 3 business days, the PHD staff member shall inform the DEQ Decision Support Analyst by forwarding the email ticket with the ticket number.

7. Computer, Internet, and Electronic Mail Usage. While conducting work under this CONTRACT the PHD shall adhere to Executive Order 2005-22 Establishing Statewide Policies on Computer, Internet and Electronic Mail Usage by State Employees (https://ita.idaho.gov/wpcontent/uploads/sites/3/2018/10/ExecutiveOrder200522.pdf).

The PHD shall adhere to the Idaho Technology Authority's policies P1060 -Employee Personal Computer Use, P1040 – Employee Electronic Mail and Messaging Use, and P1050 – Employee Internet Use. These policies can be found online at: https://ita.idaho.gov/resources/.

8. Domain Name System (DNS). The PHD is responsible for using either the state DNS server (highly recommended) or updating their local DNS servers in accordance with the PHD's network configuration and working with ITS staff. Alternatively, each user can manually edit the local PC's "hosts" file edited to reflect the correct IP address and name of the servers that the user will attach.

9. Meetings, Workshops, and Trainings.

a. Quarterly Review. The PHD shall participate in quarterly meetings with its DEQ REGIONAL OFFICE to review performance of the CONTRACT, program objectives and compliance activities associated with violations and/or MCL or action-level exceedances. Project goals and priorities shall be adjusted as necessary. In-person or teleconference is acceptable. See SECTION C.13.

b. Safety Training Program. A safety training awareness program is required for PHD staff conducting sanitary surveys. DEQ shall provide a General Safety Manual to the PHD staff through the SDWIS Switchboard. Documentation related to initial and ongoing review (i.e., review is every two years after initial) of the required material shall be provided to the DEQ STATE OFFICE every two years on the Safety Manual Acknowledgement Form provided as Appendix A in the IDEQ General Safety Manual (EDMS# 2015AEH1).

c. Maintaining Proficiency. PHD staff shall maintain proficiency with state and federal rules and regulations, sanitary surveys, assessment, SDWIS, EDMS, and other drinking water related activities through online or other training.

d. Monthly Drinking Water Meeting. PHD staff shall participate in DEQ's monthly drinking water meeting. PHD staff are responsible for reviewing call notes.

e. Quarterly Compliance/Enforcement Meetings. PHD staff shall attend and come prepared to discuss and participate in scheduled compliance and enforcement meetings to address PWSs identified on the enforcement targeting tool assistant (ETTA) and any systems under formal enforcement.

f. Statewide In-Service Training. PHD staff shall participate in scheduled inservice trainings provided by DEQ.

g. Workgroups. The PHD is encouraged to participate in drinking water
workgroups as time permits.

10. Rule Implementation. The PHD shall implement the National Primary Drinking Water Regulations and the Idaho Rules for Public Drinking Water Systems, IDAPA 58.01.08, and shall follow all DEQ drinking water related guidance, policies, directives, and procedures. Specific rule implementation questions or interpretations shall be directed to the DEQ STATE OFFICE rule leads and staff identified in the document "State Office Drinking Water Contacts" (EDMS# 2016ANQ1).

11. Sanitary Surveys and Level 2 Assessments.

a. *Approved Staff to Conduct Sanitary Surveys and Assessments*. Only PHD staff that have completed the STATE OFFICE sanitary survey training requirements are allowed to conduct independent sanitary surveys or assessments. Prior to conducting a sanitary survey, staff must complete the "New Inspector Training Checklist and Acknowledgement Form" (EDMS# 2017ANP21). This checklist is intended to provide new Drinking Water inspectors with the necessary training to conduct sanitary surveys and assessments on their own. Completion of training will be tracked by the Decision Support & Field Services Supervisor using the "Drinking Water Sanitary Survey Training – Tracking Form" (EDMS# 2018ABI36).

b. *Sanitary Survey Frequency.* The PHD shall conduct sanitary surveys within 6 months prior to the SDWIS site visit "Next Due Date." The PHD shall ensure that all inspections are completed at all PWSs consistent with the inspection frequency as required by the GWR and as outlined in Table 2. Overdue surveys and surveys that are coming due can be found on the QA/QC Tool under Priority Level 4 and Priority Level 1, respectively.

c. Priority of Sanitary Surveys. The highest priority should be given to PWSs with overdue surveys or systems with potential public health issues. Surveys of high-risk systems, such as those with persistent water quality problems (e.g., acute E. coli MCLs) or other violations will take precedence over routine sanitary surveys. Sanitary survey goals and priorities shall be reviewed and adjusted as necessary at quarterly meetings with the DEQ REGIONAL OFFICE.

d. Format of Sanitary Surveys. The PHD shall use the electronic sanitary survey and report tool and adhere to the most current templates and forms such as the sanitary survey form, report template, and report statements or other survey tool provided by DEQ for all sanitary surveys. The sanitary survey report must ensure that significant deficiencies are clearly identified, and any generic report statements are amended or appended as necessary to accurately reflect the specific situation observed at the PWS. Sanitary surveys shall be conducted in accordance with the "Standard Operating Procedures for Conducting a Sanitary Survey" (EDMS# 2019ANP55). The PHD shall be subject to, and comply with periodic audits of, the sanitary surveys that have been conducted. e. Preliminary Inspection Findings Form (PIFF). A completed PIFF is required for each sanitary survey. After conducting a sanitary survey, the PHD shall distribute copies of the PIFF as follows:

i. The duplicate, non-original shall be left with the PWS.

ii. An electronically scanned copy shall be registered into the DEQ EDMS record management system, consistent with the locations outlined in the Drinking Water Filing Index (EDMS# 2009ABP2) and forwarded to the Drinking Water Bureau's Capacity Development Analyst.

iii. If no deficiencies are identified during the inspection, write on the PIFF in the Potential Violations Pending Further Review section that no deficiencies or violations were found during the inspection, and the Disclaimer clause (found on the back of the PIFF) was explained to the PWS representative.

f. Sanitary Survey Reports.

i. Sanitary survey reports, which include the transmittal letter and electronic sanitary survey form for all inspection modules, must be completed within 30 calendar days of the date of inspection. A sanitary survey is not completed until the transmittal letter, appropriate sanitary survey form, and other supporting documents are delivered via email or mail to the PWS and the Water System Notification Date is entered into SDWIS.

ii. The PHD shall complete the email or mail and data entry tasks on the same day.

iii. The PHD shall provide a cover letter and sanitary survey report to the PWS owner or operator. The cover letter shall summarize the findings and the report that identifies the significant deficiencies, deficiencies, and recommendations. The cover letter/ report template language/ format shall be modified to the needs of the system (Highlighted items and comments addressed with comments removed from the final report). The report must utilize the Drinking Water Bureau developed report statements that include rule citations and be amended for specificity to the system and for clarity. The report must include a narrative regarding all parts of the PWS and be fact based with no personal opinions or recommendations.

iv. The PHD shall register an electronic copy of the sanitary survey form, sanitary survey report, a cover letter, and other relevant documentation into the DEQ EDMS. The electronic copy must be the same document and information that is provided to the PWS owner.

12. Engineering Waivers. Sanitary surveys identifying potential engineering issues including sources that violate sanitary setbacks for sewer lines, septic tanks, and property lines may require an engineering review by the DEQ REGIONAL OFFICE to determine applicability of a potential engineering waiver or other necessary actions, particularly for newly discovered systems. If the owner requests an engineering waiver, the PHD shall coordinate with the DEQ REGIONAL OFFICE. Engineering waivers shall be issued by the DEQ REGIONAL OFFICE and not by the PHD.

13. Monitoring Waivers and Sampling Delays.

a. RTCR/ Sample Delays or Sample Invalidation. Monitoring frequency decisions shall be documented in writing to the PWS and maintained in accordance with the primacy requirements in 40 CFR § 142.14. Specific forms with requirements and instructions are found on the internal Public Water System Switchboard under Forms/Information under the "MCL Follow-up/RTCR Forms" button. The forms address delay of repeats, sample invalidation, and waiver of 3 temporary routines for systems on quarterly monitoring. No waivers are allowed for repeat samples in accordance with 40 CFR § 141.858(a)(1).

b. Chemical Monitoring Waivers. The PHD shall review monitoring waiver applications in accordance with DEQ guidance (Drinking Water Monitoring Waiver Guidance, revised February 2011; EDMS# 2011ABP4), standard operating procedures (Drinking Water Monitoring Waiver Evaluations, July 2020; EDMS# 2019ABP33), and policies or newer guidance and procedures when finalized. Evaluations shall be conducted using the evaluation form provided by DEQ and available on the Internal Switchboard.

The signature authority for monitoring waiver decisions is delegated to the PHD's Environmental Health Directors, or PHD's Division Administrator overseeing Environmental Health, in accordance with the March 18, 2011 delegation memorandum. The delegation to the Environmental Health Directors is not transferable. PHD staff shall make a recommendation to approve or deny monitoring waivers to the Environmental Health Director.

The PHD shall ensure monitoring schedules in SDWIS reflect the monitoring decisions.

Application and final approval documents related to monitoring waivers shall be registered into the appropriate location in the DEQ EDMS, consistent with the locations outlined in the Drinking Water Filing Index (EDMS# 2009ABP2).

14. Idaho Division of Occupational and Professional Licenses (IDOPL) Responsible for Licensing. IDOPL issues licenses for drinking water operators. The PHD shall contact IDOPL at https://dopl.idaho.gov/ if questions arise and for information pertaining to licensed operators for the State's community and non-community water systems. Please contact the Decision Support & Field Services Supervisor with questions as necessary.

15. Compliance Assistance and Enforcement

a. Compliance Assistance. The PHD shall provide technical assistance to PWSs to establish and maintain compliance.

b. Pre-enforcement and Informal Enforcement Actions. The PHD shall take timely and appropriate action for non-compliance in accordance with DEQ's established policies, procedures, and guidance. The PHD shall collaborate with the DEQ REGIONAL OFFICE and DEQ STATE OFFICE Compliance and Enforcement Supervisor early in the compliance process. The PHD shall ensure that PWSs are notified of violations in writing, make contact attempts via phone or email with every written letter, and provide informal enforcement actions in a timely manner. The PHD shall coordinate with the DEQ REGIONAL OFFICE to conduct pre-enforcement compliance meetings. A log of communication or communication attempts shall be maintained by the PHD and be provided to the DEQ REGIONAL OFFICE as part of any enforcement referral being sent to the DEQ STATE OFFICE. Communication logs shall be maintained in EDMS.

c. Report Review. The PHD shall review and provide timely and accurate input on compliance reports prepared by the DEQ STATE OFFICE such as for routine auto-dialer calls and operator licensing reviews.

d. Formal enforcement. DEQ does not delegate formal enforcement authority to the PHD. The PHD shall ensure timely and appropriate action is taken in accordance with EPA's Enforcement Response Policy in SECTION C.15.h. If DEQ recommends or requests that an enforcement action be taken against a PWS, the PHD shall follow DEQ compliance and enforcement policies and procedures, including the submission of referral packages and relevant documents to the DEQ REGIONAL OFFICE drinking water program supervisor, and any other materials DEQ may deem necessary to conduct an enforcement action. See SECTION C.15.b for supporting documentation requirements.

e. Compliance tracking. After DEQ takes a formal enforcement action, such as entry into a Consent Order (CO) or a Compliance Agreement Schedule (CAS), the DEQ REGIONAL OFFICE staff will coordinate with PHD staff to ensure compliance with the timelines of the order. The PHD will continue to provide oversight of the system unless negotiated with the DEQ REGIONAL OFFICE in accordance with Section D.2 of this CONTRACT.
f. Food License and Daycare Coordination. The PHD shall coordinate transfer of PWS information between the PWS staff and food licensing and daycare licensing staff for those licensed food or daycare establishments that are, or should be, regulated PWSs. The PHD shall ensure coordination occurs between the food licensing and daycare licensing staff and PWS staff when there are contamination events.
g. Public Notification.
i. The PHD shall ensure PWS owners and operators are notified in a timely manner regarding the requirements to provide public notification and verify that proper and timely public notification is conducted.
ii. If a PWS owner or operator does not issue a required public notice for Tier 1 violations or situations requiring Tier 1 public notification within 24 hours of being notified by the PHD, then the notice or news release shall be issued by the PHD in conformance with IDAPA 58.01.08. PHD staff shall notify the DEQ REGIONAL OFFICE and the DEQ STATE OFFICE and request assistance when necessary. The PHD shall notify and coordinate with the DEQ REGIONAL OFFICE when a PWS does not perform a Tier 2 public notification. Violations shall be assessed for a system not providing the required public notification, even if the PHD issued the notification.
h. Enforcement Response Policies. The PHD shall comply with EPA's 2009 Enforcement Response Policy and any subsequent policies to ensure that the PWS obtains timely and appropriate compliance.
i. New PWSs. The PHD shall coordinate with the DEQ REGIONAL OFFICE upon the discovery of an existing, but currently unregulated PWS. Upon determination that the PWS falls within the jurisdiction of the PHD, the PHD shall coordinate with the DEQ REGIONAL OFFICE to determine if there are engineering records on file or other pertinent information. A determination of approval to serve may be necessary from the DEQ REGIONAL OFFICE, which may include the DEQ REGIONAL OFFICE performing a well site evaluation or other reviews as necessary. The PHD shall request a new PWS ID and EDMS container from the DEQ STATE OFFICE Decision Support Analyst and add the relevant information in SDWIS. The PHD will schedule and perform a sanitary survey and provide the new system owner with technical assistance.
16. Access to Records. All records pertaining to regulated PWS are the property of DEQ. The PHD shall maintain and provide access to records of all analytical results, correspondence, sanitary surveys, enforcement actions, monitoring frequency decisions, and other pertinent information as outlined in 40 CFR § 142.14. The PHD shall provide copies of records when requested by DEQ and in the format requested by DEQ (electronic or hard copy) if the record is not in the DEQ EDMS.
17. Professional Documentation. The PHD shall ensure letters, surveys, reports, and other documentation are of high quality and presented in a professional manner. At a minimum, the document shall:
a. Be written in a succinct, clear, and thoughtful manner;
b. Contain correct grammar, spelling, and punctuation;
c. Follow formatting and style guides, and the requirements described in the Standard Operating Procedure for Conducting a Sanitary Survey (EDMS# 2019ANP55) when applicable;
d. Use the most current DEQ template letters and forms; and,
e. Provide PWS owners or operators with clear requirements and timelines as necessary.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.136 Injury Prevention and Control Research and State and Community Based Programs 16.838 BJA FY21 Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program | People who use drugs or those who serve persons who use drugs | 9/1/2024 | 8/30/2025 | $114,000.00 | $99,650.00 | $14,350.00 | $114,000.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES

A. Subgrantee Education and Training (Required)

1. The Subgrantee staff must familiarize themselves with the Public Health and Safety Teams (PHAST) materials, linkage to care materials, harm reduction materials, public education materials, and naloxone training materials by reviewing materials located at: https://idhw.sharepoint.com/sites/PublicHealth-EPP/CEH/PDOPEP/SitePages/Home.asp x within sixty (60) calendar days of this Subgrant's execution.

2. The Subgrantee staff must familiarize themselves with updates and additions to the education materials within thirty (30) calendar days of receiving notification of new materials from the Department.

B. Infrastructure and Meetings (Required)

1. The Subgrantee must:

a. Have one (1) staff member join an Idaho Opioid Misuse and Overdose Prevention strategic plan goal group and actively participate in goal group calls and contribute to strategic planning action steps if activities are within the scope of the Subgrant.

b. Participate in monthly calls with the Department's Drug Overdose Prevention Program staff and other Public Health District Subgrantees. Call schedule to be determined by the Department.

c. Send a minimum of one (1) staff member to a reverse site visit meeting in Boise, Idaho in June 2024. Funding to support travel costs are included in the Cost/Billing Procedure section of this Subgrant. The meeting must occur, and staff must attend for the Subgrantee to bill for these funds.

d. Have a minimum of one (1) staff member participate in a virtual kick-off meeting in October 2023.

C. Subgrant Workplan (Required)

1. By September 30, 2023, the Subgrantee must complete and submit a Subgrant workplan to the Subgrant monitor for review and approval.

a. The Subgrant workplan must include all required deliverables and the optional deliverables selected by the Subgrantee.

b. A template for the workplan must be provided by the Department by September 1, 2023 and located at: https://idhw.sharepoint.com/sites/PublicHealth-EPP/CEH/PDOPEP/SitePages/Home.aspx.

D. Part 1: CDC Overdose Data to Action (OD2A) Funded Activities. For this priority area, the Subgrantee must complete the required deliverable by selecting one (1) of the two (2) optional deliverables to complete.

1. Public Health and Safety Teams (PHAST) (Required)

a. (Option1: Planning Year) By August 31, 2024, the Subgrantee must establish a PHAST team within their region.

i. Subgrantees are encouraged to use the PHAST toolkit as a guide and complete Module One (1) of the toolkit within this planning year.

ii. PHAST teams will serve to identify and implement opportunities within their regions such as Overdose Fatality Review teams, Overdose Mapping and Application Program (ODMAP) implementation, and spike alerts.

iii. PHAST team stakeholders may include but are not limited to Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) program, Idaho State Police regional public safety officers, and local law enforcement.

iv. PHAST toolkit and additional resources are available at: https://phast.org/.

b. (Option 2: Implementation Year) By August 31, 2024, the Subgrantee must work with the established PHAST team to develop a comprehensive regional plan based on the PHAST toolkit.

i. Subgrantees are encouraged to use the PHAST toolkit as a guide and complete Module Two (2) or Module Three (3) of the toolkit within this implementation year.

ii. PHAST teams will serve to identify and implement opportunities within their regions such as Overdose Fatality Review teams, Overdose Mapping and Application Program (ODMAP) implementation, and spike alerts.

iii. PHAST team stakeholders may include but are not limited to Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) program, Idaho State Police regional public safety officers, and local law enforcement.

iv. PHAST toolkit and additional resources are available at: https://phast.org/.

E. Education and Promotion of Harm Reduction Services (Required). For this priority area, the Subgrantee must complete the required deliverable and must choose two (2) of the optional deliverables to complete.

1. (Required) By August 31, 2024, the Subgrantee must conduct at least three (3) outreach events to people who use drugs (PWUDs) and friends and family of PWUD.

a. Subgrantees may use existing resource platforms such as FindHelpIdaho.org and collaborate with Drug-Free Community coalitions, Idaho harm reduction organizations, and local recovery/crisis centers serving PWUD to educate on and promote access to harm reduction services in their communities.

b. Outreach events may include but are not limited to formal presentations, media campaigns, and/or tabling.

i. Subgrantees are encouraged to tailor messaging to target audiences and work with local stakeholders to center the voices of people with lived or living experience with substance use.

c. Priority populations for presentations may be determined by Idaho overdose mortality data and the Idaho opioid overdose vulnerability assessment.

i. Idaho overdose mortality data can be accessed at: https://www.gethealthy.dhw.idaho.gov/drug-overdose-dashboard

ii. Idaho opioid overdose vulnerability assessment: to be provided by the Department.

2. (Optional) By August 31, 2024, the Subgrantee must organize, promote, and hold at least one (1) public awareness event for International Overdose Awareness Day or National Fentanyl Awareness Day in their district.

3. (Optional) By August 31, 2024, the Subgrantee must participate in a minimum of five (5) peer-to-peer Syringe Service Program (SSP) statewide calls.

4. (Optional) By August 31, 2024, the Subgrantee must partner with a harm reduction organization to provide a minimum of two (2) harm reduction events, including education and resources, to PWUD or people in recovery.

5. (Optional) By August 31, 2024, the Subgrantee must develop or continue a stigma reduction campaign or educational campaign/resources regarding opioid use and overdose.

a. Examples may include words matter public awareness campaign or educational resources to the public to reduce stigma; education around addiction as a medical disease.

F. Community-Based Linkage to Care Activities (Required): For this priority area, the Subgrantee must complete the required deliverable and must choose one (1) of the optional deliverables to complete.
1. (Required) By August 31, 2024, the Subgrantee must work with organizations that interact with PWUDs such as recovery centers, crisis centers, and/or treatment centers in their region to conduct at least three (3) outreach or educational events on primary prevention of drug misuse, program resources, and organization connections.
2. (Optional) By August 31, 2024, the Subgrantee must update the local treatment and recovery resources on their district opioid asset map or work with FindHelpIdaho.org to update resources for local substance use recovery and treatment.
3. (Optional) By August 31, 2024, the Subgrantee must share their local treatment and recovery resource list with a minimum of five (5) emergency departments or primary care clinics in their district.
4. (Optional) By August 31, 2024, the Subgrantee must work with their regional PHAST teams to help facilitate the sharing of linkage to care resources and information across sectors including public safety and treatment, recovery, and crisis centers.

G. Local Capacity (Optional)
1. This option aims to enhance coordination and partnerships at the local level regarding drug misuse prevention, harm reduction and linkage to care. In selecting this priority area, the Subgrantee must choose one (1) of the following activities:
a. From September 1, 2023 to August 31, 2024, continue the coordination and implementation of a regional or district-wide strategic plan regarding opioid misuse and/or stimulant misuse with local stakeholders.
b. From September 1, 2023 to August 31, 2024 join or continue active participation in established substance misuse prevention, suicide prevention, or harm reduction coalition(s) within their region.

H. Tribe Partnerships (Optional)
1. This option aims to build partnerships with federally recognized tribes residing in Idaho health districts regarding the risks of opioids and stimulants.
a. By August 31, 2024, the Subgrantee must collaborate with the federally recognized tribe in their health district to provide education and resources regarding opioid, and/or stimulant use and overdose.

I. Part 2: BJA Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Funded Activities. All activities under COSSUP are required.
1. Naloxone Trainings
a. By August 31, 2024, the Subgrantee must organize, promote, and conduct a minimum of five (5) in-person or virtual naloxone trainings to the public, public safety, or other community organizations within their district. Trainings must include availability of naloxone, opioid overdose warning signs, how to administer and access naloxone, and the Idaho Good Samaritan Law.
i. Naloxone training template and survey will be provided by the Department on the DOPP external SharePoint site: https://idhw.sharepoint.com/sites/PublicHealth-EPP/CEH/PDOPEP/SitePages/Home.aspx
ii. Naloxone training surveys are to be provided at all trainings for attendees to complete and submit to the Department by August 31, 2024.
2. Prescription Drug Take-Back Events
a. By August 31, 2024, the Subgrantee must organize, promote, and implement a minimum of one (1) prescription-drug take back day event to the public within their district.
i. Subgrant funds may be used for take-back day promotion, media, and drug disposal supplies.
3. 2024 COSSUP National Meeting
a. The Subgrantee must send a minimum of one (1) and up to two (2) staff members to the BJA COSSUP National Meeting in Washington, DC in Summer/Fall 2024. Funding to support travel costs are included in the Cost/Billing Procedure section of this Subgrant. The meeting must occur, and staff must attend for the Subgrantee to bill for these funds.
4. Submission of Promotional Materials
a. The Subgrantee must submit to the Department for submission to BJA for review and approval any curricula, training materials, proposed publications, reports, or any other written materials that will be published, including web-based materials and website content, through the BJA funds from this Subgrant at least thirty-five (35) business days prior to the targeted dissemination date.
i. Submissions can be made to the Subgrant Monitor via email. Submissions are only required for BJA funded naloxone trainings and take-back day event materials developed by the Subgrantee.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.991 Preventative Health and Health Services Block Grant: Fit and Fall Proof | Community dwelling older adults. | 10/1/2024 | 9/30/2025 | $95,897.00 | $79,897.00 | $16,000.00 | $95,897.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES
A. Priority Area 1-4: PHHS Block Grant Funded Activities and State Funded Activities
1. Priority Area 1: Maintain and Report Progress of FFP Class Sites: By September 30, 2025, the Subgrantee must maintain twenty-three (23) sites, or increase the number of sites.
a. A 'site' is the physical location where the class is held. If a site offers multiple class sessions at non-consecutive times (for example: 9:00 a.m. and 3:00 p.m. at the same location), each class session must count as an individual site. Classes held at the same site at consecutive times may be considered as individual sites.
b. The Subgrantee must ensure class sites are open to the public and may be established at any facility except skilled nursing, assisted living or other facilities where the resident pays for services beyond room and board.
i. If the Subgrantee receives a request to start a new class site at one (1) of these locations, communication with the Department must occur to determine next steps.
c. The Subgrantee must provide a certificate of liability insurance with the standard liability limit of five hundred thousand dollars ($500,000) to each site location with a unique address, if requested
i. A certificate of insurance request form may be submitted online or via email to the Risk Management Program. The Department will provide the request form.
d. The Subgrantee must add FFP class information to www.findhelpidaho.org and update information on a quarterly basis.
i. The Department will provide training and technical assistance.
e. The Subgrantee must offer classes at no charge or low cost. For example, sites may charge ten dollars ($10) per ten (10) week session.
i. The Subgrantee must list the sites charging a fee and the amount of the fee on the state fiscal year (SFY) 2025 Site Tracking Form Tab in the Subgrant Monitoring Report (SMR).
f. The Subgrantee must offer forty-five (45) to sixty (60) minutes of active exercise
each class, at least two (2) times per week, for a minimum session of ten (10) weeks, with every effort made to keep the weeks consecutive.
g. Once a site is established (after the first year), the Subgrantee's maintenance sites must hold a minimum of one (1) session, three (3) times during the Subgrant year. The first year a new site is established, the Subgrantee must hold the following number of sessions:
i. If established in the first quarter - conduct a minimum of three (3) sessions of ten (10) weeks each.
ii. If established in the second quarter - conduct a minimum of two (2) sessions of ten (10) weeks each.
iii. If established in the third or fourth quarters - conduct a minimum of one (1) session of ten (10) weeks.
h. If a new ten (10) week session begins in September and finishes in the new fiscal year, the Subgrantee may request that the session to be counted as active in the new Subgrant year, with prior approval from the Department.
i. The same session may not be counted in multiple Subgrant years.
i. The Subgrantee must ensure attendance is collected for each active class session using the class record sheet provided by the Department, and must communicate the importance of collecting the following data to all class leaders:
i. First and last names or first name and last initial (e.g., Sally Smith or Sally S.) are required for each participant in each class.
ii. Any additional demographic information added by the third-party evaluator, such as age and gender, are required.
iii. For evaluation purposes, all new participants (e.g., has not participated in any classes in the past year): Must check the appropriate box indicating they are "New" on the class record sheet; Must list how they heard about the class on the class record sheet in the space provided. Referrals should be collected and noted on the class record sheet in effort to gauge the success and reach of referrals.
iv. Test scores must be recorded with the proper notation made on the class record sheet.
v. The Subgrantee must transfer all class record sheets to typed Excel files to ensure clarity and completeness to the extent possible.
j. The Subgrantee must ensure pre- and post-Timed Up and Go (TUG) tests are conducted with all participants during a minimum of two (2) sessions per year, including during the site's first and third sessions of the year.
i. During their first week of participation, new participants must receive a pre-test upon joining a class already in session. The post-test must be conducted at the end of the session. If a participant starts at the end of a session, they may be tested at the beginning of the next session. Test scores must be recorded and submitted quarterly to the Department and the Boise State University (BSU) Evaluation Team.
ii. Participants may choose to opt out of testing.
iii. Class leaders must be trained to conduct the TUG test during Class Leader
Training, as outlined in the manual, so they may administer the pre- and post-test and complete all required class participation paperwork. The Subgrantee must ensure class leaders are prepared to perform all record-keeping duties required of the program prior to the start of their first session and that all leaders receive annual refreshers on completing all class record requirements (e.g., through site visits or one-on-one [1:1] meetings).
k. The Subgrantee must purchase all materials/supplies, as needed and as approved by the Department for classes.
i. The Subgrantee must document on the SMR, sites that purchase class materials and supplies independent of Subgrantee support, such as through collection of participant fees or donations, therefore offsetting costs to the Subgrantee.
ii. Class sites must be provided with supporting materials for administration of the class, such as: exercise balls, bands, music materials, etc.
l. The Subgrantee must monitor the exercise class sites throughout the year, as needed.
i. Each site must be visited, in-person, one (1) time during the Subgrant year, and then as needed. A technical assistance (TA) call or video conference is required for each ten (10)-week session when an in-person visit was not made. New leaders may potentially need more visits and TA calls. The Subgrantee must consider experience level of leaders when planning number of visits and calls. Site visits must be utilized as coaching opportunities to empower leaders in their role, ensure adherence to program fidelity, nurture relationships, observe class leader performance, provide constructive feedback, assess adherence and cueing for safety precautions, assess class participation, provide materials, and to ensure valid recording of participation and evaluation data by class leaders on the class record sheet provided by the Department.
ii. During site visits, the Subgrantee must utilize the feedback forms, developed by the Department, as needed, to provide constructive feedback to class leaders and to ensure consistency in instruction and program fidelity across the state. Outcomes of feedback findings or discussions with sites/leaders must be reported in the Site Visit Summary Tab in the SMR.
m. The Subgrantee must collect and submit quarterly program data to the Department using the Site Tracking Form. The Subgrantee must:

i. Complete and submit an electronic copy of the Site Tracking Form (including all information on active sites and classes held) provided by the Department.
ii. Collect and submit specific data for each site, as listed on the Site Tracking Form, including address, county, organization type, and number of leaders.
iii. Include a running list of each session to ensure each site completes the minimum number of sessions required.
iv. Quarterly, update the Site Tracking Form template included as a tab in the SMR.
n. The Subgrantee must collect and submit quarterly program data to the Department using the Class Record Sheets:
i. The Subgrantee must submit typed electronic copies of the Class Record Sheets each quarter.
ii. The Subgrantee must e-mail all late-submitted Class Record Sheets to the Department and the BSU Evaluation Team, as they are received, after the corresponding SMR was submitted; updating the Site Tracking Form and corresponding SMR, as necessary; and include these forms in the e-mail correspondence.
iii. Records must be submitted electronically with an updated Site Tracking Form and emailed to the BSU Evaluation Team at IdahoFFP@Boisestate.edu after the end of each corresponding quarter. Submission of hard copies is not necessary.
iv. Under Subgrant Services and Activities II., Priority Area 1, the Subgrantee must list, in alphabetical order, all active sites that completed or will complete a session each quarter. The Subgrantee must list all completed and submitted record sheets, noting any missing record sheet(s).
o. The Subgrantee must collect and submit quarterly program data to the Department using the Leader Tracking Form.
i. The Subgrantee must complete a comprehensive list of all trained and active leaders and include the leaders name, date of training, and location where they teach.
ii. The Leader Tracking Form template is included as a tab in the SMR and must be updated quarterly.

2. Priority Area 2: FFP New Leaders and Training: By September 30, 2025, the Subgrantee must recruit new class leaders, as needed, and host new trainer training sessions.
a. The Subgrantee must train class leaders, as needed.
b. The Subgrantee must work towards ensuring peer class leaders are trained for every site that includes a university student volunteer leader, as applicable.
c. Training may be coordinated with neighboring districts.
d. The Subgrantee must provide guidance and communicate the importance of wearing appropriate attire, as outlined in the manual, and modeled by class leaders during trainings and while teaching classes.

3. The Subgrantee must make every effort to utilize local Master Trainers when conducting FFP Class Leader trainings. The Subgrantee must make all class-related arrangements, including working with local Master Trainers to find an acceptable training date.
a. The Subgrantee must inform the Department via email of any scheduled trainings and Master Trainers travel time.
b. In the event local Master Trainers are unavailable to conduct a local FFP Class Leader Training, the Subgrantee must coordinate trainings with the Core Master Trainer, with a courtesy email to the Department. All training costs must be supported by the Subgrantee. All travel costs for the Core Master Trainer will be supported by the Department.
c. Local Master Trainers mileage may be reimbursed through operating costs as a means to accomplish the scope of work. In cases of mileage reimbursement, Subgrantees must create a travel policy for Master Trainers. Policies require the Subgrantee provide travel forms to document mileage and set a standard reimbursement rate.

4. The Subgrantee must ensure Master Trainers and lay leaders adhere to fidelity requirements to ensure FFP is delivered as outlined in the manual. The Subgrantee must:
a. Ensure class leaders are trained to properly administer and model instructions for the TUG test, emphasizing walking at normal pace, to ensure fidelity and adherence to the national standard.
b. Ensure Master Trainer candidates meet all requirements for Master Trainers as designed by the Department. Discuss candidates' eligibility and potential with Core Master Trainers prior to accepting attendance at an upcoming training.

5. The Subgrantee may provide meals and/or refreshments at exercise class leader trainings and events, lasting three (3) hours or more.
a. The Subgrantee must comply with Department policy on meals and refreshments, as provided by the Department.

6. The Subgrantee may provide promotional items such as tote bags, water bottles, or exercise shirts to FFP leaders, as appropriate.
a. Items must be used to support leaders in their role and while instructing the exercise program.

b. Items must be reviewed for appropriateness and cost. Items must include the FFP program logo, and be approved by the Department prior to purchasing.
c. Invoicing for promotional items is explicitly outlined in the Cost Billing section of this Subgrant.

7. Priority Area 3: FFP Workshops and Training
a. By September 30, 2025, the Subgrantee must coordinate a minimum of one (1) half-day or full-day Volunteer Leader Refresher/Recognition Workshop. Additional workshops must be provided as needed and determined by the Subgrantee.
i. The Subgrantee must develop a recognition and refresher curriculum for a workshop to recognize Master Trainers and class leaders, and ensure they are up-to-date and teaching to the fidelity of the program.
ii. Dates, agenda, and expectations of the Core Master Trainer's presentations and participation must be communicated with the Core Master Trainer. The Subgrantee must notify the Department of training dates during quarter one (Q1) with information reported on the first quarter SMR.
iii. Purchase of recognition materials must be approved by the Department and must be included in operating costs.
iv. Core Master Trainers' service costs must be supported by the Subgrantee at the following rates. FY25 pricing for half-day is three hundred dollars ($300) and full day is six hundred dollars ($600). Costs may be shared with other health districts if coordinating training together.

v. Core Master Trainers' travel costs will be supported by the Department.
vi. A half-day workshop must last a minimum of three (3) hours and up to four (4) hours in duration.
vii. A full-day workshop must last a minimum of five (5) hours and up to seven (7) hours duration.
viii. The Subgrantee may provide meals and or refreshments at trainings and events with exercise class leaders.
ix. Invoicing for meals and or refreshments is explicitly outlined in the Cost Billing section of this Subgrant and must comply with Department policy on meals and refreshments, as provided by the Department.

8. September 30, 2025, select Qualified Candidates and Coordinate a Master Trainer Workshop.
a. The Subgrantee must work with the Core Master Trainer to plan and conduct Master Trainer Workshop to certify new volunteer Master Trainer candidates, as needed.
i. Dates of the training and subsequent Master Trainer Observations must be coordinated with the Core Master Trainer.
ii. The Subgrantee must notify the Department of training and observation dates during Q2 with information reported on the second quarter SMR.
iii. Core Master Trainer's costs for training and observing candidates must be supported by the Subgrantee; FY25 pricing for a Master Trainer training is six hundred dollars ($600) and observation is one hundred fifty dollars ($150).
iv. Core Master Trainer's travel costs will be supported by the Department.
v. The Subgrantee may provide meals and/or refreshments at trainings and events with exercise class leaders.
vi. The Subgrantee must comply with Department policy on meals and refreshments, as provided by the Department.

9. Priority Area 4: FFP and Home Safety Checks Promotion and Outreach
a. By September 30, 2025, the Subgrantee must conduct at least three (3) unique media/messaging campaigns or public service announcements (PSAs) to boost public awareness about FFP classes, home safety checks for fall prevention, and community resources.
i. The Subgrantee must follow FFP branding strategies and efforts developed by the Department and adhere to the registered trademark requirement. Branding strategies include an FFP promotional class flyer, FFP brochure, and other media materials. Use of the FFP logo must be visible on all promotional and incentive materials to keep a clear and consistent message about the FFP program.
ii. Media and messaging should include educational content and a call-to-action, not solely event promotion.
iii. Report the campaign topics, number of media outlets, and outcomes in the SMR.

10. By September 30, 2025, the Subgrantee must conduct at least three (3) educational presentations annually on FFP classes and home safety checks to community leaders, healthcare professionals, senior center managers, etc. Topics should cover exercise for fall prevention, home safety checks, healthy aging, and volunteer engagement.
a. Presentations solely for distributing program materials are not acceptable.
b. Report presentations quarterly in the SMR Presentations Tab, including date, audience, number of attendees, topic, materials shared, and outcomes.
c. Use Department-provided materials (PowerPoint templates, videos) and the latest data from the BSU Evaluation Team.

B. Priority Area 5-7: State Funded Activities
1. Priority Area 5: Fit and Fun Playscapes and Super Stickers
a. By September 30, 2025, the Subgrantee must work with a minimum of one (1) childcare provider, park, or a school to make playground improvements and updates using painted playground stencils or install Super Stickers® to increase and improve physical activity opportunities. Each location equals one (1) stencil or sticker activity. Multiple stencils, or a stencil and a sticker at one (1) location do not count as more than one (1) activity. See www.fitandfunplayscapes.com for examples of stencils and stickers. The Subgrantee must:
i. Assess environment to ensure adequate space for stencil or sticker application.
ii. Work with staff to determine design and location of playground stencils or sticker to encourage physical activity and learning.
iii. Work with staff and community members to enlist help with painting stencil or applying sticker.
iv. Purchase outdoor grade paint, drop cloth, and foam roller brushes, etc.
v. Work with staff or volunteers to schedule an appropriate time to assist in the application of stencils or stickers.
vi. Ensure the proper steps are taken to prepare the area(s) to be painted or for stickers to be applied. Information on preparing the playground for painting and sticker application can be found at https://www.fitandfunplayscapes.com.
vii. Take before and after photos to include in quarterly reports and presentations.

2. Priority Area 6: Professional Development and Collaborations
a. By September 30, 2025, the Subgrantee must attend, in-person or virtually, a professional local, regional or national conference or training related to a Subgrant activity.
i. The conference or training must be approved by the Subgrant Monitor prior to attendance and must be reported in the SMR.

3. By September 30, 2025, the Subgrantee must join the Idaho Falls Prevention Coalition as a general member and attend, in-person or virtually, a minimum of six (6) Coalition meetings.
a. The Subgrantee must share relevant information with partners and with FFP Class Leaders, as deemed appropriate by the Subgrantee.

4. By September 30, 2025, the Subgrantee must develop a flexible partnership framework that facilitates community collaboration to enhance physical activity, nutrition, and senior fall prevention programs across the lifespan.

5. By May 30, 2025, the Subgrantee must coordinate with the Public Health District's (PHDs) dental hygienist, or a hygienist determined by the Department, to implement the Oral Health Adult Basic Screening Survey (Adult BSS) and Health Questionnaire.
a. The FFP Coordinator must identify the most suitable FFP class sites, based on factors such as location, participation rates, and the built environment, for the dental hygienist to conduct a voluntary Adult BSS and distribute paper and electronic Oral Health Questionnaire to FFP participants.
b. Support communication with FFP Class Leaders by engaging in verbal discussions and distributing promotional materials and consent forms, developed by the Department, to inform FFP participants about the Adult BSS and Questionnaire and to encourage voluntary participation.
c. Ensure that FFP Coordinators and Class Leaders clearly communicate to FFP participants that participation in the Adult BSS and Questionnaire is voluntary and separate from their involvement in FFP classes.
d. At certain FFP class sites, only the Questionnaire must be administered. For these sites, FFP Coordinators must collaborate with Class Leaders to distribute a quick response (QR code and/or paper Questionnaires to participants. Coordinators must then collect the completed forms from Class Leaders or participants and return them to the dental hygienist in a manner that ensures confidentiality and compliance with the Health Insurance Portability and Accountability Act [HIPAA]).
e. No personally identifiable information will be collected through the Adult BSS or Health Questionnaire; all data will be shared only in aggregate form.

6. Priority Area 7: Infrastructure and Planning
a. The Subgrantee must participate in at least two (2) virtual meetings with Idaho Physical Activity and Nutrition Program (IPAN) staff and other IPAN Subgrantees, meeting schedule to be determined.
b. The Subgrantee must attend two (2) in-person meetings with IPAN staff led by the Department and Core Master Trainer (location to be determined).
i. The Subgrantee must be responsible for making travel plans, including flight arrangements and hotel stay.
ii. The Department will provide a specific date for the workshop at least thirty (30) calendar days prior to the meetings.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Disease investigation and reporting to Bureau of Communicable Disease and Prevention; shipping to Idaho Bureau of Laboratories | All | 7/1/2021 | 6/30/2026 | $84,203.00 | NA | NA | $84,203.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES
A. The Subgrantee shall conduct a case investigation on all reported cases of disease or conditions, except where specified in the Idaho Investigative Guidelines for Public Health.

B. The Subgrantee shall report all diseases as listed in the current Idaho Reportable Disease rules (IDAPA 16.02.10) according to the timeframes listed therein.
1. In addition to mandated fields listed in IDAPA 16.02.10 040.01, investigation reports shall contain the following data elements:
a. Reporter information:
i. The reporting facility
b. Date of illness onset
c. Date of report
d. Case Status

C. The Subgrantee shall conduct an epidemiologic investigation on all outbreaks, except as mutually agreed upon by Subgrantee and Department Epidemiology staff.

D. Epidemiology Outbreak Report Form and Documentation
1. The Subgrantee shall submit a full Outbreak Report completed per the Outbreak Report instructions for all epidemiologic investigations except as noted in II.D.3 and II.D.4 below.
a. The Subgrantee shall submit a completed copy of the NORS form with any full Outbreak Report for foodborne, waterborne, and zoonotic outbreaks. (Forms can be found on the CDC website (http://www.cdc.gov/nors/forms.html) and samples can be found on external Epidemiology SharePoint [Attachment D and Attachment E]).
2. The Subgrantee shall submit a brief Outbreak Report Form completing the fields available per the instructions noted on the Outbreak Report Form in the following instances:
a. An outbreak of norovirus, influenza, or gastrointestinal illness in a residential facility where there is no evidence of foodborne or waterborne transmission.
b. An outbreak of other etiologies with fewer than five (5) cases and where the outbreak venue is not solely the index case household.
c. The Subgrantee shall submit a completed copy of the NORS form with any brief Outbreak Report for foodborne, waterborne, and zoonotic outbreaks. (Forms can be found on the CDC website

(http://www.cdc.gov/nors/forms.html) and samples can be found on external Epidemiology SharePoint [Attachment D and Attachment E]).
3. For all household-associated clusters, the Subgrantee shall document the outbreak number in the appropriate NBS field and provide a brief summary of the epidemiologic investigation in the NBS comments fields for each suspect, probable, or confirmed case.
a. The Subgrantee shall include in the NBS comments field, at a minimum:
i. Epidemiologic or other investigative methods employed,
ii. Specific control measures or other interventions that were recommended,
iii. Environmental investigation efforts or environmental sampling laboratory results,
iv. The leading hypothesis for initial exposure and route of transmission, and
v. The total number of symptomatic household members included in the outbreak.
b. If, during the epidemiologic investigation, the Subgrantee determines the outbreak extends beyond the household, refer to II.D.2.
c. The Subgrantee shall submit a completed brief Outbreak Report Form for any household-associated outbreaks upon request of the Department.
d. The Subgrantee is not required to submit a NORS form for household- associated clusters.
4. The Subgrantee shall send an email to the designated Department Epidemiology Lead if an outbreak number has been assigned to an event that is determined to not be an outbreak within the same due date timelines as outbreak reports.

E. The Subgrantee may use funding to ship specimens to the Idaho Bureau of Laboratories (IBL) up to the amount identified in the Cost/Billing Procedure.

F. The Subgrantee may use Department Epidemiology-purchased medications for the prevention or treatment of tuberculosis cases.
1. The Subgrantee shall make a reasonable attempt to contact Department Epidemiology staff to receive approval to use medications for other purposes (e.g., the prophylaxis of contacts to a case of meningococcal disease with rifampin).
2. The Subgrantee shall work with Department Epidemiology staff and other Public Health Districts to redistribute medications as needed.
3. The Subgrantee may pay for shipping of Department Epidemiology-purchased medications between public health districts using funds in this subgrant by contacting Department Epidemiology staff for approval to use the Department Epidemiology Federal Express account.

G. The Subgrantee shall send one (1) epidemiologist to the annual fall and spring epidemiology training conferences sponsored by State Epidemiology staff. Preferably, a second epidemiologist shall be sent l, if funds are available.

H. The Subgrantee shall have an epidemiologist(s) attend conference calls when hosted by State Epidemiology staff, during quarters in which there is no state conference (II.G. above), to discuss epidemiology issues affecting the state.

I. The Subgrantee shall determine individual training needs of epidemiologist(s) and send them to at least one (1) training, if funds are available. Examples of training include the approach to multidisciplinary investigation, proper investigation sampling and submission techniques, general epidemiology conferences (in addition to the state spring and fall conferences), epidemiology or biostatistics classes, and computer training.

J. When the Subgrantee determines it is needed, and if funds are available, the Subgrantee shall carry out active surveillance projects or activities to address issues of under-reporting, surveillance of non-reportable diseases, or in response to a new public health threat or outbreak.

K. The Subgrantee's epidemiology team shall participate in the annual site review conducted by Department Epidemiology staff.
1. The Subgrantee shall respond in writing to a letter summarizing the results of the site review to provide clarification or follow-up information if requested.

L. The Subgrantee shall attend regular meetings of the infection prevention team at one (1) of the nearest large hospitals.

M. The Subgrantee shall present disease trend or disease prevention information to medical professionals or community organizations at least once during the subgrant period.

N. The Subgrantee shall enhance, or initiate, written communication to the medical community through regular disease bulletins, disease advisories or disease alerts, if funds are available.

O. After the conclusion of an outbreak, the Subgrantee shall present a "lessons learned" summary of the outbreak, as requested by State Epidemiology staff, at either the fall or spring epidemiology training conference or on conference calls during the quarters no state epidemiology conference is held.

Performance Metrics

Case Investigation.

The Subgrantee shall conduct a case investigation on all reported cases of disease, except where specified in the Idaho Investigative Guidelines for Public Health.
Required Level of Expectation:

100%
Method of Monitoring:
Review of case investigations submitted via NBS; quarterly reports (Attachment A); timeliness/completeness reports; annual site review.
Monitoring Frequency:
Quarterly
Strategy for Correcting Non-Compliance:
State Epidemiology staff will document deficiencies and contact the Subgrantee to identify and agree upon resolutions. If the identified deficiencies are not corrected as agreed, the Department may consider further action.

Epidemiologic Investigation.

The Subgrantee shall conduct an epidemiologic investigation on all outbreaks, except as mutually agreed upon by the Subgrantee and the State Epidemiology Program and submit all required forms or complete all required NBS fields.
Required Level of Expectation:
100%
Method of Monitoring:
Review of Epidemiology Outbreak Report Forms, NORS forms, summary reports, and NBS investigations; quarterly reports (Attachment A); annual site review.
Monitoring Frequency:
Quarterly
Strategy for Correcting Non-Compliance:
State Epidemiology staff will document deficiencies and contact the Subgrantee to identify and agree upon resolutions. If the identified deficiencies are not corrected as agreed, the Department may consider further action.

Site Specific Program Review.

Subgrantee's epidemiology team shall participate in the annual site-specific program review conducted by the State Epidemiology Staff and shall respond in writing to a letter summarizing the results of the site review to provide clarification or follow-up information if requested.
Required Level of Expectation:
100%
Method of Monitoring:
Quarterly report (Attachment A); post site-review communication.
Monitoring Frequency:
Annually
Strategy for Correcting Non-Compliance:
The State Epidemiology staff will document deficiencies and contact the Subgrantee to identify and agree upon resolutions. If the identified deficiencies are not corrected as agreed, the Department may consider further action.

Annual Epidemiology Training Conference.

At least one, and preferably a second, epidemiologist will attend the annual fall epidemiology conference and spring epidemiology training developed by State Epidemiology staff.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sexually Transmitted Disease (STD) and Human Immunodeficiency Virus (HIV) Case and Outbreak Investigation and Response | All | 2/1/2025 | 5/31/2026 | $32,984.00 | NA | NA | $22,129.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES

A. Case, Contact, and Epidemiologic Investigation

1. (AMD 1) The Subgrantee must report and investigate HIV infection and HIV Infection Stage 3, also referred to as Acquired Immune Deficiency Syndrome (AIDS), to the Department as required by Idaho Code sections 39-602 and 39-606 and further delineated by Idaho Reportable Diseases (IDAPA 16.02.10).

a. Case investigations must be documented by the Subgrantee as directed in the Idaho Investigative Guidelines for Reportable Diseases and Conditions, with the applicable HIV/AIDS Case Report Form (Adult or Pediatric) submitted to the Department within one (1) month of notification of a case confirmed by laboratory results or verified previous diagnosis.

i. Documentation of each open case investigation at its current state of completeness must be submitted on the applicable Adult or Pediatric HIV/AIDS Case Report Form by the Subgrantee monthly from the date of initial report until the investigation is closed.

b. As possible, in conjunction with information completed in the National Electronic Disease Surveillance System (NEDSS) Base System (NBS), core demographic fields must be completed for each reported HIV infection case in the applicable adult or pediatric HIV/AIDS reporting form. The CDC standard for core data completion is greater than or equal to ninety-seven percent (97%). Core demographic fields include:

i. Name
ii. Sex at birth
iii. Date of birth
iv. Vital status
v. Date of death (if deceased)
vi. Ethnicity
vii. Race
viii. Country of birth
ix. Residence at diagnosis of HIV infection
x. Residence at diagnosis of HIV Stage 3 (AIDS)

c. Antiretroviral (ARV) medication use history must be documented by the Subgrantee on the Idaho Adult HIV/AIDS Report Form for each reported adult case (thirteen [13] years of age or older). The CDC standard for completion of ARV fields is greater than or equal to seventy percent (70%). The following ARV-related questions must be completed:

i. Ever taken any ARV medication
ii. Reason for ARV use
iii. Name(s) of ARV medication taken
iv. Date ARV use first began
v. Date of last ARV use

d. Previous HIV test history must be documented by the Subgrantee on the Idaho Adult HIV/AIDS Report Form for each reported newly diagnosed adult case (thirteen [13] years of age or older). The CDC standard for documentation of the previous negative HIV test indicator is greater than or equal to seventy percent (70%). The following test-related questions must be completed:

i. Ever had a negative HIV test (Y/N, Unknown)
ii. [Negative HIV test] Collect date.
iii. Number of negative HIV tests within twenty-four (24) months before first positive test.

e. Completion of the cluster of differentiation 4 (CD4) T lymphocyte and HIV viral load results most proximal to the HIV infection diagnosis of newly diagnosed HIV infection cases must be documented by the Subgrantee on the Idaho Adult HIV/AIDS Report Form in the laboratory section, if such tests have been collected and resulted at the time of case closure. The CDC standard for CD4 and HIV viral load laboratory completion is greater than or equal to eighty-five percent (85%) within one (1) month of diagnosis.

f. Completion of client risk factors must be documented by the Subgrantee on the Idaho Adult HIV/AIDS Report Form for each newly reported HIV infection case. The CDC standard for risk factor ascertainment is greater than or equal to eighty percent (80%).

g. Documentation of each open case investigation at its current state of completeness must be submitted by the Subgrantee monthly from the date of initial report until the investigation is closed.

2. The Subgrantee must conduct active HIV surveillance activities with at least one (1) facility monthly. Active surveillance is the process of initiating contact with providers or facilities to ascertain new or previously unreported cases. When the Subgrantee determines it is needed, additional active surveillance project(s) or activities must be conducted to address issues of under-reporting, failure to report cases in a timely manner, or in response to an outbreak.

3. (AMD 1) HIV infection cases of public health importance (COPHI) must be investigated by the Subgrantee within three (3) months of notification of COPHI risk according to the Idaho Investigative Guidelines for Reportable Diseases and Conditions, (https://healthandwelfare.idaho.gov/providers/reportable-diseases/idaho-reportable- diseases).

a. The Subgrantee must complete COPHI investigation documentation as directed in the Idaho Investigative Guidelines for Reportable Diseases and Conditions to the Department within three (3) months of reported COPHI risk.

4. To the extent possible, the Subgrantee must comply with CDC Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD, and TB Programs.

a. The Subgrantee must review and update as necessary protocols for surveillance data by the end of each subgrant funding period.

b. The Subgrantee Overall Responsible Party (ORP) must provide certification of the Subgrantee's compliance with CDC Security and Confidentiality Guidelines by the end of each subgrant funding period using the ORP Certification of Compliance with Security and Confidentiality Guidelines and submit to the Department as directed in the Reports section.

5. The Subgrantee must participate in STD or HIV epidemiology training which may include Department semiannual conferences, as funding allows.

6. The Subgrantee's STD and HIV investigation personnel must participate in an annual site review conducted by the Department. A letter summarizing the results of the review visit will be prepared by the Department. The Subgrantee may be asked to respond in writing to the letter and provide any clarification or follow-up that may be requested.

7. The Subgrantee must conduct STD and HIV case investigations over the Subgrant period, including interviews to provide Partner Services, to high-priority cases as defined in the Idaho Investigative Disease Guidelines:
a. Lymphogranuloma Venereum (LGV)
b. Suspected antimicrobial resistant gonorrhea
c. Disseminated gonococcal infection (DGI)
d. Early syphilis (primary, secondary, and early latent)
e. (AMD 1) Any person who is pregnant or who is either assigned female sex at birth or has been otherwise ascertained to have uterine anatomy and aged twelve to forty-nine years (12-49 years) reported with any stage of syphilis
f. (AMD 1) HIV infection as noted in this Scope of Work
i. (AMD 1) Diagnosed within the previous twelve (12) months and,
ii. (AMD 1) Acute HIV infection (Stage 0) case classification according to the current CDC HIV case definition, or
iii. (AMD 1) Pregnant or having given birth in the previous twelve (12) months, or
iv. (AMD 1) Less than or equal to thirteen (13) years of age, or
v. (AMD 1) Part of an HIV infection cluster or outbreak, which may be defined as:
vi. (AMD 1) Three (3) or more molecularly linked cases within a twelve (12) month period; or
vii. (AMD 1) Three (3) or more epidemiologically linked cases having characteristics such as a large transmission or risk network, large proportions of cases at risk for poor health outcomes, large proportions of cases without evidence of viral suppression or HIV medical care, or
viii. (AMD 1) One (1) or more individuals in a network where the likely mode of transmission has been determined as receiving medical care or having been a recipient of human tissue, organ, blood, or blood products from an HIV-infected individual or HIV-contaminated source, or
ix. (AMD 1) As otherwise defined by the investigating Public Health District or Bureau of Environmental Health and Communicable Disease (BECD) in consultation with the investigating PHD.
x. (AMD 1) Other HIV infections prioritized by the Public Health District as resources and funding allows.
xi. (AMD 1) Language removed in amendment 1.

8. For high-priority STD/HIV conditions, the Subgrantee must include a detailed description of the case investigation in the notes section of each investigation, as well as a summary of the interview with information that may not otherwise be conveyed through NBS data fields.

9. NBS investigation fields must be completed for STD/HIV infection case reports according to the "Definitions & Rules for Entering STD/HIV Investigations" document. This document is located on the external Department SharePoint site under NBS and Other Resources - STD/HIV (https://idhw.sharepoint.com/sites/PublicHealth- EPP/CDP/EPI/NBS%20%20Other%20Resources/Forms/AllItems.aspx).

10. Laboratory results must be added to or associated with the investigation in NBS which are included in the applicable condition case definition and associated manifestations, at the least.

11. Treatment record(s) must be added to and associated with NBS case investigations for any gonorrhea case, any syphilis case, and any high-priority STI/HIV, and for partners when presumptively treated.

12. Efforts must be made to coordinate with the client and appropriate provider, to the extent possible, appropriate treatment for high-priority gonorrhea and syphilis to occur as quickly as possible, preferably no more than fourteen (14) calendar days after diagnosis. When first treatment begins greater than fourteen (14) calendar days after diagnosis, an explanation of the circumstances should be added to comments in the NBS investigation.

13. Efforts must be made to start high-priority STD/HIV investigations within three (3) business days of report to county. If an investigation is initiated greater than three (3) business days after report, an explanation must be included in the investigation's Surveillance Notes field.

14. Efforts must be made to interview any person diagnosed with a high-priority STD/HIV condition within seven (7) calendar days of report. If an interview is conducted greater than seven (7) calendar days after report, an explanation must be included in the investigation's Field Follow-Up Notes or Investigation Notes fields in the Case Management Tab. If an interview is not conducted, the corresponding Patient Interview status field value must be selected.

15. The Subgrantee must ensure that all congenital syphilis case investigations are completed within thirty (30) calendar days of report.

16. The Subgrantee must ensure that all syphilis case investigations have documented pregnancy status in the Pregnant Information section and documented clinical indications of adverse outcomes (as defined by the presence of otic, ocular, neurologic, disseminated, and late clinical symptoms) in the Syphilis Manifestations or Investigation Comments section of NBS.

17. The Subgrantee must ensure that a random sample of incoming gonorrhea cases have expanded case investigations that capture core epidemiologic variables including, but not limited to: age, sex,

county, diagnosing facility type, specimen collection date, anatomic site(s) of infection, race/ethnicity, gender identity/sexual orientation, sex of sex partner(s), clinical signs/symptoms, pregnancy status, HIV status, partner treatment, gonorrhea- related sequelae (i.e., presence of pelvic inflammatory disease (PID), disseminated gonococcal infection (DGI), etc.), substance use, date of diagnosis, treatment received (including names and doses of treatment), date of treatment, co-infection with other STIs, and history of gonorrhea infection.

18. If the Subgrantee is unable to document or investigate all reported infections or meet timeframes described throughout section II. I, the Subgrantee must proactively communicate with the Department's Epidemiology Section about capacity and support needs. Indicators prompting communication between the Department's Epidemiology Section and Subgrantee include:
a. A request for assistance by the Subgrantee to the Department's Epidemiology Section Manager based on unforeseen or outside circumstances resulting in performance concerns such as reduced Subgrantee case or epidemiological investigation capacity, or requirement for additional investigation capacity.

b. The number of reported cases is greater or equal to two (2) standard deviations above the expected monthly mean from the prior five (5) year period, as calculated by the Department.
i. The number of open case investigations exceeds the average proportion of investigations submitted by the respective public health district over the prior five (5) years out of the statewide total, as calculated by the Department.
ii. The Subgrantee experiences changes in key disease investigator(s), staff responsible for contact investigations, or staff epidemiologist(s).

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Viral Hepatitis Case Monitoring, Investigation, and Reporting | Individuals who have been reported as an confirmed or probable case of viral hepatitis | 5/5/2025 | 4/30/2026 | $8,915.00 | NA | NA | $8,915.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES
A. ELR of Viral Hepatitis
1. The Subgrantee must within five (5) business days, review viral hepatitis ELRs.
a. The Subgrantee must remove the ELR from the "Documents Requiring Review" queue into an NBS investigation file within five (5) business days of transfer to the jurisdiction.

2. The Subgrantee must associate all laboratory reports received via ELR in the electronic NBS investigation(s).

3. The Subgrantee must update information in the NBS disease investigation with ELR information.
a. For Documents Requiring Review (DRR) observations, in which a new person record is created or a new reportable condition added for an existing person record, the Subgrantee must verify the patient's address and transfer the record to the appropriate jurisdiction for follow up if the patient has relocated out of the Subgrantee's jurisdiction.

B. Documentation and Investigation of viral hepatitis cases
1. The Subgrantee must investigate and document reportable viral hepatitis infection cases as described in in the Idaho Reportable Disease rules (IDAPA 16.02.10) and the Idaho Investigative Guidelines for Reportable Diseases and Conditions for the following: hepatitis A, acute and chronic hepatitis B, perinatal hepatitis B, acute and chronic hepatitis C, and perinatal hepatitis C.
a. Subgrant funds must be prioritized to enhance practices to improve case documentation in NBS and investigation timeliness and completeness for cases of acute or perinatal viral hepatitis.
b. Investigation of viral hepatitis must be initiated:
i. Within three (3) business days of direct provider report of acute or perinatal viral hepatitis;
ii. Within three (3) business days of laboratory report which meets the laboratory criteria for diagnosis of acute hepatitis A or acute hepatitis B; and
iii. Within five (5) business days of first processing ELR out of the NBS DRR queue which do not meet criteria in II.B.1.b.i or II.B.1.b.ii.
c. If the Subgrantee is unable to document or investigate all reported infections or meet timeframes described in II.A.1 and II.B.1.b, the Subgrantee must communicate with the Department's Epidemiology Section about capacity and support needs. Indicators prompting communication between the Department and Subgrantee include:
i. A request for assistance by the Subgrantee to the Epidemiology Section Manager based on unforeseen or outside circumstances resulting in performance concerns such as reduced Subgrantee investigation capacity, or requirement for additional investigation capacity.
ii. The number of reported cases is greater or equal to two (2) standard deviations above the expected monthly mean from the prior five (5)-year period, as calculated by the Department.
iii. The number of open investigations exceeds the average proportion of investigations submitted by the respective PHD over the prior five (5) years out of the statewide total, as calculated by the Department.
iv. The PHD experiences changes in key disease investigator(s) or staff epidemiologist(s).

C. Documenting viral hepatitis case investigations in NBS
1. The Subgrantee must submit data collected during case investigations for all cases of probable or confirmed viral hepatitis by completing the investigation fields in the NBS.
a. For reportable viral hepatitis conditions that do not require case investigations be completed, as referred to in II.B, the minimum fields must be completed within the appropriate disease or condition investigation. These fields include:
i. Name;
ii. Age and date of birth;
iii. Sex;
iv. Address, including city and county;
v. Phone number, if available;
vi. Date of specimen collection, if applicable;
vii. Physician name, address, and phone number;
viii. Date of report;
ix. Reporting source; and
x. Case status.
b. All investigations documented in NBS must be completed within thirty (30) calendar days after initial report.
i. If completion cannot be achieved by thirty (30) calendar days after initial report, circumstances must be noted in the NBS investigation comments field.
ii. The Subgrantee must continue to exchange information with the Department as described in IDAPA 16.02.10 according to the timeframes therein for investigations that remain open until the point of closure.
c. Subgrant funds must not be used to support personnel and operating costs associated with data entry into or maintenance of non-NBS databases or surveillance systems (e.g., in-house database) unless requested by or approved by the Department.
d. Completion of investigation fields in NBS.
i. In addition to minimum fields enumerated in II.C.1.a above, the Subgrantee must complete the NBS fields listed in the Investigative Protocol for each viral hepatitis infection. The Subgrantee must achieve a ninety percent (90%) completion rate of applicable fields (responses other than "Unknown" or missing/blank) as calculated by the Department for cases reported to the Subgrantee greater than thirty (30) calendar days prior.

D. Contact investigation
1. The Subgrantee must investigate exposed contacts of probable or confirmed acute or perinatal viral hepatitis cases and submit data to the Department.

a. The Subgrantee must implement or coordinate restrictions or other interventions with contacts as needed according to the Idaho Investigative Guidelines for Reportable Diseases and Conditions.
b. Contacts with unknown infection status must be offered, or referred to, testing services by the Subgrantee. Contacts determined to be infected must be referred to medical care and must be investigated according to II.A through II.C.
c. The Subgrantee must complete a contact record for each identified contact of an acute or perinatal hepatitis case, including the Contact Follow Up tab in the NBS case investigation.

E. Cluster and outbreak investigation
1. The Subgrantee must notify the Department:
a. Within one (1) business day when healthcare associated transmission is suspected within the past twelve (12) months for any case of viral hepatitis;
b. Within one (1) business day of cluster identification when transmission by food or a food handler is suspected; and
c. Within three (3) business days when viral hepatitis outbreaks are detected which are not suspected to involve healthcare, food, or food handler transmission.

F. Human immunodeficiency virus (HIV) testing and referral to care
1. The Subgrantee must recommend and refer, or provide voluntary HIV antibody testing to all cases of acute hepatitis C infection unless tested concurrently or within two (2) weeks prior to onset or diagnosis date.
a. If testing results determine HIV positivity, the Subgrantee must make a referral for HIV medical care services if the person is not already receiving HIV medical care.

G. Local Resources Inventory
1. The Subgrantee must develop and submit a resource list for referring people with, or exposed to, hepatitis C for the following services in their jurisdiction and, where applicable, proximal cross-border communities:
a. Additional testing for hepatitis C infection to confirm infection or to evaluate exposure to hepatitis C, including school or university health centers;
b. Medical care for hepatitis C infection, including providers who provide Medicare and Medicaid and low or reduced cost services (e.g., community health centers);
c. Clinics serving men who have sex with men;
d. Drug or alcohol prevention and treatment programs and facilities;
e. Family planning clinics;
f. Sexually transmitted disease (STD) and tuberculosis clinics;
g. Hospital emergency departments;
h. Hospital or other urgent care centers;
i. Men's and women's health clinics;
j. Migrant health centers;
k. HIV and viral hepatitis testing outreach services; and
l. Syringe services programs.

H. Epidemiology conference attendance
1. The Subgrantee may use Subgrant funds to send at least one (1) epidemiologist to the annual fall or spring epidemiology training conference sponsored by the Department's Bureau of Communicable Disease Prevention (BCDP) Epidemiology Section when viral hepatitis topics are included in the conference.

I. Participation in annual site reviews
1. The Subgrantee must participate in annual site reviews with the BCDP Epidemiology Section.

III. QUALITY ASSURANCE
A. The Subgrantee must meet with the Department, as requested, to review Subgrant compliance, to participate in mutually agreed upon training, to collaboratively plan improvements and to discuss safety concerns or any special preparation and planning needs.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tuberculosis Control and Directly Observed Therapy | Individuals who have been clinically diagnosis with active tuberculosis | 01/27/2025 | 12/31/2025 | $12,016.00 | NA | NA | $12,016.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES

A. Notification and consultation for suspect and confirmed cases. The Subgrantee must notify the Department's TB program as soon as a suspected or confirmed case of TB disease is identified and participate in a fifteen to thirty (15-30) minute initial call with the program, including the Division of Public Health medical director, when requested, to discuss case management and response activities. The Subgrantee must also participate in a follow-up call if requested by the Department.

B. Reporting suspected and confirmed cases. The Subgrantee must report all cases of confirmed TB disease to the Department within three (3) business days of identification by completing and submitting the CDC Report of a Verified Case of TB (RVCT) via the National Electronic Disease Surveillance System (NEDSS) Base System (NBS) or by phone, email, or on a report form provided by the Department.

C. RVCT completion for all patients with TB disease. The Subgrantee must complete and submit to the Department the CDC RVCT Form via NBS:
1. Available data for the Initial Report (in the "Patient," "Case Info," and "Tuberculosis" tabs) must be submitted within two (2) weeks of laboratory or clinical confirmation of TB.
2. Available data for the Follow-up Report 1 (in the "TB Disease Only - Clinical History and Findings; Initial Treatment Information, Genotyping and Drug Susceptibility" tabs) must be submitted within two (2) weeks of receipt of initial drug susceptibility results.
3. Data for the Follow-up Report 2 (in the "TB Disease Only - Case Outcome" tab) and any other available data not previously reported must be submitted within four (4) weeks of completion or discontinuation of therapy, or when the patient is lost to follow-up.

D. Monthly contact with all persons with TB disease. To appropriately monitor the clinical status of patients with TB disease, the Subgrantee must maintain monthly contact with all active TB patients, including those not on Directly Observed Therapy (DOT), and at least initial contact with the provider. Contact with the medical provider must occur again if there are questions about the patient's regimen or concern about lack of clinical improvement. Individuals with TB disease must be followed from the time they are identified until the time they stop or complete therapy to monitor treatment adherence and completion.

E. Engage with providers who are treating a patient with TB disease. The Subgrantee must identify the treating provider, offer to perform collection of samples for smear and culture if necessary, and ensure providers managing patients with TB disease are aware of:
1. The necessity of obtaining follow-up cultures and smears;
2. Methods for monitoring for drug toxicity, including visual acuity and audiogram tests, as appropriate, when ethambutol or streptomycin are used;
3. The necessity for baseline laboratory tests to be done as soon as possible, ideally before treatment starts but at least within the first two (2) weeks of the initiation of therapy for TB disease, to be repeated monthly or more frequently if signs and or symptoms of toxicity develop. This should include at a minimum a comprehensive metabolic panel (CMP), a complete blood count (CBC), and one (1)-time human immunodeficiency virus (HIV) testing following the American Thoracic Society/CDC/Infectious Diseases Society of America (ATS/CDC/IDSA) treatment guidelines linked below;
4. The ATS/CDC/IDSA treatment guidelines "Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis" https://academic.oup.com/cid/article/63/7/e147/2196792.

F. DOT for infectious and noninfectious cases. The Subgrantee must provide DOT for patients being treated for active TB, unless the patient refuses or there is an agreement between the Department and the Subgrantee that DOT for a particular patient is not feasible or not necessary. The Subgrantee must:
1. Record medications given, by date, on the DOT Record (provided by the Department) or another form as mutually agreed upon by the Subgrantee and the Department.
2. Submit record of DOT to the Department on the DOT Report form (provided by the Department) or another form as mutually agreed upon by the Subgrantee and Department, when the course of DOT is completed.
3. Perform at least ten (10) successful in-person DOT visits for infectious patients, and at least six (6) DOT visits for noninfectious patients, unless there is an agreement between the Department and the Subgrantee to allow for a shorter time period.
4. After this time, and at the Subgrantee's discretion, implement electronic DOT (eDOT), if available and applicable, and used until treatment completion.
a. If eDOT is used, the Subgrantee must submit record of eDOT to the Department:
i. On the DOT Report form or another form mutually agreed upon by the Subgrantee and Department at the time of quarterly report submission, or
ii. In the eDOT system, if available, at the time eDOT dose is verified by the Subgrantee.
b. The Subgrantee must revert to in-person DOT when:
i. Two (2) or more scheduled consecutive eDOT events are missed, unless previously approved by Subgrantee, or
ii. eDOT is determined by the Subgrantee to be an unreliable approach for ensuring treatment completion for that patient.

G. Notifying the Department about treatment concerns. The Subgrantee must notify the Department if there is a concern about therapy, including providers prescribing treatment that does not follow ATS/CDC/IDSA guidelines or if patients are non-adherent with therapy and efforts to work with the patient and provider are not resulting in improved adherence. Incentives and enablers may be used within the parameters outlined in the Cost/Billing Procedures.

H. Documentation for non-DOT patients. For patients not on DOT provided or supervised by the Subgrantee, the Subgrantee must monthly record basic information, such as: clinical response to therapy, current medications, adherence to therapy, and projected completion of therapy dates. This information must be kept in the patient's file at the Subgrantee's location. Documentation must be kept for:
1. Persons refusing DOT.
2. Persons for whom other treatment systems are in place (e.g., they are currently in the hospital or a long-term care facility with daily supervision of their medications).

3. Persons discussed with the Department and agreed to not require DOT for any other reason, including some persons with noninfectious active TB and as agreed upon by the Department and the Subgrantee.

I. Incentives and enablers. Use of incentives (small rewards to encourage continued adherence to treatment, [e.g., food gift cards]) and enablers (small amounts of funding or other assistance to help ensure continued adherence, [e.g., gas gift cards]) must be reported on the Quarterly Report (provided by the Department) form including cost per incentive, description of how they were used, and why they were used.
J. Staff training. Subgrantee staff directly involved in investigation and follow-up of TB must participate in at least one (1) training activity dedicated to TB, as funding allows.

K. Maintenance of isolation. The Subgrantee must ensure compliance of infectious persons in maintaining respiratory isolation.

L. Targeted testing. In collaboration with Idaho's state TB program, the Subgrantee must identify at least one (1) high-risk population and propose a brief written plan to increase screening, testing, and treatment in this population, including developing collaborative relationships with organizations that serve these populations.

M. Contact investigation. The Subgrantee must conduct an investigation of close contacts of confirmed infectious cases, provide or ensure testing of contacts, and expedite referral for possible window prophylaxis for high-risk individuals.
1. The Subgrantee must submit the Contact Tracing Form (provided by the Department) to the Department:
a. Within four (4) weeks of laboratory or clinical confirmation of TB in the index case, and
b. Again, within four (4) weeks of the last treated contact ending treatment for latent TB infection (LTBI), or
c. If no contacts are started on LTBI treatment, the Contact Tracing Form must be submitted within four (4) weeks of the final contact completing evaluation or being declared lost to follow up.
2. The Subgrantee must conduct a source investigation of all children less than seven (7) years old who are reported to be tuberculin skin test positive, interferon gamma release assay (IGRA) positive, or who are diagnosed with TB disease.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Electronic Disease Surveillance System (NEDSS) capacity and enteric disease investigation data entry. | All those individuals are confirmed of a communicable disease on the Idaho Reportable List (IDAPA 16.02.10) | 08/01/2025 | 07/31/2026 | $93,634.00 | NA | NA | $93,634.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES
A ELR REPORTING
1. The Subgrantee must, within two (2) working days, review ELRs.
a. The Subgrantee must remove the ELR from the "Documents Requiring Review" queue into an NBS patient file within two (2) working days of transfer to the jurisdiction.
b. (AMO 1) Exceptions to this timeframe include follow-up/additional ELRs for patients reported with the isolation of methicillin-resistant Staphylococcus aureus (MRSA), respiratory syncytial virus (RSV), or ELRs related to sexually transmitted disease (STD) or human immunodeficiency virus (HIV)/CD4 count.
c. (AMO 1) REMOVED IN AMENDMENT 1.
2. The Subgrantee must include ALL laboratory reports received via ELR in the patient's electronic file and ensure they are associated with the appropriate investigations .
3. The Subgrantee must update information in the NBS disease investigation with ELR information. This information includes, but is not limited to, identified serogroup, strain characterization, drug resistance, and confirmatory tests.
4. For diseases that do not require investigations to be completed (HCV, invasive MRSA, RSV), the patient file must include an NBS investigation with jurisdiction and case status populated and lab report(s) associated to the investigation. Other investigation fields are optional for these diseases.

B. CASE INVESTIGATION DATA AND MINIMUM FIELDS
1. The Subgrantee must report all diseases and associated case investigation data via the NBS within mandated timeframes outlined in the Idaho Reportable Disease rules (IDAPA 16.02.10).
a. Exception: The Subgrantee may decide whether or not to enter probable Norovirus cases into the NBS. Confirmed norovirus cases must be entered into the NBS.
2. For all diseases requiring investigation, the following NBS investigation fields must be completed:
a. Investigation Start Date (mm/dd/yyyy)
b. Investigation Status (Open / Closed)
c. Date of Report (mm/dd/yyyy)
d. Reporting Source (select text)
e. Hospitalized Indicator (Yes/ No/ Unknown)
f. Diagnosis Date (mm/dd/yyyy)
g. Outbreak Indicator (Yes/ No/ Unknown)
h. Outbreak Name (If Outbreak Indicator= "Yes" include outbreak number)
i. Confirmation Method (select text)
j. Confirmation Date (mm/dd/yyyy)
k. Case Status (Confirmed / Probable/ Suspect/ Not a Case)
3. For all enteric diseases [salmonellosis, campylobacteriosis, cryptosporidiosis , Giardia, shigellosis, shiga-toxin producing E. coli (STEC), Typhoid fever], the following additional NBS investigation fields must be completed:
a. Patient Contact (applicable fields in the section)
b. Interventions for Common Enterics fields (applicable fields in the section)
c. 4-Day Food History fields (all fields in the section)
d. Day Care fields (all fields in the section)
e. Food Handler after onset (Yes/ No/ Unknown)
f. Food Handler last date worked (If Food Handler after onset= "Yes," enter date)
g. Travel History (Yes/ No/ Unknown)
h. Drinking Water Exposure (usual source and untreated water fields)
i. Recreational Water Exposure (Yes/ No/ Unknown)
j. Recreational Water Exposure Type (If Recreational Water Exposure = "Yes")
k. Animal Contact (Yes/ No/ Unknown)
l. Type of Animal (If Animal Contact= "Yes")
m. Related Cases (all fields in the section)
4. For all vaccine-preventable diseases [diphtheria, *Haemophilus influenzae*, hepatitis A, HBV, measles, mumps, *Neisseria meningitidis*, pertussis, poliomyelitis, rubella, tetanus, *Streptococcus pneumoniae*), the following additional NBS investigation fields must be completed:
a. Associated Vaccinations (if available)
b. Date Administered
c. Vaccine Administered
5. The Subgrantee must make reasonable efforts to obtain associated vaccinations records, by looking up relative information in Idaho 's Immunization Reminder Information System (IRIS) and the patient's medical records or by obtaining the records directly from the patient. If the information is unable to be obtained , the Subgrantee must document the efforts made in the NBS investigation and the Subgrant Monitor and Vaccine-preventable Diseases Lead must be contacted by email which must include the Case Identification (ID) number and "vaccination records missing" in the subject line.
6. For meningococcal disease, the Subgrantee must make reasonable efforts to complete the disease tab and collect risk factor data specified in the Manual for the Surveillance of Vaccine Preventable Diseases. The Subgrantee must enter the risk factor data in the appropriate NBS investigation fields or enter the information into the general comments tab. Risk factors include:
a. HIV status

b. anatomic or functional asplenia status
c. complement component deficiencies status
d. eculizumab treatment status
e. housing information
f. active or passive smoking status
g. recent upper respiratory tract infections
h. race (patient information tab)
i. vaccine history of cases
j. sexual partner preferences
k. socio-economic status
l. case contacts

C. OUTREACH AND EDUCATION
1. The Subgrantee must engage in outreach and education of healthcare providers and laboratories to encourage submission of isolates for all vaccine preventable diseases.
2. The Subgrantee must provide vaccine-preventable disease trend or vaccine-preventable disease prevention information to infection preventionists in Idaho facilities located in the public health district at least twice during the Subgrant period. This may be done through presentations at infection prevention committee meetings, other meetings with infection preventionists, email communication, or other means of communication such as Health Alert Network messages where infection preventionists are one (1) of the primary recipients. The Subgrantee may also partner with their immunization program staff to coordinate communication with this audience, as appropriate. Specific topics may include, but are not limited to, education and information on the following topics:
a. Vaccine-preventable disease surveillance priorities as outlined in the Manual for the Surveillance of Vaccine-Preventable Diseases.
b. Awareness regarding acute flaccid myelitis (AFM) surveillance.
c. Idaho or jurisdiction-specific vaccine-preventable disease incidence, changes in vaccine recommendations, and control of vaccine-preventable diseases.
3. The Subgrantee must present community-specific vaccine-preventable disease data and disease prevention information to medical professionals and community organizations as appropriate and as opportunities arise, through newsletters, webpages, presentations, and social media.

D. INFRASTRUCTURE AND MEETINGS
1. The Subgrantee must participate in quarterly Idaho NBS user group (NUGIT) calls or in-person meetings with the Department's Surveillance Program.
2. The Subgrantee must participate in two (2) vaccine-preventable disease surveillance evaluations and subsequent quality improvement projects led by the Department, time not to exceed 4 (four) hours per project.

Ill. QUALITY ASSURANCE
A The Subgrantee must meet with the Department, as requested, to review Subgrant compliance, to participate in mutually agreed upon training, to collaboratively plan improvements and to discuss any special preparation and planning needs.

B. In the second week of each month the Department will run a quality assurance report (QA report)" using data from the NBS for the entire prior month and use that dataset to assess data completeness and data quality. The Subgrantee must correct the identified data entry errors, complete missing data or provide comments stating why the data could not be obtained, by the end of the month in which the QA report is provided.

C. The Subgrantee must ensure all the previous year's investigation data are entered and that all investigations have been closed.in the NBS by February 15 of the following year.

D. The Subgrantee must work in conjunction with the Subgrant Manager to ensure all tasks pertaining to year-end data reconciliation efforts in the NBS are completed by April 30 of the following year.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Perinatal Hepatitis B surveillance and case management | All women of childbear-ingage 14 to 40 who are reported as having hepatitis B. | TBD | TBD | TBD | TBD | TBD | TBD | NA | 24.95 | No | No | No |

II. CONTRACT SERVICES AND ACTIVITES

A. Perinatal Hepatitis B Surveillance
1. The Contractor must work with BECD Epidemiology and Immunization staff to ensure pregnancy status is identified in all women of childbearing age fourteen to forty four (14- 44) years who are reported as having hepatitis B. The Contractor must manage all identified HBsAg positive pregnant women in accordance with the Idaho Investigative Guidelines for Public Health.
2. The Contractor must document the mother's insurance status whether it is public, private or uninsured at the time of being identified as a pregnant woman with Hepatitis B.
3. The Contractor must report all identified cases as per reporting protocols published in Idaho Reportable Diseases administrative rules (IDAPA 16.02.10).
4. The Contractor must report summary case management activities using the BECD Idaho Immunization Program (IIP) provided Perinatal Hepatitis B Mother Case Management Form (Attachment C), Perinatal Hepatitis B Infant Case Management Form (Attachment D), and Perinatal Hepatitis B Contact Case Management Form (Attachment E).
a. The forms must be submitted to the Department's Perinatal Hepatitis B Coordinator within the timeframes specified on the forms.
5. The Contractor must work with BECD Epidemiology and Immunization staff to ensure follow-up activities with HBsAg positive pregnant women and their close and household contacts are conducted in accordance with the Idaho Investigative Guidelines for Public Health.
6. The Contractor must ensure the anticipated delivery hospital is aware of the expected delivery.
7. The Contractor must take all appropriate measures to help ensure all infants born of HBsAg positive mothers are appropriately vaccinated concurrently with HBIG and hepatitis B vaccine within 12 hours of birth.
8. The Contractor must provide tracking and recall services for infants born to HBsAg positive women reported and for all close and household contacts of these women in accordance with the Idaho Investigative Guidelines for Public Health.
9. The Contractor must take all appropriate measures to ensure that post-vaccination serology testing is completed between nine (9) and eighteen (18) months of age with a minimum of one (1) month after the last dose of hepatitis B vaccine is given.

B. Submission of Perinatal Hepatitis B Program Lab Specimens to Idaho Bureau of Laboratories (IBL)
1. The Contractor must submit any specimens sent to the Idaho Department of Health and Welfare, Bureau of Laboratories using the Virology Test Requisition Form (Attachment B).
2. The Contractor must include in the "TEST ORDERED BY/SEND REPORTS TO" section of the Virology Test Requisition Form "Perinatal Hepatitis B" and the Contractor's information.

lll. QUALITY ASSURANCE
A. The Contractor must work with the Contract Monitor to determine any barriers to evaluating household members, notifying birth hospitals, obtaining post-vaccination serology, or administration of birth dose of HBIG and hepatitis B vaccination series.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public Health Emergency Preparedness | All | 08/01/2025 | 06/30/2026 | $402,839.00 | NA | NA | $402,839.00 | NA | 24.95 | Yes | 10% | No |

SUBGRANT SERVICES AND ACTIVITIES

A. Community Preparedness
1. The Subgrantee must collaborate with the Department in the state Risk Assessment where the state will be identifying and prioritizing risks, risk-reduction strategies, and risk-mitigation efforts in coordination with community partners and stakeholders.
Output: The Subgrantee must collaborate with the Department and must facilitate collecting and disseminating information to local partners within its jurisdiction. (06/30/2026)
Outcome: The outcome of this activity will be to strengthen community partnership through data collection to identify public health risks and hazards.
2. The Subgrantee must complete a seminar or workshop with emergency management and the healthcare coalition to review response plans and standard operating procedures for a minimum of two threats or hazards identified in the state Risk Assessment. (Threats must not be repeated from previous year).
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned
f. Feedback from participants. (06/30/2026)
Outcome: The outcome of this activity will be to strengthen community partnership through data collection to identify public health risks and hazards.

3. The Subgrantee must have primary and secondary staff members trained to use Geographic Information System applications. The Subgrantee must sustain staff competency through practical application and participation in an exercise to coordinate data sets, pre-identified Geographic Information System information and training. The Department will provide quarterly or as-requested training, to develop and sustain Geographic Information System skills for the public health district Geographic Information System users. The Department will provide an agenda and training objectives for each training prior to the training taking place. The Subgrantee must take part in two (2) Department-led drills using Geographic Information System applications. The Subgrantee must assist with the development of these required exercises.
Output: The Subgrantee must have improved knowledge and incorporate Geographic Information System applications in response plans. The Subgrantee must document Geographic Information System related training and list projects it completes using Geographic Information System. One (1) of the drills must be conducted to map access and functional needs populations within the local jurisdiction. Real-world activities that include using Geographic Information System for mapping can be used in place of drills. (09/30/2025), (12/31/2025), (03/31/2026), (06/30/2026)
Outcome: The outcome of this activity ensures competency and proficiency with using ArcGIS platforms and products.
4. The Subgrantee must gather and maintain information on a Partner Planning Sheet Excel document that captures a minimum of eight planning elements for jurisdictional partners.
Output: The Subgrantee must provide the Department with an Excel document that includes eight partner planning elements for both internal and external emergency response partners. (06/30/2026)
Outcome: The outcome of this activity ensures that the Subgrantee has effective partner coordination and can coordinate well with its community partners to realize its mission. (06/30/2026)
5. The Subgrantee must plan and execute a capabilities gap assessment conference to increase partner engagement and gather partner feedback to enhance and align preparedness efforts.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned
f. Feedback from participants. (06/30/2026)
Outcome: The outcome of this activity establishes an annual process to ensure that it integrates its community partner feedback and priorities in its annual workplan.
6. The Subgrantee must conduct a review of community partners' plans where the Subgrantee is given a response role to ensure that the role identified can be fulfilled.
Output: The Subgrantee must provide the Department with the complete list of partner plans and the role identified. (06/30/2026)
Outcome: The outcome of this document log will be to improve community partner collaboration by knowing the expectations from community partners on how the Subgrantee will support community partners during an emergency.
7. The Subgrantee must schedule at least one preparedness outreach opportunity with each
jurisdictional county. This may include but is not limited to presentations at Local Emergency Planning Committees meetings, community health fairs, and community events. The Subgrantee must attend all active Local Emergency Planning Committees meetings in its jurisdiction to provide updates and report outs on public health response activities.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (06/30/2026)
Outcome: The outcome of this activity will showcase to its community partners the great work being completed by the Subgrantee, plus it provides a better understanding for its partners to ascertain its role in a community response.

B. Community Recovery
1. The Subgrantee must conduct a needs assessment for each jurisdictional county to understand better how recovery is being addressed and incorporated into planning, training, and exercise efforts.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (09/30/2025)
Outcome: The outcome of this activity is to have a comprehensive understanding about the recovery planning efforts from the county emergency managers to best understand how to integrate public health recovery into the overall community recovery planning.
2. The Subgrantee must maintain a comprehensive list of district access and functional needs partners. This list must be reviewed once every two quarters for updates.
Output: The Subgrantee must provide the department with a list of its access and functional needs partners. (09/30/2025), (12/31/2025), (03/31/2026), (06/30/2026)
Outcome: The outcome of this activity is to have an accurate, updated list of access and functional needs entities to improve partner engagement for recovery efforts.
3. The Subgrantee must train its jurisdictional county emergency managers on the essential services that will be provided by the Subgrantee during a Continuity of Operations activation.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended

b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (12/31/2025), (06/30/2026)
Outcome: The outcome of this activity is to increase knowledge and understanding for the county emergency managers to be aware of the essential services being provided when the Subgrantee's Continuity of Operations is activated.
4. The Subgrantee must coordinate with district county emergency managers to determine and provide a resource list of public health assets during the recovery phase of the incident.
Output: The Subgrantee must provide the Department with a summary of the Subgrantee's recovery resources that was shared with the county emergency managers. (09/30/2025)
Outcome: The outcome of this activity is to ascertain that recover resources are updated, mission ready, and deployable.

C. Emergency Operations Coordination
1. The Subgrantee must provide a situation report that includes community lifelines updates during each operational cycle during response and support efforts to the Department of any Emergency Support Function Emergency Support Function 6 Mass Care, Emergency Support Function 7 Logistics Management and Resource Support, Emergency Support Function 8 Public Health and Medical Services, Emergency Support Function 10 Oil and Hazardous Materials Response, Emergency Support Function 11 Agriculture and Natural Resources, Support Annex 5 Worker Safety and Health, Incident Annex 4 Nuclear/Radiological Incident, or Incident Annex 6 Pandemic activations within its jurisdiction, starting within the first six (6) hours. The Department will designate the system to be used for this information sharing.
Output: The Subgrantee must ensure that notification is complete, and that the Department designated dashboard is updated as directed by the Department. (12/31/2025), (06/30/2026)
2. The Subgrantee must notify the Department of any Emergency Support Function 6, Emergency Support Function 7, Emergency Support Function 8, Emergency Support Function 10, Emergency Support Function 11, Support Annex 5, Incident Annex 4 or Incident Annex 6 activations in Idaho Resource Tracking System and WebEOC within its jurisdiction that involve a public health response within sixty (60) minutes of activating its incident management team for an incident, and keep information updated in the Idaho Resource Tracking System dashboard throughout the activation.
Output: The Subgrantee must ensure that notification is complete, and dashboard is updated as directed by the Department. (12/31/2025), (06/30/2026)
3. The Subgrantee must define the role of Emergency Support Function 8 with its jurisdictional counties to understand how the Subgrantee will support the counties when the county emergency operations center is activated.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (09/30/2025), (12/31/2025)
Outcome: The outcome of this activity to become more integrated with county emergency operation center activations that will lead to a more timely and cohesive response.
4. The Subgrantee must define trigger points for emergency operations center and incident management team activities, including but not limited to monitoring phase, activation, expansion to outside resources, and demobilization.
Output: The Subgrantee must provide a plan update with these trigger points and submit to the Department. (09/30/2025), (12/31/2025)
Outcome: The outcome of this activity will increase the proficiency of the Subgrantee's need to activate its emergency operations center and incident management team.
5. The Subgrantee must activate its Emergency Operations Center to a level III (monitoring phase) year-round to conduct monthly incident briefings.
Output: The Subgrantee must provide the Department, an incident action plan and a copy of the Incident Command System 201 form for each briefing.
(09/30/2025,12/31/2025,03/31/2026,06/30/2026)
Outcome: The outcome of this activity is to gain regular proficiency with emergency operations center and incident management team activities by conducing monthly incident briefings, developing monthly incident plans, and using Incident Command System forms.
6. The Subgrantee must exercise at minimum one incident management team transition of appropriate Command and General Staff positions.
Output: The Subgrantee must complete a tabletop exercise, and must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. After-Action Report/Improvement Plan. (06/30/2026)
Outcome: The outcome of this activity will be to demonstrate the Subgrantee's ability to successfully transition incident management team positions from a Level III to a Level II or I activation.
7. The Subgrantee must maintain its current list of Memorandum of Understanding for alternative location(s) for emergency operations center operations.
Output: The Subgrantee must provide the Department a list of Memorandum of Understanding for alternate locations for the emergency operations center, which may include a virtual emergency operations center. (06/30/2026)
Outcome: The outcome of this activity is to ensure continuity of emergency operations center operations when the primary location is unavailable.
8. The Subgrantee must provide the Department with an update to the administrative preparedness plan on emergency funding standard operating procedures.
Output: The Subgrantee must provide the Department with an updated Administrative Preparedness Plan. (12/31/2025), (06/30/2026)
Outcome: The outcome of this activity ensures emergency funding capabilities and emergency staffing augmentation when primary funding resources are not available.

9. The Subgrantee must utilize newly developed job action sheets for its Command and General Staff as well as develop new job action sheets for other positions as appropriate.
Output: The Subgrantee must provide job action sheets to the Department. (06/30/2026)
Outcome: The outcome of this activity makes training of emergency operations center incident management team positions more effective and efficient through updated and accurate job action sheets. Provide the Department with a list of newly created job action sheets and lessons learned from the current job action sheet.
10. The Subgrantee must hold quarterly trainings with its assigned phone carriers to be prepared for receiving State Communication phone calls.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (09/30/2025), (12/31/2025), (03/31/2026), (06/30/2026)
Outcome: The outcome of this activity ensures a trained, skilled on-call team to response to public health emergencies.

D. Emergency Public Information and Warning
1. The Subgrantee must ensure public information personnel are trained in the following courses:
a. Introduction to the Incident Command System (IS -100.C)
b. An Introduction to the National Incident Management System (IS-700.B)
c. Public Information Officer Awareness (IS-29. A)
d. Basic Emergency Operations Center functions (IS-2200)
e. Basic Public Information Officer (G-0290) or Public Information Basics (E-0105).
Output: The Subgrantee must provide the Department documentation of training courses to include completion dates. The Subgrantee must provide documentation of tracking of availability and, if courses are not available in the budget period, how this training will be addressed. (06/30/2026)
Outcome: The outcome of this activity ensures a trained, skilled on-call team to response to public health emergencies.
2. The Subgrantee must ensure public information personnel have completed training within six (6) months of hire and at least once every five (5) years thereafter or when curriculum has been updated, to develop key messages to be used during a public health emergency.
Output: The Subgrantee must provide the Department documentation of training course. (06/30/2026)
Outcome: The outcome of this activity ensures a trained, skilled on-call team to response to public health emergencies.
3. The Subgrantee must maintain plans or procedures and exercise with Department-defined metrics an emergency notification platform for its jurisdiction (e.g., AlertSense, Call-Em All, Everbridge).
Output: The Subgrantee must provide the Department with:
a. The name of the notification system it is using
b. Provide a list of procedures in place that use the notification system.
c. A list of participants in the notification system to alert staff about an emergency.
d. Drill or real-world information to include:
i. Date and time of notification
ii. Lapsed time to respond to the notification
iii. Lapsed time to report for assigned duties (06/30/2026)
Outcome: The outcome of this activity ensures public health messages are sent in a timely manner with minimal margins for error.
4. The Subgrantee must provide refresher training to subject matter experts who support the public information officers when there are media request and requests for technical information. Training must include on, and off-camera interviews as requested by the media.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (03/31/2026)
Outcome: The outcome of this activity builds confidence for subject matter experts to give media interviews to the public regarding public health issues.
5. The Subgrantee must update the risk communication plan to ensure public information functions, roles, and responsibilities are accurate and up to date.
Output: The Subgrantee must provide the Department with the completed updated plan. (06/30/2026)
Outcome: The outcome of this activity will ensure that all public health information functions are current, accurate, and can be readily developed during a public health emergency.
6. The Subgrantee must include, at minimum, one risk communication objective as part of the required tabletop exercises in accordance with the Idaho Department of Health and Welfare Five-Year Exercise Strategic Framework.
Output: The Subgrantee must complete a tabletop exercise, and must provide the Department with the following:
a. Meetings attended
b. Agenda, including objective(s)

c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. After-Action Report/Improvement Plan. (06/30/2026)
Outcome: The outcome of this activity tests the risk communication plan and identifies future corrective actions for quality improvement.
7. The Subgrantee must coordinate with public information officers from other sectors to develop a regional joint information center.
Output: The Subgrantee must provide the Department with minutes and action items from conference calls to establish a joint information center. (12/31/205), (06/30/2026)
Outcome: The outcome of this activity measures public information officer partner engagement to develop a region joint information system.
8. The Subgrantee must include at maintain contact lists for public information officers from various sectors and disciplines.
Output: The Subgrantee must provide the Department with contact lists for non-public health information officers on a quarterly basis. (09/30/2025), (12/31/2025), (03/31/2026), (06/30/2026)
Outcome: The outcome of this activity ensures public information officer partner engagement to activate a regional join information system.

E. Fatality Management
1. The Subgrantee must develop a StoryMap for its county coroners as a training resource to understand the role of public health for mass fatality operations.
Output: The Subgrantee must provide the Department the mass fatality StoryMap. (12/31/2025)
Outcome: The outcome of this activity will increase the knowledge base of its county coroners and help to strengthen the partnership between public health and the county coroner's office.
2. The Subgrantee must provide information/education to its county coroners on the epidemiology and transmission of infectious disease with a focus on tuberculosis and chronic wasting disease.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (06/30/2026)
Outcome: The outcome of this activity will be providing awareness for the coroners and forensic staff about transmission of infectious diseases to ensure safe handling of specimens.
3. The Subgrantee must coordinate with each county jurisdiction to review its county mass fatality plan and ensure the role of the Subgrantee is appropriate. The Subgrantee must update internal procedures that list identified how public health districts will address these roles.
Output: The Subgrantee must provide the Department with a document log of the plan reviews and any other findings to implement the public health role in a county mass fatality plan. (06/30/2026)
Outcome: The outcome of this activity is a current understanding for each county's mass fatality plans and where the public health role can be implemented.
4. The Subgrantee must conduct an equipment/inventory assessment to determine the public health resources required for a mass fatality operation.
Output: The Subgrantee must provide the Department with the assessment product and/or instrument used to determine the equipment or supplies needed to support mass fatality operations. (03/31/2026)
Outcome: The outcome of this activity will identify the resources needed for public health to support a mass fatality incident.

F. Information Sharing
1. The Subgrantee must have one (1) lead and one (1) backup Idaho Resource Tracking System users who must attend trainings and exercises provided by the Department to build or maintain proficient use of Idaho Resource Tracking System to conduct medical countermeasures queries.
Output: The Subgrantee must respond to all needed medical countermeasure queries and conduct at least one (1) drill for each six (6) month period when no actual queries are needed. (12/31/2025), (06/30/2026)
Outcome: The outcome of this activity will ensure that community partners can provide data for medical countermeasures queries in a timely manner.
2. The Subgrantee must update regional plans and conduct training and exercises using Department of Health and Human Services emPOWER datasets to test the exchange of emPOWER information and discuss the requirement of how this information is destroyed after thirty (30) days of receipt. Encrypted data exchange is being planned, trained and exercised between the Department of Health and Welfare and public health districts but should be expanded and trained between the Department of Health and Welfare and public health districts and then expanded to regional partners. The Department will maintain a Department of Health and Human Services emPOWER protocol and will notify the Subgrantee when updates are available. The most current version will be provided on SharePoint. Considerations for emPOWER datasets should include access and functional needs populations who rely on electricity for communication and durable medical equipment. This population must be a core part of all exercise planning and must be exercised semi-annually.
Output: The Subgrantee must provide training to district staff and partners, and must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned. (06/30/2026)
Outcome: The outcome of this activity will ensure that community partners can provide for medical countermeasures needs that could be time sensitive in a timely manner.
3. The Subgrantee must work to identify and incorporate at-risk populations not captured within emPOWER data, including non-Medicare recipients who rely on similar life-sustaining medical equipment, transportation assistance, in-home caregiving, or other critical support services. These populations may include Medicaid recipients, uninsured individuals, individuals receiving

care through community health centers or other vulnerable groups within their jurisdiction. In Budget Period 2, the Subgrantee must collaborate with local emergency management, healthcare providers, social services, and community-based organizations to identify these individuals and ensure they are included in planning to ensure a comprehensive approach to ensure equitable access to emergency preparedness resources and response efforts. In Budget Period 3, district staff should be trained to requesting data sets for specific groups that could be affected by a disaster. In Budget Period 4, emPOWER data sets and data sets not captured within and emPOWER request need to be exercised at the local public health district.
Output: The Subgrantee must provide a list of partnerships to include a list of meetings held including dates and times and data sets discussed at the meetings to the Department. The Subgrantee will provide the Department a list of improvements made to plans and planning elements. (06/30/2026)
Outcome: The outcome of this activity will ensure that community partners can provide for medical countermeasures needs that could be time sensitive in a timely manner.
4. The Subgrantee must send emails to county emergency managers, regional healthcare coalition leads, and the Department for upcoming press releases, product recalls, or significant developments that could lead to an incident management team or emergency operations center activation.
Output: The Subgrantee must provide the Department with emails to Emergency Support Function 8 inbox (ESF8@dhw.idaho.gov) for events that could lead to an incident management team or emergency operations center activation to maintain situational awareness. (09/30/2025), (12/31/2025), (03/31/2026), (06/30/2026)
Outcome: The outcome of this activity establishes a common operating picture for community partners for potential health incidents.
5. The Subgrantee must continue to use the Department's Health Alert Network for disseminating health alerts to medical providers.
Output: The Subgrantee must provide the Department with all issued Health Alert Network messages on a quarterly basis. (09/30/2025), (12/31/2025), )03/31/2026), (06/30/2026)
Outcome: The outcome of this activity will increase situational awareness for the medical provider community regarding potential public health threats.

G. Mass Care
1. The Subgrantee must provide the Department any update to the Subgrantees public health role in mass care operations.
Output: The Subgrantee must provide written identified public health roles for mass care operations to the Department. (09/30/2025)
Outcome: The outcome of this activity will raise awareness for community partners on what the Subgrantee must provide during mass care operations.
2. The Subgrantee must develop an objective on its mass care role for the natural disaster (flooding) tabletop exercise to ascertain that plans and procedures are current.
Output: The Subgrantee must complete a tabletop exercise, and must provide the Department with the following:
a. Meetings attended
b. Agenda, including objective(s)
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. After-Action Report/Improvement Plan. (12/31/2025)
Outcome: The outcome of this activity will confirm that plans for mass care sheltering are current and readily deployable. It will also identify any corrective actions for improvement.
3. The Subgrantee must coordinate with the American Red Cross to identify if a Memorandum of Understanding must be established in the Subgrantee's jurisdiction to ensure that both entities are integrated with shelter locations for an incident.
Output: The Subgrantee must provide a list of Memorandum of Understanding and submit to the Department. (09/30/2025)
Outcome: The outcome of this activity will ensure that public health and American Red Cross are not in conflict with the use of locations during an incident.
4. The Subgrantee must provide online training resources for the food inspectors for their role in a mass care operation.
Output: The Subgrantee must provide the Department with following:
a. Proof of Attendance
b. Training Materials and courses completed
c. Lessons Learned (if applicable) (06/30/2026)
Outcome: The outcome of this activity will be to have food inspector teams trained in their duties and responsibilities to ensure food safety during a mass care operation.
H. Medical Countermeasure Dispensing and Administration
1. The Subgrantee must conduct a regional workshop, working with regional pharmacies, to develop a process for sharing information, increasing, and establishing participation in regional exercises, and developing a process to improve pharmacy queries, and understanding the pharmacy's role in a public health event.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned
f. Feedback from participants
g. Updates to regional plans for queries involving pharmacies (06/30/2026)
Outcome: The outcome of this activity is to build relationships with pharmacy partners and to support medical countermeasure activities in the jurisdiction.
2. The Subgrantee must have a minimum of two (2) staff members attend and participate in Department-led planning, training, and exercises for the Inventory Management and Tracking System. The Subgrantee must attend the Department training on the Inventory Management and Tracking System's standard operating procedure.
Output: The Subgrantee must assist the Department in updating a standard operating procedure on how the Department and Subgrantee must utilize the system. The Subgrantee must develop a procedure for implementing and using Inventory Management and Tracking System within their jurisdiction. The Subgrantee must participate in trainings held by the Department and must actively participate in drills held by the Department. (12/31/2025), (06/30/2026)

Outcome: The outcome of this activity will be to have an operational state-wide inventory management system to track medical countermeasures.
3. The Subgrantee must maintain a listing of community partners from the Partner Planning Sheets and update signed Memorandum of Understanding for medical countermeasure operations.
Output: The Subgrantee must provide the Department with an updated list of partners from the Partner Planning Sheets and developed Memorandum of Understanding for medical countermeasure operations. (06/30/2026)
Outcome: The outcome of this activity ensures partner coordination for medical countermeasure operations.
4. The Subgrantee must review its current Points of Dispensing strategies with its leadership to ensure that the Subgrantee can carve out all necessary actions in its plans.
Output: The Subgrantee must provide the Department with a summary from the leadership meeting and all updates made to the Points of Dispensing plan per leadership recommendations. (12/31/2025)
Outcome: The outcome of this activity ensures seamless coordination between Subgrantee policy makers for planned operational functions.
5. The Subgrantee must update its pharmacy partner StoryMap to ensure that the information is up to date. The Subgrantee must work with its pharmacy partners to initiate agreements with the Department's Idaho Immunization Program to receive and administer vaccines during the time of an emergency.
Output: The Subgrantee must provide the Department with the following:
a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. Lessons learned
f. Feedback from participants.
Outcome: The outcome of this activity establishes a concept of operations for a tiered based dispensing model.
6. The Subgrantee must coordinate with dispensing and administration sites to validate Memorandum of Understanding and processes for receiving Strategic National Stockpile assets.
Output: The Subgrantee must provide the Department with partnership listings of sites with copies of Memorandum of Understanding to ensure coordination with the Department on shipping modalities such as direct ship to points of dispensing sites, pharmacies, and hospitals.
Outcome: The outcome of this activity ensures readiness to mobilize Points of Dispensing sites in a timely manner.
7. The Subgrantee must update medical countermeasure plans to ensure the proper distribution of medical countermeasures, updates must be presented to Cities Readiness Initiative partners.
Output: The Subgrantee must provide the Department with its StoryMap and with any updated changes. The Subgrantee will also provide the Department with pharmacy Memorandum of Agreement documentation, from any pharmacy that will be receiving directly shipped medications. (12/31/2025)
Outcome: The outcome of this activity ensures that pharmacy partners understand the coordination efforts with the Subgrantee for inventory requests and/or medical countermeasure distribution efforts.
8. The Subgrantee must plan and conduct a flooding tabletop exercise in accordance with the Idaho Department of Health and Welfare Public Health Preparedness and Response Five-Year Strategic Framework.

**Output:** The Subgrantee must complete a tabletop exercise, and must provide the Department with the following:

a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. After-Action Report/Improvement Plan. (06/30/2026)

9. The Subgrantee must plan and conduct a measles functional exercise in accordance with the Idaho Department of Health and Welfare Public Health Preparedness and Response Five-Year Strategic Framework.

**Output:** The Subgrantee must complete a functional exercise, and must provide the Department with the following:

a. Meetings attended
b. Agenda
c. List of attendees
d. Presentation materials (e.g., PowerPoint, StoryMaps, videos, etc.)
e. After-Action Report/Improvement Plan. (06/30/2026)

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pre-Prosecution Diversion Program | Individuals referred from the Canyon County Prosecutor's Office | 8/31/2023 | 6/30/2026 | $1,829,513.35 | $856,053.00 | $414,140.00 | $1,270,193.00 | NA | 10% indirect max | No | No | No |

Program Description

Southwest District Health will follow the Collective Impact Model to form a collaborative of key stakeholders and community partners to identify and develop a framework for successful implementation and management of a PPD program in Canyon County. The framework will be informed by the sequential intercept model (SIM) and will focus on intercepts 0 and 1. The framework, once completed, will provide insight and direction to key stakeholders and community partners to understand where they fit in the PPD process and how their resources can be best utilized to prevent justice involvement for those with unmanaged behavioral health conditions or in a behavioral health crisis. Stakeholders and community partners include but are not limited to Canyon County Prosecuting Attorney's Office (CCPA), law enforcement agencies, Courts, defense attorneys, healthcare and behavioral health providers, and support service organizations (e.g., housing, food, employment, and faith-based organizations).

Once the service model is defined by the key stakeholders, eligibility and referral processes, outcome measures, and coordination and communication plans will be developed. The PPD will be designed in such a way to meet the unique needs of individuals in Canyon County. At present, our justice and behavioral health systems are not well coordinated, and individuals face significant barriers when attempting to navigate through the system and these barriers are further exacerbated by a lack of affordable housing and reliable transportation.

Single Point of Entry

As a result of the SIM workshop that was held in Canyon County last year, an idea was born to establish a single point of entry to reduce barriers and decrease the rates of recidivism. From subsequent meetings of a small group of stakeholders, several ideas are in the infancy of development and will be further refined through the Collective Impact Model.

Referral

Individuals identified as potential candidates for the program will be referred to the PPD program. This process will be voluntary. Following the initial behavioral health screening, each potential candidate will be sent to an assembled panel of community partners for review and acceptance into the PPD program.

Conditions of Entrance into the PPD Program

Upon acceptance into to the PPD program from the panel, the CCPA will not proceed with the filing of charges for a period of time that will be identified by CCPA based on the nature of the crime and the statute of limitations associated with the identified crime. The intent of this step in the process is to allow the program participants the maximum amount of ⍰me to engage in services and treatment. Throughout the entirety of participation in the program, the participant will be assigned a public defender to apprise the participant of the legal ramifications of their crime and participation in the program. If the participant has been referred to the program for a victim-based crime, it will be important for the victim to support the participant's participation in the program. Part of the responsibility of the Prosecutor's Office is to attempt to make victims whole again. It will be important that if there is restitution owing to a victim, the participant make full restitution for their crime. A participant's inability to make a full restitution payment will not be held against them. Instead, a monthly payment amount will be required as part of their responsibility for participation in the program.

As participants stabilize in their programming, the assessment team may add additional requirements for the participant to engage in community service. Ideally, PPD will partner the participant with an organization that is meaningful to them. This would encourage the participant to engage with the community partner.

The level of supervision to be provided during programming will largely be determined based on assessment and need. If the participant is in the beginning stages and needs immediate resources, they may be required to check in as much as one time per week. As the participant continues to engage in services, their requirement for weekly check-in may be reduced to once every two weeks. Additionally, if the participant begins to slide on their individualized plan, their requirement to check in may be increased. Western Idaho Community Crisis Center in Caldwell offers 24/7/365 assessments that may assist in ascertaining the stages of drug or alcohol use disorders and whether or not a participant may be a danger to themselves or others. The program will work towards accessing and addressing trauma severity and a long-term treatment plan for trauma-based participants.

For some participants, once stabilized, it may be of benefit to visit an IDOC facility to offer insight and motivation into staying on a treatment-based path. This op⍰on will likely be best offered on a case-by-case basis and at the discretion of the treatment team. Community service may also be considered in the same way, and there is likely value for participants, once stabilized and with a period of success, to pay it forward to the program by participating in peer-to-peer support of new participants, or engaging in service to the community that is meaningful to the participant. The utilization of these options will be offered as a stepping stone as the participant progresses, rather than a requirement. The overall goal for this program will be to provide as many co-located community resources as possible in one location to allow the participant to minimize the number of places they may be required to travel to and maximize a participant's willingness to engage in the program.

Acceptance into the PPD Program

Upon acceptance into the program, the assembled community partners assess the immediate and ongoing needs of the participant. During this ⍰me, there will be resources available to assist and stabilize the participant suffering from a mental health crisis, such as medical or behavioral health treatment, temporary housing, or access to basic food and hygiene needs. This initial contact will be the cornerstone of getting the participant to engage in the process.

After this first contact, the community partners will work with the participant to complete the individualized plan with the participant and, if available, a supportive person (e.g., family, peer counselor, sponsor, etc.) to walk alongside the participant and help ensure a successful outcome. Ultimately, the type and amount of treatment needed for a participant will largely be based on individual assessment at the ⍰me of screening.

Supportive community partners who have expressed willingness to participate in the PPD program include:

• Health systems: Saint Alphonsus, St. Luke's, and West Valley Medical Center

• Terry Reilly Certified Community Behavioral Health Clinic
• Western Idaho Community Crisis Center
• The Courts
• The Canyon County Public Defender's Office
• The Canyon County Prosecuting Attorney's Office
• Law Enforcement
• Department of Health and Welfare, Division of Behavioral Health
· Department of Corrections, Proba□on and Parole
• Canyon County Community-based programs
• Southwest District Health
• City of Nampa
• Supportive housing providers

Southwest District Health and CCPA will develop a communication and outreach strategy to bring other support services and resources into the PPD program once it is funded. Other support services and resources include, but are not limited to:

• Behavioral health services
• Child Care (WICAP) – Early learning collaborative
• Housing (Jesse Tree & CATCH)
• Employment – Services (Job Corp)
• Probation and Parole
• Law Enforcement
• Substance abuse evaluation and treatment, consisting of AA/NA meetings, testing, and one-on-one treatment
• Regular meetings with a panel to discuss participant's progress in the program
• Parental support and training.
• STI screening and treatment

Connection to SIM This program will be modeled a□er the Sequen□al Intercept Model of Criminal Justice (SIM), which is a nationally accepted model. The SIM details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system. The SIM is based upon intercept levels as follows:

• Intercept 0: Community Services
• Intercept 1: Law Enforcement
· Intercept 2: Ini□al Deten□on/Ini□al Court Hearings
• Intercept 3: Jails/Courts
• Intercept 4: Re-Entry
• Intercept 5: Community Corrections

As a starting point, the PPD program will be focused on building a more coordinated system of care and resources in Intercept 0 and Intercept 1, of the SIM as follows:

Intercept 0: Community Services

Intercept 0 involves opportunities to divert people into local crisis care services. There are limited resources available to assist individuals in a behavioral health crisis and these resources are often hard to find or access; therefore, individuals often inappropriately seek emergency services (i.e., 911, 988, and law enforcement). In this intercept, law enforcement is supported in responding to both public safety emergencies and behavioral health crises. It enables diversion to treatment before an arrest takes place. By doing so, it reduces pressure on resources at local emergency departments and inpatient psychiatric beds/units for urgent but less acute mental health needs.

What is needed for this particular intercept to work effectively is:

1. Warm lines and hotlines that serve as alternatives to 911. These link people to clinical treatment providers and services without the involvement of law enforcement. This allows emergency response agencies to direct their resources to other needs in the community.
2. Mobile crisis outreach teams. These teams allow behavioral health clinicians to respond to people in crisis in the community. In situations involving a public safety concern, a behavioral health practitioner may accompany law enforcement. Mobile crisis teams allow mental health professionals the opportunity to stabilize a person in crisis, identify underlying reasons for the person's symptoms (for example, the person stopped taking medication), and initiate or link the person to case management services. Mobile crisis teams can also reconnect an individual with mental and substance use disorders to case managers or treatment providers who have already worked with them.
3. Law enforcement-friendly crisis services. Instead of arresting people in crisis or bringing them to a hospital emergency department, law enforcement officers can bring them to locations such as stabilization units, crisis centers, or respite centers. Processes that allow quick and simple drop-offs make this diversion option more effective. Additionally, the cost-savings of diver□ng individuals in crisis to facilities other than hospital emergency departments or jails are considerable. It also increases the potential of keeping individuals out of the criminal justice system.
4. Peer-operated crisis response support and/or respite. Peer response is provided by people with lived experience with a mental or substance use disorder. They may also have been involved in the justice system. Peers can provide helpful information and support that is shaped by their own experience to help people with a mental or substance use disorder. Programs run by peers and services employing peers have shown promising results in helping people recover.

5. Substance use-focused early diversion strategies. Self-referral programs, active outreach, and opioid response teams are showing promising outcomes in reducing substance use, overdoses, and fatalities due to overdose. These strategies rely on partners from different fields, such as behavioral health providers, emergency medical services and fire departments, law enforcement, prosecutors, and public defenders (where applicable), working together to provide life-saving treatments and support.

Intercept 1: Law Enforcement
Intercept 1 involves diversion performed by law enforcement and other emergency service providers who respond to people with mental and substance use disorders. At this intercept, people are to be diverted to treatment instead of being arrested or booked into jail. This stage begins with law enforcement responding to a person with mental or substance use disorders and ends when the individual is arrested or diverted into treatment. To make this intercept successful, trainings, programs, and policies must be available to help behavioral health providers and law enforcement to work together.

What is needed for this particular intercept to work effectively is:
1. Dispatcher training about mental health and mental crises can improve a dispatcher's ability to detect when responders with mental health expertise are needed.
2. Specialized law enforcement training can teach law enforcement officers how to identify the signs and symptoms of mental disorders and de-escalate crises. These trainings prepare responders to effectively support people with mental and substance use disorders when they see them.
3. Specialized law enforcement responses include partnerships between law enforcement and behavioral health crisis centers, clinicians, and case managers. Specialized law enforcement responses can help people with mental and substance use disorders access the most appropriate services.
4. Data sharing, analysis, and evaluation. Data sharing, analysis, and evaluation of carious intervention methods is vital to understanding what works and what does not in Canyon County. When agencies and systems collect and share data, it's easier to tell if an individual is using 911 or emergency services frequently – becoming a "familiar face" across the criminal justice and emergency systems. Law enforcement agencies, crisis services, and hospitals can use data to identify familiar faces and follow up after a crisis. Once these individuals are identified, they can be connected with the preventive care they need.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternal Infant Early Childhood Home Visiting Grant Program | Pregnant women and parents with a child under 5 years of age | 7/1/2025 | 6/30/2026 | $556,687.00 | $516,186.85 | $68,145.03 | $584,331.88 | NA | 24.95 | No | No | No |

I. GENERAL REQUIREMENTS:
A. This Subgrant is funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Grant Awards awarded August 21, 2023, and August 27, 2024, through the Department of Health and Human Services (HHS) with a total award amounts of three million four hundred twenty-seven thousand five hundred eighty-six dollars ($3,427,586) and four million one hundred ninety-eight thousand one hundred ninety dollars ($4,198,190).
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. Reserved
2. State, Local, Tribal, Uniform Administrative Requirements www.ecfr.gov - CFR Title 45 Part 75, Subpart C, 75.201.
3. Federal Awardee Performance and Integrity Information System (FAPIIS) Disclosure: Consistent with 45 CFR 75.113, Subrecipients must disclose, within ten (10) calendar days of discovery, in writing to the Department and the 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. Department of Health and Human Services; Health Resources and Services Administration; Office of Federal Assistance Management; Division of Grants Management Operations; 5600 Fishers Lane, Mailstop 10SWH03; Rockville, MD 20879; and
b. U.S. Department of Health and Human Services; Office of Inspector General; Attn: Mandatory Grant Disclosures, Intake Coordinator; 330 Independence Avenue, SW, Cohen Building; Room 5527; Washington, DC 20201.
E. The Subgrantee must comply with:
1. The Idaho Home Visiting Program (IHVP) procedures outlined in Attachments 1-7.
2. The most recent Parents as Teachers (PAT) Quality Assurance Guidelines and Essential Requirements located at www.parentsasteachers.org and as provided by the PAT National Office or electronically by the Department or Nurse-Family Partnership (NFP) Model Elements and/or Early Head Start standards of Practice, or whichever set of guidelines aligns with chosen Evidence-Based Home Visiting (EBHV) Model or Models.
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. Specific Staffing Requirements: The Subgrantee must hire and maintain staff, as required under this Subgrant, and as outlined in their chosen EBHV Model elements/requirements.
a. The Subgrantee must ensure that all MIECHV home visitors funded under this Subgrant serving current identified MIECHV service counties charge actual time spent serving a minimum of one (1) family to this Subgrant and that caseload records substantiate the same. Personnel and associated operating costs will not be reimbursed for home visitors who do not meet the minimum requirement.
i. Home visitors who code one quarter (.25) full-time equivalent (FTE) or more to this Subgrant must report entire caseload to IHVP via model specific data entry process.
b. The Subgrantee must employ a home visiting supervisor that fits within the guidelines of the chosen EBHV model.
c. The Subgrantee must hire home visitors that meet the requirements of their chosen EBHV model.
d. Data Entry Support: The Subgrantee must ensure timely and accurate data entry may, if they choose, dedicate administrative support staff for data entry related to home visiting services and other activities within the current identified MIECHV service counties.
e. Outreach Support: The Subgrantee must ensure viable referrals and full caseloads and may, if they choose, dedicate support staff time for outreach support related to home visiting services.
f. The Subgrantee must ensure that bilingual staff (English and Spanish) or translation services are available as appropriate.
g. The Subgrantee must allow for adequate space for confidential virtual home visits either in a designated private workspace or a home office as appropriate when virtual home visiting is being utilized for safety or convenience.
h. The Subgrantee must ensure the minimum FTE requirement is met in accordance with chosen EBHV model.
3. Supervision Requirements:
a. Home Visiting Supervisor: The Subgrantee must maintain a designated home visiting supervisor in accordance with their chosen EBHV model. This supervisor must dedicate time to the program as defined by model standards.
i. Home visiting supervisors must meet with home visitors following parameters set by their chosen EBHV models.
ii. A PAT home visitor may complete supervisory duties and code a portion of their time as a home visiting supervisor.
b. Administrative Supervisor: The Subgrantee must provide administrative supervision to the home visiting supervisor overseeing MIECHV funded home visitors.
i. Administrative Supervisors must work with home visiting supervisors to support the ongoing implementation of the program. This must include budgeting, strategic planning, and other forms of support.
ii. The home visiting supervisor and the administrative supervisor may be the same individual.

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 access to personnel for the purposes of interview and discussion related to such documents within two (2) business days.
3. The Subgrantee must respond to all deficiencies pertaining to monitoring of the Subgrant in a timely and appropriate manner.
4. This Subgrantee's risk level has been assessed as high this Subgrant year and is reassessed annually.
a. Reserved
b. Enhanced monitoring may be include monthly technical assistance calls with Division of Public Health staff. Calls will be scheduled to coincide with report and invoice submission and must occur prior to payment authorization.
i. A technical assistance site visit with program staff and the Division of Public Health Federal Compliance Officer may be scheduled.
J. The Subgrantee agrees to maintain, safeguard, and report all equipment purchased with federal and/or state funding in compliance with 2 CFR 200.313 and applicable state of Idaho property management regulations. Equipment purchased must be used solely for authorized programmatic purposes, tracked in an updated inventory system, and made available for monitoring and audit purposes as requested. Any unauthorized use, sale, or disposition of equipment without agency approval may result in repayment obligations, withholding of future funding, or other compliance actions as deemed necessary.

K. 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 X10MC50298-01-00 from the Health Resource and Services Administration (HRSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Welfare or HRSA. [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 or this conference was made possible in part, by X10MC50298-01-00 from Health Resource and Services Administration (HRSA). The views expressed in written conference materials or publications and by speakers and moderators do not reflect the official policies of the Department or HRSA 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., as applicable) was supported by grant X10MC50298-01-00 from Health Resource and Services Administration (HRSA). Its contents are solely the responsibility of [name of subrecipient] and do not necessarily represent the official views of the Department or HRSA."

L. 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.

M. Subgrantee must comply with Idaho Code sections 56-203 and 67-7903 regarding the verification of legal presence.

N. DEFINITIONS
1. Full-time equivalent (FTE): The calculation of FTE is an employee's scheduled hours divided by the employer's hours for a full-time work week. For example, for a forty (40) hour work week, employees who are scheduled to work forty (40) hours per week for MIECHV are one point zero (1.0) FTEs. Employees scheduled to work twenty (20) hours per week for MIECHV are zero point five (0.5) FTEs.
2. Model Fidelity: Adherence to model developer requirements for high-quality implementation as well as any applicable affiliation, certification, or accreditation required by the model developer, if applicable.
3. Evidence Based Home Visiting Program (EBHV): Programs identified as eligible for MIECHV funding by Home Visiting Evidence of Effectiveness (HomVEE) guidelines found at https://homvee.acf.gov/.

II. SUBGRANT SERVICES AND ACTIVITIES
A. Permissible Uses of Funding - The Subgrantee must use funding for the operation and implementation of an EBHV. Direct Costs associated with service delivery, referral, supervision, professional development, resources for families, and maintaining model fidelity are allowable. Direct costs outside of this scope must be pre-approved via email by the Department.

B. Reflective Supervision - The Subgrantee must:
1. Ensure that home visitors and supervisors are competent to implement the chosen EBHV program and adhere to all model-related requirements related to reflective supervision.
2. Notify the Department of the reflective supervision plan for home visitors and home visiting supervisors.
3. Ensure that supervisors provide reflective supervision to home visitors in the following ways:
a. One-to-one (1:1) reflective supervision: individual meeting between supervisor and home visitor for the purpose of reflection related to the provision of home visiting services. Supervision meetings must be at least one (1) hour and may take place in- person or via a virtual platform.
b. Reflective supervision must be conducted during protected time outside of any administrative tasks or meetings.
c. Supervisors must use the principles of reflection as outlined by the chosen EBHV Models and the guide: Reflective Supervision: A Guide from Region X to Enhance

Reflective Practice Among Home Visiting Programs: https://www.dcyf.wa.gov/sites/default/files/pdf/RegionX-ReflectSupGuidelines.pdf.
C. Service Capacity and Delivery, MIECHV Service Area, and Specific MIECHV Requirements - The Subgrantee must:
1. Recruit and enroll eligible families to receive EBHV services in current identified MIECHV service county including but not limited to:
a. Provide services to clients in the county with priority given to clients residing in rural areas.
b. Maintain a strong referral network of relevant community agencies within the current identified MIECHV service counties to cross-promote appropriate services and allow for recruitment and enrollment in home visiting services.
c. Convene a long-term Community Advisory Board that meets at least twice per year to implement a community support system to promote program quality and sustainability.
2. Prioritize serving the populations identified in the MIECHV authorizing legislation. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/miechv-orientation-guide. pdf. Adhere to designated MIECHV priority populations:
a. Defined legislatively as:
i. Low income, measured by percent of federal poverty level (Guidance indicates this is measured according to chosen EBHV model.);
ii. Pregnant women under the age of twenty-one (21);
iii. History of child abuse or neglect;
iv. History of substance abuse or currently needs substance abuse treatment;
v. Users of tobacco in the home;
vi. Low student achievement;
vii. Child with developmental delay or disability; and
viii. Serving or formerly served in the United States Armed Forces.
b. Defined in the 2024 Amended Idaho Home Visiting Program Needs Assessment as high need.
3. Maintain Model Fidelity regarding service delivery.
a. Understand and adhere to model fidelity regarding home visitor qualifications and home visiting service; and
b. Understand and adhere to model requirements in Attachment 1 regarding caseload per home visitor.
4. Adhere to federal guidelines regarding home visiting service under this Subgrant.
a. Follow current HRSA guidance on allowable expenses, staffing, and caseload.
b. Adhere to HRSA guidance on virtual home visiting including:
i. At least one (1) in-person home visit must be conducted for each client during each twelve (12) month period of enrollment, beginning with their date of entry into the program; and
ii. Conduct at least sixty percent (60%) of home visits in-person.
5. The Subgrantee must make all efforts to reduce client attrition in the event of Home Visitor turnover, which may include the use of warm handoffs and supervisor coverage of caseloads.

D. Professional Development: The Subgrantee must:
1. Share all professional development opportunities sponsored by the Department under the MIECHV program with Subgrantee's home visitors and encourage attendance when possible.
a. Ensure a minimum of one (1) staff person attend the IHVP annual meeting.

E. Continuous Quality Improvement (CQI). The Subgrantee must:
1. Participate in any CQI projects offered and facilitated by the Department or complete a mutually agreed upon independent project in accordance to federal guidelines.
a. Designate at least one (1) home visitor per project to serve as a CQI Lead and perform duties as assigned. Ensure active participation from all other home visiting staff as required.
b. Complete and submit all necessary and appropriate supporting documents by the outlined due dates provided by the Department.
c. Make all reasonable efforts to aid in data collection and analysis related to CQI projects.
d. Assist in Identification of areas for improvement as needed throughout the Subgrant period.

F. Data Collection, Documentation, and Reporting - The Subgrantee must:
1. Ensure all home visiting supervisors and data entry support staff are trained and knowledgeable about the chosen EBHV data requirements as well as MIECHV data requirements and are able to adequately utilize the data system.
a. The home visiting supervisor must work collaboratively with the Department on any data guidance, questions, or concerns.
b. The Subgrantee must ensure that all home visiting staff are aware of and understand the nineteen (19) MIECHV performance measures (https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/form-2-performance- measurement-toolkit.pdf) and are able to appropriately document the performance measures.
c. The Subgrantee must work with the Department to demonstrate improvement in measurement-level performance data to baseline data as well as the national threshold.
i. Baseline data for each measure is calculated by computing the mean of the two
(2) previous years for each measure.
ii. The national threshold for each measure will be provided by HRSA and will be calculated by computing the national mean value of the two (2) preceding years.

III. RECORDS AND DOCUMENTATION
A. The Subgrantee must:
1. Document the number of families and children served in each category where costs are allocated according to the cost allocation plan submitted to the Department.
a. The Subgrantee must work with the Department to determine the best way to enter, track, and report data in accordance with federal guidelines.
2. Ensure that all home visiting data is entered into the model's database and verified as accurate by the fifth business day of each month, unless otherwise specified.
a. The Annual Report Data must be entered within three (3) business days after September 30, to ensure federal deadlines are met.
3. Ensure corrections to any data errors reported by IHVP within two (2) business days.
4. Provide reports from the data system or other documentation to the Department as requested and as mutually agreed upon by all parties.
5. Ensure reasonable efforts are made to respond to any data requests from the Department's indicated Evaluation Team on behalf of the Department and ensure participation in additional IHVP program evaluation activities as mutually agreed upon by the Subgrantee, the Department, and the Evaluation Team.
6. Request approval of the Department and the chosen EBHV program prior to conducting or participating in research beyond MIECHV program evaluation.
7. Ensure client information is confidential and maintained in a secure location.
a. Document that clients are informed of client rights to confidentiality, consent for information release, other informed consent, privacy protections, grievance procedures, and that participation in home visiting services is voluntary.

IV. QUALITY ASSURANCE
A. The Subgrantee must meet with the Department, as requested, to review Subgrant compliance, to participate in mutually agreed upon training, to collaboratively plan improvements, and to discuss safety concerns or any special preparation and planning needs.
1. The Subgrantee must participate in one (1) Department-led site visit every two (2) years, either in-person or virtually to determine Subgrant compliance and model fidelity.
B. The Subgrantee must perform Randomized Client Contact in accordance with IHVP Procedure 007 (Attachment 6).
C. Reserved

V. RESERVED

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.243 Behavioral Health Partnerships for Early Diversion of Adults and Youth | All | 9/30/2024 | 9/29/2025 | $148,611.00 | $83,856.00 | $15,331.00 | $99,187.00 | $49,424.00 | 10% indirect max | Yes | $37,153 | No |

Award recipients must use SAMHSA's funds to support direct services primarily. This includes the following activities:
• Convene a new or continue an existing interagency Behavioral Health Partnership workgroup that is committed to integrating the Early Diversion program into the existing system of care; and, designing, implementing, and overseeing a plan of comprehensive strategies to divert adults or youth with a mental illness or COD to community-based services prior to arrest or booking. At a minimum, the required key stakeholder partners must be representatives from the criminal and/or juvenile justice system and the mental health and substance use treatment and recovery systems. Examples of other stakeholders are veterans, law enforcement, civil first responders, schools, child welfare system, youth and young adults with lived experience, family members with lived experience, and social welfare agencies.
• Within the first 4 months of award, conduct a criminal/juvenile justice early diversion community system mapping such as the Sequential Intercept Mapping (SIM) focusing on intercepts 0 and 1 to identify diversion opportunities, potential partners and desired outcomes.
• Develop a comprehensive plan of evidence- and community-based mental health services using a multi-agency approach to divert adults or youth with amental illness or COD prior to arrest or booking. This plan should include providing the following services within 6 months of award to the population of focus:
o Case management;
o Assertive community treatment;
o Medication management and access;
o Integrated mental health and co-occurring substance use disorder
treatment;
o Psychiatric rehabilitation;
o Peer recovery support services;
o Life skills training;
o Housing placement;
o Vocational training;
o Education or job placement;
o Primary health care;
o Screening protocols or procedures to identify the needs of adults or youth with a mental illness or COD being diverted;
o Procedures or protocols for coordination with law enforcement, local crisis, and 988 systems on diversion efforts prior to arrest and booking;
o Procedures or protocols for direct transfer/warm hand off12 to behavioral healthcare (e.g., law enforcement officer or civilian first responder conducts the outreach to the behavioral health worker to meet the individual in crisis at the scene, etc.); and Procedures or protocols for follow up and outreach to ensure adults or youth who are diverted are connected to transition planning and services.
• Expand and integrate into the Early Diversion program existing mental health, substance use treatment, and recovery support services.
• Train law enforcement officers, attorneys, judges, civilian first responders, paraprofessionals and other professionals on mental health and substance use awareness and identification, de-escalation, diversion, and crisis resolution practices in a culturally-appropriate manner.
• By the end of Year 3, develop a plan for sustainability to continue the program following the conclusion of federal funding.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N/A - Crisis Centers funding from Magellan | All | 7/1/2024 | auto renew | $1,500,000.00 | NA | NA | $1,500,000.00 | NA | 24.95 | No | No | No |

1. Crisis Center Providers. Crisis Centers shall based on the Medicaid Crisis Standards of Care:
a) Have an integrated, systematic approach to behavioral health crisis care to address the needs of adults and youth experiencing a mental health crisis.
b) Provide easy access to crisis service alternatives that reduce the inappropriate use of emergency departments, inpatient services, and jail;
c) Offer a dedicated first responder drop-off area;
d) Address the cultural and special population needs of their community including the ability to manage complex needs in populations such as individuals with intellectual and developmental disabilities, LBTBQIA individuals, and veterans or active military;
e) Incorporate some form of intensive support beds into a partner program (either internally or with external providers) to support flow for individuals who need additional support;
f) Provide data on chair capacity to the real-time IPBSR operated by the IDHW to support efficient connection to needed resources;
g) Coordinate connections to ongoing care;
h) Embed users, peers and Members in their organization's design and leadership;
i) Train and integrate peer support staff in crisis service delivery;
j) Adopt a zero-suicide philosophy;
k) Engage family and friends in crisis care;
l) Engage in community outreach regarding availability of crisis stabilization services;
m) Collect and report data as outlined in the Contract and the IDHW Standards;

n) By the end of the second year of the Contract, provide applicable data to Magellan to develop dashboards that display real-time, meaningful data and outcome measures that support continuous quality improvement;
o) Administer Naloxone in cases of opioid overdose;
p) Offer each member, upon discharge, a satisfaction survey that includes questions related to the quality of service, the outcomes of services and their perception of additional needs not addressed by the facility. The results of these surveys shall be sent to Magellan for use as outlined in App. B, Section 51, Continuous Quality Improvement and Stakeholder Engagement in the Crisis System;
q) Access and use Magellan's Care Management Platform;
r) Connect to ACT and ICC staff to help coordinate care as appropriate;
s) Utilize the IDHW-approved protocols for safety planning; and
t) Develop a collaborative discharge plan that addresses safety, stability and treatment progress.
u) Enhance current operations by adopting the BHL platform, which will fulfill Magellan's IBHP contractual requirements for quarterly reporting.
2. Implementation Plans.
a) Crisis Centers shall develop implementation plans to meet the IDHW Crisis Center Standards (currently available at: https://healthandwelfare.idaho.gov/providers/behavioral-health-providers/behavioral-healthservice-providers) and SAMHSA's best practice guidelines for Minimum Expectations to Operate a Crisis Receiving and Stabilization Service (currently available at: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care02242020.pdf) during the first year of the contracts. The plans must be implemented by the end of the second year of the new contracts.
b) Youth Crisis Centers shall develop implementation plans to meet the IDHW Youth Crisis Center Standards and SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care (currently available at: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/nationalguidelines-child-youth-behavioral-health-crisis-care_1.pdf) during the first year of the contracts. The plans must be implemented by the end of the second year of the new contracts. (The IDHW Youth Crisis Center Standards are currently being developed.) If crisis stabilization services are co-located with other specialty mental health services (such as adult services and/or substance use services), these areas need to be physically separated completely by locked doors and walls, so that there is no co-mingling between Members, regardless of age. There must be no co-mingling between adult Members and youth Members allowed at any time, for any reason.
3. The Crisis Center must comply with all provisions of state and federal laws, rules, regulations, policies, standards, and guidelines as indicated, amended, or modified that govern performance of the services. This specifically includes, but is not limited to:
a) Idaho Code Title 39 Chapter 91, Behavioral Health Community Crisis Centers.
b) Idaho Code sections 16-2428 and 37-3102 that govern youth's consent to disclosure of treatment information, as well as general use and disclosure and privacy requirements of state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1302(a), 42 U.S.C. 1320d-1320d-9, and its implementing regulations, 45 CFR parts 160, 162, 164, and laws related to the confidentiality of substance use disorder (SUD) records, 42 U.S.C. 290dd-2, and its implementing regulations at 42 CFR Part 2 and ensure procedural safeguards are followed in confidentiality requirements according to IDAPA 16.05.01, Use and Disclosure of Department Records as outlined in the Business Associate Agreement attached hereto as a Rider.
c) The Department's HIPAA Business Associate Agreement.
d) Idaho's Open Meeting Law as established in Idaho Code §§ 74-201 through 74-208.
e) The Idaho Behavioral Health Plan (IBHP)'s Idaho Department of Health and Welfare (IDHW)-approved Supervisory Protocol.
4. The Crisis Center must:
a) Provide, operate, and manage their crisis center as follows:
i) Operate twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.
ii) Provide services to members in a behavioral health crisis for no more than twenty-three (23) hours and fifty-nine (59) minutes per single episode of care. A "single episode of care" is defined as a time period consisting of a rolling 23 hours and 59 minutes after the member is admitted.
iii) Provide services on a voluntary, outpatient basis to individuals experiencing a behavioral health crisis.
iv) Provide case management services to assist in the creation and follow through of treatment and discharge planning.
v) Ensure age-appropriate members participate in crisis stabilization planning.
b) Ensure for Youth Crisis Centers (YCC):
i) Parent/Guardian and/or Law enforcement be contacted if the member arrived at the facility unaccompanied by the parent or guardian.
ii) If a staff member suspects a member has been abused, abandoned, or neglected a report to the appropriate parties must be made as required by Idaho Code 16-1605.
c) Ensure the facility can provide services to individuals in crisis including:
i) Individuals with co-occurring conditions or considerations including, but not limited to:
i. Mental health conditions.
ii. Substance Use Disorders (SUDs).
iii. Medical needs (not requiring immediate hospitalization).
iv. Intellectual/developmental disabilities.
v. Physical disabilities.
vi. Members who may be uninsured or unable to pay for services.
vii. Youth who may lack residency or legal immigration status.
viii. Lesbian, gay, bisexual, transgender, queer, intersex, agender (LGTBQIA+) members.
d) Incorporate peer recovery support services as part of the overall crisis service delivery system.
e) Use a department provided real time bed registry.
i) Update the bed registry a minimum of once per 12-hour period, morning, and evening.
f) Develop and maintain policies and procedures that address the following:

i) Engage member’s natural supports.
ii) Maximum capacity.
iii) Staff training requirements include but are not limited to:
i. Overdose training response and naloxone injection
ii. Basic life support (BLS) certification
iv) Cultural competency plan.
v) Staff to member ratios, including minimum staff to remain open.
vi) Bilingual Services.
vii) Non-discriminatory practices.
viii) Member's personal possessions, including medications.
ix) Transportation of members (if provided);
x) Member resting areas.
xi) Crisis Assessment Tool (CAT) data submission platform.
xii) Behavioral management system: de-escalation and safety.
xiii) Member conducts and rules violation.
xiv) Critical Incidents.
xv) Emergency policies and procedures.
xvi) Quality management plan.
xvii) Reporting of abuse and or neglect, including alleged.
xviii) Maintenance and care of the facility.
xix) Use of program animals.
xx) Disposal of contraband/weapons.
xxi) Alcohol, tobacco products, and illegal or illicit drugs.
xxii) Grievances and complaints.
xxiii) Background checks.
xxiv) Member eligibility.
xxv)Admission and discharge.
xxvi) Clinical supervision.
xxvii) Law enforcement referrals.
xxviii)Visitors.
xxix) Member records.
xxx)Policy to transfer youth to adult center.
xxxi) Policy to readmit youth if additional few hours of stabilization is needed.
xxxii) Member rights including the acceptance and refusal of services; and
xxxiii) For YCC:
i. Non-episode participants, such as siblings.
ii. Member reporting as runaways.
xxxiv) Medical assessment and treatment requirements that include but are not limited to:
i. Response to overdoses
ii. Naloxone
iii. Identification of withdrawal symptoms (and high-risk scenarios where hospital is needed for withdrawal management).
xxxv) Medication Management requirements that include but are not limited to:
i. Storage and administration of prescription and non-prescription medication.
ii. Storage of all prescription and over-the-counter medication under lock and key.
iii. Ensure the keys are not accessible to unauthorized individuals, including members, parents, visitors, or staff not authorized to assist with medications.
iv. Administration of medication be recorded by authorized personnel and in accordance with physician's orders.
v. Staff who administer and assist with self-administration of medications must be certified by a qualified medical professional.
vi. Consultation of a qualified medical professional before discontinuing, changing, or adding prescribed medication.
vii. If applicable; parent/guardian consent before discontinuing, changing, or adding prescribed medication.
viii. Documentation of all consultations regarding changes in prescription medications.
ix. Documentation for all prescription medication issued by a qualified medical professional's valid order that includes the dosage to be given, and documentation of each dose given, name of the member, date and time, amount of dosage given and whether the member did or did not take the medication; and person who administered or assisted in the self-administration of the medication.
g) In coordinated effort with the Department, for Youth in department custody, the YCC must allow and encourage the member’s parent/guardian to be involved in crisis treatment, treatment planning and discharge planning, unless it is the Department's determination that such involvement would endanger the member. Efforts and activities related to family and natural support involvement must be documented in the member's case record established by the YCC.

h) Provide a Program Services description detailing all the services provided. Services must include but are not limited to:
i) Crisis stabilization services.
ii) Parent/guardian education.
iii) Relapse prevention.
iv) Case management/care coordination.
v) Referral services.
vi) Aftercare planning.
vii) Safety planning.
viii) Meets general facility requirements.
i) The Crisis Center Facility must:
i) Ensure that if crisis stabilization services are co-located with other specialty mental health services (such as adult services and/or substance use services) these areas must be physically separated by locked doors and walls, so there is no co-mingling between members, regardless of age. There must be no co-mingling between adult members and child/youth members allowed at any time, for any reason. Adult members and child/youth members must be physically separated by locked doors and walls, so there is no co mingling between members.
j) Meet capacity requirements:
i) YCC's must have capacity for up to eight (8) members. The maximum number can be achieved and/or expanded in stages during implementation and as approved by Department.
ii) Adult Crisis Centers must have capacity for ten (10) male/female beds for a total of twenty (20) beds.
iii) Ensure that the facility has separate resting areas for members, based on age and other identified factors, as appropriate.
k) Have capacity that includes:
i) Lobby space with chairs and tables.
ii) Confidential office space for medical, case management, and behavioral health interventions.
iii) A triage area that is quiet and private.
iv) Spaces that are trauma informed in their design and promote privacy and dignity as well as safety.
v) Quiet space in the physical environment away from the milieu of the main stabilization area.
i. This area must be used for de-escalation and calming, not seclusion. There must be no restrictions in terms of entry and exit.
vi) A family friendly, welcoming physical space and environment for persons in crisis that offers developmentally suitable supports for members and families.
vii) Confidential spaces for families to gather, with the member and without, where the families and/or member may receive clinical services and supports.
viii) Bathrooms that are gender neutral.
ix) Develop and maintain a policy to decrease safety risks for members who may be alone or unsupervised in a location, such as but not limited to a bathroom. Anti-ligature equipment for these locations is required.
x) A dedicated first responder drop off area separate from the main entrance.
xi) A means of securing personal possessions including medication, valuables, clothing, etc.
xii) Member protection from potential threats to their safety by implementing a security policy and practice.
xiii) Recommendation to provide limited daily transportation to community partner places of business such as the Department of Labor, Social Security Administration and Public Health Department.
l) Have Available:
i) Plastic eating utensils and cups.
ii) Beverages such as water, coffee, etc.
iii) Non-perishable, self-prepared snack items such as cup of soup, granola bars, cheese and crackers, peanut butter sandwiches, pudding cups or other similar items; and
iv) Have available, on an "as needed" basis:
i. Sweatpants, scrubs, tee shirts, sweatshirts, etc.
ii. Personal care products, toiletries/toilet paper, paper towels.
iii. Bus and cab vouchers
5. Staffing requirements must include:
a) Assessment and screenings being overseen by a Licensed Medical Professional and/or a Licensed Mental Health Professional. The professionals must have the training, skills, current professional licensure and/or certification to accurately diagnose members.
b) All service provisions delivered by professionals who meet licensure and/or certification qualifications, as appropriate within their field of study. Evidence of licensure, certification, and any other applicable qualifications must be provided to the IBHP contractor.
c) A clinical supervisor to provide direction and guidance of all clinicians doing integrated mental health and substance use disorders assessments.
i) There must be a minimum of one (1) medical staff which could be inclusive of; Certified Nursing Assistant (CNA), Emergency Medical Technician (EMT), Licensed Practical Nurse (LPN), or Registered Nurse (RN) on site at all times. This staff can be counted as one (1) of the minimum two (2) staff on site.
ii) Required staffing ratios: One (1) direct care staff for every three (3) members and a minimum of two
(2) staff on site at all times.
iii) Ability to provide 1:1 supervision as needed.
6. Available screening/services and interventions must include:
a) Medical Screening/Assessment:
i) A medical professional, as described above, assesses physical health needs, and determines any need for immediate medical treatment. The medical professional may deliver care for minor physical

health challenges. The Screening/Assessment must also provide a health history.
b) Plan of Care and Service Planning:
i) A plan of care based on findings from the medical screening and behavioral health assessment/CAT for each member admitted. The plan of care must be individualized, person-centered, strengths-based, collaborative, family, and community focused, culturally competent, utilize natural supports, and be outcomes based. The plan of care must be documented in the Department-approved data submission platform outlined by the contractor.
ii) Depending on the age of the member, member and/or their parents or guardians must direct the development of the member's service plan through a person-centered, family driven, member guided planning process. The Contractor must ensure information and support is provided to members and families to maximize their ability to make informed choices and decisions.
c) For each YCC member, there must be a completed and or updated CAT per admission, administered by a certified staff member. This must include intake information to develop the plan of care, intervention services and referral services. The CAT must be documented in a department-approved data submission platform.
i) CAT (Crisis Assessment Tool)
i. REFERENCE-GUIDE_Standard-CAT-6-thru 20_Final_2022.12.15.docx (https://praedfoundation.org/tcom/tcom-tools/crisis-assessment-tool-cat/)
d) Intervention Services
i) Including stage-wise treatment and intervention services based on the Dr. Kenneth Minkoff, M.D. model to address co-occurring psychiatric and substance use disorders. This includes:
i. Acute Stabilization - safe sobering up and stabilization of acute psychiatric symptoms.
ii. Motivational Enhancement - individualized motivational strategies to help individuals who have made no commitment to change.
iii. Active Treatment - for individuals who need to learn and practice skills to manage their substance and mental health symptoms.
iv. Relapse Prevention - specific skills training on participation in self-help recovery programs, as well as specialized self-help programs like Dual Recovery Anonymous.
v. Rehabilitation and Recovery - developing new skills and capabilities based on strengths, and on developing improved self-esteem, pride, dignity, and sense of purpose in the context of the continued presence of mental health and substance use disorders.
e) Referral Services
i) Based on identified functional areas of impairment (medical, vocational, financial, housing, family, social activities of daily living, transportation, legal, and substance use). This information must be documented in a department-approved data submission platform.
ii) For YCC's this includes a warm handoff to home and community-based providers working with the member discharging from the YCC. This work may include but is not limited to: scheduling appointments for the member which would include a discussion with the provider about the needs and strengths of the member and family.
f) Aftercare Plan
i) Each member, prior to leaving the Crisis Center must be provided an after-care plan which includes, at a minimum, connection to a peer or Recovery Support Specialist.
ii) This plan must be documented in a department approved data submission platform.
iii) The plan must anticipate a variety of needs associated with aftercare. Ideas include but not limited to:
i. Safety Planning.
ii. Primary/Peer Support.
iii. Education Planning.
iv. Relapse Prevention Planning; and
v. Continuing Treatment Planning.
g) Medication Management
i) Medication Storage and Administration policies and procedures regarding the storage and administration of prescription and non-prescription medication.
h) Behavioral Management
i) Have a nationally recognized behavior management system to structure prevention and intervention approaches that is approved by the Department.
ii) Ensure all staff are trained in and use crisis management and intervention techniques that employ verbal de-escalation methods and non-physical intervention strategies. Ensure there is no restraint either mechanical, physical, or chemical (pharmacological) of members by agency staff, or other members.
i) A process and policy to transfer a member to a higher level of care if needed.
Crisis Centers will enhance current operations by adopting the BHL platform which will fulfill Magellan's IBHP contractual requirements for quarterly reporting.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.243_Substance Abuse and Mental Health Services Projects of Regional and National Significance | ALICE and Spanish-speaking | 9/30/2023 | 9/29/2028 (NoA on file through 9/29/2025) | $374,455.00 | $107,606.00 | $3,095.00 | $110,701.00 | $237,405.00 | 10% indirect max | No | No | No |

Goal A Decrease risk factors and increase protective factors that contribute to youth substance initiation and use of alcohol, marijuana, and stimulants through implementing a community-led youth substance use prevention model, specifically the Icelandic Prevention Model.
1. Objective A1 By the end of year one, partner with a community to develop a prevention coalition workgroup and implement the Icelandic Prevention Model (IPM).
2. Objective A2 By the end of year one the prevention coalition workgroup will develop and implement at least two strategies that address factors identified through IPM survey data.
3. Objective A3 By the end of year five, see a significant increase in community protective factors associated with youth alcohol, marijuana, and stimulant use.
4. Objective A4 By the end of year five, see a significant change in youth alcohol, marijuana, and stimulant use.
5. Objective A5 By the end of year three (October 1, 2025), partner with an additional community to develop a prevention coalition workgroup to implement the IPM and repeat objectives A1 – A3.
6. Objective A6 Prevention efforts within partner communities will be sustained by year three of community IPM implementation
Goal B Increase district wide community capacity to prevent youth substance use by providing trainings, evidence-informed prevention curricula and projects, and youth, parent, and community education.
1. Objective B1 Each year of the five-year project, SWDH will offer/support a project or educational activity to all six counties.
2. Objective B2 Communicate and support connections to education, resources, trainings, and effective primary prevention methods to all six counties.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.243_Substance Abuse and Mental Health Services Projects of Regional and National Significance | ALICE and Spanish-speaking | 9/30/2023 | 9/29/2028 (NoA on file through 9/29/2025) | $45,000.00 | $40,000.00 | $5,000.00 | $45,000.00 | $237,405.00 | 10% indirect max | No | No | No |

Goal A Decrease risk factors and increase protective factors that contribute to youth substance initiation and use of alcohol, marijuana, and stimulants through implementing a community-led youth substance use prevention model, specifically the Icelandic Prevention Model.
1. Objective A1 By the end of year one, partner with a community to develop a prevention coalition workgroup and implement the Icelandic Prevention Model (IPM).
2. Objective A2 By the end of year one the prevention coalition workgroup will develop and implement at least two strategies that address factors identified through IPM survey data.
3. Objective A3 By the end of year five, see a significant increase in community protective factors associated with youth alcohol, marijuana, and stimulant use.
4. Objective A4 By the end of year five, see a significant change in youth alcohol, marijuana, and stimulant use.
5. Objective A5 By the end of year three (October 1, 2025), partner with an additional community to develop a prevention coalition workgroup to implement the IPM and repeat objectives A1 – A3.
6. Objective A6 Prevention efforts within partner communities will be sustained by year three of community IPM implementation
Goal B Increase district wide community capacity to prevent youth substance use by providing trainings, evidence-informed prevention curricula and projects, and youth, parent, and community education.
1. Objective B1 Each year of the five-year project, SWDH will offer/support a project or educational activity to all six counties.
2. Objective B2 Communicate and support connections to education, resources, trainings, and effective primary prevention methods to all six counties.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description: Dental sealants, fluoride varnish, and oral health education. | elementary and middle schools (grade kindergarten through eighth [K-8] or ages five to fourteen [5-14]) | 7/1/2023 | 6/30/2026 | $134,880.00 | NA | NA | $134,880.00 | NA | 24.95 | No | No | No |

1. GENERAL REQUIREMENTS
A. This Subgrant is funded by the Maternal and Child Health (MCH) Services Block Grant, 93.994 through the Health Resources Services Administration with a total award amount as indicated on the

Notice of Award (NOA).
B. This Subgrant supports the Department's Strategic Plan and the Division of Public Health
priorities.
C. Reserved.
D. The Subgrantee must adhere to the following:
1. For State, Local, and Tribal: 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.
E. The Subgrantee must read and comply with:
1. Association of State and Territorial Dental Directors, Best Practice Approach Report:
School-based Dental Sealant Programs. (https://www.astdd.org/bestpractices/school-based-dental-sealant-programs-bpar-2022-final.pdf)
2. Association of State and Territorial Dental Directors, Best Practice Approach Report:
Perinatal Oral Health. (https://www.astdd.org/bestpractices/perinatal-oral-health-bpar-final-2019.pdf)
3. Association of State and Territorial Dental Directors, Best Practice Approach Report: Prevention and Control of Early Childhood Tooth Decay. (BPAR ECCPandM (astdd.org)
4. Center for Disease Control (CDC) Recommendations for School-Based School Sealant Programs.
(https://www.cdc.gov/oralhealth/dental_sealant_program/school-sealant-programs.htm &https://www.cdc.gov/oralhealth/dental_sealant_program/implementation-of-school-sealant-programs.htm)
5. Association of State and Territorial Dental Directors, Best Practice Approach Report: Use of Fluoride in Schools. (https://www.astdd.org/docs/final-approved-fluoride-in-schools-bpar-july-2018.pdf)
6. Language removed in Amendment 1.
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.
Scope of Work
2. Specific staffing requirements include having a registered dental hygienist with a current active Idaho license.
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 may 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 may 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. 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]."
b. 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]". OR "The project described was supported 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]."
c. 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.
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.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strengthening U.S. Public Health Infrastructure, Workforce, & Data Systems | SWDH employees & everyone served by SWDH | 7/1/2022 | 6/30/2026 | $1,600,000.00 | $299,315.95 | $102,671.05 | $401,987.00 | NA | 24.95 | No | No | No |

SCOPE OF WORK I. GENERAL REQUIREMENTS

A. This Subgrant is funded by the Strengthening U.S. Public Health Infrastructure, Workforce, & Data Systems grant awarded December 1, 2022 through the Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC) with a total award amount of twenty-four million four hundred fifty-five thousand nine hundred thirty-eight dollars ($24,455,938).

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

C. Reserved.

D. The Subgrantee must adhere to the following: 1. For State, Local, Tribal, Uniform Administrative Requirements www.ecfr.gov - CFR Title 45 Part 75, Subpart C, 75.201.

E. Reserved.

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.

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. This Subgrant's risk level has been assessed as high for this Subgrant year. a. Reserved. b. Enhanced monitoring may include monthly technical assistance calls with Division of Public Health staff. Calls will be scheduled to coincide with report and invoice submission and must occur prior to payment authorization. i. A technical assistance site visit with program staff and the Division of Public Health Federal Compliance Officer may be scheduled. 2

J. The Subgrantee agrees to maintain, safeguard, and report all equipment purchased with federal or state funding in compliance with 2 CFR Part 200.313 and applicable state of Idaho property management regulations. Equipment purchased must be used solely for authorized programmatic purposes, tracked in an updated inventory system, and made available for monitoring and audit purposes as requested. Any unauthorized use, sale, or disposition of equipment without Department approval may result in repayment obligations, withholding of future funding, or other compliance actions as deemed necessary.

K. 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 NE11OE000102 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Welfare or the CDC. [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 NE11OE000102 from the Centers for Disease Control and Prevention (CDC). The views expressed in written conference materials or publications and by speakers and moderators do not reflect the official policies of the Department or the CDC 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., as applicable) was supported by grant NE11OE000102 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of [name of subrecipient] and do not necessarily represent the official views of the Department or the CDC."

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

M. Reserved.

N. Reserved.

O. Reserved.

II. SUBGRANT SERVICES AND ACTIVITIES

A. A1 - Workforce 1. The Subgrantee must use these funds as outlined in the Subgrant Attachment 1 - Workplan for A1: a. Retain public health staff. b. Support and sustain the public health workforce. c. Train new and existing public health staff. d. Strengthen workforce planning, systems, processes and policies. 3 2. All activities outlined in the workplan must be completed by June 30, 2026.

B. A2 - Foundational Capabilities 1. The Subgrantee must use these funds as outlined in the Subgrant Attachment 1 - Workplan for A2: a. Strengthen organizational competencies addressing information technology, human resources, financial management, contract, and procurement services. 3. All activities outlined in the workplan must be completed by June 30, 2026.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IDJC: FY23 Safe Teen Assessment Center Grant | Youth under age 18 | 7/1/2022 | 6/30/2025 | $1,500,000.00 | $171,000.00 | $195,232.22 | $366,232.22 | $1,133,767.78 | 0 | No | No | No |

The Idaho Department of Juvenile Corrections, in consultation with the Idaho Juvenile Justice Commission and Idaho Behavioral Health Council, announce funding to improve the juvenile justice and children's systems in Idaho by addressing the needs of juveniles through Safe Teen Assessment Centers which provide a single point of contact, screening for need, and when appropriate, providing more comprehensive assessment of youth and families to inform an individualized plan connecting youth and families with community-based resources within their area. The goal of the grant is to prevent youths' further entrance into the juvenile justice and child welfare systems by providing connection to community-based resources and services. These community-based interventions may occur in response to underlying issues or concerning behavior identified at school, by parents or caregivers, at point of contact with law enforcement, etc. Underlying issues or concerns may be related to trauma, delinquency, mental health, substance use, familial issues, etc.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IDJC: FY24 Assessment Center Limited Longevity Support | Youth under age 18 | 7/1/2023 | 6/30/2026 | $448,468.00 | $48,468.00 | $2,750.00 | $51,218.00 | $397,250.00 | 0 | No | No | No |

The Idaho Department of Juvenile Corrections, in consultation with the Idaho Juvenile Justice Commission and Idaho Behavioral Health Council, announce funding to improve the juvenile justice and children's systems in Idaho by addressing the needs of juveniles through Youth Assessment Centers which provide a single point of contact, screening for need, and when appropriate, providing more comprehensive assessment of youth and families to inform an individualized plan connecting youth and families with community-based resources within their area. The goal of the grant is to prevent youths' further entrance into the juvenile justice and child welfare systems by providing connection to community-based resources and services. These community-based interventions may occur in response to underlying issues or concerning behavior identified at school, by parents or caregivers, at point of contact with law enforcement, etc. Underlying issues or concerns may be related to trauma, delinquency, mental health, substance use, familial issues, etc.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IDJC: Assessment Center FY2025 | Youth under age 18 | 7/1/2024 | 6/30/2025 | $33,150.00 | $0 | $18,150.00 | NA | $15,000.00 | 0 | No | No | No |

The Idaho Department of Juvenile Corrections seeks to provide small grants to enhance services, increase scope, or to improve skill sets, but not support the day-to-day operations of existing Assessment Centers (per Legislative guidance. Funding is intended to support existing Safe Teen Assessment Center projects previously established under FY23, FY24 funding. Funding is designed to provide limited support to help ensure project success.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IDJC: FY25 Title II Assessment Center Grant | Youth under age 18 | 3/17/2025 | 9/30/2025 | $50,000.00 | NA | NA | NA | $50,000.00 | 0 | No | No | No |

The Idaho Department of Juvenile Corrections and Idaho Juvenile Justice Commission seeks to support day to day operations of existing Assessment Centers. Funding is intended to support existing Safe Teen Assessment Center projects previously established under FY23 and FY24 funding. The Title II Assessment Center Grant is designed to provide short-term funding to support sustainability

Since 1974, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the United States Department of Justice has administered the Title II Formula Grants Program to support state and local delinquency prevention and intervention efforts and juvenile justice system improvements. The Formula Grant funds are administered by the Idaho Department of Juvenile Corrections (IDJC) and the Governor appointed Idaho Juvenile Justice Commission (IJJC), which establish funding priorities. Project applicants who have been awarded funds from the IJJC are considered grantees. The purpose of this manual is to give project grantees an outline of the financial and reporting requirements and responsibilities involved with an award by the IJJC. The manual is brief in order to make it readable and usable. If you have any questions or need more clarification in any matters discussed, please contact IDJC staff.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
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| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IDJC: Millennium Income Fund Grant Award | Youth under age 18 | 7/1/2025 | 6/30/2026 | $200,000.00 | NA | NA | NA | $200,000.00 | 0 | No | No | No |

Senate Bill 1215 was passed during the 2025 legislative session, which appropriates emergency funding for FY25 and one time funding for FY26 for assessment centers to be distributed through the Idaho Department of Juvenile Corrections (IDJC). This bill sets clear expectations related to the funding process and clearly establishes these funds as a one-time appropriation with no expectation of future financial support. This communication provides guidance related to Senate Bill 1215, which can be read in its entirety here: https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2025/legislation/S1215 The Bill establishes requirements for Centers to provide a comprehensive sustainability plan, that details how Centers can remain operational without reliance on state funds. Additionally, the Bill establishes the requirement that each Center sign an attestation letter that demonstrates how distributed moneys will be used and accounted for; and demonstrates operational and fiscal accountability. Both documents are required to be submitted to IDJC and the Budget and Policy Analysis Division of the legislative Services Office prior to the Department of Juvenile Corrections distributing any moneys.

The Bill also articulates that funding shall be distributed to eligible Assessment Centers based on criteria set forth by the IDJC. Consideration will be given to Centers based on a multitude of factors, which include but are not limited to, Tier I vs. Tier II, youth and families served, attachment area of center, sustainability work described in requested Sustainability Plans, and remaining funds from previous grant years, including open grants and carryover funds.

IDJC has provided draft templates of the sustainability plan and funding request, as well as the Attestation Form. Each Center will need to submit a sustainability plan and funding request no later than May 5th, 2025. Centers may opt out of applying for this funding if their center has reached the goal of sustainability. IDJC will review all requests and distribute FY25 funds as soon as practicable. FY26 funds will be distributed no later than July 15, 2025, with the second distribution to occur no later than December 1, 2025.

Each Center that receives funding must provide reports that include data-driven results on the success of the Center on a template to be developed by the Coalition. The initial report must be submitted no later than September 1, 2025, with the updated report to be submitted no later than June 1, 2026. Both reports must be submitted to IDJC and Budget and Policy Analysis Division of the Legislative Services Office.

In addition, to the guidance on the Millennium Income Funding, IDJC is requesting each Center review the individualized budget closeout guidance that was issued by IDJC on or around 1/06/25, regarding closeout budget instructions for your unspent historical funding. Each Assessment Center was provided expectations and deadlines related to remaining funds. The goal of the funding from the Millennium Income Fund is to ensure Centers become sustainable by July 1, 2026. It is our sincere hope that the Centers can use this funding to become sustainable and continue their amazing work in communities across the state. Thank you for the collaboration and for your dedication to Idaho's youth and families.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Suicide Prevention Activities | All, with a focus on veterans, youth and rural communities. | 7/1/2025 | 6/30/2026 | $45,000.00 | $40,000.00 | $5,000.00 | $45,000.00 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES

A. Regional Collectives. The Subgrantee must:

1. Coordinate, participate, and/or facilitate a district-wide collective (Collective) of individuals, businesses, community members, and survivors, whose purpose is to develop a plan with strategies consistent with the most recent Idaho State Suicide Prevention Plan to reduce deaths by suicide. Work of the Collective must include:

a. Establishing partnerships in each county in the region to work on suicide prevention, intervention, and postvention initiatives. Partnerships are intended as two-way relationships that share information and input for advancing collective impact throughout the district.

b. Meetings or dialog under an agenda to includes priorities of the Collective, no less than quarterly.

c. By September 30, 2025, assembling an updated list of Collective partners representing each county. The list should include the partner's name, agency, location, and connection to suicide prevention. The list must be submitted once by September 30, 2025, and any updates on collective membership, if applicable, with the quarterly SMRs.

d. By September 30, 2025, compiling a report to describes notable suicide prevention efforts implemented across the district during the year. District reports are intended to inform funders and key state decision makers of activities and initiatives intended to impact suicide rates in Idaho. Districts reports are to align to Idaho's Suicide Prevention Plan 2024-2028 using as much quantifiable data as possible to demonstrate impact.

B. RESERVED

C. District Suicide Prevention Action Plan

1. By June 30, 2026, and under the advisement and approval of the Districtwide Collective, review and update the District's Suicide Action Plan (Plan), which supports the goals and objectives outlined in the current statewide five (5)-Year Suicide Prevention Plan. The Plan must include actionable objectives to be implemented in the community, based on the results of the most recent gap analysis. The Plan must be reviewed by the Department's Suicide Prevention Program prior to implementation and prior to sharing the Plan district-wide. The Plan must include:

a. Engagement with the State Department of Education and/or its Subgrantee to support implementation of suicide prevention programs and policies and, as needed, engagement with local school districts for intervention and postvention plans targeted to the youth population in the district.

b. Data collection and data sharing plans should ensure methods of evaluation of suicide prevention effectiveness are adequate to make decisions and to understand impact of efforts.

2. The Plan may include but is not limited to:

a. Elements of the most recent Idaho State Suicide Prevention Plan for objectives to address district needs and priorities;

b. Suicide prevention education and awareness training to target high risk or priority populations;

c. Loss survivor support policies and procedures, including but not limited to aiding and promoting district-wide loss survivor support groups, identifying support material for loss survivors, and identifying a distribution plan for survivor loss material;

d. A plan for Lethal Means Safety (LMS), including but not limited to limiting access to firearms, suffocation, and poisoning; and

e. Plans to foster education/outreach activities at community and formal events, shows, conferences, and gatherings where high risk or priority populations will come together.

3. Learning Action Network (LAN) – a quarterly meeting for the Public Health Districts (PHD)s is hosted online by the Suicide Prevention Program. These meetings are intended to be informational or educational and provide space to exchange successes, challenges, questions, and brainstorm. The Subgrantee is encouraged to attend each quarter or send a representative, but no requirement exists for attendance. Meeting minutes are always provided, and recordings will be shared when possible.

III. QUALITY ASSURANCE

A. The Subgrantee must meet with the Department, as requested, to review Subgrant compliance, to participate in mutually agreed upon training, to collaboratively plan improvements and to discuss safety concerns or any special preparation and planning needs.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Childcare Subgrant | Childcare providers & Users of childcare services | 7/1/2025 | 6/30/2026 | $150,535 | NA | NA | All | No | 24.95 | No | No | No |

CENTRAL DISTRICT HEALTH
Subgrant Agreement

Subgrantee: Southwest District Health
Subgrantee's Federal I.D. No. 826000952BU
CFDA Number and Title: 93.575 Child Care and Development Block Grant
Unique Entity ID: f ETJC2JYM3W6

Subgrant Amount: $150,535.00

This subgrant outlines the relationship between Central District Health, hereinafter referred to as CDH, and Southwest District Health, hereinafter referred to as the Subgrantee, for the purposes of achieving the objectives of the Idaho Department of Health and Welfare (IDHW) Child Care Program subgrant deliverables. This subgrant is effective as of July I, 2025, and will expire on June 30, 2026.

The Subgrantee agrees to provide, and CDH agrees to accept the services detailed in the Scope of Work.

Subgrant Terms and Conditions

I. Subgrant Effectiveness and Renewal. The subgrant is effective as of July I, 2025, and will expire on June 30, 2026.

Performance. CDH to require strict performance of any term or condition of this agreement or to exercise any option herein, in any one or all instances, shall not be construed to be a waiver or relinquishment of any such term or condition. The same shall be and remain in full force and effect, unless there is a prior written waiver by CDH.

Fiscal Records. The Subgrantee agrees to maintain all fiscal records, including its books, audit papers, documents, and any other evidence of accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this subgrant. These records shall be available for and subject to inspection, review or audit and copy by CDH.
Records. The Subgrantee shall maintain all records and documents relevant to this subgrant for three years from the date of final payment. CDH shall have full access to and the right to inspect, review, and audit any of these materials during the retention period. If an audit, litigation or other action involving records is initiated before the three-year period has expired, the records must be retained until all issues arising out of such action are resolved, or until an additional three-year period has passed, whichever is later.

Monitoring. The Subgrantee shall be monitored on a frequency to be determined by CDH, and the program shall be periodically reviewed. The results of this program review may be used, with other information, to evaluate the Subgrantee 's provision of services funded by this subgrant.

Independent Status. The Subgrantee's status under the subgrant shall be that of an independent subgrantee and not that of an agent or employee of CDH. The Subgrantee shall be responsible for paying all employment-related taxes and benefits, such as federal and state income tax withholding, social security contributions, worker's compensation and unemployment insurance premiums, health and life insurance premiums, pension contributions and similar items.

Confidentiality. The Subgrantee shall comply with all applicable state and federal laws, rules, and regulations concerning confidentiality.
HIPAA. The Subgrantee acknowledges that it may have an obligation, independent of this subgrant, to comply with the Health insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law I04-19 I, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, Subgrantee shall comply witJ1all amendments to the law a11d federal regulations made during the term of the subgrant.
Lobbying.
Influence. The subgrantee certifies that none of the funds provided by this subgrant have been paid or will be paid by or on behalf of the Subgrantee to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the State Legislature in connection with the awarding, continuation, renewal, amendment, or modification of any contract, subgrant, loan or cooperative agreement.

Standard Form LLL. [f any funds, other than funds provided by this subgrant, have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the State Legislature in connection with the subgrant, the Subgrantee shall complete and submit Standard Form LLL, 'Disclosure Form to Report Lobbying', in accordance with its instructions, and a copy of Standard Form LLL to CDH.
False Statement. The Subgrantee understands that a false statement of this certification may be grounds for rejection or te1111ination of the subgrant, and that their signature upon this 'Standard Subgrant' is a material representation of fact upon which reliance was placed when this subgrant was made or entered into. Jn addition, under Section 1352. Title 31U.S. Code, a false statement shall be subject to a civil penalty of not less than $10,000.00 and not more than $ I00,000.00 for each such false statement.

Single Audit Act. The Subgrantee acknowledges that it may have an obligation; independent of this subgrant, to comply with the terms of the "Single Audit Act" of 1984. Funds provided under the subgrant may be used to pay for compliance with this act in proportion to other funding sources available to the Subgrantee for the services provided pursuant to the subgrant.

Termination for convenience. CDH or the Subgrantee may cancel this subgrant at any time without cause upon 30 calendar days' written notice specifying the date of termination. The obligations and liabilities of the parties shall cease upon the date of termination except that the obligations or liabilities incurred prior to the termination date shall be honored.

Appropriation by Legislature Required. CDH is a government entity, and this agreement shall in no way or manner be construed so as to bind or obligate CDH beyond the term of any particular appropriation of funds by the State's Legislature as may exist from time to time. CDH reserves the right to terminate this agreement in whole or in pa1t (or any order placed under it) it: in its sole judgment, the Legislature of the State of Idaho fails, neglects, or refuses to appropriate sufficient funds as may be required for CDH to continue such payments or rescinds or requires any return or "give-back'' of Funds required for CDH to continue payments, or if the Executive Branch mandates any cuts or holdbacks in spending. All affected future rights and liabilities of the parties hereto shall thereupon cease within 10 calendar days after notice to the Subgrantee. It is understood and agreed that CD H's payments herein provided shall be paid from Idaho State Legislative appropriations.

In Witness where of the parties have executed this agreement.

GENERAL REQUIREMENTS

A. This subgrant is funded by the Child Care and Development Block Grant awarded October I, 2021, through the Administration for Children and Families (ACF), Catalog of Federal Domestic Assistance (CFDA) number 93.575, Federal Award identification Number (FAIN) G 190110.
B. The purpose of this subgrant is to support the goals and objectives of the IDHW Child Care agreement by ensuring that all children in childcare settings are in a healthy and safe environment while receiving childcare.
C. The Subgrant shall comply with the IDHW policy on meals and refreshments, a copy will be provided by CDH upon request.
D. The Subgrantee shall adhere to the following:
For State, Local, and Tribal: Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments. www.ecfr.gov - CFR Title 45 Part 75.
E. The Subgrant shall read and comply with all components of the IDHW agreement WCI08400, a copy will be provided upon request.
CDH will disseminate pertinent program information to the Subgrantee that is received from lDHW.
F. CDH will act as the subgrant administrator for the purpose of satisfying the IDHW requirement for a single agreement and will represent the Subgrantee as the single point of contact for DHW. The Community and Environmental Health Division Administrator will serve as CDH's Project Officer for this subgrant.
G. The Subgrantee shall establish collaborative relationships and coordinated services with the IDHW Resource and Referral/Professional Development Contractor, local cities, and counties, and other IDHW stakeholders for the delivery of childcare services required in this subgrant.
H. The Subgrantee shall operate according to the requirements of the subgrant and the guidelines of the Idaho Child Care Management Manual for all sections of the subgrant. This manual, developed and agreed to by all applicable stakeholders, identifies standardized processes and procedures to ensure consistent statewide service delivery.
I. The Subgrantee shall establish a system of continuous program assessment and quality improvement as defined in the Idaho Public Health Districts' Quality Assurance Plan for Child Care Health, Safety, and Complaints Program.
J. The Subgrantee shall share this subgrant with staff, as applicable, to ensure their knowledge of the expectations and ability to meet subgrant and compliance requirements.
K. Child Care Health and Safety Inspectors must be, at minimum, the equivalent of an Environmental Health Specialist I, and shall meet professional licensure, certification, or be eligible for licensure, if required, in order to conduct specified childcare health and safety inspections.
1. Inspectors must receive training in related health and safety requirements appropriate to provider settings and age of children served.
2. The Subgrantee shall maintain a sufficient number of inspectors to ensure timeliness of all inspections per subgrant requirements.
L. The Subgrantee will establish unique PCAs as determined by the Public Health Districts' Environmental Health Directors' Working Group to track expenses associated with this subgrant.
M. The Subgrantee will be paid $515.00 per establishment inspected for that month, minus fees collected and limited to actual year-to-date costs each month.
N. The Subgrantee will also be reimbursed for actual costs related to receipt, response, and follow- up actions for Child Care complaints as described in this subgrant. A separate PCA is required to document tracking of these costs.
O. The Subgrantee will participate in meetings, trainings, conference calls or other program coordination activities with CDH and other program stakeholders as needed.
P. The Subgrantee will be responsible for printing/coping their own supply of inspection forms or educational materials required as part of the subgrant.
Q. The Subgrantee shall comply with all programmatic and financial monitoring activities required by CDH as outlined in this subgrant.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.898 Cancer Prevention and Control Programs for State, Territorial and Tribal Organizations | All, with a focus on youth prevention. | 7/25/25 | 6/29/2026 | $19,365.71 | $16,365.71 | $3,000.00 | $19,365.71 | NA | 24.95 | No | No | No |

II. SUBGRANT SERVICES AND ACTIVITIES

A. Priority Area 1 – Infrastructure and Capacity

1. The Subgrantee must participate in up to four (4) conference calls with the Department's Idaho Comprehensive Cancer Control Program (ICCCP) to receive and provide program updates, disseminate educational information to inform current work, and share best practices among Public Health Districts (PHDs) in Idaho.

a. One (1) of the conference calls will be a virtual kick-off meeting with training and resources provided on the various components within the Subgrant deliverables. The virtual kick-off meeting is anticipated to take place in July 2025.

b. The two (2) - three (3) additional conference calls will be either one-on-one calls with the Department or cohort calls with other Cancer Coordinators. During Q3 there will be a cohort call in which the subgrantee will be asked to prepare a short PPT (3-5 slides) showcasing their work.

2. The Subgrantee must be a participating member of the Comprehensive Cancer Alliance for Idaho (CCAI) within the Prevention Workgroup.

a. The Subgrantee must attend the CCAI Annual Meeting either in-person or virtually, date and location for 2026 to be determined.

b. The Subgrantee is required to sit on the Prevention Workgroup, which will be facilitated by the Department. The Prevention Workgroup will bring together cancer prevention champions to network and collaborate on current issues and advance priority areas within Idaho's 5-year Strategic Cancer Plan. The Prevention Workgroup will meet monthly for a minimum of one (1) hour. This Subgrant does not beholden any of the PHDs to carry out additional work set forth by the CCAI workgroups. The workgroup must meet approximately ten (10) times per year. If the CCAI Board cancels a meeting, the Subgrantee will not be penalized. Dates and times for monthly meetings to be determined for FY26 by the CCAI Board of Directors.

B. Priority Area 2 – Coalition Work - Newsletters

1. The Subgrantee must develop and distribute a cancer control newsletter to support continued information sharing with local and regional partners/stakeholders. The newsletter must:

a. Be distributed a minimum of four (4) times per year.

b. Include relevant and timely information to include: cancer data, events, news, and resources.

2. One (1) of the four (4) newsletters must include tobacco cancer data and information on Idaho Quitline services, through Project Filter - https://projectfilter.org

3. One (1) of the four (4) newsletters must include information and/or resources on Women's Health Check - https://healthandwelfare.idaho.gov/services- programs/medicaid-health/womens-health-fit-fall-quit-smoking/womens-health-check

a. The Subgrantee must identify individuals to receive the newsletter.

b. The Subgrantee must utilize a newsletter platform that allows for individuals to subscribe and unsubscribe, open rate tracking, and link click tracking (ex. Mailchimp, Constant Contact).

c. The Subgrantee must provide quarterly statistics on the newsletter (number of subscribers, percent open rate, etc.) using the Newsletter tab in the SMR.

d. The Subgrantee must ensure the Department is a recipient of the newsletter.

C. Priority Area 3 – Evidence Based Interventions

1. The Subgrantee must partner with a minimum of one (1) outdoor organization or facility (i.e. city parks, ski resorts, public pools, golf courses, outdoor concert venues, zoos, libraries, green spaces, and more) to enact and implement policies around sun safety. In addition, the Subgrantee must organize one (1) community- wide campaign (i.e. community awareness event) in their respective region to promote cancer screenings, and to encourage cancer prevention through physical activity and/or healthy eating.

2. Sun Safety – Environmental Approaches:

a. The Subgrantee must partner with a minimum of one (1) organization or facility to implement or enhance environmental changes to promote sun-protective behaviors.

i. Organizations or facilities must be identified in Q1 and communicated to the Department in the Q1 Subgrant Monitoring Report (SMR) report.

b. The Subgrantee must provide information about sun safety and the effects of ultraviolet (UV) radiation to facility staff through staff educational sessions/trainings.

i. The number of recreation/tourism organizations or facility staff trained must be reported in the quarterly SMR to the Department.

c. The Subgrantee must provide technical assistance (TA) for the implementation of sun-protective environmental changes.

i. A minimum of one (1) environmental or systems change (i.e. increasing the availability of sun-protective items such as sunscreen, sunscreen dispensers, protective clothing, etc) and/or adding sun-protective features to the physical environment (i.e. shades structures, sun sails, educational signage, etc.).

ii. The Subgrantee must provide the Department with documentation of environmental changes implemented and number of staff/individuals impacted (reach).

d. The Subgrantee must coordinate and collaborate, as appropriate, with other health promotion programs and/or coordinators within their Public Health District to support no-smoking signage for a minimum of one (1) recreation/tourism organization or facility to curb tobacco/vaping. Partner organizations or facilities may be the same as in previous years.

3. Community-Clinical Linkages:

a. To promote cancer screenings, and to encourage cancer prevention through physical activity and/or healthy eating the Subgrantee must organize one (1) community-wide cancer prevention campaign or cancer awareness event in their respective region.

i. The community-wide campaign must be identified in Q1 and communicated to the Department in the Q1 SMR report.

ii. Examples of community-wide campaigns may include, but are not limited to: organizing a walk/run, cooking classes for cancer, cancer wellness classes such as yoga or hiking, cancer awareness month campaigns, utilization of a mammogram bus, collaboration with local health systems or clinics to host a health clinic (i.e. a vaccination event), and/or any other ideas that are pre-approved by the Department. This can be a single day event, or classes over a set amount of time.

b. The Subgrantee must provide technical assistance for the community-wide campaign.

i. The Subgrantee must provide information about cancer screenings and prevention using evidence-based materials, strategies, and best practices.

ii. The Subgrantee may team up with a community event already in their region to add a cancer prevention angle.

iii. The Subgrantee must provide the Department with documentation of the community-wide campaign implemented and number of individuals impacted (reach).

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10.557 - Women, Infants & Children and WIC Breastfeeding Peer Counseling | Pregnant women; breastfeeding women; women who had a baby within the last six months; parents, step-parents, guardians, and foster parents of infants and children up to their 5th birthday | 10/1/2024 | 9/30/2025 | $1,266,364.00 | NA | NA | $1,266,364.00 | NA | 24.95 | No | No | No |

Scope of Work

I. GENERAL REQUIREMENTS:

A. This Subgrant is funded by the Women, Infants and Children (WIC) Grant, ALN 10.557, WIC Admin, awarded October 1, 2024 through the US Department of Agriculture, Food and Nutrition Service (FNS) with a total award amount as indicated on the Award Letter; and Breastfeeding Peer Counseling Grant, ALN 10.557, WIC Breastfeeding Peer Counseling, awarded October 1, 2023 through the US Department of Agriculture, FNS, with a total award amount of four hundred forty thousand seven hundred and ninety-seven dollars ($440,797).

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

C. Reserved.

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. United States Department of Agriculture, FNS policy statement located at https://www.fns.usda.gov/wic/wic-laws-and-regulations.

3. The Federal Office of Management and Budget (OMB) Circular 2 CFR 200: Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, located at https://www.federalregister.gov/documents/2017/05/17/2017-09909/uniform-administrative-requirements-cost-principles-and-audit-requirements-for-federal-awards.

4. Federal Awardee Performance and Integrity Information System (FAPIIS) Disclosure:

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 United States Department of Agriculture (USDA) and to the HHS OIG at the following addresses: Food and Nutrition Service, Western Regional Office, 90 Seventh St, Suite 10-100, San Francisco, CA 94103.

E. The Subgrantee must read and comply with:

1. Idaho WIC Program Policy Manual found at https://healthandwelfare.idaho.gov/providers/wic/wic-staff.

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 and summarized in the Idaho WIC Program Policy Manual.

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. The Subgrantee must provide a one (1) Full Time Employee (FTE) WIC Coordinator who is a Registered and Licensed Dietitian or who is qualified to be a Program Manager per the State of Idaho job classification to manage and administer the WIC Program. When the WIC Coordinator is unavailable, the Subgrantee must provide a back-up person in charge to oversee operations.

3. The Subgrantee must provide a Breastfeeding Promotion and Support Coordinator (BFC) who is a Registered and Licensed Dietitian, Registered and Licensed Nurse and/or an International Board Certified Lactation Consultant (IBCLC) to coordinate breastfeeding promotion and support activities, participate in breastfeeding training activities for all staff, and other responsibilities outlined in the Idaho WIC Policy Manual.

4. The Subgrantee must provide a Designated Breastfeeding Expert (DBE) who is a Registered and Licensed Dietitian, Registered and Licensed Nurse, Physician or a Physician's Assistant, and/or an IBCLC. The DBE must have a minimum of one (1) year of experience in counseling breastfeeding mother/infant dyads. The DBE must oversee complex breastfeeding challenges, assist with breastfeeding

assessments and follow-up in coordination with other applicable staff.
5. The Subgrantee must provide Registered and Licensed Dietitian(s) to provide services such as high-risk nutrition counseling, formula, milk substitute, and/or nutritional authorization and staff training oversight.
6. The Subgrantee must provide a Training Lead who is a Registered and Licensed Dietitian or a WIC Certifier with two (2) years of local agency WIC experience to administer and oversee Idaho WIC Program staff training per the Idaho WIC Policy Manual.
7. The Subgrantee must determine and provide an adequate number of trained Certifiers to determine participant eligibility and provide low-risk nutrition education per the Idaho WIC Program Policy Manual.
8. The Subgrantee must have a Breastfeeding Peer Counselor Coordinator to plan, direct, and manage the general operations of the peer counseling program. The Peer Counselor Coordinator should have specialized training in lactation management and care such as an IBCLC or Certified Lactation Counselor/Educator (CLC/CLE).
9. The Subgrantee must have Breastfeeding Peer Counselor(s) to provide breastfeeding services. Peer Counselors must have breastfeeding experience. When possible, Peer Counselors should be current or previous WIC participants.
10. The Subgrantee must have two (2) Vendor Leads to serve as the WIC Authorized Food List experts and assist with vendor activities.
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. This Subgrantee's risk level has been assessed as high for this Subgrant period.
a. Enhanced monitoring may 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, may 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 grant 257IDID7W1003 from the U.S. Department of Agriculture. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Welfare or the U.S. Department of Agriculture. [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 257IDID7W1003 from the U.S. Department of Agriculture. The views expressed in written conference materials or publications and by speakers and moderators do not reflect the official policies of the Department or the U.S. Department of Agriculture 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 257IDID7W1003 from the U.S. Department of Agriculture. Its contents are solely the responsibility of [name of subrecipient] and do not necessarily represent the official views of the Department or the U.S. Department of Agriculture.
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. Reserved
N. The Subgrantee must ensure that the Assurance and Signature page (Attachment 1) regarding discrimination laws is signed, returned to Department and adhered to.
1. Program Specific Requirements. The Subgrantee must:
a. Comply with WIC program applicant processing time frames according to 7 CFR part 246.7. Required time frames are outlined in the Idaho WIC Program Policy Manual.
b. Determine eligibility of persons requesting WIC services by screening individuals in accordance with procedures set forth in the Idaho WIC Program Policy Manual. Note that income eligibility criteria change July 1 each year.
c. Perform WIC certification procedures such as categorical and income screening, measures, and health and nutrition assessments in accordance with the Idaho WIC Program Policy Manual.
d. Provide information to participants and check for their understanding of WIC program rules, regulations, WIC-approved foods, and use of food benefits at a participant's initial appointment. A copy of the Rights, Responsibilities and Consent form (available at https://wic.dhw.idaho.gov) signed by the participant or participant's representative must be kept on file to document that this training has taken place.
e. Prescribe a WIC food package appropriate to participant nutritional risk(s) and category, and issue food benefits as set forth in the Idaho WIC Program Policy Manual.
f. Not implement a waiting list or priority restriction of participant categories without prior written approval from the Department. g. Prohibit smoking in the physical space used to provide WIC services, post "No Smoking" signs, and ensure signage is consistent with federal WIC regulations.
h. Ensure confidentiality for all WIC applicants and participants. Confidentiality must be maintained in the clinic environment and by protecting records with personal information.
i. Notify the Department's Subgrant Monitor, in writing, that an audit has been conducted within thirty calendar (30) days of the audit. The Subgrantee must submit a copy of the audit report to the Department whenever the audit report includes a WIC finding.
j. Submit to the Department, on letterhead and prior to purchase, requests to purchase computers, printers, or capital outlay over two thousand dollars ($2,000) using WIC funds. The written request must include the description of the item, purchase cost, and reason for purchase. The Department will determine if the request is reasonable and necessary according to regulation.
k. Notify the Department's Subgrant Monitor, in writing on letterhead, of impending closure of any WIC clinic site at least thirty (30) calendar days prior to the actual closing date. The notification must

include the date of the clinic closure and a plan for serving the participants impacted by the closure.
l. Notify the Department's Subgrant Monitor, in writing on letterhead, when opening a new WIC clinic site or relocating a current WIC clinic at least thirty (30) calendar days prior to the actual opening date.
m. Complete nutrition assessment following the Value Enhanced Nutrition Assessment (VENA) requirements, which can be found at:
https://wicworks.fns.usda.gov/resources/value-enhanced-nutrition-assessment-venaguidance
n. Provide participant-centered nutrition education to all participants and appropriately utilize participant focused counseling materials provided by the Department. Nutrition education must be in accordance with the guidelines set forth in the Idaho WIC Program Policy Manual.
o. Offer participants nutrition education contacts as defined in the Idaho WIC Program Policy Manual.
p. Ensure that the provision of high risk nutrition education/counseling by a Registered Dietitian to all participants deemed high risk on assessment occurs as often as necessary per the Idaho WIC Program Policy Manual.
q. Expend at least twenty percent (20%) of the annual local agency's grant for nutrition education activities. Guidance for WIC category coding can be found on the Idaho WIC website.
i. WIC Category Coding Guidance: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=5197&dbid=0&repo=PUBLIC-DOCUMENTS
ii. Time Coding Guidance:
https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=5198&dbid=0&repo=PUBLIC-DOCUMENTS
r. Expend at least four percent (4%) of the annual local agency's grant for breastfeeding promotion, support and education.
s. Promote breastfeeding to pregnant and postpartum WIC participants, and refer to and promote the breastfeeding peer counseling program.
t. Provide peer counseling services, when funded or appropriate for the participant following the requirements of the peer counseling Subgrant. Services must be made available outside of usual clinic hours and outside of the WIC clinic, but must also be available during usual clinic hours and in the WIC clinic.

II. SUBGRANT SERVICES AND ACTIVITIES
A. General Program Services and Requirements
1. The Subgrantee must perform services/activities associated with this Subgrant in their geographic service area with specified populations for the term of the Subgrant.
2. The Subgrantee must maintain a quarterly average caseload level of ninety-seven to one hundred percent (97-100%) of the authorized participating caseload (including migrant clients) allocated by the Department. Authorized caseload is defined as the caseload number used to calculate funding and is based on the average participation of prior months.
a. Caseload will be reviewed on a quarterly basis. If a Subgrantee is serving less than ninety-seven percent (97%) of the authorized participating caseload during Semiannual Report period, a corrective action plan must be completed and submitted to the Department by the agency for review and approval. If the local agency caseload is not met during Semiannual Report period, the Department will have the option to amend the Subgrant for the next quarter to adjust caseload and funding according to current performance.
b. If funding is available, the Department may renegotiate, redistribute, and amend Subgrant funds to local agencies that are conducting satisfactory performance measures in the current federal fiscal year. If a Subgrantee is serving greater than one hundred percent (100%) of authorized participating caseload during Semiannual Report period and federal funds are available, the Department may redistribute and amend Subgrant funds.
c. If funds are available in the following federal fiscal year, the Department may readjust authorized participating caseloads based on the previous federal fiscal year performance. In addition, amendment requests will not be considered unless funds are available, and the local agency is conducting satisfactory performance measures.
d. Authorized Participant Caseload for Federal Fiscal Year 2025 (FFY25) is five thousand eight hundred and one (5,801) participants per month. Ninety seven percent (97%) of authorized caseload is five thousand six hundred twenty seven (5,627) participants per month.
B. Data/Computer System
1. The Subgrantee must provide adequate computer hardware, software, and information technology (IT) maintenance and support to WIC staff in order to effectively deliver WIC services.
2. The Subgrantee must supply and maintain sufficient data transfer lines, servers, routers, Local Area Network connectivity, and Internet connectivity to WIC staff in order to efficiently deliver WIC services.
3. The Department will supply WIC card readers, signature pads and associated supplies for use by the Subgrantee's WIC staff in the delivery of WIC food benefits.
4. The Department will supply and maintain WIC Information System Program (WISPr) software for use by the Subgrantee's WIC staff for the delivery of WIC services and data collection. The Department will provide training and technical support for WISPr usage. The Subgrantee must utilize WIC card readers and signature pads, software, and training provided by the Department to operate the Subgrantee's portion of WISPr.
5. The Subgrantee must ensure all data elements of WISPr are completed and entered accurately, as outlined in the Idaho WIC Program Policy Manual.
6. The Subgrantee must maintain an inventory listing of all equipment purchased with WIC funds as defined in the Idaho WIC Program Policy Manual. This inventory must be reviewed annually.
7. The Subgrantee must allow Department staff to access all training materials including videos through platforms such as YouTube.
8. The Subgrantee must provide a shared email address for Department staff to allow documents to be submitted electronically and securely (for example: WIC applications or interest forms).
9. The Subgrantee must ensure participant confidentiality, network security and appropriate staff training and use of software to provide remote services or telehealth. The Subgrantee must submit high risk remote procedures in writing for approval sixty (60) days prior to conducting remote services or telehealth appointments. The procedures must be initially reviewed by the Department WIC Office Staff and then reviewed by the local agency biannually thereafter. The local agencies must develop low risk remote procedures and a procedure for how Subgrantee will attempt to obtain any applicable missing anthropometric and blood work data. These do not need to be submitted to the state office but need biannual reviews by the local agencies.
C. Vendor Relations
1. The Subgrantee must provide two (2) WIC employees to serve as Vendor Leads who, at the request of the Department must:
a. Assist with vendor activities such as compliance buy investigations, test buys, pre-authorization, universal product code (UPC) collection, or other vendor visits.
b. Attend vendor and food list trainings.
c. Follow up on vendor issues or concerns in accordance with the Idaho WIC Program Policy Manual.
d. Act as the food list expert and vendor point person for you’re the Subgrantee.

D. Meetings
1. The Subgrantee must ensure all staff who perform WIC services attend mandatory trainings as determined by the Department.
E. Other
1. Outreach and Referrals
a. The Subgrantee must develop an outreach plan targeting high risk and underserved populations. The plan must include specific outreach activities for the targeted populations and timelines for implementation. At least one (1) specific outreach activity must include information about the benefits of WIC program participation.
b. Any outreach materials developed that address program eligibility must receive prior approval by the Department before distribution.
c. The Subgrantee must provide program participants with information about available health and social services to which the participant can be referred. Mandatory referrals to Special Supplemental Assistance Program (SNAP), Temporary Assistance for Families in Idaho (TAFI), and Substance Abuse must be made, as appropriate.
2. The Subgrantee must coordinate WIC staff services with other health and social services available within the geographic service area, including, but not limited to, immunizations, voter registration, and breastfeeding support.
III. RECORDS AND DOCUMENTATION
A. The Subgrantee must prepare and submit a Nutrition Education Plan using the form provided by the Department's WIC Office.
B. The Subgrantee must prepare and submit a Breastfeeding Peer Counseling Plan using the form provided by the Department.
C. The Department will conduct an on-site evaluation of the Subgrantee every two (2) years to review program activities and service delivery. The evaluation will include a financial review. The Subgrantee must make requested program and financial reports available to the evaluation team.
1. Upon receipt of the on-site evaluation report, the Subgrantee must prepare a written response within sixty (60) calendar days, including a plan to remedy areas requiring corrective action.
D. The Subgrantee must maintain on file and make available for review, audit, and evaluation all criteria used to determine eligibility and certification, including information on geographic service area and referral.
E. The Subgrantee must maintain complete, accurate, and current accounting of all local, state, and federal funds received and expended for the purpose of program delivery.
F. The Subgrantee must maintain all records pertaining to WIC operations for a minimum of four (4) years unless otherwise specified in the policy manual.
G. The Subgrantee must have a written agreement, such as a Memorandum of Understanding (MOU), with any agency or program that it shares participant information with, including other programs within the Department or tribal organizations. The agreement must be in accordance with 7 CFR part 246.26(d) and the Idaho WIC Program Policy Manual.
IV. QUALITY ASSURANCE:
A. The Subgrantee must meet with the Department, as requested, to review Subgrant compliance, to participate in mutually agreed upon training, to collaboratively plan improvements and to discuss safety concerns or any special preparation and planning needs.
B. The Subgrantee must:
1. Ensure that all client records are maintained on the premise and secured in a locked cabinet. All confidential client records must have limited access to key positions identified in the Organizational and Staffing section.
2. Ensure coordination with the Department Subgrant Monitor to ensure clear communication of program processes.
3. Ensure use of participant feedback to improve program delivery.
V. SUBGRANT TRANSITION PLAN:
A. The Subgrantee must notify the Department's Subgrant Monitor, in writing, if WIC services will no longer be conducted by the Subgrantee at least six (6) months prior to the end of the Subgrant's expiration date.
B. The Subgrantee must develop and submit a Transition Plan to the Department three (3) months prior to the end of Subgrant services. The Transition Plan must describe the process for ensuring a smooth transition for WIC participants and services.
C. The Subgrantee must return all equipment and supplies purchased with WIC funds as requested by the Department.
D. All electronic or hard copies of WIC participant information must be returned to the Department or destroyed at the Department's request.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Laura Moore Cunningham Grant | Participants of PAT and NFP | 5/9/2025 | 3/31/2026 | $20,000.00 | 00.00 | 00.00 | 00.00 | 20,000.00 | N/A | No | No | Yes |

**General Terms of acceptance of 2025 LMCF Grant**

1. I am an authorized agent of the above organization.
2. The organization is a qualified tax-exempt entity. Any change in tax exempt status will be communicated immediately to LMCF.
3. The organization will submit a timely and comprehensive final report and annual interim reports through Submittable until the project is completed. The organization will provide additional reporting to LMCF upon request.
4. The organization will deposit the LMCF grant check within one week of receipt.
5. The organization will ensure that all notifications and submissions through Submittable are monitored.
6. The organization will complete the project within the timeline in the application.

7. If the organization determines the project or timeline is no longer feasible, the organization will notify LMCF.
8. LMCF will evaluate alternative proposals but any changes are subject to LMCF approval.
9. The organization will maintain sufficient accounting records to be able to identify when and how all LMCF funds are expended and provide these accountings to the LMCF in the interim and final reports.
10. If any of the terms of this Grant Contract are not met, the organization agrees to return the LMCF funds to the LMCF.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Buckle Up for Life | Participants of WIC, NFP and PAT | 6/18/2025 | 6/17/2026 | N/A | N/A | N/A | N/A | 50 car seats | 00.00 | No | No | No |

I agree, on behalf of my organization, that we can and will distribute 50 convertible car seats, free of charge, to families in need in our community, during this program year. We also agree to provide Buckle Up for Life approved education and hands-on installation assistance from a Child Passenger Safety Technician (CPST) to all families receiving a Buckle Up for Life car seat. We further agree to comply with all expectations outlined within the Curriculum and Brand Use Agreement, and we agree to submit required quarterly reports to BUFL in a timely manner, per instructions that will be provided during the Welcome Webinar.

| Description/ ALN Name | Target Population | Original Effective Date | Current Expiration Date | Total Funding Amount | Personnel Funding | Operating Funding | Personnel & Operating | Other Contract Amounts | Indirect % | Match Rqd | Match Amount | Restrictions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Implementation of evidence-based strategies to increase cancer screening and prevention/93.898 Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations | All | 7/29/2025 | 6/29/2026 | $19,365.71 | $16,365.71 | $3,000.00 | $19,365.71 | | 24.95 | No | N/A | No |

Priority Area 1 – Infrastructure and Capacity
The Subgrantee must participate in up to four (4) conference calls with the Department's Idaho Comprehensive Cancer Control Program (ICCCP) to receive and provide program updates, disseminate educational information to inform current work, and share best practices among Public Health Districts (PHDs) in Idaho.
One (1) of the conference calls will be a virtual kick-off meeting with training and resources provided on the various components within the Subgrant deliverables. The virtual kick-off meeting is anticipated to take place in July or August 2025.
The two (2) to three (3) additional conference calls will be either one-on-one (1:1) calls with the Department or cohort calls with other Cancer Coordinators. During Quarter 3 (Q3) there will be a cohort call in which the Subgrantee must present a short Power Point (three to five [3-5] slides) that they have prepared, showcasing their work.
The Subgrantee must be a participating member of the Comprehensive Cancer Alliance for Idaho (CCAI) within the Prevention Workgroup.
The Subgrantee must attend the CCAI Annual Meeting either in-person or virtually, date and location for 2026 to be determined.
The Subgrantee must sit on the Prevention Workgroup, which will be facilitated by the Department. The Prevention Workgroup will bring together cancer prevention champions to network and collaborate on current issues and advance priority areas within Idaho's five (5)-year Strategic Cancer Plan. The Prevention Workgroup will meet monthly for a minimum of one (1) hour. This Subgrant does not require any of the PHDs to carry out additional work set forth by the CCAI workgroups. The Prevention Workgroup must meet approximately ten (10) times per year. If the CCAI Board of Directors cancels a meeting, the Subgrantee will not be penalized. Dates and times for monthly meetings to be determined for fiscal year 2026 (FY26) by the CCAI Board of Directors.
Priority Area 2 – Coalition Work - Newsletters
The Subgrantee must develop and distribute an electronic version of a cancer control newsletter to support continued information sharing with local and regional partners/stakeholders. The newsletter must:
Be distributed a minimum of four (4) times per year.

Include relevant and timely information to include: cancer data, events, news, and resources.
One (1) of the four (4) newsletters must include tobacco cancer data and information on Idaho Quitline services, through Project Filter - https://projectfilter.org.
One (1) of the four (4) newsletters must include information and/or resources on Women's Health Check - https://healthandwelfare.idaho.gov/services- programs/medicaid-health/womens-health-fit-fall-quit-smoking/womens-health-check.
The Subgrantee must identify individuals to receive the newsletter.
The Subgrantee must utilize a newsletter platform that allows for individuals to subscribe and unsubscribe, open rate tracking, and link click tracking (e.g. Mailchimp, Constant Contact).
The Subgrantee must provide quarterly statistics on the newsletter (number of subscribers, percent open rate, etc.) using the Newsletter tab in the Subgrant Monitoring Report (SMR).
The Subgrantee must ensure the Department is a recipient of the newsletter.
Priority Area 3 – Evidence Based Interventions
There are two (2) activities for Priority Area 3: 1) environmental approaches and 2) community-clinical linkages. For the first activity, environmental approaches, the Subgrantee must partner with a minimum of one (1) outdoor organization or facility (for example (i.e. city parks, ski resorts, public pools, golf courses, outdoor concert venues, zoos, libraries, green spaces, and more) to enact and implement policies around sun safety. For the second activity, community-clinical linkages, the Subgrantee must organize one (1) community-wide campaign (i.e. cancer screening event) in their respective region to promote cancer screenings, and to encourage cancer prevention through physical activity and/or healthy eating.
Activity 1 - Environmental Approaches:
The Subgrantee must partner with a minimum of one (1) organization or facility to implement or enhance environmental changes to promote sun-protective behaviors.
Organizations or facilities must be identified in Quarter 2 (Q2) and communicated to the Department in the Q2 SMR report.
The Subgrantee must provide information about sun safety and the effects of ultraviolet (UV) radiation to facility staff through staff educational sessions/trainings.
The number of recreation/tourism organizations or facility staff trained must be reported in the quarterly SMR to the Department.
The Subgrantee must provide technical assistance (TA) for the implementation of sun-protective environmental changes.
A minimum of one (1) environmental or systems change (i.e. increasing the availability of sun-protective items such as sunscreen, sunscreen dispensers, protective clothing, etc.) and/or adding sun-protective features to the physical environment (i.e. shades structures, sun sails, educational signage, etc.).
The Subgrantee must provide the Department with documentation of environmental changes implemented and number of staff/individuals impacted (reach).
The Subgrantee must coordinate and collaborate, as appropriate, with other health promotion programs and/or coordinators within their PHD to support no-smoking signage for a minimum of one (1) recreation/tourism organization or facility to curb tobacco/vaping. Partner organizations or facilities may be the same as in previous years.
Activity 2 - Community-Clinical Linkages:
To promote cancer screenings, and to encourage cancer prevention through physical activity and/or healthy eating the Subgrantee must organize one (1) community-wide cancer prevention campaign or cancer awareness event in their respective region.
The community-wide campaign must be identified in Q2 and communicated to the Department in the Q2 SMR report.
Examples of community-wide campaigns may include, but are not limited to: organizing a walk/run, cooking classes for cancer, cancer wellness classes such as yoga or hiking, cancer awareness month campaigns, utilization of a mammogram bus, collaboration with local health systems or clinics to host a health clinic (i.e. a vaccination event), and/or any other ideas that are pre-approved by the Department. This can be a single day event, or classes over a set amount of time.
The Subgrantee must provide TA for the community-wide campaign.
The Subgrantee must provide information about cancer screenings and prevention using evidence-based materials, strategies, and best practices.
The Subgrantee may team up with a community event already in their region to add a cancer prevention angle.
The Subgrantee must provide the Department with documentation of the community-wide campaign implemented and reach.

AUGUST 19, 2025

# SWDH INITIATED CONTRACTS AND SUBGRANTS

| Board of Health Report - SWDH Initiated Contracts or Subgrants | | | | |
|---|---|---|---|---|
| **Service** | **Funding Amount** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
| Media buyer | $90,909 | Federal grant & subgrant | 15-Aug-24 | 30-Jun-26 |

The scope of work identified is to:
1. Work with Southwest District Health (SWDH) staff to identify each campaign's target audience and recommend media outlets and placements, including but not limited to:
   - Spanish radio
   - KTVB.com pre-roll ads
   - Spanish broadcast television
   - Mailers
   - Outdoor boards
   - Newspapers
   - Digital
   - and other campaign-related materials that may help Southwest district Health reach its campaign objectives;
2. Negotiate with the various media outlets for cost-effective rates, favorable schedules/showings and bonus runs;
3. Work to secure matches (i.e. earned media, free airings or in-kind contributions) when placing broadcast media messages;
4. Evaluate industry trends and emerging technologies to identify new outreach opportunities and make recommendations accordingly;
5. Provide services based upon research, analysis and recommendations to ensure that target audiences are reached with messages in the most cost-effective manner;
6. Collaborate with Southwest District Health Marketing & PR Manager to schedule for Public Health District (3) rural and urban markets where campaigns are being conducted;
7. Remain knowledgeable about the current media environment including new technologies and research, such as changes in the demographic segment within commonly used media outlets;
8. Monitor new and emerging technologies and provide recommendations on their use;
9. Demonstrate an understanding of the scope of work and suggested approach to the project;
10. Have the capacity to perform the work within schedule and budget;
11. Have appropriate personnel and resources to complete the work.

| **Service** | **Funding Amount** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
|---|---|---|---|---|
| Electronic Health Record - Julota | $31,878 | State subgrant | 1-Jul-25 | 30-Jun-26 |

License and Deliverables:
1. Services: Julota will license to Customer access to a web-based and mobile integrated software for tracking services provided to Help Seekers on the Platform, which is called "Julota Reach." Customer and its authorized users may access the Services for the purpose of providing long-term Health Seeker contact, tracking, monitoring and care. Customer will, through the administration panel of Julota Reach, create and authorize new authorized users. Julota Reach software will allow Customer and its authorized users to communicate action steps necessary to integrate and coordinate the care of Help Seekers.
2. Authorized users: Authorized users may be individuals from Customer's organization or Care Teams and their employees. Customer may authorize an unlimited number of authorized users to access Julota Reach through
Customer's license.
3. Usage and Storage: The amount of usage of the Hosted Services (not including enrollments) and data storage is unlimited.
4. Excess Hosted Service Usage Fee: $0
5. Service Levels: Julota will provide general support for Julota Reach as provided for in the SLA attached as Exhibit “B” to the Agreement.

| **Service** | **Funding Amount** | **Funding Source** | **Original Effective Date** | **Current Expiration Date** |
|---|---|---|---|---|
| Idaho Diaper Bank - Diapers | $1,200 | PAT General funds | 31-Jan-24 | 31-Jan-26 |

Distribution of Diapers: We agree to provide diapers to you on a once-per-month basis. You agree to provide diapers received by us to your client families, at no charge to the families, with no more than 50 diapers provided per baby per month. You agree to distribute diapers received from us to your client families on a monthly basis to the best of your ability; you agree to not stockpile diapers. You will not sell, barter, or exchange any diapers or other products received from us. You will thoroughly cross out all UPC codes on all packages of diapers and other products received from us to prevent resale by your clients or other individuals. You will not provide diapers or other products received from us to your staff or volunteers for personal use. You will provide diapers received from us to your clients on a non-discriminatory basis. You will not condition your client's receipt of diapers on attendance at religious services, educational classes, or other events.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Electronic Health Record - BestNotes | $832 | Opioid Settlement | 1-Jan-25 | N/A-month to month |

Scope of Services. During the term of the Agreement, BestNotes will provide Customer the following Support Services relating to the BestNotes System: (a) correction of Substantial Defects in the BestNotes System so that the BestNotes System will operate as described in the current Documentation in all material respects, (b) at the sole discretion of BestNotes, periodic updates to the BestNotes System that may incorporate (i) corrections of any substantial Errors, (ii) fixes of any minor bugs and (iii) enhancements to the BestNotes System, and (c) unlimited off-site support to Users from 8:00 am to 5:00 pm (MST) during regular business days Monday through Friday not including national holidays, on the use of the BestNotes System and the BestNotes Service. Such Support may be provided via electronic mail, telephone service, remote assist software, public bulletin boards, and/or other similar methods deemed appropriate by BestNotes.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Provide post opioid overdose assessment, peer support, and referral to treatment. | $9,999 | Opioid Settlement | 1-Jul-25 | 31-Dec-25 |

SUBGRANT SERVICES AND ACTIVITIES

- Provide post opioid overdose assessment, peer support, and referral to treatment for individuals within Canyon, Adams, Gem, Payette, Washington, and Owyhee counties.
- Receive list of eligible participants for Project Hope Helps – Nampa Narcan program from Nampa Fire Department.
- Assess potential participant interest in Nampa Narcan program.
- Coordinate enrollment of eligible and interested participants in Nampa Narcan program.
- Monitor enrollment rates and participant outcomes, compile report to share with Southwest District Health.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming. | $10,000 | Federal Grant | 18-Oct-24 | 15-Sep-25 |

SUBGRANT SERVICES AND ACTIVITIES
Implementation of Positive Action
1. Boys and Girls Club of the Western Treasure Valley will implement the evidence-based curriculum, Positive Action to help prevent youth use of alcohol and marijuana through increasing protective factors to avoid substance use.
2. Staff will purchase the Positive Action middle school curriculum.
3. Staff will offer the Positive Action program as written at least twice weekly with club members aged 10-14 at their location.
4. Staff will conduct pre and post surveys offered by the Positive Action and program and will submit the de-identified results with SWDH project coordinator.
5. Staff will follow existing internal consent processes for providing education to and collecting survey data from youth.
6. Staff will track and record participation in the program and report to SWDH.
7. Staff will administer substance use risk perception pre post survey provided by SWDH at the same time as other pre and post survey.
8. Staff will track and record participation in the program and report to SWDH.
9. Staff will complete prevention training (examples include webinars, online self-paced learning modules, or in-person prevention training) as designated by SWDH. All requests will be reasonable and developed in partnership with the subrecipient.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Annual survey administration, data analysis, technical assistance to support SW Idaho Communities for Youth Work. | $497,640 | Federal Grant | 14-Nov-23 | 30-Sep-28 |

PROJECT SUMMARY

To collect, analyze, and report the data needed to guide a strategic approach to prevention and intervention for substance use and mental health needs for Southwest District Health to implement the evidence-based Icelandic Prevention Approach. Activities will include (for up to 3 school districts):
1. Host pre-survey informational meetings with school staff, parents, students, and/or other community members to raise awareness of youth mental health and the Southwest Idaho Communities for Youth initiative as needed.
2. Each year, create a survey with evidence-informed questions on youth mental health and edit the survey to meet changing district/school needs. The survey will be available for edits and approval by the district/school at least six weeks prior to survey administration date.
3. Each year, provide the district/school with parental consent paperwork (both paper and electronic) for pa1ticipation at least three weeks prior to survey administration date.
4. Each year, ensure the survey is available electronically to the district/school via a secure, confidential online link.
5. Each year, summarize survey results and provide a summary report to the school within two weeks post-survey if at least 60% of the students have participated. This rep01t can be reviewed with school leaders if requested.
6. Each year, co-host with SWDH, the district/school at least one meeting with the community and coalition members within two months post-survey to review key survey data points and help the community define 2 applicable goals for improving youth mental health over the next year.
7. Provide media that the district/school can use to spread awareness of community meeting(s). This can be, but is not limited to, mailers, flyers, posters, social media messaging, email messaging, and/or media and press. The media will be available for edits and approval by the district/school at least three weeks prior to the scheduled meeting(s).
8. Assist the community coalition as requested for creating action plans, connecting resources, planning, promoting goals, and raising awareness and education.
9. Host additional meetings to review key survey findings with parents, additional school staff, and/or students, if requested.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming. | $4,435 | Federal Grant | 10-Dec-25 | 5-Jan-26 |

A. Implement Botvin Life skills Program
1. Heritage Community Charter School will implement the evidence-based curriculum, Botvin Life skills (LST) to help prevent youth use of alcohol and marijuana through increasing protective factors to avoid substance use.
2. Staff will purchase the Botvin Life skills middle school curriculum.
3. Staff will implement the LST program with fidelity with Cohorts of students in the 6th, 7th and 8thgrade during the 2024- 2025 school year.
4. Staff will implement the LST program with fidelity with cohorts of students in 6th, 7thand 8thgrade during the 2025-2026 school year.
5. Staff will conduct pre and post surveys offered by the Life skills program and submit the de-identified results to the SWDH project coordinator.
6. Staff will administer substance use risk perception pre and post survey provided by SWDH at the same time as the LST pre and post survey.
7. Staff will follow existing internal consent processes for providing education to and collecting survey data from students.
8. Staff will track and record participation in the program and report to SWDH.
9. Staff will follow existing internal consent processes for providing education to and collecting survey data from participants.
10. Staff will track and record participation in the program and report to SWDH.
11. Staff will complete prevention training (examples include webinars, online self-paced learning modules, or in-person prevention training) as designated by SWDH. All requests will be reasonable and developed in partnership with the subrecipient.

B. 3rd Millennium Prevention & Intervention Program
1. Heritage Community Charter School (HCCS) will utilize the 3rd Millennium Program as a component of their student substance use and alternatives to suspension program. Applicable referral "intervention" courses will be assigned as appropriate on a case-by case basis as decided upon administration.
2. HCCS will receive an academic year (24-25) of unlimited access to 3•dMillennium prevention and referral intervention courses for their students.
3. HCCS will develop a sustainability plan to continue curriculum implementation for when PFS funding is no longer available. They will submit this plan in the project summary report.
4. HCCS will submit 4 quarterly reports and a final report that will include the# of students referred, # of courses completed, # of repeat referrals/suspension escalations throughout year, and# of prevention courses taken. HCS will share the pre and post data reported
by and available through 3rd Millennium.
5. Program staff will participate in a kick-off meeting, a de-brief meeting at the end of the year, and up to two additional group or one on one meetings.
6. HCCS will purchase the 3rd Millennium subscription directly from the provider and will submit an invoice to SWDH within 10 days of payment.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Social norms marketing to support youth substance use prevention | $9,900 | Federal Grant | 25-Sep-24 | 25-Sep-25 |

A. Implement Botvin Life skills Program
1. Heritage Community Charter School will implement the evidence-based curriculum, Botvin Life skills (LST) to help prevent youth use of alcohol and marijuana through increasing protective factors to avoid substance use.
2. Staff will purchase the Botvin Life skills middle school curriculum.
3. Staff will implement the LST program with fidelity with Cohorts of students in the 6th, 7th and 8thgrade during the 2024- 2025 school year.
4. Staff will implement the LST program with fidelity with cohorts of students in 6th, 7thand 8thgrade during the 2025-2026 school year.
5. Staff will conduct pre and post surveys offered by the Life skills program and submit the de-identified results to the SWDH project coordinator.
6. Staff will administer substance use risk perception pre and post survey provided by SWDH at the same time as the LST pre and post survey.
7. Staff will follow existing internal consent processes for providing education to and collecting survey data from students.
8. Staff will track and record participation in the program and report to SWDH.
9. Staff will follow existing internal consent processes for providing education to and collecting survey data from participants.
10. Staff will track and record participation in the program and report to SWDH.
11. Staff will complete prevention training (examples include webinars, online self-paced learning modules, or in-person prevention training) as designated by SWDH. All requests will be reasonable and developed in partnership with the subrecipient.

B. 3rd Millennium Prevention & Intervention Program
1. Heritage Community Charter School (HCCS) will utilize the 3rdMillennium Program as a component of their student substance use and alternatives to suspension program. Applicable referral "intervention" courses will be assigned as appropriate on a case-by- case basis as decided upon administration.
2. HCCS will receive an academic year (24-25) of unlimited access to 3•dMillennium prevention and referral intervention courses for their students.
3. HCCS will develop a sustainability plan to continue curriculum implementation for when PFS funding is no longer available. They will submit this plan in the project summary report.
4. HCCS will submit 4 quarterly reports and a final report that will include the# of students referred, # of courses completed, # of repeat referrals/suspension escalations throughout year, and# of prevention courses taken. HCS will share the pre and post data reported
by and available through 3rdMillennium.
5. Program staff will participate in a kick-off meeting, a de-brief meeting at the end of the year, and up to two additional group or one on one meetings.
6. HCCS will purchase the 3rd Millennium subscription directly from the provider and will submit an invoice to SWDH within 10 days of payment.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Social norms marketing to support youth substance use prevention | $12,500 | Federal Grant | 27-Sep-24 | 29-Sep-25 |

CONTRACT SERVICES AND ACTIVITIES

A. Youth Vision - Youth substance use prevention social norms targeted messaging

1. IDFY will create positive social norms messaging focused on preventing youth alcohol use, marijuana use, and stimulant use, with messages that will resonate with the priority population, region 3 youth (10-19). Messaging ads will be submitted to the contract monitor for approval.
2. IDFY will pre-buy and provide proof of purchase for approximately 6 months (180 days) of ad spots that will reach the priority population in all 6 counties (Adams, Canyon, Gem, Payette, Owyhee, and Washington).
3. IDFY will work with the contract monitor to develop a monitoring plan and will submit monthly reach reports and monthly messaging plans.
4. IDFY will run agreed upon messages in the pre-purchased ad spots for the length of the contract.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming. | $16,496 | Federal Grant | 18-Oct-24 | 6-Jul-26 |

Implement the Strengthening Families Program
1. Insight Matters will implement the 12 session evidence-based Strengthening Families Program {SFP} with families {parents and youth} with the goal to "create a supportive and nurturing environment that significantly reduces the likelihood of youth engaging in substance use.
2. Trained staff will implement the SFP with fidelity with families at their Nampa location in order to address decreasing risk factors and increasing protective associated with youth substance use {alcohol, marijuana, and/or stimulants}. The program will address the following risk factors: family conflict, poor communication, peer pressure, and poor decision-making. It will increase protective factors: parental involvement, parental supervision, and strong family bonds.
3. Staff will conduct pre and post surveys offered by the SPF program and enter the pre and post data into a SWDH provided tool. SWDH will share summary data.
4. Staff will administer substance use risk perception pre post survey provided by SWDH at the same time as other pre and post survey.
5. Staff will follow existing internal consent processes for providing education to and collecting survey data from participants.
6. Staff will track and record participation in the program and report to SWDH.
7. Staff will complete prevention training {examples include webinars, online self-paced learning modules, or in-person prevention training} as designated by SWDH. All requests will be reasonable and developed in partnership with the subrecipient.

Coalition Development
1. Attend National Coalitions Academy through CADCA.
2. By June 2026: Increase the capacity of Insight Matters Inc. and Payette County to implement evidence-based environmental and policy prevention strategies.
3. By June 2026: Strengthen collaboration with community partners to address youth substance use prevention, including involving youth and elevating their voices to the coalition
4. By June 2026: Apply training knowledge to secure 12 coalition members to represent 12 separate community stakeholders {defined by CADCA} of the community, including prevention education and community outreach efforts.
5. By June 2026: Lead the Payette County Drug-Free Coalition short-term action team members in proven SAMHSA CSAP 6 Prevention Strategies, guiding them to identify community needs and align action programs and resources with CSAP6 strategies that fit our community and take action.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Provide SBIRT Trainings to Community Partners | $9,999 | Federal Grant | 8-Nov-23 | 30-Sep-25 |

CONTRACT SERVICES AND ACTIVITIES

A. SBIRT "How to talk to youth and adults about substance use" training
1. Conduct up to 12 SBIRT trainings in the Southwest District Health region per year.
2. Provide training and technical assistance to community organizations as needed and as determined by the SWDH Partnerships for Success program coordinator, SWDH Opioid Settlement program coordinator, and Jim Winkle.
3. If approved and determined necessary, travel to provide SBIRT trainings.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming. | $4,865 | Federal Grant | 18-Oct-24 | 15-Sep-25 |

Implementation of Evidence Based Prevention Programs
1. Lifespan director will oversee the implementation of the evidence-based programs Positive Action (18 sessions) and/or Second Step (22 sessions) with the goal to decrease likelihood of youth engaging with alcohol, marijuana, stimulants and other substances.
2. Trained Lifespan personnel will implement the 18 Positive Action program sessions with fidelity in the 4th, 6th and 10th grade classrooms in the Council School District, and the 4th and 5th grade classrooms in Bruneau and Grandview elementary schools to address the risk factor of youth low perception of harm for alcohol, marijuana, and stimulant use.
3. Lifespan trained personnel will implement the 22 session Second Step program sessions with fidelity in 26th grade classrooms in the Fruitland School District to address the risk factor of youth low perception of harm for alcohol, marijuana, and stimulant use.
4. Lifespan personnel will conduct pre and post surveys offered by the Positive Action and Second Step programs and share the de-identified results with SWDH project coordinator.
5. Staff will administer substance use risk perception pre post survey provided by SWDH at the same time as other pre and post survey.
6. Lifespan personnel will follow existing internal consent processes for providing education to and collecting survey data from students.
7. Lifespan personnel will track and record participation in the program and report to SWDH.
8. Staff will follow existing internal consent processes for providing education to and collecting survey data from participants.
9. Staff will track and record participation in the program and report to SWDH.

10. Staff will complete prevention training (examples include webinars, online self-paced learning modules, or in-person prevention training) as designated by SWDH. All requests will be reasonable and developed in partnership with the subrecipient.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming via Communities for Youth model. | $30,000 | Federal Grant | 29-Sep-24 | 29-Sep-25 |

SUBGRANT SERVICES AND ACTIVITIES

A. Activities to support the Southwest Idaho Communities for Youth, youth substance use prevention effort:
1. Build community coalition focused on youth wellbeing and substance use prevention in the Marsing community. Coalition membership should include parents, educators, policy makers, grandparents, and small business leaders, with a special focus on representation from individuals who are Spanish-speaking and who qualify as ALICE (asset limited income constrained employed).
2. Conduct youth survey.
a. Ensure parental consent received prior to survey administration
3. Host at least one community event to present the youth survey results.
4. Host coalition meetings monthly, and develop an action plan with 3-4 goals and activities to address the risk and protective factors related to youth substance use and wellbeing identified in the youth survey.
a. Include SWDH Project Coordinator on monthly coalition meeting invites
b. Consider and document barriers to reaching Spanish speaking and ALICE populations for each goal in the action plan.
c. Develop and document strategies for addressing identified barriers for reaching Spanish-speaking and ALICE populations in the action plan to ensure they are reached.
5. Implement activities, programs, and initiatives developed to address the risk and protective factors related to youth substance use and wellbeing identified in the youth survey.
6. Implement programming to enhance life skills, create sense of community, promote physical and mental well-being, and prevent youth substance use.
7. Create opportunities for Marsing community youth/teens to develop positive relationships with peers and adults.
8. Use awarded funds to support the operational costs of projects and activities outlined. All activities and costs must be approved on a case-by-case basis by the SWDH project coordinator.

B. Infrastructure
1. Identify local community coalition lead
2. Coalition lead will meet with the SWDH project coordinator monthly
3. Identify designated contact for project deliverables (invoices, operating cost review, action plan, and reporting)
4. Submit activity and budget requests in the SWDH provided request and reporting form.
S. Update and submit reporting template.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming via Communities for Youth model. | $30,000 | Federal Grant | 13-Feb-25 | 29-Sep-26 |

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4. Submit activity and budget requests in the SWDH provided request and reporting form.
5. Update and submit reporting template.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Implement youth substance use prevention programming. | $11,180 | Federal Grant | 16-Oct-24 | 15-Sep-25 |

Implement Planet Youth Identified Alternative Activities for Youth
1. Implement after-school program in Meadows Valley which will increase access to positive leisure time activities, decreasing the risk of youth substance use (alcohol, marijuana, and stimulants).
2. Meadows Valley After School Program personnel will provide supervised after school programming to enhance life skills, create sense of community, and promote physical and mental well-being, which are protective factors to youth substance use as identified in the Planet Youth survey.
3. Personnel will create opportunities for Meadows Valley youth/teens to develop positive relationships with peers and adults through supervised out of school activities.
4. Staff will administer substance use risk perception pre post survey provided by SWDH at with participants.
5. Staff will follow existing internal consent processes for providing education to and collecting survey data from participants.
6. Staff will track and record participation in the program and report to SWDH.
7. Staff will complete prevention training (examples include webinars, online self-paced learning modules, or in-person prevention training) as designated by SWDH. All requests will be reasonable and developed in partnership with the subrecipient.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Data collection, analysis, and reporting for the 2026 Greater Treasure Valley Community Health Needs Assessment | $9,304 | Federal Grant | 4-Dec-24 | 1-Jul-26 |

Background and Purpose
This Agreement is established to facilitate a comprehensive data collection and analysis process aimed at identifying the health needs of Idaho's southwestern region. Partner organizations supporting the Western Idaho Community Health Collaborative (WICHC) agree to jointly create the 2026 Greater Treasure Valley Community Health Needs Assessment (CHNA).

The partners in this collaboration include Idaho Central District Health, Idaho Southwest District Health, Saint Alphonsus Health System, St. Luke's, and United Way of Treasure Valley. The authorized representatives of each organization agree to contribute financial resources to support the CHNA.
This Agreement outlines the terms and conditions under which the partners will jointly engage and fund Metopio to conduct the CHNA. The CHNA will cover the following counties in Idaho: Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington. The project period will span from October 2024 to June 2026, culminating in a final report in June 2026.
United Way of Treasure Valley will serve as the fiscal agent for this contract. Upon completion of the Partner Funding Agreement, United Way will enter into and maintain the contract with Metopio to develop the CHNA.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Increase awareness of FindHelpIdaho.org through training and marketing activities | $50,000 | Health Plan Contribution | 26-Feb-25 | 31-Dec-25 |

About Findhelpidaho.org
This resource connects Idahoans seeking help with resources in their local community. It's free, confidential, easy to use, and provides up-to-date information in more than 100 languages.

Contract services and activities
A. Objective 1: By December 31, 2025, United Way of Treasure Valley (UWTV) will host 10 FHI 101 training courses and 2 certification training courses for WICHC and Southwest Idaho community members and partners.
a. UWTV will promote trainings among WICHC members and within the WICHC Region (Districts 3 and 4).
b. UWTV will coordinate training logistics (e.g., Meeting locations, refreshments, etc.).
c. UWTV to evaluate training to ensure knowledge is gained through a brief post-training survey.

B. Objective 2: By December 31, 2025, UWTV will incentivize and acknowledge up to 25 WICHC member organizations who utilize FHI.
a. UWTV will report on the following:
*i. Number of WICHC organizations listed on FHI*
*ii. Number of cards per organization*
*iii. Number of incentives distributed to WICHC members*
b. UWTV will acknowledge WICHC members via an Appreciation Campaign.

C. Objective 3: By December 31, 2025, market FHI to organizational and community members to increase use of FHI.
a. UWTV and SWDH will meet bi-weekly to review subgrant progress.
b. UWTV to develop and/or provide marketing campaign/materials to promote FHI in alignment with available media. All materials are to be reviewed by WICHC prior to distribution.
c. UWTV to complete and purchase media buys for a marketing campaign within WICHC Region (Districts 3 and 4) (not to exceed $30,000.00).

**Note:** $45,000 was directed towards UWTV's efforts to promote Findhelpidaho.org in the Greater Treasure Valley. The remaining $5,000 is directed towards SWDH managing the funding and for developing a health provider survey aimed at identifying opportunities for platform improvement.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Adult Crisis Center | $1,392,000/year | Federal & State (Magellan) | 23-Jun-23 | 22-Jun-27 |

General Requirements

I. District Responsibilities – Southwest District Health shall:
   A. Oversee the Western Idaho Community Crisis Center (WIDCCC) to ensure compliance with Idaho Administrative Code (IDAPA) 16.07.30, Behavioral Health Community Crisis Centers and Idaho Code Title 39 Chapter 91, Behavioral Health Community Crisis Centers Act; application of the model, associated rules and patient safety. The District shall perform annual audits, on-site visits, and ongoing monitoring of the WIDCCC as necessary to fulfill its oversight responsibility.
   B. Assist the Subgrantee with accessing Idaho Department of Health and Welfare services such as behavioral health, Medicaid, food stamps, child support, Navigation services, etc

II. Subgrantee's Responsibilities – The Subgrantee shall:
   A. Comply with all provisions of the Idaho Medicaid Crisis Center Minimum Requirements.
   B. Ensure that all service provisions are delivered by persons who meet licensure and or certification qualifications, as appropriate within their field of study, and provide evidence of licensure, certification, and any other applicable qualifications.
   C. Utilize an Idaho Department of Health and Welfare's approved EHR system to capture all client related treatment and history and maintain additional needed data from the intervention.
   D. Participate on the Western Idaho Community Crisis Center (WIDCCC) Advisory Committee to guide the organization, implementation, and operation of WIDCCC.
   E. Ensure services to be provided are non-discriminatory. The Subgrantee shall not refuse services to any person because of race, color, religion or because of inability to pay.
   F. Report to the District's Subgrant Manager any facts regarding irregular activities or practices that mayconflict with federal or state rules and regulations discovered during the performance of activities under the Subgrant.
   G. Ensure all subSubgrantees and their employees meet all Subgrant requirements. If the Subgrantee utilizes any entity other than their own entity to provide any of the services required, the relationship is considered that of a Subgrantee-sub-recipient for purposes of this Subgrant. The Subgrantee shall for each subSubgrantee:
      i. Complete and submit the Idaho Department of Health and Welfare's Acceptance of Subgrant form,provided upon request, prior to the subSubgrantee performing any Subgranted service.
      i. Shall supply to the District a copy of the subSubgrantee agreement between Subgrantee and subrecipient/affiliate outlining their designated service.
   H. Ensure the WIDCCC has an operational flow process with the crisis system providers in Region 3 that allows access during the crisis and post discharge to provide comprehensive services to clients.
   I. Meet with the District Subgrant monitor once a week, or as needed, for 6 months from Subgrant execution date. Frequency of meetings to be determined by District contact monitor.

Idaho Behavioral Health Plan (IBHP) Managed Care Organization Requirements

I. Crisis Centers shall:
   A. Have an integrated, systematic approach to behavioral health crisis care to address the needs of adults and youth experiencing a mental health crisis.
   B. Provide easy access to crisis service alternatives that reduce the inappropriate use of emergency departments, inpatient services, and jail
   C. Offer a dedicated first-responder drop-off area.
   D. Address the cultural and special population needs of their community including the ability to manage complex needs in populations such as individuals with intellectual and developmental disabilities, LBGTQIA individuals, and veterans or active military.
   E. Incorporate some form of intensive support beds into a partner program (either internally or with external providers) to support flow for individuals who need additional support.
   F. Provide data on chair capacity to the real-time IPBSR operated by the IDHW to support efficient connection to needed resources.
   G. Coordinate connections to ongoing care.
   H. Embed users, peers, and Members in their organization's design and leadership.
   I. Train and integrate peer support staff in crisis service delivery.
   J. Adopt a zero-suicide philosophy.
   K. Engage family and friends in crisis care.
   L. Engage in community outreach regarding availability of crisis stabilization services.
   M. Collect and report data as outlined in the Subgrant and IDHW Standards.
   N. By the end of the second year of the Subgrant, provide applicable data to SWDH and Magellan to develop dashboards that display real-time, meaningful data and outcome measures that support continuous quality improvement.
   O. Administer Naloxone in cases of opioid overdose.

P. Offer each member, upon discharge, a satisfaction survey that includes questions related to the quality of service, the outcomes of services and their perception of additional needs not addressed by the facility. The results of these surveys shall be sent to Magellan and SWDH for continuous quality improvement and stakeholder engagement in the crisis system.
Q. Access and use Magellan's Care Management Plan Platform.
R. Connect to ACT and ICC staff to help coordinate care as appropriate.
S. Utilize the IDHW-approved protocols for safety planning.
T. Develop a collaborative discharge plan that addresses safety, stability, and treatment progress.
U. Enhance current operations by adopting the BHL platform, which will fulfill Magellan's IBHP Subgrantual requirements for quarterly reporting.

II. Implementation Plans:
A. Crisis Centers shall develop implementation plans to meet the IDHW Crisis Center Standards and SAMHSA's best practices guidelines for Minimum Expectations to Operate Crisis Receiving and Stabilization Service during the first year of the Subgrants. The plans must be implemented by the end of the second year of the new Subgrants.

III. Available screening/services must include:
A. Intervention Services:
i. Including stage-wise treatment and intervention services based on the Dr. Kenneth Minkoff, MD model to address co-occurring psychiatric and substance use disorders. This includes:
a. Acute Stabilization – safe sobering up and stabilization of acute psychiatric symptoms.
b. Motivational Enhancement – individualized motivational strategies to help individuals who have made no commitment to change.
c. Active Treatment – for individuals who need to learn and practice skills to manage their substance and mental health symptoms.
d. Relapse Prevention – specific skills training on participation in self-help recovery programs, as well as specialized self-help programs like Dual Recovery Anonymous.
e. Rehabilitation and Recovery – developing new skills and capabilities based on strengths, and on developing improved self-esteem, pride, dignity, and sense of purpose in the context of the continued presence of mental health and substance use disorders.
B. Medication Management:
i. Medication Storage and Administration policies and procedures regarding the storage and administration of prescription and non-prescription medication.

Idaho Medicaid Crisis Center Minimum Requirements

I. The Crisis Center must comply with all provisions of state and federal laws, rules, regulations, policies, standards, and guidelines as indicated, amended, or modified that govern performance of the services. This specifically includes, but is not limited to:
A. Idaho Code Title 39 Chapter 91, Behavioral Health Community Crisis Centers.
B. Idaho Code sections 16-2428 and 37-3102 that govern youth's consent to disclosure of treatment information, as well as general use and disclosure and privacy requirements of state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1302(a), 42 U.S.C. 1320d-1320d-9, and its implementing regulations, 45 CFR parts 160, 162, 164, and laws related to the confidentiality of substance use disorder (SUD) records, 42 U.S.C. 290dd-2, and its implementing regulations at 42 CFR Part 2 and ensure procedural safeguards are followed in confidentiality requirements according to IDAPA 16.05.01.
C. The department's HIPAA Business Associate Agreement.
D. Idaho's Open Meeting Law as established in Idaho Code §§ 74-201 through 74-208.
E. The Idaho Behavioral Health Plan (IBHP)'s Idaho department of Health and Welfare (IDHW)-approved Supervisory Protocol.

II. The Crisis Center must:
A. Provide, operate, and manage their crisis center as follows:
i. Operate twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.
ii. Provide services to clients in a behavioral health crisis for no more than twenty-three (23) hours and fifty-nine (59) minutes per single episode of care.
iii. Provide services on a voluntary, outpatient basis to individuals experiencing a behavioral health crisis.
iv. Provide case management services to assist in the creation and follow through of treatment and discharge planning.
v. Ensure age-appropriate clients participate in crisis stabilization planning.
B. Ensure the facility can provide services to individuals in crisis including:
i. Individuals with co-occurring conditions or considerations, with cognitive functioning at a sufficient level to perform their own personal care and self-governance including, but not limited to:
a. Mental health conditions.
b. Substance Use Disorders (SUDs).

c. Medical needs (not requiring immediate hospitalization).
d. Intellectual/developmental disabilities.
e. Physical disabilities.
f. Clients who may be uninsured or unable to pay for services.
g. Lesbian, gay, bisexual, transgender, queer, intersex, agender (LGTBQIA+) clients.

C. Incorporate peer recovery support services as part of the overall crisis service delivery system.
D. Use a department provided real time bed registry.
   i. Update the bed registry a minimum of once per 12-hour period, morning, and evening.
E. Develop and maintain policies and procedures that address the following:
   i. Engage client's natural supports.
   ii. Maximum capacity.
   iii. Staff training requirements include but are not limited to:
      a. Overdose training response and naloxone injection
      b. Basic life support (BLS) certification
   iv. Cultural competency plan
   v. Staff to client ratios, including minimum staff to remain open
   vi. Bilingual Services
   vii. Non-discriminatory practices
   viii. Client's personal possessions, including medications.
   ix. Transportation of clients (if provided)
   x. Client resting areas
   xi. Crisis Assessment Tool (CAT) data submission platform.
   xii. Behavioral management system: de-escalation and safety
   xiii. Client conducts and rules violation
   xiv. Critical Incidents
   xv. Emergency policies and procedures
   xvi. Quality management plan
   xvii. Reporting of abuse and/or neglect, including alleged
   xviii. Maintenance and care of the facility
   xix. Use of program animals
   xx. Disposal of contraband/weapons
   xxi. Alcohol, tobacco products, and illegal or illicit drugs
   xxii. Grievances and complaints
   xxiii. Background checks
   xxiv. Client eligibility
   xxv. Admission and discharge
   xxvi. Clinical supervision
   xxvii. Law enforcement referrals
   xxviii. Visitors
   xxix. Client records
   xxx. Transfer of a client to a higher level of care if needed
   xxxi. Medical assessment and treatment requirements that include but are not limited to:
      a. Response to overdoses
      b. Naloxone
      c. Identification of withdrawal symptoms (and high-risk scenarios where hospital is needed for withdrawal management).
   xxxii. Medication Management requirements that include but are not limited to:
      a. Storage and administration of prescription and non-prescription medication
      b. Storage of all prescription and over-the-counter medication under lock and key

c. Ensure the keys are not accessible to unauthorized individuals, including clients, parents, visitors, or staff no authorized to assist with medications
d. Administration of medication be recorded by authorized personnel and in accordance with physician's orders
e. Staff who administer and assist with self-administration of medications must be certified by a qualified medical professional
f. Consultation of a qualified medical professional before discontinuing, changing, or adding prescribed medication
g. If applicable; parent/guardian consent before discontinuing, changing, or adding prescribed medication
h. Documentation of all consultations regarding changes in prescription medications
i. Documentation for all prescription medication issued by a qualified medical professional's valid order that includes the dosage to be given, and documentation of each dose given, name of the client, date and time, amount of dosage given and whether the client did or did not take the medication; and person who administered or assisted in the self-administration of the medication

ii. Provide a Program Services description detailing all the services provided. Services must include but are not limited to:
i. Individual, group and family counseling.
ii. Parent/guardian education.
iii. Relapse prevention
iv. Case management/care coordination
v. Referrals services.
vi. Aftercare planning
vii. Safety planning
viii. Meets general facility requirements

III. The Crisis Center Facility must:
A. Ensure that if crisis stabilization services are co-located with other specialty mental health services (such as adult services and/or substance use services) these areas must be physically separated by locked doors and walls, so there is no co-mingling between clients, regardless of age. There must be no co-mingling between adult clients and child/youth clients allowed at any time, for any reason. Adult clients and child/youth clients must be physically separated by locked doors and walls, so there is no co-mingling between clients.
B. Meet capacity requirements:
i. Adult Crisis Centers must have capacity for ten (10) male/female beds for a total of twenty (20) beds. The maximum number can be achieved and/or expanded in stages during implementation and as approved by the IBHP Subgrantee.
ii. Ensure that the facility has separate resting areas for clients, based on age and other identified factors, as appropriate.
C. Have capacity that includes:
i. Lobby space with chairs and tables.
ii. Confidential office space for medical, case management, and behavioral health interventions.
iii. A triage area that is quiet and private.
iv. Spaces that are trauma informed in their design and promote privacy and dignity as well as safety.
v. Quiet space in the physical environment away from the milieu of the main stabilization area.
i. This area must be used for de-escalation and calming, not seclusion. There must be no restrictions in terms of entry and exit.
vi. A family friendly, welcoming physical space and environment for persons in crisis that offers developmentally suitable supports for clients and families.
vii. Confidential spaces for families to gather, with the client and without, where the families and/or client may receive clinical services and supports.
viii. Bathrooms that are gender neutral.
ix. Develop and maintain a policy to decrease safety risks for clients who may be alone or unsupervised in a location, such as but not limited to a bathroom. Anti-ligature equipment for these locations is required.
x. A dedicated first responder drop off area separate from the main entrance.
xi. A means of securing personal possessions including medication, valuables, clothing, etc.
xii. Client protection from potential threats to their safety by implementing a security policy and practice.
xiii. Recommendation to provide limited daily transportation to community partner places of business such as the department of Labor, Social Security Administration and Public Health department.
D. Have Available:
i. Plastic eating utensils and cups.
ii. Beverages such as water, coffee, etc.

iii. Non-perishable, self-prepared snack items such as cup of soup, granola bars, cheese and crackers, peanut butter sandwiches, pudding cups or other similar items; and
iv. Have available, on an "as needed" basis:
i. Sweatpants, scrubs, tee shirts, sweatshirts, etc.
ii. Personal care products, toiletries/toilet paper, paper towels.
iii. Bus and cab vouchers

IV. Staffing requirements must include:
A. Assessment and screenings being overseen by a Licensed Medical Professional and/or a Licensed Mental Health Professional. The professionals must have the training, skills, current professional licensure and/or certification to accurately diagnose clients.
B. All service provisions delivered by professionals who meet licensure and/or certification qualifications, as appropriate within their field of study. Evidence of licensure, certification, and any other applicable qualifications must be provided to the IBHP Subgrantee.
C. A clinical supervisor to provide direction and guidance of all clinicians doing integrated mental health and substance use disorders assessments.
i. There must be a minimum of one (1) medical staff which could be inclusive of; Certified Nursing Assistant (CNA), Emergency Medical Technician (EMT), Licensed Practical Nurse (LPN), or Registered Nurse (RN) on site at all times. This staff can be counted as one (1) of the minimum two (2) staff on site.
ii. Required staffing ratios: One (1) direct care staff for every three (3) clients and a minimum of two (2) staff on site at all times.
iii. Ability to provide 1:1 supervision as needed.

V. Available screening/services and interventions must include:
A. Medical Screening/Assessment
i. A medical professional, as described above, assesses physical health needs, and determines any need for immediate medical treatment. The medical professional may deliver care for minor physical health challenges. The Screening/Assessment must also provide a health history.
B. Plan of Care and Services Planning
i. A plan of care based on findings from the medical screening and behavioral health assessment/CAT for each client admitted. The plan of care must be individualized, person-centered, strengths-based, collaborative, family, and community focused, culturally competent, utilize natural supports, and be outcomes based. The plan of care must be documented in the department-approved data submission platform outlined by the Subgrantee.
ii. Depending on the age of the client, client and/or their parents or guardians must direct the development of the client's service plan through a person-centered, family driven, client guided planning process. The Subgrantee must ensure information and support is provided to clients and families to maximize their ability to make informed choices and decisions.
C. Referral Services
i. Based on identified functional areas of impairment (medical, vocational, financial, housing, family, social activities of daily living, transportation, legal, and substance use). This information must be documented in a department-approved data submission platform.
D. Aftercare Plan
i. Each client, prior to leaving the Crisis Center must be provided an after-care plan which includes, at a minimum, connection to a peer or Recovery Support Specialist.
ii. This plan must be documented in a department approved data submission platform.
iii. The plan must anticipate a variety of needs associated with aftercare. Ideas include but not limited to:
i. Safety planning
ii. Primary/Peer Support
iii. Education Planning
iv. Relapse Prevention Planning
v. Continuing Treatment Planning

E. Behavioral Management
i. Have a nationally recognized behavior management system to structure prevention and intervention approaches that is approved by the department.
ii. Ensure all staff are trained in and use crisis management and intervention techniques that employ verbal de-escalation methods and non-physical intervention strategies. Ensure there is no restraint either mechanical, physical, or chemical (pharmacological) of clients by agency staff, or other clients.
F. Management/Contingency Plans
i. For any center not meeting these minimum requirements, there must be an approved management or contingency plan in place with the IBHP Subgrantee.
i. A contingency plan may be put in place when the IBHP Subgrantee deems a sufficient exception to requirements may be made without risking quality or efficacy of care.

ii. A management plan may be put in place when the IBHP Subgrantee determines a requirement ineligible for contingency planning.
iii. Timelines set in a management plan for meeting requirements determined ineligible by the Subgrantee for contingency plan may not exceed one year from the plan being signed.

Southwest District Health (SWDH) requirements:

I. Operation Services – the Subgrantee shall:
   A. Maintain Americans with Disabilities Act (ADA) compliance.
   B. Provide telehealth crisis center access in rural and remote areas of the region, as needed, or scheduled, based on staff availability.

II. Admission and Discharge – the Subgrantee shall:
   A. Document in approved EHR system, the reason for denying services to those applying for services.
   B. Conduct intake eligibility assessment within a reasonable timeframe of application (no later than two (2) hours due to acuity of crisis, third-party referral, etc.) for services and must include written/signed consent, client rights/responsibilities, and information about the crisis center's grievance/complaint policy. The intake eligibility assessment shall determine if a person is in a behavioral health crisis and whether or not they require a higher level of care (e.g., inpatient, emergency room or urgent care services). The intake eligibility assessment must be documented in the approved EHR system. The intake eligibility assessment must be possible by telephone or other telehealth method whenthe client is not physically onsite.
   C. Complete a behavioral health assessment on each client. The behavioral health assessment shall be used to develop the plan of care, intervention services and referral services to ensure the appropriate continuum of care is identified for each client. An updated behavioral health assessment may be used on clients who were assessed within the last three (3) months (90 days). The behavioral health assessment shall include:
      i. Presenting concern
      i. Treatment history at a minimum shall include:
         a. Hospitalizations
         b. Emergency room visits
         c. Outpatient treatment
         d. Medications
         e. Substance abuse history, and
         f. Recommendations
   D. The medical assessment, risk assessment, behavioral health assessment and/or other assessments conducted by the WIDCCC staff shall be documented in the approved EHR system.

III. Intervention Services – the Subgrantee shall:
   A. Document in approved EHR system interventions rendered and client response.

IV. Referral Services – the Subgrantee shall:
   A. Utilize ongoing observation, assessment and evaluation to make changes to serviceswhile at the WIDCCC. This information, along with the client's benefits and resources, shall be used to make referrals to ongoing care and services.
   B. Document referrals in the approved EHR and client response.

V. Aftercare Plan – the Subgrantee shall:
   A. Provide each client with their written aftercare plan prior to leaving the WIDCCC. The aftercare plan should include services that are accessible within seven (7) days.
   B. Attempt to identify a collateral contact for each client, and whenever possible, include the contact(s) in the aftercare plan.
   C. Develop a follow-up process and use the process to follow-up with all clients and/or collateral contact.
   D. Document clients' follow-up of their aftercare in approved EHR system and include, as applicable:
      i. Whether the client kept their initial appointment
      i. Barriers or challenges to completing the aftercare plan
      i. Sought care with a different resource or was incarcerated

VI. Staffing:
   A. Staff seeking to provide peer services that receive an unconditional denial from the Idaho Department ofHealth and Welfare's (IDHW) Criminal History Unit may apply for an Idaho Department of Health and Welfare Division of Behavioral Health Background Check Waiver.

VII. Cultural Competence:
   A. The Subgrantee's Cultural Competency Plan shall outline clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Native Americans' and Hispanics' needs. The Subgrantee shall finalize the Cultural Competency Plan and submit it no later than forty-five (45) calendar days prior to the anticipated service implementation date.

B. The Subgrantee shall ensure bilingual/multicultural staff are available at the WIDCCC. Bilingual/multicultural staff shall, at a minimum, speak English and Spanish and any other language spoken by at least five percent (5%) of the population within the service area.

VIII. Outcomes Measures and Data – the Subgrantee shall:
A. The Subgrantee shall compile and report data on a weekly, month, including weekly reports to the District Subgrant monitor, weekly monthly report-outs to the WIDCCC advisory committee, and quarterly reports to the District Subgrant monitor. See Reports section for a detailed description of data requirements, reporting formats, and timelines for completion.

IX. Community Engagement – the Subgrantee shall:
A. Engage community partners with a shared goal of improving community behavioral health.
B. Identify opportunities to form formal and informal relationships or partnerships that support the patients' broader healthcare needs.
C. Pursue opportunities for in-kind donations or support that can help control costs associated with the operations of the crisis center.
D. Work with SWDH Subgranted marketing agency to develop and implement promotional and community engagement activities.
E. Utilize WIDCCC communication templates (ex. PowerPoint, letterhead) and language such as, "The Western Idaho Community Crisis Center operated by Clarvida" on external facing communication and marketing.

X. Quality Assurance – the Subgrantee shall:
A. Maintain a quality improvement plan that documents the process to be used in ensuringthe quality of services laid out in the Idaho Medicaid Crisis Center Minimum Requirements.
B. Meet regularly, or as needed with the District, Idaho Department of Health and Welfare, Magellan Idaho, and/or county Crisis Intervention Teams to staff individual cases, treatment recommendations and service responsibilities.
C. Distribute annual surveys via email, print, verbally, or another mechanism approved by the District to ancillary service vendors, stakeholders, hospitals, law enforcement, government entities, insurers, community-based organizations, and other organizations affiliated with the WIDCCC. Questions on the survey shall address the quality of services, the outcomes of services, and the organization's perception of additional needs not addressed at the WIDCCC.

XI. Records and Documentation – the Subgrantee shall:
A. Use approved EHR to document all delivered services in the individual's record and maintain the record at the Subgrantee's location. Required data includes, but is not limited to:
i. Results of intake, including eligibility, risk, behavioral health assessments, presenting concerns, etc.
i. Client demographics (gender, county of residence, age, veteran status, homeless status, identified substance use, etc.)
i. Client-identified diversion
i. Plan of care
i. Intervention services provided
i. Referral sources and out-bound referrals
i. Aftercare plan
i. Client satisfaction
i. Follow-up results
B. Work with the District to develop complete and accurate reports, as some data may be collected, analyzed, and submitted by the District.

XII. Transition of Services:
A. The Subgrantee shall develop a draft transition plan within first six months of agreement that describes the process for ensuring a smooth transition of project services and transfer of project materials, documentation and data either to the District or to another Subgrantee upon termination or expiration of the Subgrant. A list of minimum components of the plan will be provided by the District.
B. Upon initiation of a termination, a final Transition Plan shall be negotiated with the District upon Subgrant termination or ninety (90) calendar days prior to expiration of the Subgrant, whichever comes first.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Youth Crisis Center | $1,456,620/year | Federal & State (Magellan) | 11-Dec-23 | 28-Jan-28 |

General Requirements

I. District Responsibilities – Southwest District Health shall:
   A. Oversee the Western Idaho Youth Support Center (WIYSC) to ensure compliance with Idaho Administrative Code (IDAPA) 16.07.30, Behavioral Health Community Crisis Centers and Idaho Code Title 39 Chapter 91, Behavioral Health Community Crisis Centers Act; application of the model, associated rules and patient safety. The District shall perform annual audits, on-site visits, and ongoing monitoring of the WIYSC as necessary to fulfill its oversight responsibility.
   B. Assist the Contractor with accessing Idaho Department of Health and Welfare services such as behavioral health, Medicaid, food stamps, child support, Navigation services, etc.

II. Contractor's Responsibilities – The Subcontractor shall:
   A. Comply with all provisions of the Idaho Medicaid Crisis Center Minimum Requirements.
   B. Ensure that all service provisions are delivered by persons who meet licensure and or certification qualifications, as appropriate within their field of study, and provide evidence of licensure, certification, and any other applicable qualifications.
   C. Utilize an Idaho Department of Health and Welfare's approved EHR system to capture all client related treatment and history and maintain additional needed data from the intervention.
   D. Participate on the Western Idaho Youth Support Center (WIYSC) Advisory Committee to guide the organization, implementation, and operation of WIYSC.
   E. Ensure services to be provided are non-discriminatory. The Contractor shall not refuse services to any person because of race, color, religion or because of inability to pay.
   F. Report to the District's Contract Manager any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations discovered during the performance of activities under the contract.
   G. Ensure all subcontractors and their employees meet all contract requirements. If the Contractor utilizes any entity other than their own entity to provide any of the services required, the relationship is considered that of a contractor-sub-recipient for purposes of this contract. The Contractor shall for each subcontractor:
      i. Complete and submit the Idaho Department of Health and Welfare's Acceptance of Contract form,provided upon request, prior to the subcontractor performing any contracted service.
      i. Shall supply to the District a copy of the subcontractor agreement between Contractor and subrecipient/affiliate outlining their designated service.
   H. Ensure the WIYSC has an operational flow process with the crisis system providers in Region 3 that allows access during the crisis and post discharge to provide comprehensive services to clients.
   I. Meet with the District contract monitor once a week, or as needed, for 6 months from contract execution date. Frequency of meetings to be determined by District contact monitor.

Idaho Behavioral Health Plan (IBHP) Managed Care Organization (MCO) Requirements

VI. Crisis Centers shall:
   A. Have an integrated, systematic approach to behavioral health crisis care to address the needs of adults and youth experiencing a mental health crisis.
   B. Provide easy access to crisis service alternatives that reduce the inappropriate use of emergency departments, inpatient services, and jail.
   C. Offer a dedicated first-responder drop-off area.
   D. Address the cultural and special population needs of their community including the ability to manage complex needs in populations such as individuals with intellectual and developmental disabilities, LBGTQIA individuals, and veterans or active military.
   E. Incorporate some form of intensive support beds into a partner program (either internally or with external providers) to support flow for individuals who need additional support.
   F. Provide data on chair capacity to the real-time IPBSR operated by the IDHW to support efficient connection to needed resources.
   G. Coordinate connections to ongoing care.
   H. Embed users, peers, and Members in their organization's design and leadership.
   I. Train and integrate peer support staff in crisis service delivery.
   J. Adopt a zero-suicide philosophy.
   K. Engage family and friends in crisis care.
   L. Engage in community outreach regarding availability of crisis stabilization services.
   M. Collect and report data as outlined in the Contract and IDHW Standards.
   N. By the end of the second year of the MCO Contract, provide applicable data to SWDH and Magellan to develop dashboards that display real-time, meaningful data and outcome measures that support continuous quality improvement.
   O. Administer Naloxone in cases of opioid overdose.
   P. Offer each member, upon discharge, a satisfaction survey that includes questions related to the quality of service, the outcomes of services and their perception of additional needs not addressed by the facility. The results of these surveys shall be sent to SWDH and Magellan for continuous quality improvement and stakeholder engagement in the crisis system.
   Q. Access and use Magellan's Care Management Plan Platform.
   R. Connect to ACT and ICC staff to help coordinate care as appropriate.
   S. Utilize the IDHW-approved protocols for safety planning.
   T. Develop a collaborative discharge plan that addresses safety, stability, and treatment progress.
   U. Enhance current operations by adopting the BHL platform, which will fulfill Magellan's IBHP contractual requirements for quarterly reporting.

VII. Implementation Plans:
  A. Crisis Centers shall develop implementation plans to meet the IDHW Crisis Center Standards and SAMHSA's best practices guidelines for Minimum Expectations to Operate Crisis Receiving and Stabilization Service during the first year of the contracts. The plans must be implemented by the end of the second year of the new contracts.

VIII. Available screening/services must include:
  A. Intervention Services:
    i. Including stage-wise treatment and intervention services based on the Dr. Kenneth Minkoff, MD model to address co-occurring psychiatric and substance use disorders. This includes:
      f. Acute Stabilization – safe sobering up and stabilization of acute psychiatric symptoms.
      g. Motivational Enhancement – individualized motivational strategies to help individuals who have made no commitment to change.
      h. Active Treatment – for individuals who need to learn and practice skills to manage their substance and mental health symptoms.
      i. Relapse Prevention – specific skills training on participation in self-help recovery programs, as well as specialized self-help programs like Dual Recovery Anonymous.
      j. Rehabilitation and Recovery – developing new skills and capabilities based on strengths, and on developing improved self-esteem, pride, dignity, and sense of purpose in the context of the continued presence of mental health and substance use disorders.
  B. Medication Management:
    i. Medication Storage and Administration policies and procedures regarding the storage and administration of prescription and non-prescription medication.

Idaho Medicaid Crisis Center Minimum Requirements

I. The Crisis Center must comply with all provisions of state and federal laws, rules, regulations, policies, standards, and guidelines as indicated, amended, or modified that govern performance of the services. This specifically includes, but is not limited to:
  A. Idaho Code Title 39 Chapter 91, Behavioral Health Community Crisis Centers.
  B. Idaho Code sections 16-2428 and 37-3102 that govern youth's consent to disclosure of treatment information, as well as general use and disclosure and privacy requirements of state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1302(a), 42 U.S.C. 1320d-1320d-9, and its implementing regulations, 45 CFR parts 160, 162, 164, and laws related to the confidentiality of substance use disorder (SUD) records, 42 U.S.C. 290dd-2, and its implementing regulations at 42 CFR Part 2 and ensure procedural safeguards are followed in confidentiality requirements according to IDAPA 16.05.01.
  C. The department's HIPAA Business Associate Agreement.
  D. Idaho's Open Meeting Law as established in Idaho Code §§ 74-201 through 74-208.
  E. The Idaho Behavioral Health Plan (IBHP)'s Idaho department of Health and Welfare (IDHW)-approved Supervisory Protocol.

II. The Crisis Center must:
  A. Provide, operate, and manage their crisis center as follows:
    i. Operate twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.
    ii. Provide services to clients in a behavioral health crisis for no more than twenty-three (23) hours and fifty-nine (59) minutes per single episode of care.
    iii. Provide services on a voluntary, outpatient basis to individuals experiencing a behavioral health crisis.
    iv. Provide case management services to assist in the creation and follow through of treatment and discharge planning.
    v. Ensure age-appropriate clients participate in crisis stabilization planning.
  B. Ensure for Youth Crisis Centers (YCC):
    i. Parent/Guardian and/or law enforcement be contacted if the client arrived at the facility unaccompanied by the parent or guardian.
    ii. If a staff member suspects a client has been abused, abandoned, or neglected a report to the appropriate parties must be made as required by Idaho Code 16-1605.
    iii. In coordinated effort with the department, for Youth in department custody, the YCC must allow and encourage client's parent/guardian to be involved in crisis treatment, treatment planning and discharge planning, unless it is the department's determination that such involvement would endanger the client. Efforts and activities related to family and natural support involvement must be documented in the client's case record established by the YCC.
  C. Ensure the facility can provide services to individuals in crisis including:
    i. Individuals with co-occurring conditions or considerations, with cognitive functioning at a sufficient level to perform their own personal care and self-governance including, but not limited to:
      a. Mental health conditions.
      b. Substance Use Disorders (SUDs).
      c. Medical needs (not requiring immediate hospitalization).
      d. Intellectual/developmental disabilities.
      e. Physical disabilities.
      f. Clients who may be uninsured or unable to pay for services.

g. Lesbian, gay, bisexual, transgender, queer, intersex, agender (LGTBQIA+) clients.

D. Incorporate peer recovery support services as part of the overall crisis service delivery system.

E. Use a department provided real time bed registry.

i. Update the bed registry a minimum of once per 12-hour period, morning, and evening.

F. Develop and maintain policies and procedures that address the following:

i. Engage client's natural supports.

ii. Maximum capacity.

iii. Staff training requirements include but are not limited to:

a. Overdose training response and naloxone injection

b. Basic life support (BLS) certification

iv. Cultural competency plan

v. Staff to client ratios, including minimum staff to remain open

vi. Bilingual Services

vii. Non-discriminatory practices

viii. Client's personal possessions, including medications.

ix. Transportation of clients (if provided)

x. Client resting areas

xi. Crisis Assessment Tool (CAT) data submission platform.

xii. Behavioral management system: de-escalation and safety

xiii. Client conducts and rules violation

xiv. Critical Incidents

xv. Emergency policies and procedures

xvi. Quality management plan

xvii. Reporting of abuse and/or neglect, including alleged

xviii. Maintenance and care of the facility

xix. Use of program animals

xx. Disposal of contraband/weapons

xxi. Alcohol, tobacco products, and illegal or illicit drugs

xxii. Grievances and complaints

xxiii. Background checks

xxiv. Client eligibility

xxv. Admission and discharge

xxvi. Clinical supervision

xxvii. Law enforcement referrals

xxviii. Visitors

xxix. Client records

xxx. Transfer of youth to adult center if needed

xxxi. Transfer of a client to a higher level of care if needed

xxxii. Readmission of youth if additional few hours of stabilization is needed

xxxiii. Client rights including the acceptance and refusal of services

xxxiv. For YCC:

a. Non-episode participants, such as siblings

b. Client reporting as runaways

xxxv. Medical assessment and treatment requirements that include but are not limited to:

a. Response to overdoses

b. Naloxone

c. Identification of withdrawal symptoms (and high-risk scenarios where hospital is needed for withdrawal management).

xxxvi. Medication Management requirements that include but are not limited to:

a. Storage and administration of prescription and non-prescription medication
b. Storage of all prescription and over-the-counter medication under lock and key
c. Ensure the keys are not accessible to unauthorized individuals, including clients, parents, visitors, or staff no authorized to assist with medications
d. Administration of medication be recorded by authorized personnel and in accordance with physician's orders
e. Staff who administer and assist with self-administration of medications must be certified by a qualified medical professional
f. Consultation of a qualified medical professional before discontinuing, changing, or adding prescribed medication
g. If applicable; parent/guardian consent before discontinuing, changing, or adding prescribed medication
h. Documentation of all consultations regarding changes in prescription medications
i. Documentation for all prescription medication issued by a qualified medical professional's valid order that includes the dosage to be given, and documentation of each dose given, name of the client, date and time, amount of dosage given and whether the client did or did not take the medication; and person who administered or assisted in the self-administration of the medication

G. Provide a Program Services description detailing all the services provided. Services must include but are not limited to:
i. Individual, group and family counseling.
ii. Parent/guardian education.
iii. Relapse prevention
iv. Case management/care coordination
v. Referrals services.
vi. Aftercare planning
vii. Safety planning
viii. Meets general facility requirements

III. The Crisis Center Facility must:

A. Ensure that if crisis stabilization services are co-located with other specialty mental health services (such as adult services and/or substance use services) these areas must be physically separated by locked doors and walls, so there is no co-mingling between clients, regardless of age. There must be no co-mingling between adult clients and child/youth clients allowed at any time, for any reason. Adult clients and child/youth clients must be physically separated by locked doors and walls, so there is no co-mingling between clients.

B. Meet capacity requirements:
i. YCC's must have capacity for up to eight (8) clients. The maximum number can be achieved and/or expanded in stages during implementation and as approved by the IBHP contractor.
ii. Ensure that the facility has separate resting areas for clients, based on age and other identified factors, as appropriate.

C. Have capacity that includes:
i. Lobby space with chairs and tables.
ii. Confidential office space for medical, case management, and behavioral health interventions.
iii. A triage area that is quiet and private.
iv. Spaces that are trauma informed in their design and promote privacy and dignity as well as safety.
v. Quiet space in the physical environment away from the milieu of the main stabilization area.
i. This area must be used for de-escalation and calming, not seclusion. There must be no restrictions in terms of entry and exit.
vi. A family friendly, welcoming physical space and environment for persons in crisis that offers developmentally suitable supports for clients and families.
vii. Confidential spaces for families to gather, with the client and without, where the families and/or client may receive clinical services and supports.
viii. Bathrooms that are gender neutral.
ix. Develop and maintain a policy to decrease safety risks for clients who may be alone or unsupervised in a location, such as but not limited to a bathroom. Anti-ligature equipment for these locations is required.
x. A dedicated first responder drop off area separate from the main entrance.
xi. A means of securing personal possessions including medication, valuables, clothing, etc.
xii. Client protection from potential threats to their safety by implementing a security policy and practice.
xiii. Recommendation to provide limited daily transportation to community partner places of business such as the department of Labor, Social Security Administration and Public Health department.

D. Have Available:
i. Plastic eating utensils and cups.

ii. Beverages such as water, coffee, etc.
iii. Non-perishable, self-prepared snack items such as cup of soup, granola bars, cheese and crackers, peanut butter sandwiches, pudding cups or other similar items; and
iv. Have available, on an "as needed" basis:
i. Sweatpants, scrubs, tee shirts, sweatshirts, etc.
ii. Personal care products, toiletries/toilet paper, paper towels.
iii. Bus and cab vouchers

IV. Staffing requirements must include:
A. Assessment and screenings being overseen by a Licensed Medical Professional and/or a Licensed Mental Health Professional. The professionals must have the training, skills, current professional licensure and/or certification to accurately diagnose clients.
B. All service provisions delivered by professionals who meet licensure and/or certification qualifications, as appropriate within their field of study. Evidence of licensure, certification, and any other applicable qualifications must be provided to the IBHP contractor.
C. A clinical supervisor to provide direction and guidance of all clinicians doing integrated mental health and substance use disorders assessments.
i. There must be a minimum of one (1) medical staff which could be inclusive of; Certified Nursing Assistant (CNA), Emergency Medical Technician (EMT), Licensed Practical Nurse (LPN), or Registered Nurse (RN) on site at all times. This staff can be counted as one (1) of the minimum two (2) staff on site.
ii. Required staffing ratios: One (1) direct care staff for every three (3) clients and a minimum of two (2) staff on site at all times.
iii. Ability to provide 1:1 supervision as needed.

V. Available screening/services and interventions must include:
A. Medical Screening/Assessment
i. A medical professional, as described above, assesses physical health needs, and determines any need for immediate medical treatment. The medical professional may deliver care for minor physical health challenges. The Screening/Assessment must also provide a health history.
B. Plan of Care and Services Planning
i. A plan of care based on findings from the medical screening and behavioral health assessment/CAT for each client admitted. The plan of care must be individualized, person-centered, strengths-based, collaborative, family, and community focused, culturally competent, utilize natural supports, and be outcomes based. The plan of care must be documented in the department-approved data submission platform outlined by the contractor.
ii. Depending on the age of the client, client and/or their parents or guardians must direct the development of the client's service plan through a person-centered, family driven, client guided planning process. The Contractor must ensure information and support is provided to clients and families to maximize their ability to make informed choices and decisions.
C. For each YCC client, there must be a completed and or updated CAT per admission, administered by a certified staff member. This must include intake information to develop the plan of care, intervention services and referral services. The CAT must be documented in a department-approved data submission platform.
i. CAT (Crisis Assessment Tool)

D. Referral Services
i. Based on identified functional areas of impairment (medical, vocational, financial, housing, family, social activities of daily living, transportation, legal, and substance use). This information must be documented in a department-approved data submission platform.
ii. For YCC's this includes a warm handoff to home and community-based providers working with the client discharging from the YCC. This work may include but is not limited to: scheduling appointments for the client which would include a discussion with the provider about the needs and strengths of the client and family.
E. Aftercare Plan
i. Each client, prior to leaving the Crisis Center must be provided an after-care plan which includes, at a minimum, connection to a peer or Recovery Support Specialist.
ii. This plan must be documented in a department approved data submission platform.
iii. The plan must anticipate a variety of needs associated with aftercare. Ideas include but not limited to:
i. Safety planning
ii. Primary/Peer Support
iii. Education Planning
iv. Relapse Prevention Planning
v. Continuing Treatment Planning
F. Behavioral Management
i. Have a nationally recognized behavior management system to structure prevention and intervention approaches that is approved by the department.
ii. Ensure all staff are trained in and use crisis management and intervention techniques that employ verbal de-escalation methods and non-physical intervention strategies. Ensure there is no restraint either mechanical, physical, or chemical (pharmacological) of clients by agency staff, or other clients.

G. Management/Contingency Plans
    i. For any center not meeting these minimum requirements, there must be an approved management or contingency plan in place with the IBHP contractor.
    i. A contingency plan may be put in place when the IBHP contractor deems a sufficient exception to requirements may be made without risking quality or efficacy of care.
    ii. A management plan may be put in place when the IBHP contractor determines a requirement ineligible for contingency planning.
    iii. Timelines set in a management plan for meeting requirements determined ineligible by the contractor for contingency plan may not exceed one year from the plan being signed.

Southwest District Health (SWDH) requirements:

I. Operation Services – the Contractor shall:
    A. Maintain Americans with Disabilities Act (ADA) compliance.
II. Admission and Discharge – the Contractor shall:
    A. Document in approved EHR system, the reason for denying services to those applying for services.
    B. Conduct intake eligibility assessment within a reasonable timeframe of application (no later than two (2) hours due to acuity of crisis, third-party referral, etc.) for services and must include written/signed consent, client rights/responsibilities, and information about the crisis center's grievance/complaint policy. The intake eligibility assessment shall determine if a person is in a behavioral health crisis and whether or not they require a higher level of care (e.g., inpatient, emergency room or urgent care services). The intake eligibility assessment must be documented in the approved EHR system. The intake eligibility assessment must be possible by telephone or other telehealth method whenthe client is not physically onsite.
    C. The medical assessment, risk assessment, behavioral health assessment and/or other assessments conducted by the WIYSC staff shall be documented in the approved EHR system.
III. Intervention Services – the Contractor shall:
    A. Document in approved EHR system interventions rendered and client response.
IV. Referral Services – the Contractor shall:
    A. Utilize ongoing observation, assessment and evaluation to make changes to serviceswhile at the WIYSC. This information, along with the client's benefits and resources, shall be used to make referrals to ongoing care and services.
    B. Document referrals in the approved EHR and client response.
V. Aftercare Plan – the Contractor shall:
    A. Provide each client with their written aftercare plan prior to leaving the WIYSC. The aftercare plan should include services that are accessible within seven (7) days.
    B. Attempt to identify a collateral contact for each client, and whenever possible, include the contact(s) in the aftercare plan.
    C. Develop a follow-up process and use the process to follow-up with all clients and/or collateral contact.
    D. Document clients' follow-up of their aftercare in approved EHR system and include, as applicable:
        i. Whether the client kept their initial appointment
        i. Barriers or challenges to completing the aftercare plan
        i. Sought care with a different resource or was incarcerated
VI. Staffing:
    A. Staff seeking to provide peer services that receive an unconditional denial from the Idaho Department ofHealth and Welfare's (IDHW) Criminal History Unit may apply for an Idaho Department of Health and Welfare Division of Behavioral Health Background Check Waiver.
VII. Cultural Competence:
    A. The Contractor's Cultural Competency Plan shall outline clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Native Americans' and Hispanics' needs. The Contractor shall finalize the Cultural Competency Plan and submit it no later than forty-five (45) calendar days prior to the anticipated service implementation date.

    B. The Contractor shall ensure bilingual/multicultural staff are available at the WIYSC. Bilingual/multicultural staff shall, at a minimum, speak English and Spanish and any other language spoken by at least five percent (5%) of the population within the service area.
VIII. Outcomes Measures and Data – the Contractor shall:
    A. The Contractor shall compile and report data on a weekly, month, including weekly reports to the District contract monitor, weekly monthly report-outs to the WIYSC advisory committee, and quarterly reports to the District contract monitor. See Reports section for a detailed description of data requirements, reporting formats, and timelines for completion.
IX. Community Engagement – the Contractor shall:
    A. Engage community partners with a shared goal of improving community behavioral health.
    B. Identify opportunities to form formal and informal relationships or partnerships that support the patients' broader healthcare needs.
    C. Pursue opportunities for in-kind donations or support that can help control costs associated with the operations of the crisis center.
    D. Work with SWDH contracted marketing agency to develop and implement promotional and community engagement activities.
    E. Utilize WIYSC communication templates (ex. PowerPoint, letterhead) and language such as, "The Western Idaho Community Crisis Center operated by Clarvida" on external facing communication and marketing.

X. Quality Assurance – the Contractor shall:
   A. Maintain a quality improvement plan that documents the process to be used in ensuringthe quality of services laid out in the Idaho Medicaid Crisis Center Minimum Requirements.
   B. Meet regularly, or as needed with the District, Idaho Department of Health and Welfare, Magellan Idaho, and/or county Crisis Intervention Teams to staff individual cases, treatment recommendations and service responsibilities.
   C. Distribute annual surveys via email, print, verbally, or another mechanism approved by the District to ancillary service vendors, stakeholders, hospitals, law enforcement, government entities, insurers, community-based organizations, and other organizations affiliated with the WIYSC. Questions on the survey shall address the quality of services, the outcomes of services, and the organization's perception of additional needs not addressed at the WIYSC.

XI. Records and Documentation – the Contractor shall:
   A. Use approved EHR to document all delivered services in the individual's record and maintain the record at the Contractor's location. Required data includes, but is not limited to:
      i. Results of intake, including eligibility, risk, behavioral health assessments, presenting concerns, etc.
      i. Client demographics (gender, county of residence, age, veteran status, homeless status, identified substance use, etc.)
      i. Client-identified diversion
      i. Plan of care
      i. Intervention services provided
      i. Referral sources and out-bound referrals
      i. Aftercare plan
      i. Client satisfaction
      i. Follow-up results
   B. Work with the District to develop complete and accurate reports, as some data may be collected, analyzed, and submitted by the District.

XII. Transition of Services:
   A. The Contractor shall develop a draft transition plan within first six months of agreement that describes the process for ensuring a smooth transition of project services and transfer of project materials, documentation and data either to the District or to another contractor upon termination or expiration of the contract. A list of minimum components of the plan will be provided by the District.
   B. Upon initiation of a termination, a final Transition Plan shall be negotiated with the District upon contract termination or ninety (90) calendar days prior to expiration of the contract, whichever comes first.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| YouthROC EHR- CAPLUCK (CAP60) | $22,900 | State Grant | 28-Aug-24 | 28-Aug-27 |

Subject to all terms and conditions of this Agreement, COMPANY will provide the SUBSCRIBER with the use of the Data Management System. The COMPANY CAP60 Software is the valuable, confidential, and proprietary property of COMPANY. COMPANY shall retain exclusive title to this property, and all modifications, implementations, derivative works, upgrades, productizations and subsequent releases, both during the term and after the termination of this Agreement. To the extent that SUBSCRIBER in any way contributes to the further development of the CAP60 Software, SUBSCRIBER hereby irrevocably assigns and/or agrees to assign all rights in any such contributions or further developments to COMPANY. Without limitation, SUBSCRIBER acknowledges and agrees that all patent rights, copyrights and trade secret rights in and to the CAP60 Software shall remain the exclusive property of COMPANY at all times. EXCEPT AS OTHERWISE PROVIDED IN THIS AGREEMENT, SUBSCRIBER SHALL NOT, IN WHOLE OR IN PART, AT ANY TIME DURING THE TERM OF OR AFTER THE TERMINATION OF THIS AGREEMENT: (i) SELL, ASSIGN, LEASE, DISTRIBUTE, OR OTHERWISE TRANSFER THE CAP60 SOFTWARE TO ANY THIRD PARTY; (ii) COPY OR REPRODUCE THE CAP60 SOFTWARE IN ANY MANNER; (iii) DISCLOSE THE CAP60 SOFTWARE TO ANY PARTY, EXCEPT TO SUBSCRIBER'S EMPLOYEES AND CONTRACTORS WHO REQUIRE ACCESS TO THE CAP60 SOFTWARE FOR THE PURPOSES OF THIS AGREEMENT; (iv) ALLOW ANY CONTRACTOR TO ACCESS THE CAP60 SOFTWARE OTHER THAN WITHIN SUBSCRIBER'S LOCATION; (v) MODIFY, DISASSEMBLE, DECOMPILE, REVERSE ENGINEER, ATTEMPT TO DISCOVER THE SOURCE CODE OR UNDERLYING ALGORITHMS OR TECHNOLOGY OF THE SOFTWARE OR TRANSLATE THE CAP60 SOFTWARE; (vi) USE THE SOFTWARE IN ANY SERVICE BUREAU OR TIMESHARE CAPACITY; OR (vii) ALLOW ANY PERSON OR ENTITY TO COMMIT ANY OF THE ACTIONS DESCRIBED IN (i) THROUGH (vi) ABOVE. SUBSCRIBER shall take appropriate action, by instruction, agreement, or otherwise, with respect to its employees and contractors permitted under this Agreement to have access to the CAP60 Software, to ensure that all of SUBSCRIBER's obligations under this Section shall be satisfied.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Advocates Against Family Violence- YouthROC | $210,000 | State Grant | 1-Jul-25 | 30-Jun-26 |

1. The Subgrantee must provide comprehensive case management services in accordance with the National Assessment Framework.
2. The Subgrantee must retain case managers who are competent to deliver the service consistent with the National Assessment Center Framework. No specific licensure or education is required. A Bachelor's degree in a human services field is preferred for Case Manager positions.
3. By June 30, 2025, the Subgrantee must provide services to a minimum of twenty-five
(25) youth and no more than fifty (SO) youth per month, per FTE Case Manager- not to exceed 3.25 case manager full time equivalents (FTE). Newly hired case managers may work up to the minimum of 25 youth as they complete training and gain experience.
4. The Subgrantee must follow-up with youth and families within one (1) week of the development of the Individual Care Plan, sooner if necessary, based on youth and family's needs identified during the screening and assessment process.
5. The Subgrantee must use FindHelpIdaho.org andCAP60, the Electronic Health Record system identified by the District to coordinate referrals and conduct case management services.
6. The Subgrantee must link youth and families to a variety of services based on their individual needs and what is outlined in the Individualized Care Plan. Examples of these services can be found in the Definition section of this document.
7. The Subgrantee must facilitate remote/virtual or face-to-face contacts, home visits, and accompaniment of youth and families to provider's when necessary to ensure access.
8. The Subgrantee must ensure contacting and monitoring is made to follow up and determine the status of service and support referrals and to assess whether the youth and family has further needs.
9. The Subgrantee must have policies and procedures in place to support continuous feedback and check-in opportunities with the youth and families throughout the case management process.
10. The Subgrantee must maintain communication with the Assessment Provider and report on status of activities outlined in the Individualized Care Plan and any concerns or barriers.
11. The Subgrantee must treat youth and families as partners in the case management process.
12. The Subgrantee, when possible, must collect release forms initially at intake to receive informed consent and as needed throughout the case management process.
13. The Subgrantee must remain neutral and unbiased in service and support recommendations. For example, a case manager must refer youth and families to the most appropriate place for services and support even if the case manager's organization offers the same or similar service or support.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Service Agreement with High Focus | $40,000 | Federal subgrant | 1-Jul-22 | 30-Jun-26 |
| High Focus will provide services for one year, recognized as the SWDH Fiscal Calendar, July 1-June 30, and the contract automatically renewable for additional fiscal years as required or agreed upon by SWDH and High Focus LLC to provide: I. Support and assist key SWDH personnel as needed to implement and support priorities and objectives of the Director of SWDH II. High Focus will supply direct support, training, research, and special projects. III. High Focus will operate under an agreement of task completion at a rate of $100.00 per hour. Ongoing tasks or specific requests expected to exceed 10 hours will transition to Projects with delineated scopes of work whenever practical. The Project will be assigned a pre-determined cost and High Focus will not exceed the scope of work or the actual cost without pre-approval from the Director. | | | | |

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Master Facilities Plan and Comprehensive Financial Plan | $122,500 | Federal subgrant & Board committed - Facilities | 1-Feb-25 | 31-Mar-26 |

Assist Southwest District Health (SWDH, District) leadership in determining necessary changes to facilities and services to meet the organizational and community needs.

The scope of this work includes the following services identified as needed by the District

Master Facility and Comprehensive Financial Plan:
Initiation: Project logistics, campus tours, review existing documentation, leadership summit (citizen's committee).
Analysis: Departmental and stakeholder interviews, community survey, facility & site analysis, review & confirm demographic analysis; financial, economic, and cost forecasts; operational analysis.
Testing: Functional space programing; campus and building scenarios; preliminary cost estimates; comparative evaluations.
Recommendations: Preferred scenario with funding & financing options; study documentation; present results to decision-making body; refine plans based on feedback.
Implementation: Implementation guidance; capital investment plan; comprehensive financial planning process; identify facility, service and funding gaps; provide financial strategies including bonding and other financing opportunities.
Annual updates: Review the plans for completed projects and/or analysis of projects not completed; plan for completion strategies; facilitate Advisory Committee (AC); annual rolling update to plans.
Other services to be provided as needed to complete this scope of services.
High-Level Requirements

Deliverables:
Master Facility Plan
Final Plan and report for all departments and (4) main facilities on Schedule A. to include:
Current analysis of facilities conditions
Current analysis of space needs
Community Survey
Stakeholder Summary Report
Demographic and economic Report
Forecasted analysis of conditions and space needs looking forward 20 years
Recommended plans to address current and forecasted needs: building, remodeling, adding on, maintenance, etc.

Comprehensive Financial Planning
Future forward financial report to include:
Outlining commitment needed by municipality to meet facility Plan
Recommended financial strategies to accomplish Plan

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Nampa Family Justice Center-Safe Teen Youth Assessment Center-Assessment | $50,000 | State Grant | 31-Jul-25 | 30-Jun-26 |

1. The Subgrantee must provide a location for the coordination provision of mental health and other intervention programs and services for youth and their families who are referred to the Assessment Center by governmental agencies, community partners, or by self-referral. Subgrantees may utilize virtual technologies to complete assessments; however, in-person is preferred.
2. The Subgrantee's service area shall be within the six counties served by the District; Adams, Canyon, Gem, Payette, Owyhee, and Washington. The Subgrantee must receive referrals for assessment from partner organizations. No youth and their families shall be turned away due to residing outside of the 6-county region, unless it is against the organization's policy or safety plan to serve the youth. 2. The Subgrantee's service area shall be within the six counties served by the District; Adams, Canyon, Gem, Payette, Owyhee, and Washington. The Subgrantee must receive referrals for assessment from partner organizations. No youth and their families shall be turned away due to residing outside of the 6-county region, unless it is against the organization's policy or safety plan to serve the youth.
3. The Subgrantee must adopt and implement the National Assessment Center Framework and specifically those parts relevant to the assessment process. This includes, but is not limited to, the utilization of a validated, evidence-based assessment tool in accordance with its intended design, including scoring methodology, administration protocols, and any required data systems or platforms. Adherence to the tools' established guidelines and training is essential to ensure accuracy, reliability, and fidelity of implementation.

4. The Subgrantee must provide assessments in a timely manner:
    a. When screeners flag an emergent risk (e.g., suicide risk), an assessment is provided within twenty-four (24) hours.
    b. Non-emergent assessments must be completed in no more than five (5) business days after screening.
5. The Subgrantee must conduct comprehensive assessments of the needs of the youth and their families including, but not limited to screening for violence potential, self-destructive tendencies, abuse, neglect and future criminal behavior, sexual exploitation, homelessness, risk and treatment need factors in order to inform an Individualized Care Plan. The subgrantee must demonstrate an individualized and developmental approach to assessment.
6. The Subgrantee must make prompt referrals for the youth and their families to appropriate community services based on assessment and all other pertinent information.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Nampa Family Justice Center-Safe Teen Youth Assessment Center-Case Management | $220,000 | State Grant | 31-Jul-25 | 30-June-26 |

The Subgrantee must provide comprehensive case management services in accordance with the National Assessment Framework.

1. The Subgrantee must retain case managers who are competent to deliver the service consistent with the National Assessment Center Framework. No specific licensure or education is required. A Bachelor's degree in a human services field is preferred for Case Manager positions.
2. By June 30, 2025, the Subgrantee must provide services to a minimum of twenty-five (25) youth and no more than fifty (50) youth per month, per FTE Case Manager - not to exceed 4 case manager full time equivalents (FTE). Newly hired case managers may work up to the minimum of 25 youth as they complete training and gain experience.
3. The Subgrantee must follow-up with youth and families within one (1) week of the development of the Individual Care Plan, sooner if necessary, based on youth and family's needs identified during the screening and assessment process.
4. The Subgrantee must use FindHelpIdaho.org and CAP60, the Electronic Health Record system identified by the District to coordinate referrals and conduct case management services.
5. The Subgrantee must link youth and families to a variety of services based on their individual needs and what is outlined in the Individualized Care Plan. Examples of these services can be found in the Definition section of this document.
6. The Subgrantee must facilitate remote/virtual or face-to-face contacts, home visits, and accompaniment of youth and families to provider's when necessary to ensure access.
7. The Subgrantee must ensure contacting and monitoring is made to follow up and determine the status of service and support referrals and to assess whether the youth and family has further needs.
8. The Subgrantee must have policies and procedures in place to support continuous feedback and check-in opportunities with the youth and families throughout the case management process.
9. The Subgrantee must maintain communication with the Assessment Provider and report on status of activities outlined in the Individualized Care Plan and any concerns or barriers.
10. The Subgrantee must treat youth and families as partners in the case management process.
11. The Subgrantee, when possible, must collect release forms initially at intake to receive informed consent and as needed throughout the case management process.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Nampa Family Justice Center-Safe Teen Youth Assessment Center-Assessment Services | $50,000 | State Grant | 31-Jul-25 | 30-June-26 |

**Priority Area 1: Assessment of Youth and Families**

1. The Subgrantee must provide a location for the coordination provision of mental health and other intervention programs and services for youth and their families who are referred to the Assessment Center by governmental agencies, community partners, or by self-referral. Subgrantees may utilize virtual technologies to complete assessments; however, in-person is preferred.
2. The Subgrantee's service area shall be within the six counties served by the District; Adams, Canyon, Gem, Payette, Owyhee, and Washington. The Subgrantee must receive referrals for assessment from partner organizations. No youth and their families shall be turned away due to residing outside of the 6-county region, unless it is against the organization's policy or safety plan to serve the youth.
3. The Subgrantee must adopt and implement the National Assessment Center Framework and specifically those parts relevant to the assessment process. This includes, but is not limited to, the utilization of a validated, evidence-based assessment tool in accordance with its intended design, including scoring methodology, administration protocols, and any required data systems or platforms. Adherence to the tools' established guidelines and training is essential to ensure accuracy, reliability, and fidelity of implementation.
4. The Subgrantee must provide assessments in a timely manner:
5. When screeners flag an emergent risk (e.g., suicide risk), an assessment is provided within twenty-four (24) hours.

6. Non-emergent assessments must be completed in no more than five (5) business days after screening.
7. The Subgrantee must conduct comprehensive assessments of the needs of the youth and their families including, but not limited to screening for violence potential, self-destructive tendencies, abuse, neglect and future criminal behavior, sexual exploitation, homelessness, risk and treatment need factors in order to inform an Individualized Care Plan. The subgrantee must demonstrate an individualized and developmental approach to assessment.
8. The Subgrantee must make prompt referrals for the youth and their families to appropriate community services based on assessment and all other pertinent information.
9. The Subgrantee may provide crisis intervention to include a referral to the Western Idaho Youth Support Center and the creation of a Safety Plan for youth and their families; however, the Subgrantee must complete the assessment within six hours.
10. The Subgrantee must utilize case management resources when indicated to ensure the needs of youth and families identified in the screening and assessment process are met. Referrals are to be provided consistent with best practice as incorporated into local policies and procedures.
11. The Subgrantee must demonstrate transparency in how results from assessments inform recommendations for services and supports.
12. The Subgrantee must demonstrate consistency in staff administration of assessment tools and uniformity in the organization's response.
13. The Subgrantee must demonstrate a strengths-based and youth and family-centered approach to assessment.
14. The Subgrantee must have a method to collect feedback from youth and families.
15. The Subgrantee must report on performance metrics and use FindHelpIdaho.org and CAP60, the identified universal Electronic Health Record system identified and implemented by the District as a data management system.
16. The Subgrantee must ensure that a Licensed Clinical Social Worker or Licensed Professional Counselor perform the assessment and when indicated, develop the individualized plan with youth and families.

**Priority Area 2: Infrastructure**

1. The Subgrantee must have all employees, interns, volunteers, or any other members performing work under this agreement and having direct contact with you submit to an Idaho Criminal History Unit, Criminal History and Background Check.
2. The Subgrantee must have an affirmative action plan in place in compliance with Equal Employment Opportunity.
3. The Subgrantee must comply with all privacy and confidentiality laws and regulations and protect the rights of youth and families during the assessment process.
4. The Subgrantee must participate in SWDH sponsored trainings and conference calls to ensure the fidelity of the Safe Teen Assessment Center model across the region. SWDH staff will be available to offer technical assistance and support.
5. The Subgrantee must participate in continuous quality improvement efforts consistent with the National Assessment Center Framework.
6. The Subgrantee must provide ex-officio representation on the advisory board for the program.

**Priority Area 3: Sustainability Planning**

1. The Subgrantee must provide documented proof of efforts to obtain at minimum, partial supplemental funding to continue providing Safe Teen Assessment services to clients by the end of Quarter 2.
   i. If this should include the billing of Medicaid for reimbursement of services provided, the following shall be reported to the District:
      a. Type of certification received; whether the overall organization or individual assessment providers as necessary.
      b. Information regarding the intended billing process the Subgrantee will utilize when submitting for reimbursement once approved by Medicaid.
   ii. If this should include grants, donations or other monetary offerings for the purpose of providing Safe Teen Assessment Center services, a copy of the grant application, invoice of funds received, or other proof of efforts shall be submitted to the District in a timely fashion.
      a. The District shall be notified within 30 days of receipt of any supplemental funds to ensure necessary adjustments of District awarded funds are amended.

2. The Subgrantee must participate in community outreach and promotion activities specific to the program, using YouthROC branded and approved materials.
i. The Subgrantee organization agrees to participate in a minimum of 4 outreach events within the agreement period. This number will not be duplicated if the Subgrantee offers assessment and case management services.
ii. Any materials not provided by the District must be submitted to the contract monitor for approval prior to use or distribution.

**Priority Area 4: Data Collection and Reporting**

1. Utilization of the findhelpidaho.org system for referral management to complete (at minimum) the initial referral application
2. Utilization of identified Electronic Health Record System, CAP60 to maintain client data
3. Subgrant Monitoring Report (SMR) completed in full and submitted according to the due dates listed in the "Reports" section of this agreement
4. Any additional data needs as identified by the District, IDJC or the NAC

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Idahosports.com - Youth substance use prevention social norms | $9,000 | Federal | 8Aug25 | 30Jun25 |

**I.** Player of the week program sponsorship

A. SWDH will sponsor IdahoSports.com "player of the week", in which IdahoSports.com staff selects players from all major sports (soccer, volleyball, football, etc.) each week from SWDH schools and host a poll for the "player of the week". Polls will feature schools/players from each of the 6 counties in SWDH at least once (Adams, Canyon, Gem, Payette, Owyhee, and Washington Counties).

B. Through the sponsorship of "player of the week" program, IdahoSports.com staff will integrate the SWDH developed quiz into each poll, running a minimum of every other week, as a mandatory requirement to submit a response to the poll to provide youth alcohol, marijuana, and stimulant use prevention education and to provide healthy tips and alternatives to use.

C. All polls and the results of the polls will be shared on social media, along with the social norm quiz answer.

D. Idahosports.com staff will read a script written by SWDH at 10 games in the SWDH district throughout the school year (Adams, Canyon, Gem, Payette, Owyhee, and Washington Counties)

E. IdahoSports.com staff will place a banner on each school page for the schools in the SWDH district (Adams, Canyon, Gem, Payette, Owyhee, and Washington Counties) that will link to the SWDH page for parent education on the importance of preventing youth alcohol, marijuana, and stimulant use.

**II.** Reporting

A. IdahoSports.com will submit a quarterly reach report, which will be submitted by IdahoSports.com to SWDH contract monitor at the dates listed in the REPORTS section.

| Service | Funding Amount | Funding Source | Original Effective Date | Current Expiration Date |
|---|---|---|---|---|
| Receiving training to support their ability to provide therapy, counseling, and education to youth and families in Payette and Canyon Counties | $646 | Federal | 19Aug25 | 19Sep25 |

SCOPE OF WORK

I. GENERAL REQUIREMENTS

A. This contract is funded by Federal Award Identification Number H79SP083777, Assistance Listing Number (ALN) 93.243 - SP-23-004 Strategic Prevention Framework-Partnerships for Success for Communities, Local Governments, Universities, Colleges, and Tribes/Tribal Organizations Grant awarded October 1, 2023 through September 30, 2028 by the Department of Health and Human Services through the Substance Abuse Mental Health Services Administration Center for Substance Abuse Prevention with an annual award amount of $374,455.

B. This Contract supports the District's Strategic Plan and priorities.

C. The Contractor shall provide a point of contact to the Contract Monitor. If a change in staff ing occurs during the contract timeframe, the Contractor shall notify the Contract Monitor of the change.

D. The Contractor shall receive prior written approval from the District for any deviations from the budgeted services/activities. The Contractor shall be financially responsible for costs deemed unallowable or unapproved by the Contract monitor.

E. For the general monitoring of this contract, the Contractor shall maintain and have available for review all reporting and evaluation data and information for activities, and financial data as specified in the Records and Data section of the General Terms and Conditions.

F. The Contractor shall ensure that procedural safeguards are followed in confidentiality requirements according to IDAPA 16.05.01, Use and Disclosure of District Records.

G. The Contractor shall adhere to the Federal Office of Management and Budget (OMB) Circular 2 CFR 200: Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, located at https://federalregister.gov/a/2013-30465

CONTRACT SERVICES AND ACTIVITIES

Youth serving professional development scholarship

1. Becky Wolery will attend the 2025 Idaho Stronger Together Conference September 17-19 and utilize the training to acquire prevention skills and learnings to better serve young people in the SWDH region.
2. Becky will participate in a post-event debrief activity (either an email survey or a one on one conversation) to share how skills learned will be used to support youth.
3. Becky will complete a 6-month post-survey sent via email to provide feedback on how the skills are being used to help assess the impact of the sponsorship program impact on youth.

AUGUST 19, 2025

# SWDH STANDING PURCHASE ORDERS GREATER THAN $5,000

| Board of Health Report – Standing Purchase Orders Greater Than $5,000 | | | | |
|---|---|---|---|---|
| **Vendor** | **Scope of Work** | **Funding Amount** | **Effective Date** | **Expiration Date** |
| Homedale Community Center | Reservation fee for Homedale Community Center for use by WIC | $8,400 | 1-Jul-25 | 30-Jun-26 |
| ACCO Engineered | HVAC/Cooling Caldwell | $20,000 | 1-Jul-25 | 30-Jun-26 |
| Mike's Grading | Snow removal and winter maintenance | $ 25,000 | 1-Jul-25 | 30-Jun-26 |
| NEHA | NEHA test grading | $5,000 | 1-Jul-25 | 30-Jun-26 |
| Costco | Diapers and wipes | $7,962 | 1-Jul-25 | 30-Jun-26 |
| NEHA | English food books (quantity 2500), Spanish books (quantity 2500) | $5,000 | 1-Jul-25 | 30-Jun-26 |
| Mike Kane | Legal advice/assistance | $18,000 | 1-Jul-25 | 30-Jun-26 |
| Bruneel Point S | Oil changes and vehicle maintenance | $5,000 | 1-Jul-25 | 30-Jun-26 |
| Payette Lawn Care | Payette and Weiser office lawn maintenance and snow removal | $6,800 | 1-Jul-25 | 30-Jun-26 |
| U.S. Lawns of Boise | Caldwell landscape and maintenance | $30,000 | 1-Jul-25 | 30-Jun-26 |
| CompuNet | Microsoft 365 licensing, phones, devices, monthly fees | $90,915 | 1-Jul-25 | 30-Jun-26 |
| Next Level Mobile Oil Change | Mobile oil change services | $5,000 | 1-Jul-25 | 30-Jun-26 |
| Intelligent Design Mechanical | HVAC and plumbing services | $15,000 | 1-Jul-25 | 30-Jun-26 |

## 25 – 0# Resolution to Support Provision of Clinical Services by Local Public Health Districts

**WHEREAS**, Idaho continues to experience a critical shortage of healthcare providers, with 98.7% of Idaho being designated a Health Professional Shortage Area for primary care, 100% for Mental Health, and 95% for Dental Health, and Idaho ranks 50th in the United States[1] for the number of active physicians, which results in significant challenges for Idaho residents in accessing preventive, acute, and chronic healthcare; and

**WHEREAS**, rural communities are much more likely to experience challenges to access to care; and

**WHEREAS**, delaying preventive and chronic healthcare due to limited access may result in costly and debilitating outcomes for those individuals[2], and place undue stress on critical access hospital resources; and

**WHEREAS**, Federally Qualified Health Centers are an important piece of the healthcare landscape in Idaho, but do not have locations in all counties as local public health districts do; and

**WHEREAS**, Public Health Districts (PHDs) operate at the county or multi-county level to tailor public health programs—such as immunizations, disease surveillance, health education, and environmental health—to the unique needs of their jurisdictions; and

**WHEREAS**, Public Health Districts (PHDs) play a specialized and critical role in communicable disease control—providing services such as TB screening, treatment, and prophylaxis; animal bite and rabies exposure investigations and prophylaxis; and HIV-related prevention efforts including testing, PEP and PrEP navigation; and

**WHEREAS**, these services address nuanced and time-sensitive public health needs that complement the comprehensive primary care provided by Federally Qualified Health Centers (FQHCs), ensuring residents have access to both preventive and highly targeted interventions without service overlap; and

**WHEREAS**, 312,939 Idahoans are insured through Medicaid[3], with significant changes to Medicaid coverage anticipated in the coming months which will remove thousands of people from coverage; and

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[1] Idaho Division of Public Health, Bureau of Rural Health & Primary Care Brief (January 2023). Rural_Health_&_Primary_Care_Brief_2023

[2] Findling, M.G., Blendon, R.J., & Benson, J. M. Delayed care with harmful health consequences; reported experiences form national surveys during coronavirus disease 2019. *Journal of American Medical Association*, Vol. 1, No. 12 (December 14, 2020).

[3] 2025 Idaho Medicaid Overview

**WHEREAS**, county medical indigency funds and the State Catastrophic Health Fund were eliminated by H316, which passed the Idaho Legislature in 2021; and

**WHEREAS**, it is a national and state safety and readiness issue to ensure that trained public health professionals are available and ready to respond to natural disasters, communicable disease outbreaks, and terrorist events;

**THEREFORE, BE IT RESOLVED**, that the Idaho Association of Local Boards of Health supports local public health districts continuing to provide clinical services in Idaho.