Board of Health Meeting
Tuesday, April 28, 2026
13307 Miami Lane, Caldwell, ID 83607

Public comments specific to an agenda item for the April 28, 2026 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, April 27, 2026. 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	
9:03		Roll Call	Chairman Kelly Aberasturi
9:05	A	Call for changes to agenda; vote to approve agenda	Chairman Kelly Aberasturi
9:07		In-person public comment	
9:10	I	Introduction of new employees	Division Administrators
9:15	I	Approval of March 24, 2026 Board of Health meeting minutes	Chairman Aberasturi
9:25	I	March 2026 Monthly Expenditure and Revenue Report	Michele Hanrahan
9:35	I	Contract Services and Grant Applications	Don Lee
9:40	A	Vehicle Lease Approval	Don Lee
9:45	A	Septic Permit and Accessory Fees	Ben Shatto
9:50	A	Employee Compensation Request	Jody Waddy
10:00	A	County Contribution Request	Nikki Zogg, Michele Hanrahan
10:10	A	Fiscal Year 2027 Budget Proposal Review and Approval	Nikki Zogg, Michele Hanrahan
10:30		Break	
10:45	I	Master Facility Plan Review and Discussion	Clearwater Financial Staff
11:30	I	Executive Council Update	Commissioner Jennifer Riebe, Nikki Zogg
11:40	I	Director's Report	
		• Director approved agreements, contracts, and subgrants	
		• Budget Committee proxy forms	
		• Solid waste nuisance	
		• Director performance and compensation	
		• Integrated Community Mobile Care	
		• Subsurface sewage staffing update	
		• Board of Health member term expiration	
		○ Commissioner Viki Purdy	
11:50	I	Future agenda items	
11:55		Executive Session pursuant to Idaho Code 74-206(b)	
11:57	A	Action taken pursuant to Executive Session	
12:00	I	Adjourn	

NEXT MEETING: Tuesday, May 19, 2026 – 9:15 a.m. (after the FY27 Budget Committee Meeting)

BOARD OF HEALTH MEETING MINUTES
Tuesday, March 24, 2026

BOARD MEMBERS:
Jennifer Riebe, Commissioner, Payette County – present
Jim Harberd, Commissioner, Washington County – not 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 via Microsoft Teams
Kirk Wille, Commissioner, Gem County – present

STAFF MEMBERS:
In person: Nikki Zogg, Katrina Harshman, Don Lee, Beth Kriete, Ben Shatto, Michele Hanrahan, Jody Waddy, Wendy Young, Cas Adams

Virtual: Colton Osborne

GUESTS: Ashley Lynn

CALL THE MEETING TO ORDER
Chairman Kelly Aberasturi called the meeting to order at 10:02 a.m.

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

REQUEST FOR ADDITIONAL AGENDA ITEMS AND APPROVAL OF AGENDA
Chairman Kelly Aberasturi asked for additional agenda items. Nikki asked to amend the agenda to move the Executive Council Update earlier in the agenda. Board members had no additional agenda items or changes to the agenda.

MOTION: Commissioner Riebe made a motion to approve the agenda as amended. Commissioner Brooks 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
No new employees were introduced.

DRAFT

EXECUTIVE SESSION PURSUANT TO IDAHO CODE 74-206(b)
Pursuant to Idaho Code 74-206(b) Board members entered Executive Session at 10:08 a.m. Commissioner Wille made a motion to go into executive session. Commissioner Riebe seconded the motion. Roll call taken.

At 10:32 a.m., board members came out of executive session.

ACTION TAKEN AS A RESULT OF EXECUTIVE SESSION
No action taken as a result of the Executive Session.

FISCAL YEAR 2027 BUDGET WORKSHOP

Division Presentations

Family and Clinic Services
Beth Kriete, Family and Clinic Services (FCS) Division Administrator, shared a few of her team's efforts. The FCS team is working to shuffle personnel to adjust to the upcoming decrease in home visiting funds. Clinic efforts are focusing on Weiser to improve utilization of services. Beth also explained that the YouthROC program will be sunsetting.

Another highlight from FCS is that the Pre-Prosecution Diversion (PPD) program will continue with the support of the Canyon County Prosecuting Attorney.

Environmental and Community Health Services
Ben Shatto, Environmental and Community Health Services (ECHS) Division Administrator, shared highlights from his teams. The Community Health team continues to stay busy with programs such as Fit and Fall Proof. Food inspections are likely to change based on legislation around cottage foods. Childcare inspections continue to go well. Ben shared that as part of the Memorandum of Agreement between SWDH and the City of Nampa, 38 pools within city limits have been inspected and those inspections are going quite well.

The subsurface sewage program remains busy. Land development and subdivision work has slowed over the last four to five years. That slowing is sometimes a leading indicator to an economic slowdown. The team will see how this affects team members' workloads.

The responsibility for solid waste inspections has transitioned back to Department of Environmental Quality (DEQ). Rather than contract with health districts for this service, DEQ will be looking to hire one supervisor and two inspectors to manage the state's solid waste inspections.

Ben reported that the PHEPER (Public Health Emergency Preparedness and Epidemiological Response) program continues to go well. A forecasting model has been successfully developed and implemented for use to let schools know about anticipated risk during respiratory illness season. Infection rates for Idaho's reportable diseases are also available on an online dashboard.

Lastly, Ben shared that he anticipates bringing back a request to the Board of Health members to approve a revised fee request to adjust the septic fee. Currently, the fee is at $950 for a septic permit.

District Operations
Don Lee, Chief Operating Officer, provided a report on District Operations. The team provides finance and accounting, human resources, I.T., facility maintenance and building safety functions, data tracking, and organizational/workforce development services and support. These teams are working to increase efficiency and lower costs. Don provided three examples of this:

- Migrating to SWDH Adobe
- Fleet tracking software – Samsara
- Moving to modules in Luma allowing quicker routing and allows for less paper copies

Don also shared about efforts to minimize costs while maintaining the district's vehicle fleet. The leasing agency has provided updated numbers and leasing appears more advantageous.

Subgrants and Contracts Forecast
Nikki Zogg, District Director, shared a forecast of FY27 subgrants and contracts. There continues to be some talk at the national level regarding future shifts around whole health and nutrition. No funding opportunities around those new priorities have been identified yet. Staff continue to look for funding opportunities that align with our current strategic goals.

Fiscal Year 2027 Budget Proposal
The total budget request for FY27 is $16,071,931 representing a 6.34% decrease from prior fiscal year. The SWDH employer share of health insurance premiums is expected to increase by $1,400 per employee.

Michele shared a summary of revenues and expenditures and showed the trend over the last three years. She reminded Board members that statutorily 70% of county contributions are based on population and 30% are based on market taxable value. Updated population numbers will be available before the Board of Health meeting in April and those updated pieces of the formula will impact the calculations slightly.

Michele explained the table showing anticipated county contributions for FY27 does not reflect a moratorium that Board of Health members approved to prevent any increase in county contributions for the next two years.

Nikki shared a chart that she developed at the request of the IAC public health workgroup and included it for board member awareness. The chart was developed to attempt to capture the dollar amount going into each county in the health district relevant to the county contributions.

Nikki asked for board member feedback and will bring this proposal for approval at next month's meeting. She asked for board member feedback on what to present differently.

Commissioner Wille stated it would be helpful to understand which departments are using district funds and which are self-sufficient.

Employee Compensation Plan
Jody Waddy, Human Resources Manager, shared changes to the FY27 compensation plan. Most changes add clarifying statements. Jody highlighted the longevity recognition plan to add the 10, 15, 20, and 25-year longevity recognition awards. She also shared a proposal to change the holidays SWDH observes to remove President's Day and Columbus Day as paid holidays and instead add the day after Thanksgiving and the day before Christmas as paid holidays. SWDH is currently closed for both President's Day and Columbus Day. Jody pointed out that the suggestion for which two holidays to swap out is based on research showing that businesses in the private sector are more likely to be open on President's Day and Columbus Day.

Jody asked for approval of the compensation plan with changes as presented as well as approval of a change in holidays the District observes. She noted that if board members approve this plan the implementation will be only partial for calendar year 2026 as President's Day has already been observed as a paid holiday. She proposed that for this year, calendar year 2026, SWDH offices remain open on Columbus Day and close the day after Thanksgiving.

MOTION: Commissioner Riebe made a motion to approve the employee compensation plan as presented with the change in holidays observed to remove President's Day and Columbus Day as paid holidays and instead observe the day after Thanksgiving and day before Christmas as presented. Commissioner Wille seconded the motion. All in favor; motion passes.

Opioid Settlement Fund Spending Plan
Don Lee, COO, shared an overview of opioid settlement funds received and expended as well as planned expenditures for Fiscal Year 2027.

MOTION: Commissioner Riebe made a motion to approve the $320,000 in planned expenditures as presented in the Fiscal Year 2027 Opioid Settlement Fund Spending Plan. Commissioner Purdy seconded the motion. All in favor; motion passes.

Board members asked for a review of options for a higher interest rate yield for the opioid settlement funds. Michele indicated that currently, the opioid settlement funds are earning 3.796%.

EXECUTIVE COUNCIL UPDATE
Nikki summarized several changes in legislation that impact public health including cottage foods and parental consent regarding emergency care or crimes against children when medical care can be provided without consent. There is also a new bill around kratom consumer protection that creates a standard age to not be able to purchase natural kratom until age 21 and bans any adulterated kratom.

Also, Senate Bill 1314 eliminated the state Board of Health and Regional Behavioral Health Boards by removing those sections of Code.

APPROVAL OF FEBRUARY, 24, 2026 BOARD OF HEALTH MEETING MINUTES
Board members reviewed meeting minutes from the February 24, 2026 Board of Health meeting. No changes suggested.

MOTION: Commissioner Riebe made a motion to approve the February 24, 2026 Board of Health meeting minutes as presented. Commissioner Wille seconded the motion. All in favor; motion passes.

FEBRUARY 2026 MONTHLY EXPENDITURE AND REVENUE REPORT

Michele Hanrahan shared the February 2026 monthly expenditure and revenue report. Michele shared detail about the year-to-date program revenue. Overall, we are at 64.35% of budget revenue collected which is very close to the target for this point in the fiscal year. Currently, budgeted expenditures are at 63.74% which is also very close to target.

COMMUNITY PARAMEDICS PROGRAM OVERVIEW

Wendy Young, SWDH Program Manager, and Ashley Lynn, Washington County Community Paramedic, shared an overview of Washington County's Community Paramedics Program. The program is funded through a 5-year SAMHSA (Substance Abuse and Mental Health Services Administration) grant that began in September 2023 and runs through September 2028. The grant's purpose is to divert youth and adults with behavioral health needs from the criminal justice system. Wendy explained that the purpose of community paramedicine is to reduce unnecessary emergency department (ED) visits, hospital admissions, and justice system involvement.

Ashley Lynn was hired in October 2024 and began training to create a CIT (crisis intervention team) collaborative, providing consultations with law enforcement and seeing patients. She explained she serves as a resource to identify how to best help a patient. She can provide mental health crisis support, substance use disorder support, connections to counseling services or telehealth/medical services and family education on crisis response steps and warning signs.

DIRECTOR'S REPORT

Director approved agreements, contracts, and subgrants

Summary pages for grants, contracts, agreements, and subgrants are included in the meeting packet. Any questions can be directed to Nikki.

Retirement of Central District Health District Director

Russ Duke, Central District Health District Director, has announced his retirement effective the first part of July 2026.

Adjournment

There being no further business, the meeting adjourned at 12:58 p.m.

Respectfully submitted: Approved as written:

Nikole Zogg
Secretary to the Board

Kelly Aberasturi
Chairman

Date:

SOUTHWEST DISTRICT HEALTH

REVENUES & EXPENDITURE REPORT FOR FY2026

Modified Accrual Basis

March-26

Target **75.00%**

Fund Balances	FY Beginning	Mar 2026 Ending
General Operating Fund	$1,355,402	$732,774
LGIP Operating	$5,650,546	$5,869,126
LGIP Vehicle Replacement	$113,809	$117,389
LGIP Capital	$1,299,174	$1,299,174
Total	**$8,418,931**	**$8,018,462**

Income Statement Information	YTD	Month
Net Revenue:	**$11,515,377**	**$1,130,232**
Expenditures:	($11,641,715)	($1,208,914)
Net Income:	**($126,339)**	**($78,683)**

Revenue

	County Conributions	Fees	Subgrant/Grant/ Contract Revenue	Sale of Assets	Interest	Other	Monthly Total	YTD	Total Budget	Percent Budget to Actual
Administration & BoH	-$272,212.12	-$204,400.00	-$26,218.51		-$72,624.24		-$575,454.87	-$3,155,695.95	$4,181,624.48	75.47%
District Operations Div			$23,316.68			-$42.00	$23,274.68	$21,217.88	$0.00	
FCS										
Medical Clinic		-$20,992.19					-$20,992.19	-$171,776.19	$184,000.00	93.36%
Immunizations		-$6,640.57	-$2,871.10				-$9,511.67	-$158,157.84	$163,612.00	96.67%
HIV/STI/DIS Prevention			-$14,261.27				-$14,261.27	-$68,178.06	$118,750.00	57.41%
Women's Health Check		-$167.36	-$1,565.78				-$1,733.14	-$12,095.78	$22,560.00	53.62%
Oral Health		-$4,526.19					-$4,526.19	-$71,307.88	$70,784.60	100.74%
Nurse Family Partnership		-$18,279.36	-$30,686.69				-$48,966.05	-$507,180.01	$593,351.59	85.48%
Parents as Teachers		-$18,729.36	-$25,908.06				-$44,637.42	-$445,524.29	$491,970.41	90.56%
Behavioral Health Admin		-$4,634.06					-$4,634.06	-$58,480.25	$89,305.50	65.48%
WIC			-$138,306.52				-$138,306.52	-$811,286.75	$1,338,109.00	60.63%
Adult Crisis Center							$0.00	-$1,000,000.00	$1,847,098.00	54.14%
Youth Crisis Center							$0.00	-$1,000,000.00	$1,648,488.66	60.66%
YouthROC							$0.00	-$245,325.64	$602,960.64	40.69%
Pre-Prosecution Diversion			-$28,194.68				-$28,194.68	-$355,831.51	$379,514.57	93.76%
Other FCS							$0.00	-$250,487.53	$512,459.20	48.88%
ECHS										
Fit & Fall Proof			-$8,612.16				-$8,612.16	-$68,302.08	$99,589.96	68.58%
Prescription Drug Overdose			-$8,098.13				-$8,098.13	-$98,881.14	$112,174.31	88.15%
Suicide Prevention							$0.00	-$49,083.24	$45,000.00	109.07%
Millennium-Tobacco							$0.00	-$350,565.79	$377,473.21	92.87%
Partnership for Success/SAMSHA							$0.00	-$410,101.83	$570,542.34	71.88%
Food Programs		-$6,654.00					-$6,654.00	-$284,205.00	$346,499.92	82.02%
Child Care Inspections		-$1,400.00	-$8,241.27				-$9,641.27	-$117,239.35	$142,284.00	82.40%
Land Programs		-$118,242.00	-$11,123.15				-$129,365.15	-$972,694.93	$1,181,780.00	82.31%
Epi Investigations			-$26,473.38				-$26,473.38	-$240,680.05	$226,381.00	106.32%
Public Health Preparedness			-$45,053.42				-$45,053.42	-$281,255.62	$554,339.00	50.74%
WICHC							$0.00	-$40,000.00	$50,000.00	80.00%
Other ECHS		-$491.00	-$26,299.72			-$1,600.00	-$28,390.72	-$312,257.93	$415,987.68	75.06%
Monthly Revenue	**-$272,212.12**	**-$405,156.09**	**-$378,597.16**	**$0.00**	**-$72,624.24**	**-$1,642.00**	**-$1,130,231.61**			
						Year-to-Date Revenue		**-$11,515,376.76**	**$16,366,640.07**	**70.36%**

SOUTHWEST DISTRICT HEALTH

REVENUES & EXPENDITURE REPORT FOR FY2026

Modified Accrual Basis

March-26

Target **75.00%**

EXPENDITURES

	Personnel	Operating	Capital	T/B	Monthly Total	YTD	Total Budget	Percent Budget to Actual
Administration & BoH	$44,378.63	$99,776.31			$144,154.94	$743,800.03	$838,217	88.74%
District Operations Div (and blanks-unidentified programs)	$96,401.78	-$11,056.91			$85,344.87	$1,680,420.30	$2,619,144	64.16%
FCS								
Medical Clinic	$43,723.72	$22,623.47			$66,347.19	$517,802.90	$787,895	65.72%
Immunizations	$11,996.91	$16,422.32			$28,419.23	$233,909.95	$309,814	75.50%
HIV/STI/DIS Prevention	$10,727.33	$2,036.01			$12,763.34	$88,533.26	$112,190	78.91%
Women's Health Check	$260.30	$496.48			$756.78	$6,096.79	$21,006	29.02%
Oral Health	$6,963.68	$583.24			$7,546.92	$78,298.54	$128,345	61.01%
Nurse Family Partnership	$41,474.73	$2,729.23			$44,203.96	$441,212.63	$599,162	73.64%
Parents as Teachers	$32,968.93	$3,103.91			$36,072.84	$365,227.48	$467,053	78.20%
Behavioral Health Admin	$7,583.91	$9.68			$7,593.59	$62,299.82	$106,259	58.63%
WIC	$92,830.84	$9,143.74			$101,974.58	$1,060,930.48	$1,538,331	68.97%
Adult Crisis Center	$1,415.75	$135,486.14			$136,901.89	$1,263,716.59	$1,838,647	68.73%
Youth Crisis Center		$144,835.00			$144,835.00	$1,245,062.70	$1,653,803	75.28%
YouthROC	$4,151.94	$67.12		$51,260.17	$55,479.23	$413,753.47	$572,939	72.22%
Pre-Prosecution Diversion	$11,829.72	$315.24			$12,144.96	$168,314.44	$306,759	54.87%
Other FCS	$18,758.70	$1,735.21		$6,198.17	$26,692.08	$324,425.75	$460,862	70.40%
ECHS								
Fit & Fall Proof	$6,176.75	$321.20			$6,497.95	$66,314.58	$79,347	83.58%
Prescription Drug Overdose	$6,489.78	$42.23			$6,532.01	$64,375.66	$88,659	72.61%
Suicide Prevention	$4,923.24	$1,183.93			$6,107.17	$51,806.56	$90,637	57.16%
Millennium-Tobacco	$20,642.70	$2,662.97			$23,305.67	$221,270.73	$293,082	75.50%
Partnership for Success	$14,611.26	$240.43		$3,210.83	$18,062.52	$278,685.68	$360,562	77.29%
Food Programs	$50,583.45	$3,163.78			$53,747.23	$526,449.58	$670,190	78.55%
Child Care Inspections	$6,961.79	$271.76			$7,233.55	$75,218.85	$166,169	45.27%
Land Programs	$63,536.94	$5,816.24			$69,353.18	$681,537.33	$961,388	70.89%
Epi Investigations	$9,519.90	$5,319.23			$14,839.13	$201,863.69	$245,852	82.11%
Public Health Preparedness	$33,152.02	$4,449.61	$2,370.08		$39,971.71	$319,119.18	$467,040	68.33%
WICHC	$6,599.84	$3,996.20			$10,596.04	$103,712.59	$106,439	97.44%
Other ECHS	$36,841.60	$4,595.22			$41,436.82	$357,555.84	$476,851	74.98%
Monthly Expenditures	**$685,506.14**	**$460,368.99**	**$2,370.08**	**$60,669.17**	**$1,208,914.38**			
				Year-to-Date Expenditures		**$11,641,715.40**	**$16,366,640.07**	**71.13%**

CONTRACT SERVICES AND GRANT APPLICATIONS

Date	Program Applying	Grant	Funder	Amount Requested	Duration	Purpose	Status
4/21/2026	BH	OJJDP FY25 Family-Based Alternative Justice	OJJDP	$250,000/year	3 years	Using home visiting in pre-trial or pre-sentence diversion	in Process
Pending							
11/25/2025	BH, PAT, NFP	Pacific Source	Pacific Source	$50,000	1 year	Focus on maternal/child health and access to care for home visiting programs	Submit this week
3/11/2026	ECH	Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) for Primary Prevention Programs	SAMHSA	$50,000	1 YEAR	Providing Guiding Good Choices to parents at 5 schools in the District.	Submitted
3/4/2026	PAT NFP NEW	Cambria Health Foundation	Cambria Foundation	$50,000	1 year	Home visiting: we are waiting for new RFP	
3/3/2026	BH	Implementing Zero Suicide in Health Systems	SAMHSA	$1,060,500	year 5 years	Implement Zero Suicide in the District	Submitted
3/4/2026	ECH Aging NEW	Cambria Health Foundation HEALTHY AGING	Cambria Foundation	$50,000	2 years	Support for Fit and Fall prevention	Submitted

PROPOSED EH FEES
(April 2026)

Food Protection Program

Service Description	Cost to Provide Service	Current Fee	Date Fee was implemented	Proposed New Fee
Temporary 1 day event	These fees are set in statute. In FY23 the cost to the run the program was approx. $595,724 and the fees limited revenue to approx. $263,770	$ 35.00	2018	
Temporary 2-3 day event		$ 45.00	2018	
Temporary 4 or more days/Multiple		$ 80.00	2018	
Food License - Intermittent		$ 80.00	2018	
Food License - Mobile without Commissary		$ 80.00	2018	
Food License - Mobile with Commissary		$ 100.00	2018	
Food Establishments		$ 200.00	2018	
Food Establishments With More Than Two Licenses		$ 250.00	2018	
Plan Review and Pre-Opening Inspection		$ 100.00	2018	
Late Fee, from January 1st through January 15th		$ 35.00	2018	
Late Fee, after January 16th		$ 70.00	2018	
Request for Variance		$50/hr	2018	
Compliance Conference		$100/hr	2018	
License Re-Instatement		$ 18.00	2018	
Enforcement and Legal Fees		$150/hr	2018	
Food Class Fee		$ 35.00	2018	
Food Plan Review		$ 100.00	2018	
Federal USDA School Inspection		$ 267.00	2018	
Food Safety Manager Training		$ 125.00	2018	
Food Safety Manager Proctor Test		$ 50.00	2018	

Child Care Inspections

Service Description	Cost to Provide Service	Current Fee	Date Fee was implemented	Proposed New Fee
Licensing Fee - Center (more than 25 children)	Fees are set in contract with Dept. of Health and Welfare	$ 325.00	2022	
Licensing Fee - Center (13-25 children)		$ 250.00	2022	
Licensing Fee - Group (7-12 children)		$ 100.00	2022	
Licensing Fee - Family (Voluntary)		$ 100.00	2022	

Swimming Pools

Service Description	Cost to Provide Service	Current Fee	Date Fee was implemented	Proposed New Fee
Inspection (per Administrative Procedures Act)	Set in statute	$ 50.00	~2002	
Plan Review		$ 100.00	~2002	

Drinking Water Sample Collection				
Service Description	**Cost to Provide Service**	**Current Fee**	**Date Fee was implemented**	**Proposed New Fee**
Courier Service	$ 22.19	$10 per water sample drop off	2023	
Drinking Water Sample Collection	$ 241.14	$ 100.00	pre-2020	
Subsurface Sewage Disposal Program				
Service Description	**Cost to Provide Service**	**Current Fee**	**Date Fee was implemented**	**Proposed New Fee**
Installer License - Basic	$ 166.57	$ 130.00	pre-2020	$ 165.00
Installer License - Complex	$ 219.28	$ 195.00	pre-2020	$ 219.00
Installer Late Fee - After December 31 (Per Month)	$ 21.37	$25 per month; maximum of $100	pre-2020	$ -
Accessory Use - Office Review	$ 112.65	$ 75.00	pre-2020	$ 90.00
Accessory Use - Field Review	$ 260.32	$ 150.00	pre-2020	$ 200.00
Individual System Permit - New	$ 1,081.95	$ 950.00	pre-2020	$ 1,075.00
Individual System Permit - Replacement/Repair	$ 1,081.95	$ 950.00	pre-2020	$ 1,075.00
Central/LSAS - New		$1,000 + $100 per 250 gpd	pre-2020	$ -
EH Consulting Fee - Per hour	$ 83.74	$ 72.00	2022	$ 82.00
EH Consulting Fee - Onsite (Travel)	$ 122.75	$ -	2024	$ -
Site Evaluation Charge (Single Family Dwelling - Fee to apply toward an indivdiual system permit if application is made within two years)	$ 723.71	$ 550.00	pre-2020	$ -
Tank Only & Vault Privy	$ 566.60	$ 450.00	pre-2020	$ -
Permit Renewal Charge		$ 100.00	pre-2020	$ -
Technical Guidance Manual	$ 55.00	$ 25.00	pre-2020	$ -
Installer - Basic & Complex, Video Review		$ 30.00	pre-2020	$ -
Pumper License Permit Fee (Includes 1 truck or tank)	$ 173.12	$ 150.00	pre-2020	$ -
Pumper License Fee for each additional truck or tank		$ 30.00	pre-2020	$ -
Convienience fee of $75 for on-site pumper truck inspection	$ 107.75	$ 100.00	pre-2020	$ -
Administration Fee per Policy 3-003	$ 66.23	$ 50.00	pre-2020	$ -
Land Development				
Service Description	**Cost to Provide Service**	**Current Fee**	**Date Fee was implemented**	**Proposed New Fee**

Pre Development Meeting (Fee to apply toward SER application if within 12-months of pre-development meeting)	$ 155.97	$ 150.00	pre-2020	$ -
Pre-development site evaluation for commercial or engineered lots (includes multiple test holes and evaluation results) This is to review or assess multiple lots or parcels that will be split or developed into a subdivision. This will include up to eight test holes on one application and will allow for on-site review of the land and development proposal before the applicant actually purchases the property.	$ 826.80	$ 800.00	2021	$ -
Subdivision Application - Served by Septic and/or Individual Wells	$ 355.25	$ 300.00	pre-2020	$ 330.00
Each Lot - Served by Septic and/or Individual Wells	$ 355.25	$ 350.00	pre-2020	$ 330.00
Re-Engineering Fee	$ 333.72	$ -	2027	$ 330.00
Plat Resign w/o review	$ 111.53	$ 50.00	pre-2020	$ -
Plat Resign with site review	$ 111.53	$ 100.00	pre-2020	$ -
Subdivision Application - City Services (Requires DEQ Approval)	$ 165.36	$ 150.00	pre-2020	$ -
Subdivision Application - Served by LSAS	$ 321.24	$150 per lot	pre-2020	$ 200.00
Subdivision Application - Cemetery	$ 225.38	$ 100.00	pre-2020	$ 200.00

Solid Waste Services

Service Description	Cost to Provide Service	Current Fee	Date Fee was implemented	Proposed New Fee
Adams County	$ 2,246.95	$ 1,692.00	2023	$ -
Canyon County	$ 1,731.78	$ 1,295.00	2023	$ -
Gem County	$ 1,380.68	$ 1,036.00	2023	$ -
Payette County	$ 1,639.23	$ 1,234.00	2023	$ -
Washington County	$ 1,444.70	$ 1,103.00	2023	$ -
Timber Creek (Nampa)	$ 725.63	$ 580.00	2025	$ -
City of Nampa	$ 449.77	$ 580.00	2023	$ -
Republic Service (Homedale)	$ 754.50	$ 384.00	2023	$ -
Vision Recycling (Nampa)	$ 725.28	$ 580.00	2023	$ -
Owyhee County	$ 1,501.38	$ 1,146.00	2023	$ -

**Solid Waste Inspections handled directly by DEQ effective July 1, 2026

Request for Change in Employee Compensation (CEC) – FY2027

Southwest District Health (SWDH) is requesting a compensation adjustment consisting of a $0.25 flat increase and a 2.25% cost-of-living adjustment (COLA) for all active employees hired as of June 6, 2026, and who are not on a performance improvement plan.

The intent of the $0.25 flat increase is to provide proportionally greater support to lower wage earners across the district. The additional 2.25% COLA allows for consistency across the workforce while recognizing ongoing cost of living pressures.

When combined, the $0.25 flat increase and the 2.25% COLA result in an average overall wage increase of approximately **2.6%** district wide, with individual increases varying slightly based on current pay rates. This approach balances equity and sustainability while supporting retention and workforce stability across SWDH.

The Board is being asked to approve implementing this adjustment beginning with the June 7, 2026, pay period, aligning the effective pay date with the start of FY2027 on July 1. The estimated cost of the average 2.6% increase for FY2027 is approximately $235,655.48.

If funding supports earlier application, SWDH further requests approval to implement the adjustment early on May 11, 2026. The estimated cost of early implementation is approximately an additional $18,200.00.

SWDH leadership recommends a COLA rather than a merit increase for FY2027 in recognition of where the organization and workforce are currently positioned. Performance ratings continue to cluster at the high end, and the available budget does not support meaningful differentiation in a way that would feel fair or motivating to employees. In this context, a merit-based approach would result in only minimal differences between rating levels, offering little practical recognition. A COLA allows SWDH to provide consistent, transparent wage support across the workforce while continuing to invest in the growth and refinement of the performance evaluation system so that it can more clearly support development, engagement, and differentiation over time.

Summary of Rationale

- Performance ratings remain clustered at the high end under the newer evaluation system.
- Available funding does not support meaningful merit differentiation.
- A COLA provides a fair and consistent approach while the system continues to mature.

Justification

- With a highly performing workforce and a 3% salary increase budget, differences between merit tiers would amount to only tenths of a percent, which is too small to create meaningful or motivating differentiation.

Presented to the Board of Health on April 28, 2026.

- U.S. inflation is holding at 2.4% and food prices are projected to rise about 3.1% in 2026, meaning costs are stabilizing but not decreasing.
- Market data indicates that most employers are planning overall salary increases in the 3% to 3.5% range for 2026, keeping a 2.6% COLA competitive for attraction and retention.
- Turnover costs organizations at least $36,000 per year on average and can exceed $100,000 depending on the position, making predictable pay adjustments an important retention tool.
- The average cost to hire is about $4,700 and training a new employee averages $874 - $10,000 per person depending on the specialized nature of the position, not including lost productivity.
- A 2.6% COLA helps employees maintain purchasing power in a cost-of-living environment where inflation and food costs continue to rise.

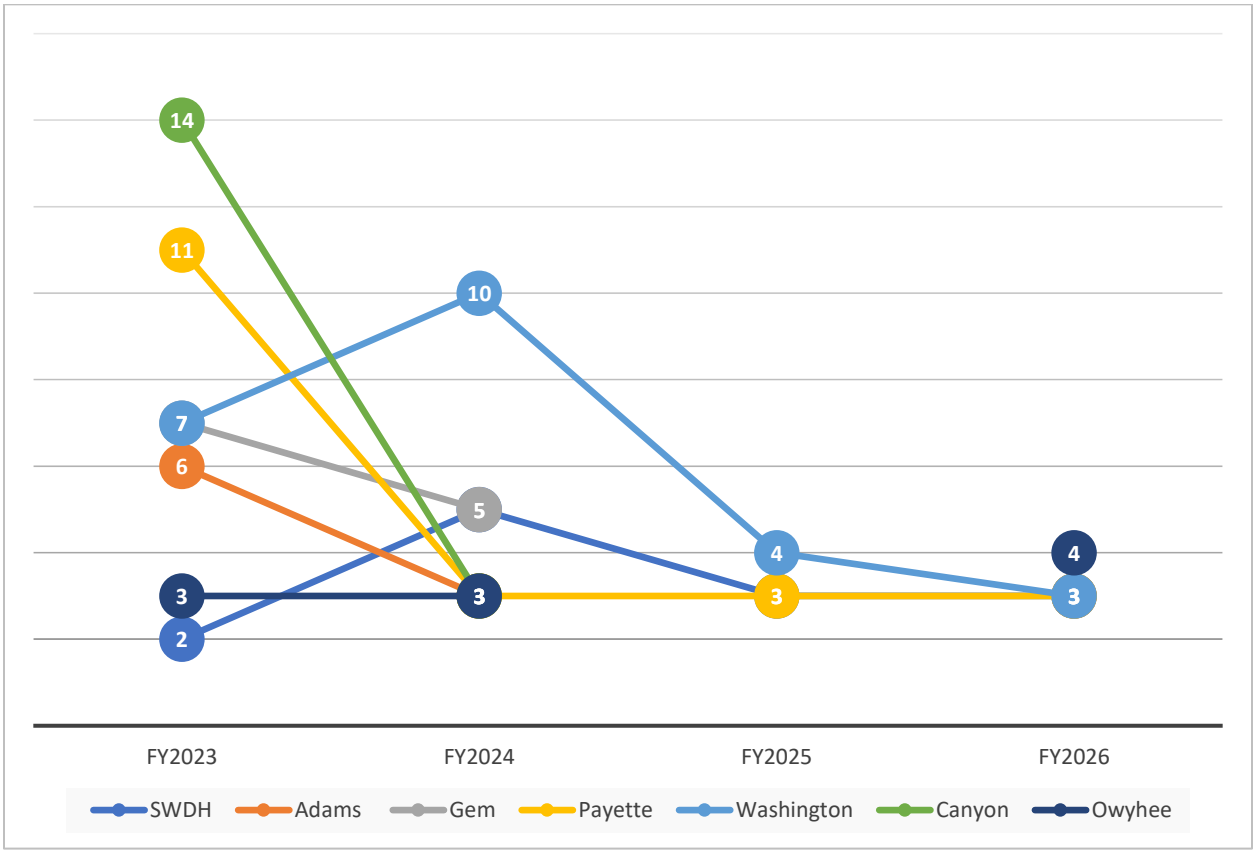
Trends

Southwest District Health's request for a 2.6% COLA increase is consistent with what other similar organizations have done across the region in the past 12 months.

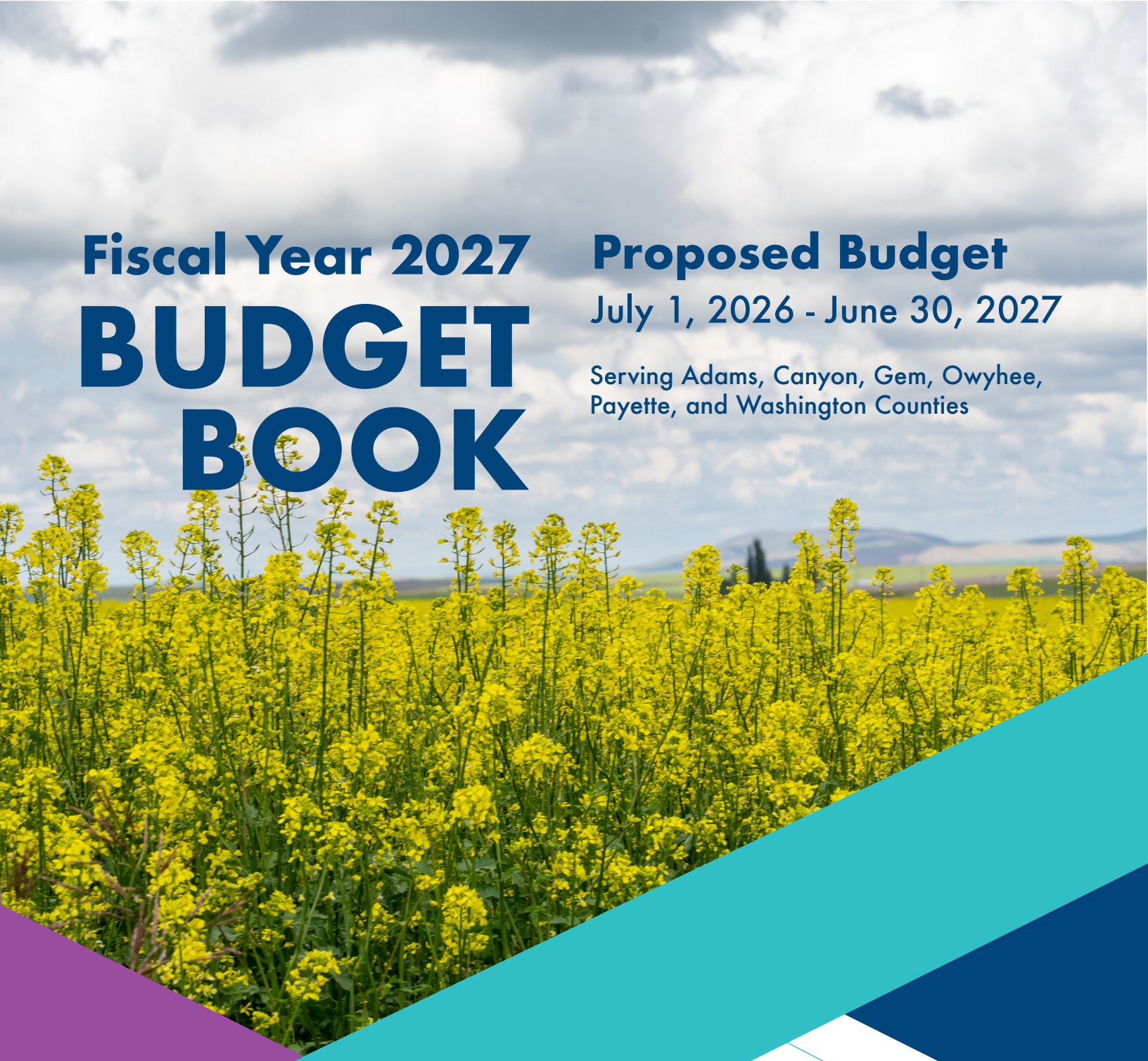
FY26 County Increases	
County	Increase
Adams	3% COLA
Canyon	$2,500 bonus to all staff – no other increases except for sheriff salary
Gem	4% COLA
Payette	3% COLA to all; 7% Equity adjustment for long-standing employees
Owyhee	$1.00 + 1% COLA
Washington	3% Merit

Other FY27 Increases in our Market	
Central District Health	Requesting a 2.5% to 4% increase based on merit
State of Idaho	No plans to implement CEC FY27

When looking at historical trends since fiscal year 2023, SWDH, on average, approves a similar change in employee compensation with the counties in the district.



Presented to the Board of Health on April 28, 2026.



Fiscal Year 2027 BUDGET BOOK

Proposed Budget

July 1, 2026 - June 30, 2027

Serving Adams, Canyon, Gem, Owyhee, Payette, and Washington Counties

SOUTHWEST DISTRICT HEALTH

Healthier Together | SWDH.org

Esteemed Members of the Board and Budget Committee,

The enclosed Fiscal Year 2027 (FY27) budget reflects the collective efforts of Southwest District Health's (SWDH) Board of Health, leadership team, and program managers who are responsible for stewarding the district's programs, services, and fiscal resources.

The FY27 budget supports the regulatory and public health services SWDH is statutorily obligated to provide, along with the operational infrastructure necessary to sustain daily functions and advance the district's mission in accordance with Section 39-409, Idaho Code. This year's budget also includes targeted investments in communication and outreach to address increasing service demand across the district.

The FY27 budget includes the following **one-time expenditures:**

- Landscape and signage repairs necessitated by the expansion of Highway 55 along the southern border of SWDH's Caldwell facility;
- Facility improvements approved by the Board in January 2026; and
- Information technology upgrades, including wireless access points, network router and firewall replacements, and Hyper-V migration.

In addition, the FY27 budget accounts for recurring cost pressures, including an ongoing increase of approximately $1,400 per employee in annual healthcare coverage premiums, as well as a proposed 2.6% employee compensation adjustment, contingent upon Board approval.

The proposed FY27 budget totals **$15,750,411**, representing an **8.15% decrease** from FY26. This reduction is primarily attributable to positions approved in FY26 to support the pre-prosecution diversion program that ultimately were not required, along with reductions in federal and state funding resulting in a loss of **8.7 full-time equivalent (FTE) positions.**

Accountability is a core value of Southwest District Health. Accordingly, the following guiding principles inform both the development and ongoing management of the district's budget:

1. Align strategic priorities with available and sustainable funding sources;
2. Ensure each position serves an essential and clearly defined function;
3. Reevaluate staffing models as vacancies arise or funding streams change; and
4. Strategically utilize county taxpayer funds to meet public health needs that cannot be fully supported through fees or other revenues.

Maintaining a lean, agile, and professional workforce enables SWDH to fulfill its public health mission while remaining responsive to changing community needs. Looking ahead, the district's consistently conservative and disciplined approach to budgeting positions Southwest District Health on a sound fiscal trajectory while preserving service quality, operational integrity, and public trust.

Nikki Zogg, PhD, MPH
District Director

Michele Hanrahan,
Financial Officer

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Board of Health

Section 39-414, Idaho Code outlines the powers and duties of the Board of Health. The board's duties include but are not limited to the administration and enforcement of all state and district health laws, regulations, and standards. They are furthermore responsible for determining the location of the main office and any branch offices, entering into contracts, depositing money or payments, establishing the fiscal control policy and fees, and entering into leases and purchasing, exchanging, or selling real property among other



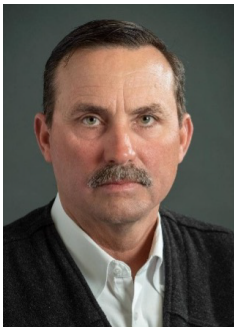
Kelly Aberasturi
Commissioner
Board of Health
Chairman
Owyhee County



Zach Brooks
Commissioner
Board of Health
Vice-Chairman
Canyon County



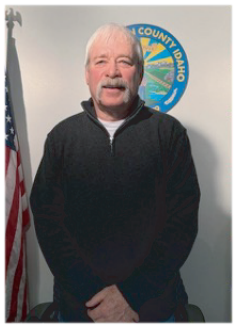
Jennifer Riebe
Commissioner
Board of Health
Executive Council
Representative and Trustee
Payette County



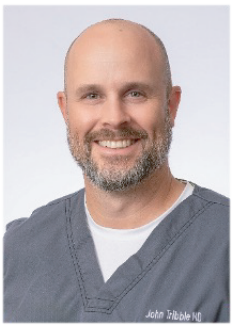
Kirk Wille
Commissioner
Gem County



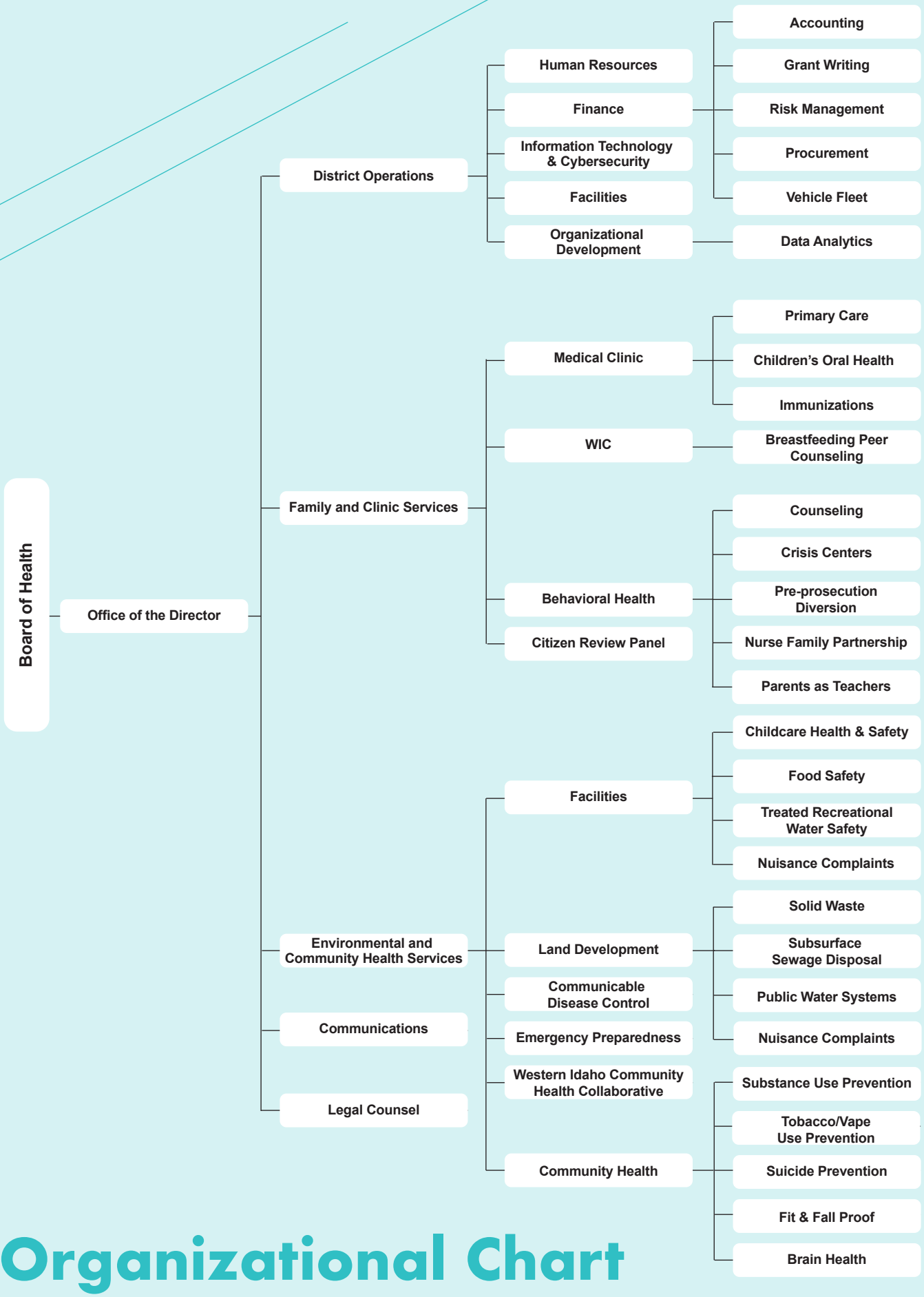
Viki Purdy
Commissioner
Adams County



Jim Harberd
Commissioner
Washington County



John Tribble, MD
Physician
Representative



Organizational Chart

History

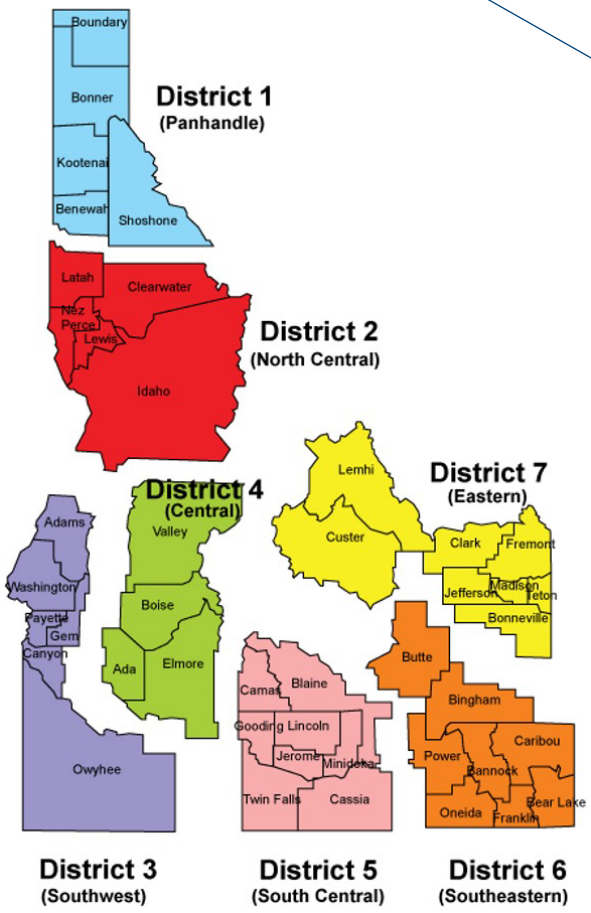
Established in 1970

Idaho's seven public health districts were established in 1970 under Chapter 4, Title 39, Idaho Code. They were created to ensure essential public health services are made available to protect the health of all citizens of the state—no matter the size of their county population.

It is legislative intent that health districts operate and be recognized not as state agencies or departments, but as governmental entities whose creation has been authorized by the state, much in the manner as other single purpose districts.

For the purposes of this chapter, a public health district is not a subdivision of the state and shall be considered an independent body corporate and politic pursuant to section 1, article VIII, of the constitution of the state of Idaho, and is not authorized hereby to levy taxes nor to obligate the state of Idaho concerning such financing.

The law (IDAPA 39-409) stipulates that public health districts provide the basic services of public health education, physical health, environmental health, and health administration. However, the law does not restrict the districts solely to these categories.



District Profile

Southwest District Health serves a six-county region across Southwest Idaho including Adams, Canyon, Gem, Owyhee, Payette, and Washington counties. The region includes a unique blend of urban, rural and frontier areas.

The region boasts a strong construction industry, agriculture, and all forms of manufacturing, from semi-conductors to trailers to cheese and frozen potato products. The region is also home to many recreational activities with easy access to skiing, snowboarding, fishing, hiking and biking trails, rushing rivers, sand dunes, historical sites, top-notch wineries, and other easily accessible adventures.

353,977



Population

County	Population
Adams	5,013
Canyon	275,123
Gem	21,773
Owyhee	12,661
Payette	27,824
Washington	11,583

35.3



Median Age

$86,018



Median Household Income

66.47%



Labor Force Participation

3.6%



Unemployment Rate

Source: Idaho Oregon Community Health Atlas American Community Survey (ACS)

Top 3 Reportable Infectious Diseases

reported in D3 in 2025

Children (0-18 years)

Respiratory syncytial virus (RSV) | 389
Pertussis | 168
Chlamydia trachomatis infection | 157

Adults (19-59)

Chlamydia trachomatis infection | 841
Gonorrhea | 105
Campylobacteriosis | 68

Seniors (60+)

Respiratory Syncytial virus (RSV) | 65
Hepatitis C, Chronic | 55
Campylobacteriosis | 53

Source: National Electronic Disease Surveillance System Base System

Social Vulnerability Index: 63.41

For the district

The index helps public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event. Ranking is determined by social factors like unemployment, minority status, disability, etc. 0 is low vulnerability, 100 is high.

District Health Needs & Priorities

According to the Community Health Needs Assessment (CHNA) completed in 2026, residents across the six-county region Southwest District Health serves ranked the following three areas as priority needs. In addition, children in foster care is a state Department of Health & Welfare priority and one that SWDH has also adopted.

Behavioral Health, Including Mental Health and Well-Being, and Substance Misuse



Drug Overdose Deaths per 100,000 Residents: 17.98
Suicide Deaths per 100,000 Residents: 17.6
Depression in Adults: 23%

*Source 1

Safe, Affordable Housing, and Homelessness



Housing Units: 119,402
Housing Vacancy Rate 4.04%

A vacancy rate below 5% indicates higher demand than housing supply.
A vacancy rate above 10% indicates more housing supply than demand.

*Source 1

Access to Affordable Health Care, Including Oral and Vision Health



Delayed Needed Physician Care Due to Cost: 19.33%
Uninsured Rate: 14.5%
Public Insurance: 31.92%
Private Insurance: 63.9%

*Source 1

Decreasing the Number of Youth Entering Foster Care



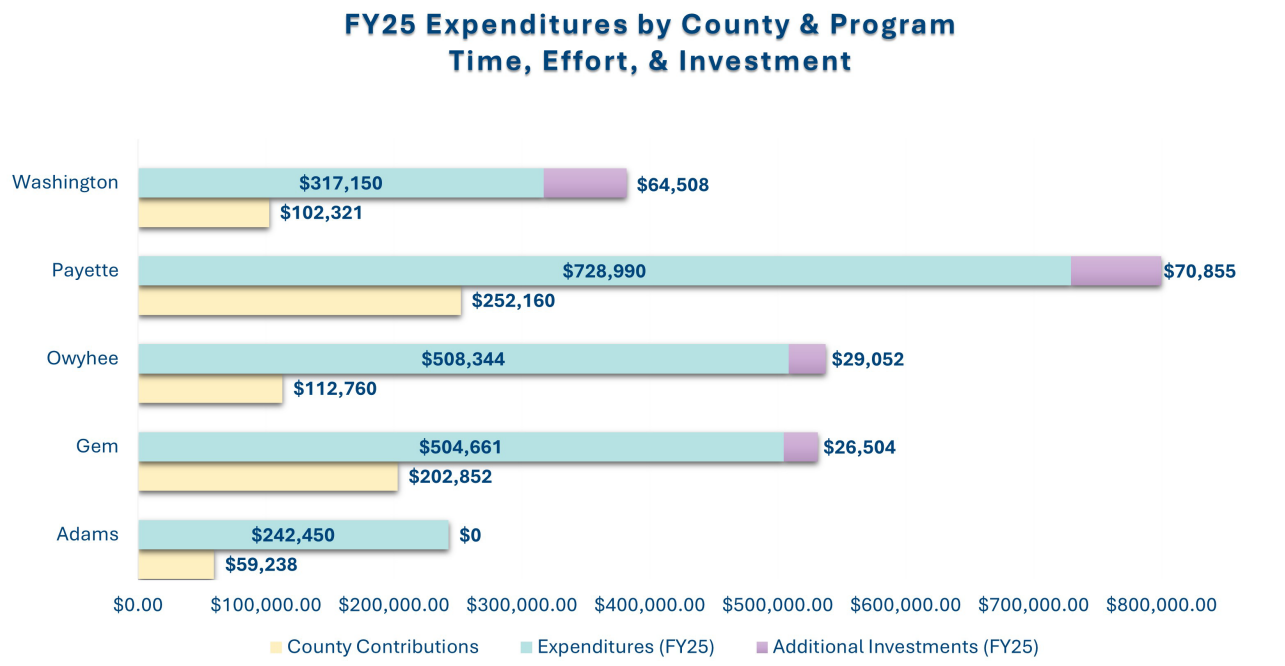
Number of Children in Foster Care:
327
in Region 3 as of March 4, 2026

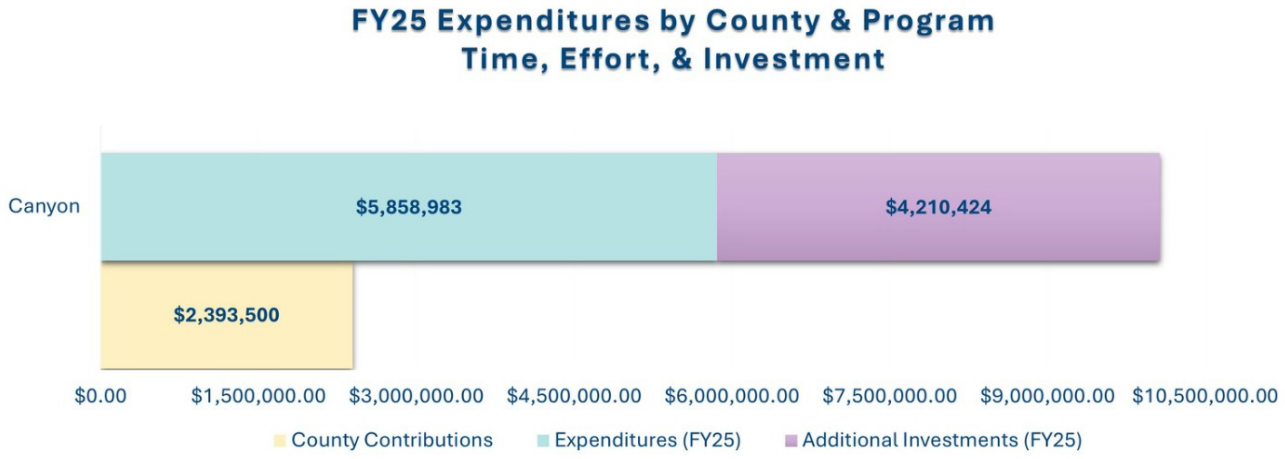
Top Reason for Removal:
Neglect, Physical Abuse, Caretaker/Parent Substance Use, Incarceration of Caretaker/Parent, Unstable Home environment

**Source 2

Source 1: Idaho Oregon Community Health Atlas American Community Survey (ACS)
***Source 2: Idaho Department of Health and Welfare*

Return on Investment - FY25





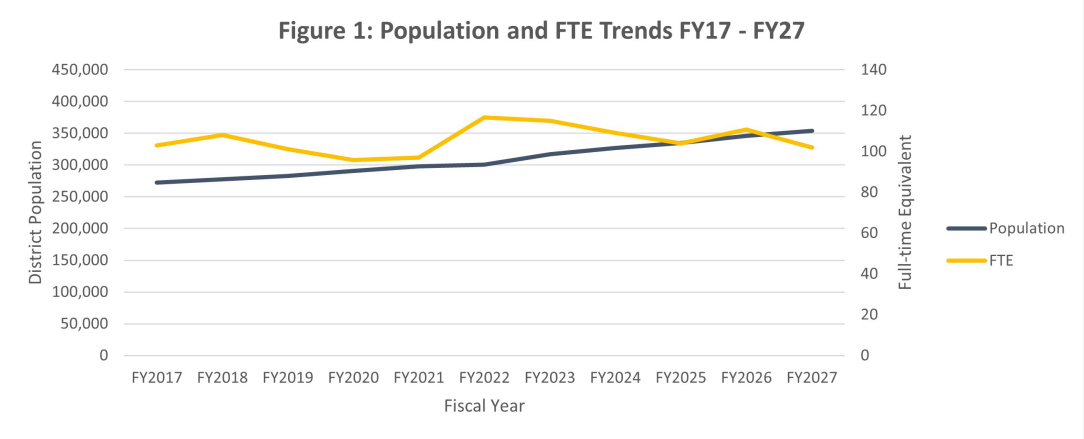
1. County contributions (yellow bar) are provided to SWDH annually. These funds, combined with fee and grant revenue, support the delivery of core public health services and reinvestment in county-specific activities (blue bar). Some counties also receive targeted investments through specific grants (i.e., pre-prosecution diversion and behavioral health community paramedicine) or trustee benefits managed by SWDH (i.e., crisis centers and youth assessment centers) (purple bar).

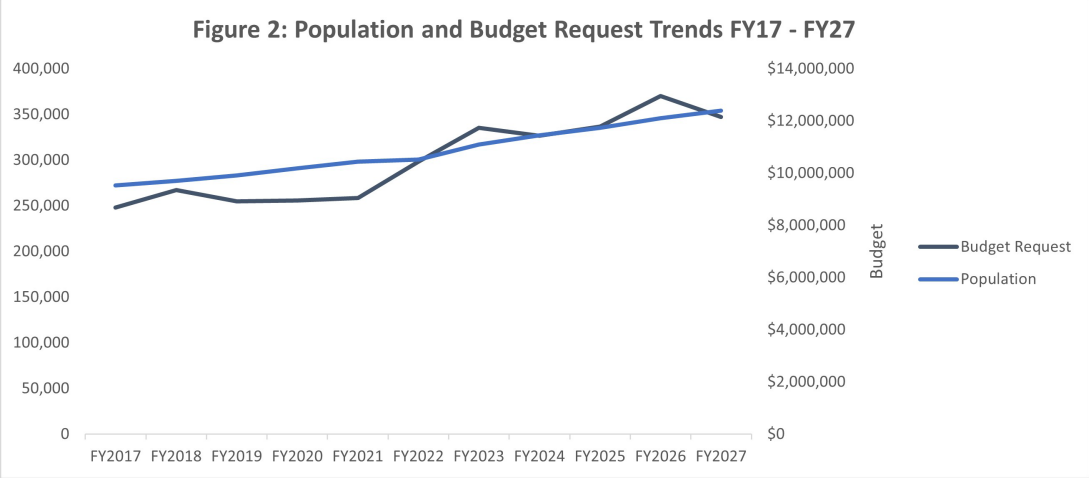
2. Some services are not included because they cannot be easily quantified. Examples include consultations with epidemiology, medical director, and environmental health staff; 24/7 response calls from State Communications; nuisance complaint response (open sewage, open dumping, rabies); grant writing support; public and stakeholder communications; and emergency response planning, training, and exercises.

Budget Request Summary

We have taken a conservative approach to our staffing model by retaining essential positions and finding ways to offer a competitive compensation package that considers salaries, benefits, and workplace culture. Table 1 captures our budgeted full-time equivalent (FTE) employee data for the past three years and Figure 1 shows SWDH's FTE compared to district population growth. Figure 2 shows the change in fiscal year budget to district population growth.

Division	FY24 Adopted FTE	FY25 Adopted FTE	FY26 Adopted FTE	FY27 Proposed FTE
Office of the Director	5	3	3.2	4
District Operations	15	26	18.5	14
Environmental and Community Health	48	41	36	30
Family and Clinic Services	41	34	53	54
Total	**109**	**104**	**110.7**	**102**





FY27 New Positions

There is a 0.5 new position built into the fiscal year FY27 budget.

1. Communications Specialist – 0.5 position (0.5 funded in FY26, adding 0.5 to make 1.0)

Public and board input has continued to point out the need to increase knowledge and awareness of what Southwest District Health does, our services and access points. One of the best ways to do that is through in-person engagement with citizens across the six counties we serve. In addition, with the growth of online and social media use there is an evolving need to share important public health messages and education to our community through these avenues.

Additional information:

- SWDH planned to add an additional counselor in FY27. Due to funding constraints, we will reevaluate the feasibility mid-year (around November/December).

- SWDH planned to add an environmental health specialist in FY27. Due to solid waste oversight being moved to DEQ and funding constraints, this need will be reevaluated when planning for FY28.

- If SWDH receives a Rural Health Transformation Grant or other large grant awards, we may add positions. The board will be kept up to date on any large funding awards.

Southwest District Health

FY27 Budget

July 1, 2026 through June 30, 2027

	FY25 Budget	FY26 Budget	FY27 Request
REVENUE			
Fees	$1,704,841	$1,757,051	$2,561,243
Federal Grants	$4,101,722	$3,966,968	$4,225,510
State Grants	$1,040,363	$2,242,350	$531,891
County Contributions	$3,122,831	$3,193,095	$3,191,575
Crisis Centers	$4,003,352	$4,086,678	$3,595,377
Other Fund Statute Transfer	$132,307	$0	$0
Interest	$337,850	$410,400	$276,000
Sale of Land, Buildings & Equip	$0	$0	$0
Other*	$1,349,107	$1,376,993	$1,368,815
Total Revenue	$15,792,373	$17,033,535	$15,750,411
EXPENDITURES			
Salary & Wage	$6,625,145	$7,250,473	$6,450,516
Employee Benefits	$2,940,379	$3,154,989	$2,925,053
Operating Expenses	$3,198,592	$3,320,140	$5,815,753
Capital Outlay	$80,000	$0	$320,520
Trustee Benefits *(Pass-thru funds)*	$2,948,257	$3,307,933	$238,569
Total Expenditures	$15,792,373	$17,033,535	$15,750,411

** FY27 includes Board Committed Funds of $645,650, Pre-Prosecution Diversion of $377,349.25*

Southwest District Health
FY27 Budget

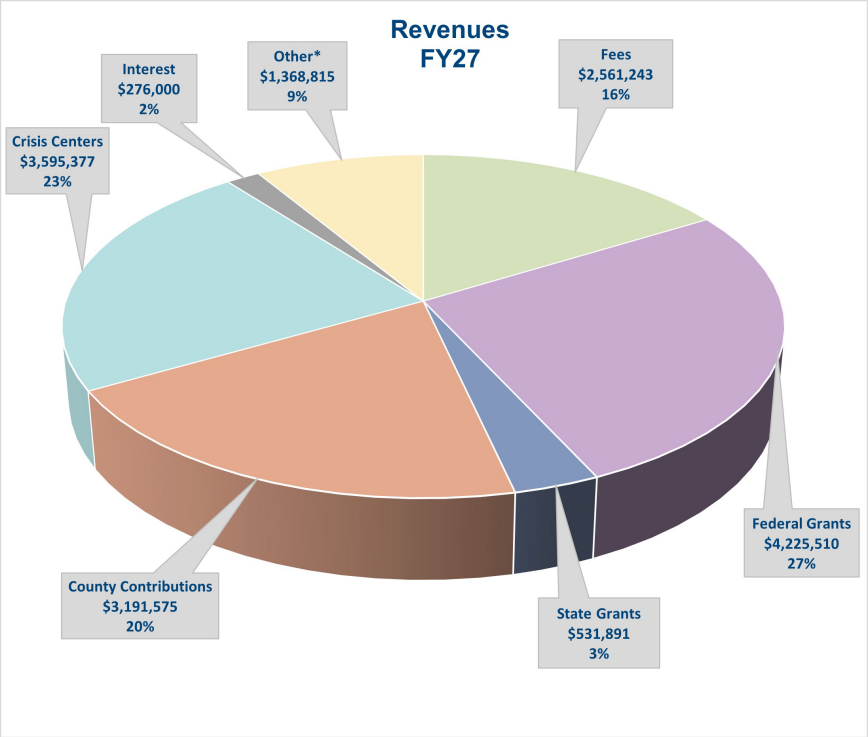
July 1, 2026 through June 30, 2027

District Summary	FY25 Budget	FY26 Budget	FY27 Request
GRAND TOTALS			
Revenues	**$15,792,373**	**$17,033,535**	**$15,750,411**
Expenditures	**$15,792,373**	**$17,033,535**	**$15,750,411**

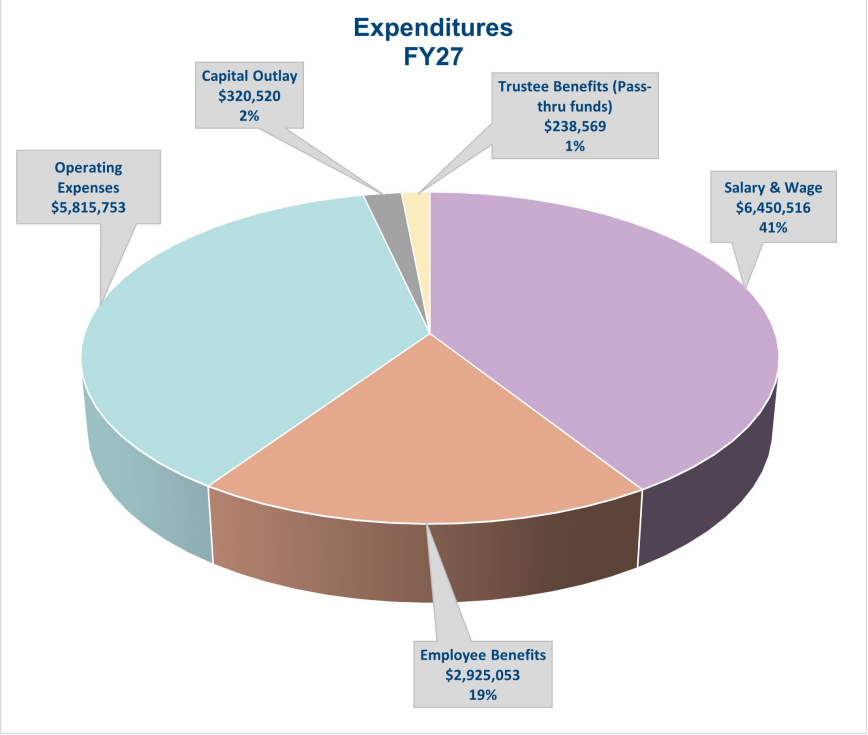
Employee Counts

FY25	FY26	FY27
104	**110.7**	**102**

Revenues



Expenditures



County Contributions

Section 31-862, Idaho Code authorizes counties to establish a special tax to be used solely and exclusively for preventive health services by county or district boards of health. The board of county commissioners is authorized to levy a special tax not to exceed four hundredths per cent (.04%) of market value. The current approved values for each county in Public Health District 3 (Southwest District Health) are as follows:

2025 Approved Preventative Health Levy Rates	
County	**Levy Rate**
Adams	0.000033115
Canyon	0.000059355
Gem	0.000062281
Owyhee	0.000054705
Payette	0.000058877
Washington	0.000061677

Source: Idaho State Tax Commission

Section 39-424, Idaho Code describes the formula that is to be used to determine the apportionment to each county in the public health district. Seventy percent (70%) shall be apportioned among the various counties based on population and 30% based on taxable market value:

	POPULATION			MARKET VALUE		
County	**2024**	**2025**	**% Change**	**2024**	**2025**	**% Change**
Adams	4,998	5,013	**0.30%**	$1,399,467,082	$1,480,630,574	**5.80%**
Canyon	266,892	275,123	**3.08%**	$37,883,599,077	$41,562,381,404	**9.71%**
Gem	21,857	21,773	**-0.38%**	$3,072,576,729	$3,193,203,314	**3.93%**
Owyhee	12,748	12,661	**-0.68%**	$1,549,383,438	$1,665,790,611	**7.51%**
Payette	27,662	27,824	**0.59%**	$3,720,156,753	$3,742,931,739	**0.61%**
Washington	11,539	11,583	**0.38%**	$1,393,698,340	$1,478,904,321	**6.11%**
Total	**345,696**	**353,977**	**2.40%**	**$49,018,881,419**	**$53,123,841,963**	**8.37%**

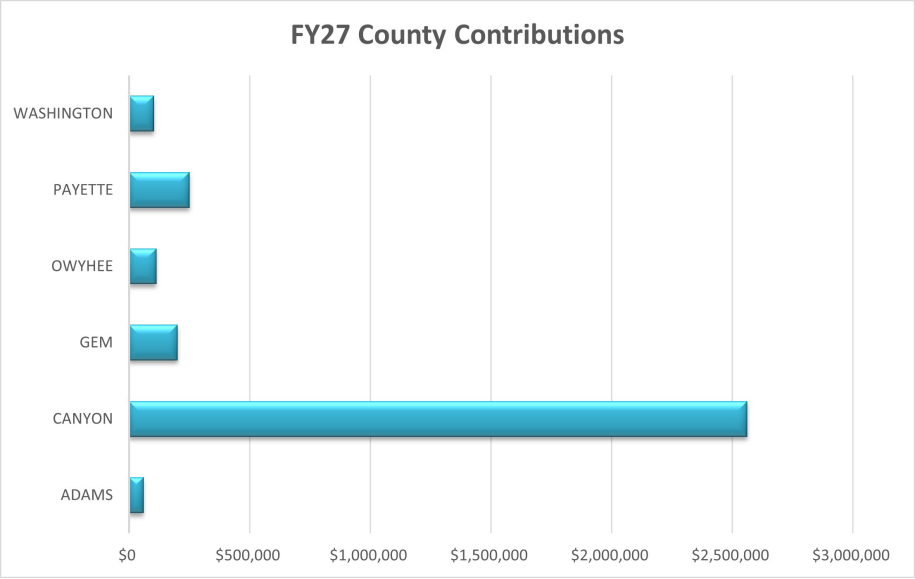
Source: U.S. Census Bureau, Population Division via Department of Commerce

County Request - 3%

Budget Request for County FY27
Period Covered: October 2026 – September 2027
Based on Section 39-424, Idaho Code

COUNTY CONTRIBUTION REQUEST

County Contribution = 70% Population Distribution + 30% Taxable Market Value (TMV)									
County	2025 Population Estimate	Population % Distribution	70% of Request Amount	2025 Property Market Values	Market value % Distribution	30% of Request Amount	FY27 County Contribution	% of County Contribution	% Change
ADAMS	5,013	1.42%	$32,604	$1,480,630,574	2.79%	$27,500	$60,104	1.83%	0.74%
CANYON	275,123	77.72%	$1,789,366	$41,562,381,404	78.24%	$771,936	$2,561,302	77.88%	3.87%
GEM	21,773	6.15%	$141,609	$3,193,203,314	6.01%	$59,307	$200,916	6.11%	-0.22%
OWYHEE	12,661	3.58%	$82,346	$1,665,790,611	3.14%	$30,939	$113,285	3.44%	0.52%
PAYETTE	27,824	7.86%	$180,964	$3,742,931,739	7.05%	$69,517	$250,481	7.62%	-0.43%
WASHINGTON	11,583	3.27%	$75,334	$1,478,904,321	2.78%	$27,468	$102,802	3.13%	0.94%
TOTAL	**353,977**	**100.00%**	**$2,302,222**	**$53,123,841,963**	**100.00%**	**$986,667**	**$3,288,890**	**100.00%**	



Contribution Changes by County

County	Approved FY26 County Contributions	FY27 County Request	*Adjust for draw from Board Committed Funds	FY27 County Request with Moratorium
ADAMS	$59,664	$60,104	$440	$59,664
CANYON	$2,465,967	$2,561,302	$95,335	$2,465,967
GEM	$201,365	$200,916	$449	$200,916
OWYHEE	$112,703	$113,285	$582	$112,703
PAYETTE	$251,554	$250,481	$1,073	$250,481
WASHINGTON	$101,843	$102,802	$959	$101,843
TOTAL	**$3,193,096**	**$3,288,890**	**$98,837**	**$3,191,575**

**Moratorium for FY27 and FY28 will be added to FY29 County Fiscal Year Request*

Office of the Director

FY27 budgeted full-time positions: 4

The mission of the Office of the Director is to be the public health leader of the region and of service to the employees, board members, and public within whom we are entrusted.

Services

Oversees the daily operations of the district.	Serves as the administrative officer to the Board of Health.
Prescribes the policies and procedures of the district in accordance with local, state, and federal laws.	Establishes the positions and qualifications of all personnel under the district director and sets rate of pay.
Manages communications for the district.	Serves as district representatives at public events and functions.

FY27: Requested Budget Highlights

Administration

- The Office of the Director provides executive leadership, strategic direction, and coordination across the district. In the upcoming fiscal year, the Director will work closely with district leadership and board members to review and prioritize recommendations from a comprehensive situational analysis completed in fiscal year 2026. This work will guide financial and operational priorities to ensure the district remains responsive, sustainable, and well positioned to meet community needs over the next 10 to 20 years.

- In addition, the Director will continue to collaborate with county officials and community leaders to identify opportunities where public health expertise and resources can be more effectively leveraged. These efforts are intended to reduce the overuse and misuse of high cost county systems—such as the justice system, jails, law enforcement, and emergency medical services—by addressing upstream public health needs and supporting more efficient, prevention focused solutions.

FY27: Requested Budget Highlights *continued*

Communications

- In the upcoming fiscal year, the communications team will increase from 1.5 to 2.0 full time equivalent positions. This additional capacity will strengthen the district's ability to engage with the community, increase awareness of available services, and deliver timely, accurate public health information using a variety of communication tools and platforms.

- Based on feedback from the community and our board, the district recognizes the need to improve transparency about its work, better inform county taxpayers who support public health services, and more clearly communicate how district services protect and improve the health and safety of the community. Expanded communications capacity will support these goals and enhance public understanding, trust, and engagement.

Administration

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support
Administration							
Administration	$ -	$ 292,641	$ 13,820	$ -	$ -		$ (306,461)
County, Interest & Other Revenues	$ 3,467,575	$ -	$ -	$ -	$ -		$ 3,467,575
Indirect Excluded Costs		$ -	$ 6,000	$ -	$ -		$ (6,000)
Board of Health		$ 7,657	$ 8,160	$ -	$ -		$ (15,817)
Board of Health Committed	$ 506,887	$ -	$ 208,837	$ 298,050	$ -		$ -
Public Information		$ 71,970	$ 8,966	$ -	$ -		$ (80,936)
Marketing		$ 101,674	$ 67,415	$ -	$ -		$ (169,089)
Subtotal	$ 3,974,462	$ 473,941	$ 313,198	$ 298,050	$ -	$ -	$ 2,889,273

Service Highlights: We hosted the Treasure Valley Communicators group where dozens of Public Information Officers from government, medical, and community organizations learned about our services and shared updates and best practices with each other. We also fielded media inquiries and issued press releases resulting in over 50 mentions across TV, radio, print, & digital. These touchpoints enhance public trust and educate those we serve to make informed health decisions for themselves and their families.

District Operations Division

FY27 budgeted full-time positions: 14

The mission of District Operations is to provide professional services, support, and customer service that empowers our whole team to carry out the mission and move closer to our vision of a healthier southwest Idaho.

Services

Information Technology & Cybersecurity	Facilities Maintenance & Building Safety
Human Resources & Employee Engagement	Organizational & Workforce Development, Data Analytics
Fleet Management	Finance, Accounting, & Procurement
Grant Writing & Management	Risk Management & Compliance

FY27: Requested Budget Highlights

- Originally planned for completion during FY26, facilities staff will be contracting for and overseeing the repairs to exterior signage and landscape following the expansion of Hwy 55 on the south side of SWDH's main facility in Caldwell. SWDH received $128,000 from ITD for the repair and this has been budgeted for in the coming year. ITD's Hwy 55 expansion project is slightly behind schedule, therefore the SWDH repairs will follow accordingly.

- Additional efficiencies were gained in Operations through the elimination of one customer service representative in one of the outer offices. Hiring one shared Administrative Assistant position to support the needs of two divisions created additional opportunities for collaboration and cross training.

- Leasing of vehicles is on the agenda for this coming year, as is replacement of one aging van in the motor pool.

FY27: Requested Budget Highlights *continued*

- Multiple IT-related components will be upgraded/replaced this year to ensure firewall security, network stability and router functionality.
- Sizeable cost-savings were realized in fiscal year 2026 with a change to the courier service that we had operating daily between all of our offices and the state laboratory. This service now runs one day each week. Additional savings were realized when the district completed a migration off of the State of Idaho's network. The total savings is expected to be $130,000 in fiscal year 2027.
- The district will be working on a website update for increased functionality and compliance with federal ADA regulation.

District Operations

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support
District Operations							
District Operations Admin	$ -	$ 291,151	$ 13,700	$ -	$ -		$ (304,851)
Finance	$ -	$ 458,522	$ 33,060	$ -	$ -		$ (491,582)
Grants and Procurements	$ -	$ 39,816	$ 2,375	$ -	$ -		$ (42,191)
Human Resources	$ -	$ 114,685	$ 11,765	$ -	$ -		$ (126,450)
Information Technology	$ -	$ 355,198	$ 302,000	$ -	$ -		$ (657,198)
Caldwell	$ -	$ 99,673	$ 300,900	$ -	$ -		$ (400,573)
Emmett	$ -	$ -	$ 32,850	$ -	$ -		$ (32,850)
Payette	$ -	$ -	$ 46,560	$ -	$ -		$ (46,560)
Weiser	$ -	$ -	$ 20,300	$ -	$ -		$ (20,300)
Fleet Management	$ -	$ -	$ 51,757	$ -	$ -		$ (51,757)
Infrastructure Grant - A1	$ 399,000	$ 218,271	$ 109,903	$ -	$ -	$ 73,863	$ (3,037)
Infrastructure Grant - A2	$ 42,787	$ -	$ 42,787	$ -	$ -		$ (0)
Subtotal	$ 441,787	$ 1,577,315	$ 967,957	$ -	$ -	$ 73,863	$(2,177,348)

Family & Clinic Services Division

FY27 budgeted full-time positions: 54

Together, empowering southwest Idaho communities to create healthier lives.

Services

Women, Infants, and Children (WIC) Nutrition Program	Family Medical Clinic
Idaho Home Visiting Programs (IHVP)	Behavioral Health Counseling
Project Oversight for Crisis Centers	Behavioral Health Partnerships for Early Diversion
Pre-Prosecution Diversion Program	

FY27: Requested Budget Highlights

- **Behavioral Health Partnership for Early Diversion -** Funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant (2023–2028), this program strengthens community capacity to divert youth and adults with behavioral health needs away from the criminal justice system and higher levels of care. Growth continues through the Washington County Community Paramedicine program. Key outcomes include crisis intervention training for approximately 90% of their first responders, reduced involuntary holds, strong cross system collaboration, and improved connections to behavioral health and community supports. Ongoing priorities include refining referral pathways and strengthening early, upstream screening.

- **Crisis Centers (Adult & Youth) -** Revenue is expected to remain stable under Magellan's current funding and billing structure. The coming year will focus on evaluation and information gathering to inform future service delivery options, including a potential transition from our district's backbone role to a direct service agreement between crisis center providers and Magellan.

- **Family Medical Clinic -** This will be a planning and assessment year, maintaining core clinic services while evaluating long-term sustainability, staffing capacity, and community needs amid funding and policy uncertainty. Expanded hours in Caldwell will continue, with increased presence in Weiser to improve rural access. Services at other locations will be maintained as staffing allows, with coordination across local providers to support continuity of care and avoid duplication. Insights gained throughout the year will guide future program direction and resource decisions.

FY27: Requested Budget Highlights *continued*

- **Idaho Home Visiting Program (IHVP) -** SWDH continues to provide evidence based home visiting services, including Parents as Teachers and Nurse Family Partnership, supporting healthy pregnancies, early learning, and positive child development. Beginning July 1, 2026, the elimination of state General Fund support will lead to measured program adjustments. Staffing and resources will be managed strategically to maintain services and promote long term stability.

- **Pre-Prosecution Diversion (PPD) Program -** Operating through continued collaboration with the Canyon County Prosecuting Attorney's Office, the program diverts adults with behavioral health needs away from deeper justice system involvement. Efforts focus on strengthened referral pathways, court coordination around treatment participation, and caseload monitoring to ensure appropriate service capacity.

- **Women, Infants, and Children (WIC) -** The WIC program anticipates a nominal grant increase, reflecting continued stable operations. Participation increased approximately 5% compared to the prior year, with more than $5.2 million in grocery benefits redeemed locally across six counties in FY25. WIC provides nutrition support, education, breastfeeding services, and referrals to community services to eligible pregnant and postpartum women and children under five, promoting healthy growth and improved early childhood outcomes.

Family Medical Clinic

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Family Medical Clinic								
Medical Clinic	$ 226,200	$ 670,158	$ 177,342	$ 8,670	$ -	$ 226,782	$ (856,752)	1,380 patients seen
STD Prevention	$ 19,500	$ 9,418	$ 16,064	$ -	$ -	$ 3,187	$ (9,169)	
HIV Prevention	$ 99,250	$ 21,264	$ 12,116	$ -	$ -	$ 7,196	$ 58,674	
Women's Health Check	$ 16,560	$ 11,930	$ 3,929	$ -	$ -	$ 4,037	$ (3,337)	
Women's Health Check - Outreach	$ 6,000	$ 4,254	$ 1,375	$ -	$ -	$ 1,439	$ (1,069)	
Immunizations Clinic - District	$ 80,000	$ 93,603	$ 100,498	$ 2,000	$ -	$ 31,675	$ (147,777)	1,674 immunizations
Immunization Cooperative Agreement	$ 95,000	$ 110,804	$ 20,423	$ -	$ -	$ 37,496	$ (73,723)	
School Health Marsing	$ 65,000	$ 85,905	$ -	$ -	$ -	$ 29,070	$ (49,975)	
Oral Health - MCH	$ 54,003	$ 80,563	$ 5,636	$ -	$ -	$ 27,262	$ (59,459)	
Oral Health - District	$ 2,000	$ 22,294	$ 6,881	$ -	$ -	$ 7,544	$ (34,720)	2,280 oral health screenings
Subtotal	$ 663,513	$ 1,110,195	$ 344,264	$ 10,670	$ -	$ 375,690	$(1,177,306)	

Service Highlights: SWDH delivers essential clinical services that improve access to care for children, adults, and underserved residents. In the past year, the district provided more than 1,600 vaccinations through walk-in clinics and targeted outreach, helping prevent outbreaks and support school and workplace health requirements. The Family Medical Clinic extends this impact by offering comprehensive primary care—including screenings, family planning, chronic disease management, and preventive services—for uninsured and underinsured community members who face barriers accessing care elsewhere. Together, these programs reduce unmet health needs, improve continuity of care, and ensure residents have reliable access to the foundational services that protect community health.

Idaho Home Visiting Programs

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Idaho Home Visiting Programs								
NFP - MIECHV	$ 275,868	$ 350,633	$ 34,297	$ -	$ -	$ 118,654	$ (227,715)	908 NFP visits
NFP - Medicaid	$ 291,986	$ 184,735	$ 21,973	$ -	$ -	$ 62,514	$ 22,764	
PAT - MIECHV	$ 275,868	$ 284,462	$ 18,360	$ -	$ -	$ 96,262	$ (123,216)	823 PAT visits
PAT - Medicaid	$ 228,594	$ 172,565	$ 18,361	$ -	$ -	$ 58,396	$ (20,728)	
Subtotal	$ 1,072,316	$ 992,394	$ 92,991	$ -	$ -	$ 335,826	$ (348,896)	

Service Highlights: SWDH Home Visiting Programs, including Nurse-Family Partnership (NFP) and Parents as Teachers (PAT), provide evidence-based support to vulnerable families through in-home services. NFP pairs eligible, low-income first-time mothers with registered nurses to promote healthy pregnancies, positive birth outcomes, and confident parenting, while PAT supports families from pregnancy through kindergarten by strengthening early learning and child development. In FY25, these programs delivered 1,731 home visits, helping families achieve critical milestones such as leaving abusive relationships, gaining employment, and securing first jobs—advancing family stability and long-term community resilience.

Community Behavioral Health

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Community Behavioral Health								
Citizens Review Panels	$ 6,000	$ 8,805	$ 3,154	$ -	$ -	$ 2,980	$ (8,939)	
FCS Opioid Settlement	$ 247,422	$ 177,542	$ 9,800	$ -	$ -	$ 60,080	$ 0	
Behavioral Health Administration	$ 81,000	$ 125,706	$ 9,788	$ -	$ -	$ 42,539	$ (97,033)	102 counseling sessions
Pre-Prosecution Div Grant	$ 358,892	$ 244,897	$ 50,607	$ -	$ -	$ 82,873	$ (19,486)	1,550 client encounters
SAMSHA - Early Diversion of Adults	$ 159,990	$ 84,073	$ 6,175	$ -	$ 92,069	$ 28,450	$ (50,778)	679 people trained on crisis system of care
Subtotal	$ 853,303	$ 641,023	$ 79,524	$ -	$ 92,069	$ 216,922	$ (176,236)	

Service Highlights: In 2024, SWDH added counseling to address rising mental health needs in our region. Services were made available to families already engaged in programs such as WIC and home visiting, and demand quickly filled the provider's schedule. One client described the impact by sharing, "Everything starts making more sense… You are safe, you have answers, and you feel valued."

Crisis Centers (Adult & Youth)

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Crisis Centers (Adult and Youth)								
Adult Crisis Center	$ 1,657,336	$ 30,892	$ 1,616,458	$ -	$ -	$ 10,454	$ (468)	1,044 adult admissions
Youth Crisis - Magellan	$ 1,839,491	$ 25,745	$ 1,805,426	$ -	$ -	$ 8,712	$ (392)	205 youth admissions
Youth Crisis - Other	$ 6,601	$ -	$ 6,601	$ -	$ -	$ -	$ -	
Social Services Block Grant	$ 49,581	$ 36,039	$ 1,890	$ -	$ -	$ 12,196	$ (544)	
Subtotal	$ 3,553,008	$ 92,676	$ 3,430,375	$ -	$ -	$ 31,362	$ (1,404)	

Service Highlights: In FY25 the Western Idaho Youth Support Center (WIYSC) moved to a new location allowing us to serve at a greater capacity. Throughout FY25, WIYSC had 237 admissions and served 167 individual youth. Because of WIYSC, over 100 youth ages 7 to 17 were diverted from ER visits, hospital admissions, law enforcement/juvenile justice involvement, self-harm, and substance use. Client disposition improved at 90% of admissions and 185 connections to aftercare were made for youth clients and their families.

Women, Infants, and Children (WIC)

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Women/Infant/Children (WIC)								
WIC - General Admin	$ 265,764	$ 352,140	$ 174,424	$ -	$ -	$ 119,164	$ (379,963)	$5M+ voucher money spent locally
WIC - Client Services	$ 582,150	$ 569,840	$ -	$ 5,000	$ -	$ 192,834	$ (185,524)	6,179 WIC participants
WIC - Breastfeeding Promotion	$ 63,277	$ 63,459	$ 350	$ -	$ -	$ 21,474	$ (22,006)	
WIC - Nutrition Education	$ 354,352	$ 357,729	$ 4,500	$ -	$ -	$ 121,056	$ (128,933)	337 prenatal vitamins distributed
WIC - Breastfeeding Peer Counseling	$ 96,481	$ 68,656	$ 5,171	$ 2,000	$ -	$ 23,233	$ (2,580)	
Subtotal	$ 1,362,024	$ 1,411,824	$ 184,445	$ 7,000	$ -	$ 477,761	$ (719,006)	
Total	**$ 15,750,411**	**$ 9,375,568**	**$ 5,815,753**	**$ 320,520**	**$ 238,569**	**$ 2,552,410**	**$ (2,552,410)**	

Service Highlights: The SWDH WIC program strengthens the local economy by directing federal food dollars to neighborhood grocery stores and farmers while ensuring mothers and children have access to nutritious foods that prevent obesity, diabetes, and other chronic diseases. Through nutrition education and personalized breastfeeding peer counseling, WIC provides trusted, one-on-one support during a critical stage of life—helping families solve real-time feeding challenges, build confidence, and make healthy choices that last a lifetime. As one parent recently shared, “She was attentive, knowledgeable, encouraging… She genuinely cares and loves the work that she does.”

Environmental & Community Health Services Division

FY27 budgeted full-time positions: 41

The mission of Environmental & Community Health is to be physically present in our communities, building relationships to create and maintain a healthier southwest Idaho.

Services

Public health emergency preparedness and epidemiological response	Community health education, prevention, and partnerships
Facility based programs	Land development and wastewater

FY27: Requested Budget Highlights

- **Community Health -** Provides education and prevention programs addressing suicide, youth vaping, substance use, overdose prevention, physical activity, nutrition, tobacco cessation, Fit and Fall Proof, and community engagement efforts (CHATs, WICHC). CDC-funded tobacco prevention ended in FY26 due to federal changes. The team received Healthy Brain Initiative funding through mid-FY27 and incorporated Board-requested priorities into existing programs (social media use, Cooking Matters).

- **Facility-Based Programs -** Responsible for food safety licensing and inspections (~2,500 annually), investigation of foodborne illness, plan reviews for new establishments, and food safety classes. Childcare program conducts ~400 inspections per year and complaint investigations. Through an FDA grant, staff mentored two Idaho health districts on FDA Standards. Public pool regulation was eliminated statewide in July 2025; with the City of Nampa's ordinance now in effect (Jan 2026), the district regulates 38 pools within Nampa only.

FY27: Requested Budget Highlights *continued*

- **Environmental Health & Land Development -** Works to protect public health and natural resources by ensuring safe development, preventing groundwater contamination, and responding to environmental health concerns.
    - **Septic/Subsurface Sewage Program -** Conducts site evaluations, reviews designs, issues permits and provides guidance.
    - **Public Water Systems (PWS) -** Regulates 161 systems. Achieved 100% on the Annual Sanitary Survey Audit—the only district/Idaho Department of Environmental Quality (IDEQ) region in Idaho to do so.
    - **Land Development Program -** Reviews subdivision applications, removes sanitary restrictions, and consults on development. Received 100% on IDEQ's annual Subsurface Sewage Disposal (SSD) Program Review. Noting subdivision applications (served by wells/septics) have declined for four years.
- **Solid Waste & Environmental Response -** Responds to environmental nuisance and safety issues. Statutory authority for Municipal Solid Waste (MSW) facilities has shifted to IDEQ; Health Districts may still support community-level concerns but no longer provide regulatory oversight.
- **Public Health Emergency Preparedness & Epidemiology Response (PHEPER) -** Responds to outbreaks for all 76 Idaho reportable diseases and maintains Centers for Disease Control & Prevention (CDC) 15 Public Health Emergency Preparedness capabilities.
    - **FY26 funding changes** - A 35% reduction in the Public Health Emergency Preparedness (PHEP) grant led to the Planner position remaining unfilled after retirement; duties were absorbed by existing staff. Other grants remained mostly level with minor decreases in Communicable Disease and National Electronic Disease Surveillance System (NEDSS) funding.

Environmental & Community Health Services Division *continued*

Community Health

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Community Health								
CHAT	$ -	$ 100,725	$ 12,015	$ 2,400	$ -	$ 34,085	$ (149,225)	27 health fairs & events attended
Alzheimer's Assoc-HBI	$ 25,000	$ 14,690	$ 5,700	$ -	$ -	$ 4,971	$ (361)	
Fit & Fall Proof - PHHS	$ 60,000	$ 78,039	$ 5,690	$ 2,400	$ -	$ 26,408	$ (52,537)	2,307 times participants attended classes
Comprehensive Cancer	$ 19,300	$ 22,646	$ 2,075	$ -	$ -	$ 7,663	$ (13,085)	Distributed 200 suns safety kits to youth
Prescription Drug Overdose Prevention	$ 100,000	$ 21,051	$ 2,480	$ -	$ -	$ 7,124	$ 69,346	262 participants trained in naloxone use
Opioid Settlement	$ 76,172	$ 6,426	$ 9,880	$ -	$ 40,000	$ 2,175	$ 17,691	
Suicide Prevention	$ 45,000	$ 68,916	$ 6,000	$ -	$ -	$ 23,321	$ (53,237)	256 suicide prevention training participants
Partnership For Success SAMSHA	$ 392,969	$ 140,695	$ 110,050	$ -	$ 106,500	$ 47,611	$ (11,887)	757 participants in substance use prevention
Seatbelt Survey-ITD	$ 5,000	$ -	$ 5,000	$ -	$ -	$ -	$ -	
Families Talking Together	$ 24,340	$ 17,978	$ 680	$ -	$ -	$ 6,084	$ (402)	24 Guiding Good Choices parent participants
Nic-Free Baby & Me	$ -	$ -	$ -	$ -	$ -	$ -	$ -	142 nicotine-free test results
Millennium Fund IDHW	$ 375,660	$ 260,487	$ 27,024	$ -	$ -	$ 88,149	$ 0	1,142 students attended Catch My Breath (CMB) vape prevention class 24 Guiding Good Choices parent participants 105 CMB parent participants 52 students participated in nictoine intervention classes
WICHC Administration	$ 85,000	$ 40,275	$ 3,418	$ -	$ -	$ 13,629	$ 27,678	
Subtotal	$ 1,208,441	$ 771,928	$ 190,013	$ 4,800	$ 146,500	$ 261,220	$ (166,019)	

Service Highlights: Despite the loss of tobacco prevention funding in Spring 2025, SWDH sustained key prevention programs and community partnerships across all six counties. The first Guiding Good Choices cohort launched in the spring, strengthening familial relationships and youth decision-making skills. Fit and Fall Proof continued to operate 24 community sites, supporting injury prevention among older adults. Catch My Breath reached five counties, providing evidence-based nicotine prevention education. Each county's Community Health Action Team delivered high-impact initiatives—from the Caldwell Bike Rodeo to the Marsing Fitness Court—and were recognized nationally for the innovation and effectivess in community-led initiatives.

Environmental & Community Health Services Division *continued*

Epidemiological Response

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Epidemiological Response								
Communicable Disease	$ 73,506	$ 58,406	$ 7,357	$ -	$ -	$ 19,764	$ (12,021)	6,736 cases of reportable diseases reported
HIV Surveillance	$ 8,915	$ -	$ -	$ -	$ -	$ -	$ 8,915	
Active TB - FED	$ 16,216	$ 13,508	$ -	$ -	$ -	$ 4,571	$ (1,863)	
Active TB - State	$ 13,000	$ 13,508	$ -	$ -	$ -	$ 4,571	$ (5,079)	
Perinatal HEP B	$ 6,000	$ 5,333	$ -	$ -	$ -	$ 1,805	$ (1,138)	
Viral Hep Prev & Control	$ 10,000	$ 10,666	$ -	$ -	$ -	$ 3,609	$ (4,275)	
NEDSS	$ 93,624	$ 97,034	$ 3,195	$ -	$ -	$ 32,836	$ (39,442)	
STD Outbreak Investigation	$ 13,668	$ -	$ -	$ -	$ -	$ -	$ 13,668	
Subtotal	$ 234,929	$ 198,455	$ 10,552	$ -	$ -	$ 67,157	$ (41,236)	

Service Highlights: Our epidemiologists developed a capability for forecasting and monitoring infectious diseases. This new capability was implemented for the first time during the 2024-25 respiratory season. The accuracy of this forecasting tool for predicted versus observed results proved to be very successful. We now provide schools, long-term care facilities, healthcare organizations, and other community partners with local data that can be used to inform decisions about protective measures to reduce the disease burden in settings with vulnerable individuals.

Facility Based Programs

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Facility Based Programs								
Food Primary	$ 250,000	$ 462,528	$ 60,208	$ -	$ -	$ 156,520	$ (429,256)	2,347 restaurant inspections
Requested Inspections	$ 27,000	$ 20,313	$ 1,000	$ -	$ -	$ 6,874	$ (1,187)	
Food Safety Trainings	$ 22,800	$ 13,211	$ 5,000	$ -	$ -	$ 4,470	$ 119	234 food manager course attendees
Food Plan Reviews	$ 15,600	$ 81,850	$ 1,800	$ -	$ -	$ 27,698	$ (95,748)	205 new businesses opened
Food Secondary	$ -	$ 23,456	$ -	$ -	$ -	$ 7,937	$ (31,393)	103 temporary food events
FDA Standards	$ 22,500	$ 20,844	$ 4,000	$ -	$ -	$ 7,054	$ (9,398)	
FDA Standards Mentorship		$ -	$ -	$ -	$ -	$ -	$ -	
Swimming Pools Primary	$ 13,000	$ 11,831	$ 300	$ -	$ -	$ 4,004	$ (3,135)	60 pool inspections
Childcare Inspections	$ 117,934	$ 149,749	$ 7,100	$ -	$ -	$ 50,675	$ (89,590)	420 childcare inspections
Complaints	$ 12,200	$ 9,437	$ 360	$ -	$ -	$ 3,193	$ (790)	
CC Administration	$ 20,400	$ 12,437	$ -	$ -	$ -	$ 4,209	$ 3,754	
Animal Bites Rabies	$ -	$ 31,698	$ 300	$ -	$ -	$ 10,727	$ (42,724)	56 investigations
Subtotal	$ 501,434	$ 837,355	$ 80,068	$ -	$ -	$ 283,361	$ (699,350)	

Service Highlights: SWDH's Food Protection Program meets national standards through Food & Drug Administration (FDA) and National Environmental Health Association (NEHA) partnerships, securing funding to strengthen food safety efforts. With expanded outreach and education, including collaboration with the Idaho Hispanic Chamber of Commerce, we're protecting public health across Southwest Idaho.

Environmental & Community Health Services Division *continued*

Land Development Programs

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support	Significant Program Metrics
Land Development Programs								
Solid Waste	$ 38,559	$ 26,577	$ 3,435	$ -	$ -	$ 8,994	$ (447)	835 septic permits issued
Wastewater	$ 1,049,000	$ 671,686	$ 87,758	$ -	$ -	$ 227,298	$ 62,258	
Water Quality	$ 7,700	$ 3,730	$ 1,115	$ -	$ -	$ 1,262	$ 1,592	
Public Water Systems	$ 135,934	$ 108,049	$ 4,618	$ -	$ -	$ 36,564	$ (13,297)	
Land Development	$ 102,000	$ 108,257	$ 6,390	$ -	$ -	$ 36,634	$ (49,281)	107 approved plat maps
Nuisance: Land/Sewage/Open Dump/Other	$ -	$ 23,780	$ 900	$ -	$ -	$ 8,047	$ (32,727)	
Subtotal	$ 1,333,193	$ 942,079	$ 104,216	$ -	$ -	$ 318,800	$ (31,901)	

Service Highlights: This program safeguards Idaho's drinking water by regulating septic system design, installation, and setbacks for properties without municipal sewer systems under IDAPA 58.01.03. Last year, hundreds of permits and inspections supported responsible growth while preventing contamination. Rising rural development and staff turnover threaten continuity, making it critical to maintain this program to protect public health and ensure compliance.

Public Health Preparedness

Description	Income	Personnel	Operating	Capital	T&B	Indirect Costs	District Support
Public Health Preparedness							
Preparedness Assessment	$ 410,000	$ 221,399	$ 15,011	$ -	$ -	$ 74,921	$ 98,669
Cities Readiness	$ 142,000	$ 104,984	$ 3,141	$ -	$ -	$ 35,527	$ (1,651)
Subtotal	$ 552,000	$ 326,383	$ 18,152	$ -	$ -	$ 110,448	$ 97,018

Service Highlights: The preparedness team established "Preparedness Seasons" that correspond with seasonal public health threats. We now provide our response partners with monthly incident action plans to establish a shared operating picture that can be integrated into a larger emergency response. This new approach improved communication, transparency, and opportunities for coordination with county emergency managers and health systems for a more unified response.

Budget Calendar

Budget development is a process of fiscal strategic planning that involves decisions and guidance from the Board of Health, input from the community, and close coordination between the executive team and numerous staff across all divisions and program areas. During the internal development of the budget document, all staff are encouraged to advance budgetary concerns and needs for their programs through their respective program manager and division administrator.

Community input is sought through our Board of Health meetings, which occur monthly and are open to the public. Starting in January each year, our staff present budget elements to the board for guidance and decisions. Below is a list of elements the board acts on leading up to the final approved proposed budget.

1. 5-Year Facility and IT Infrastructure Plan
2. Changes in Fees
3. Change in Employee Compensation
4. Opioid Settlement Plan
5. Change in County Contributions
6. Proposed Budget

In the month of May, the public has additional opportunities to provide input as the Director and Financial Officer present the proposed budget to each board of county commissioners in the district (i.e., Adams, Canyon, Gem, Owyhee, Payette, and Washington). Furthermore, the proposed budget is printed in each local newspaper in all six counties with a notice for the public hearing where the proposed budget will be approved by the Budget Committee.

Section 39-423, Idaho Code describes the duties of the Budget Committee. The chairman of the Boards of County Commissioners located within the public health district are constituted as the Budget Committee. The Board of Health will submit to the Budget Committee by the first Monday in June of each year the preliminary budget for the public health district and the estimated cost to each county, as determined by Section 39-424, Idaho Code. The Budget Committee must meet and hold a public hearing on the proposed budget on or before the first Monday in July. A budget for the public health district shall be agreed upon and approved by a majority of the Budget Committee. Such a determination shall be binding upon all counties within the district and the district itself.

Financial Information

Basis of Accounting

Basis of accounting refers to when revenues and expenditures are recognized in the accounts and reported in the financial statements, regardless of the measurement that is applied. All funds are accounted for using the modified accrual basis of accounting. Fund revenues are recognized when they become measurable and available as net current assets. Measurable means the amount of the transaction can be determined and available means the amount is collectible within the current period or soon enough thereafter to be used to pay liabilities of the current period.

Expenditures are also generally recognized under the modified accrual basis of accounting.

Cost Accounting

The district uses cost accounting to determine the proper allocation to recover costs for services provided. For each service or program, in addition to direct staff support and allocations for supplies and services, it also receives support from the administrative and operations staff and benefits from centralized services. These indirect costs (also known as administrative and overhead costs) need to be allocated to each major service or program in order to determine the full cost of providing services. Centralized service costs are typically budgeted and advanced by District dollars. District dollars are noncommitted funds that include contributions paid by the counties in the district in accordance with Section 39-424, Idaho Code and fee revenue. Cost allocation is necessary to ensure that each of these operating funds share the administrative and overhead costs equitably.

Budget Request Summary

The Budget Request Summary section details the:

- SWDH's budget request,
- County contributions, and
- Summarizes the service delivery and budgetary information for each division as follows: mission, services, and budget request highlights.



SOUTHWEST DISTRICT HEALTH

MASTER FACILITIES PLAN
&
COMPREHENSIVE FINANCIAL PLAN

APRIL 2026

SOUTHWEST DISTRICT HEALTH

CLEARWATER FINANCIAL

ACKNOWLEDGEMENTS

Southwest District Health Board of Health

Kelly Aberasturi, Chairman, Owyhee County
Zach Brooks, Vice Chairman, Canyon County
Jennifer Riebe, Executive Council Representative & Trustee, Payette County
Jim Harberd, Washington County
Kirk Wille, Gem County
John Tribble, MD, Physician Representative

Southwest District Health Staff

Nikole Zogg, District Director
Don Lee, Chief Operating Officer
Sam Semple-Kenney, (former) Project Manager
Monique Evancic, Public Information Officer
Katrina Harshman, Management Assistant
Beth Kriete, Family & Clinic Services Division Administrator
Ben Shatto, Environmental & Community Health Services Division Administrator
Jeff Buckingham, Program Manager
Charlene Cariou, Program Manager
Karen Douglass, Office Specialist
Dr. Perry Jansen, Medical Director
Berenice Medina, Community Health Strategist
Alivia "Ali" Miller, Family Nurse Practitioner
Brian Mohr, Building Superintendent
Dean Page, Manager, Information Technology
Ligia Powell, (former) Customer Service, Office Services Supervisor II

Citizens' Committee

Thomas Butler, City Councilor, City of Emmett
Adam Gonzalez, (former) Emergency Services Manager, Payette County
Surine Greenway, Co-Facilitator, Owyhee County Community Action Health Team
Patrick Nauman, Owner, Weiser Classic Candy
Andy Rodriguez, Chief Executive Officer, Nampa Housing Authority
Julie Yamamoto, Former State Representative, Idaho Legislative District 11

ACKNOWLEDGEMENTS (continued)

Internal Stakeholders

Karen Douglass, Office Specialist
Dr. Perry Jansen, Medical Director
Berenice Medina, Community Health Strategist
Ali Miller, Family Nurse Practitioner
Brian Mohr, Building Superintendent
Jennifer Riebe, Payette County Commissioner
Nikole Zogg, District Director

External Stakeholders

Greg Alexander, Principal, Emmett School District
Angie Barkell, City Clerk, Owyhee County
Kathy Bayless, Interim Director of Migrant & Seasonal Head Start, Community Council of Idaho
Jean Fitzgerald-Mutchie, Community Health, St. Luke's
Julie Good, Mayor, City of New Meadows
Heidi Hart, CEO, Terry Reilly Health Services
Ken Hart, CEO, Valley Family Health Care
Kim Keller, Dentist, Nampa Smiles
Bryan Kida, Outreach Specialist, City of Caldwell
Hilary Kile, Community Health, Weiser Memorial
Alejandro Necochea, MD, Physician, St. Luke's
Janet Northrup, Vineyard & Winery Owner, Licensed by SWDH (food, septic, PFS)
Gordon Petrie, Mayor, City of Emmett
Sarah Poe, Deputy Division Administrator (Public Health), Idaho Department of Health & Welfare
Michaela Schulte, Chief Medical Officer, St. Luke's
Norm Stewart, Superintendent, Marsing School District
Kim Stutzman, MD, Program Director Family Medicine Residency, Full Circle Health
Ray Talbot, Sheriff's Office, Canyon County
Jarom Wagoner, (former) Mayor, City of Caldwell

Consultant Team

Jace Perry, Clearwater Financial, LLC
Abbey Erquiaga, Clearwater Financial, LLC
August Williams, Clearwater Financial, LLC
Amanda Swails, Amanda Swails Design, LLC

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PART I:
INTRODUCTION

1. EXECUTIVE SUMMARY

Southwest District Health (SWDH or the District) serves a six-county region that is experiencing steady population growth and demographic change. Over the coming decades, that growth will influence service demand, facility utilization, geographic access, and operational complexity. This Master Facilities Plan (MFP) and Comprehensive Financial Plan (CFP) (the Plan) (collectively The Plan) provides a structured framework to guide thoughtful, phased decision-making through a 2040 planning horizon, with longer-term projections used to evaluate future system capacity.

This document is not a proposal for expansion. Rather, it evaluates how the District can best use, adapt, and improve its existing facilities while preparing responsibly for future community needs. This Plan emphasizes maximizing the use of existing assets, aligning operational capacity with service demand, and maintaining flexibility as conditions evolve. It is intended to support informed governance decisions grounded in data, stakeholder input, and fiscal stewardship.

The planning process incorporated demographic analysis, facility assessments, operational review, internal leadership engagement, external stakeholder interviews, and a District-wide community survey. Across these inputs, several consistent themes emerged:

- **Public Awareness and Understanding** Many residents associate the District primarily with inspections or regulatory functions. Awareness of prevention programs, behavioral health services, and broader public health initiatives is uneven, which affects both perception and utilization.

- **Behavioral and Mental Health Needs** Stakeholders consistently identified behavioral and mental health as a significant and growing community concern, particularly for youth and rural populations. The District plays an important role within a broader regional system, and opportunities exist to expand access through coordination, targeted service delivery, and alignment with community partners.

- **Geographic Access and Equity** The District's large geographic footprint creates uneven access. Residents in rural areas face longer travel distances and transportation barriers. Maintaining an appropriate presence across counties remains important to service delivery and community trust.

- **Facility Conditions and Capacity** Facilities across the District vary in age, configuration, and flexibility. While the Caldwell site functions effectively as a central hub, several satellite locations present limitations related to space, privacy, and adaptability to evolving service models.

- **Fiscal Stewardship and Long-Term Planning** Stakeholders generally view the District as responsible with public funds. At the same time, there is interest in clearer articulation of long-term priorities and how facilities, services, and financial strategies align with projected growth.

1. EXECUTIVE SUMMARY (CONTINUED)

Based on these findings, the Plan prioritizes a set of coordinated strategies to improve service delivery and long-term sustainability. These include increasing public awareness and utilization of services, expanding service hours and availability, strengthening staffing capacity in key program areas, advancing partnership-based service models, and implementing targeted facility improvements where they support operational efficiency and access.

This Plan emphasizes phased, measured investment. It prioritizes maximizing the use of existing facilities, identifying targeted modernization where warranted, and aligning any future facility improvements with verified demand and staffing capacity. In many cases, operational adjustments, such as expanded service hours or staffing alignment, may improve access and utilization prior to consideration of physical expansion.

The 2040 planning horizon serves as the primary benchmark for evaluating near- and mid-term facility needs. Longer-term projections are used to ensure that decisions made today remain viable under future growth conditions. This approach allows the District to plan deliberately, avoid overbuilding, and preserve flexibility as service models evolve.

Ultimately, this document provides a transparent decision-making framework. It equips leadership and the Board of Health with a structured approach to evaluate tradeoffs, align operational realities with community needs, and make informed, phased investments that support long-term sustainability.

2. DISTRICT FRAMEWORK & EXISTING SERVICE FOOTPRINT

Statutory Authority and Governance

Southwest District Health (SWDH) is a multi-county public health district established under Idaho law pursuant to Idaho Code Title 39, Chapter 4. Health districts are statutory governmental entities created to protect and promote public health at a regional level.

Under state law, health districts are governed by a Board of Health composed of County-appointed representatives, which may include County officials and additional appointed members representing community and professional perspectives. The Board is responsible for policy direction, fiscal oversight, and ensuring that public health services are delivered in accordance with state mandates and local needs.

Pursuant to Idaho Code, the District Board of Health is authorized and required to administer and enforce state and district health laws, regulations, and standards, and to undertake actions necessary to preserve and protect public health and advance preventive health practices. This includes coordination with the Idaho Department of Health and Welfare and the Department of Environmental Quality, as well as the ability to enter into agreements to deliver services and support statewide public health objectives.

The District is also empowered to:

- Determine the location and operation of its main and satellite offices
- Provide public health services directly or through contracts with governmental and community partners
- Establish fees for services where appropriate to support cost recovery
- Acquire, lease, and manage facilities necessary to carry out public health functions
- Accept and administer grants, funding, and other resources to support service delivery
- Enforce public health regulations and take action to address threats to community health, including communicable disease response and environmental health risks

In addition, Idaho Code provides districts with authority to address public health concerns such as disease control, environmental health regulation (including waste and sanitation oversight), and nuisance abatement, ensuring the District can respond to both routine and emergent health risks.

2. DISTRICT FRAMEWORK & EXISTING SERVICE FOOTPRINT

Health districts in Idaho exist to provide coordinated public health services across County lines. This regional model allows participating counties to:

- Share infrastructure and administrative costs
- Leverage economies of scale
- Coordinate communicable disease response
- Deliver specialized services that may not be sustainable at a single-county level
- Maintain consistency in environmental health and regulatory functions

The regional structure is particularly important in rural areas, where population density alone may not support standalone service systems.

Core Public Health Services

Southwest District Health (SWDH) delivers a comprehensive set of public health services in alignment with Idaho Code requirements and statewide public health priorities. These services are designed to protect community health, prevent disease, promote wellness, and ensure environmental safety across the District's six-county region. SWDH's services generally fall into the following categories:

Clinical and Preventive Health Services

The District provides direct clinical services focused on prevention, early intervention, and access to care, particularly for underserved populations. These services include:

- Immunizations for children and adults
- Women, Infants, and Children (WIC) nutrition services
- Family planning and reproductive health services
- Communicable disease testing, treatment coordination, and follow-up
- Limited primary care and screening services, depending on location

Behavioral Health Services

SWDH provides behavioral health services that support mental health , often in coordination with regional partners. Services may include:

- Counseling and therapy services
- Youth and family-focused behavioral health support
- Referral and coordination with external providers

2. DISTRICT FRAMEWORK & EXISTING SERVICE FOOTPRINT

Environmental Health Services

The District is responsible for protecting public health through environmental health regulation and oversight. These services include:

- Food safety inspections and licensing
- Septic system permitting and inspections
- Drinking water and well testing
- Solid waste and waste disposal oversight (discontinued as of 07/01/2026)
- Public health nuisance investigations and enforcement
- Childcarehealth and safety inspections

Epidemiology and Communicable Disease Control

SWDH monitors, investigates, and responds to communicable diseases and public health threats. Responsibilities include:

- Disease surveillance and reporting
- Case investigation and contact tracing
- Outbreak response and mitigation
- Coordination with state and federal public health agencies

Community Health and Prevention Programs

The District implements programs aimed at improving population health outcomes and addressing key risk factors. These include:

- Health education and outreach
- Chronic disease prevention initiatives
- Maternal and child health programs
- School and community-based programming

2. DISTRICT FRAMEWORK & EXISTING SERVICE FOOTPRINT

Public Health Emergency Preparedness and Epidemiology Response (PHEPER)
SWDH prepares for and responds to public health emergencies in coordination with local, regional, and state partners. This includes:

- Emergency response planning and coordination
- Mass vaccination and distribution planning
- Community response to natural disasters and public health emergencies

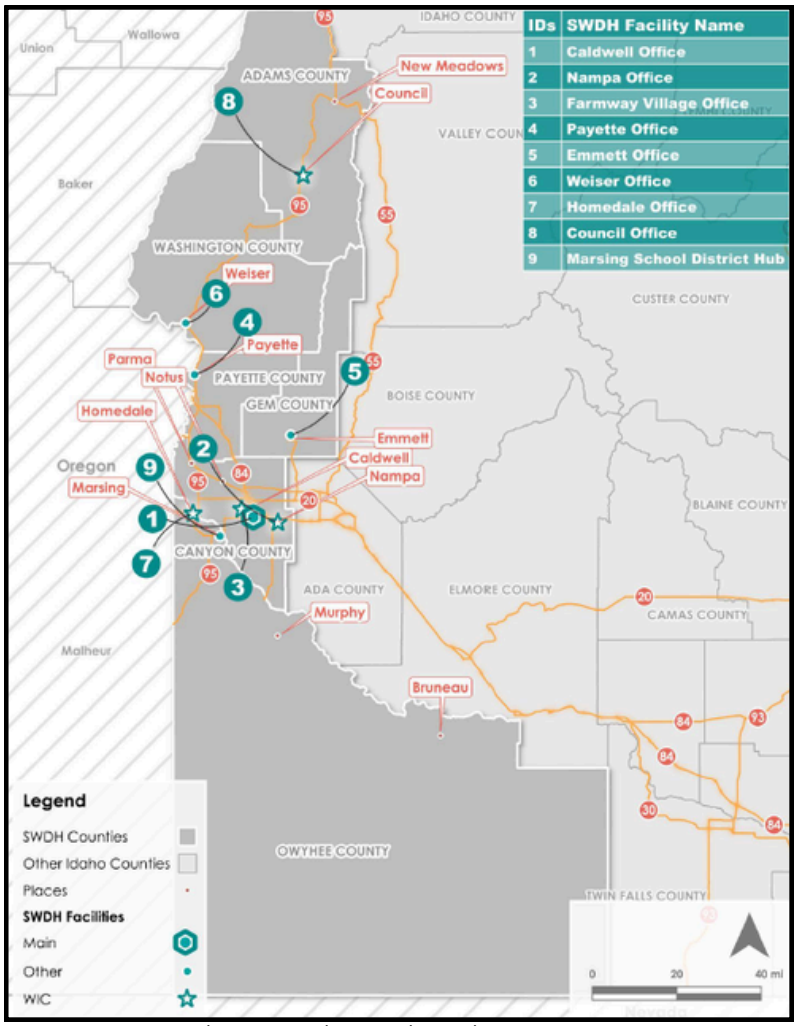
The District's service portfolio reflects both statutory responsibilities and locally identified needs. Service availability and delivery models vary by location based on population size, demand, staffing capacity, and facility constraints. As a result, SWDH uses a combination of centralized services, satellite offices, and shared or partner-based models to maintain access across its diverse geographic region.

2. DISTRICT FRAMEWORK & EXISTING SERVICE FOOTPRINT

Overview of Current Facilities by County

Southwest District Health delivers services through a combination of owned facilities, leased space, and shared community locations. This distributed network of facilities is designed to maintain geographic access across all six counties while supporting a range of public health programs.

Service availability varies by location based on population size, demand, staffing capacity, and facility constraints. The summary below provides an overview of each site and the primary services offered. While several locations are described as "full-service satellite offices," it is important to note that not all services are continuously staffed or delivered on-site. In many cases, specialized staff are based at the Caldwell hub and travel to satellite locations on a scheduled basis or provide services through regional, mobile, or coordinated delivery models. As a result, services may be available within a county but not consistently available at each physical location.



Source: Demographic Report (Appendix 11.0)

Canyon County

- **Caldwell (Main Office – District Hub):** The Caldwell facility serves as the District's primary administrative and clinical hub and houses all major service divisions. Services provided include clinic services, behavioral health, WIC, environmental health, epidemiology, emergency preparedness, community health programming, and administrative functions. The site provides substantial parking capacity and available land area, supporting flexibility for future reconfiguration or expansion if warranted.
- **Nampa (WIC Only – Leased):** The Nampa site provides WIC services within leased space at a community-based location.
- **Farmway (Services Relocated):** Women, Infants, & Children (WIC) services previously provided at this location have been relocated to an alternate community facility within the Farmway area.

2. DISTRICT FRAMEWORK & EXISTING SERVICE FOOTPRINT

Payette County

- **Payette (Full-Service Satellite Office)**: The Payette facility functions as a full-service satellite office and primary service location for the County. Services include clinic services (limited schedule), WIC, environmental health (primarily delivered through centralized staff and field-based services), community health programming (limited or primarily delivered through centralized or partner-based models), and administrative support functions.

Washington County

- **Weiser (Full-Service Satellite Office)**: The Weiser facility provides local access to core public health services, including clinic services (limited schedule), WIC, environmental health (primarily delivered through centralized staff and field-based services), community health programming (limited or primarily delivered through centralized or partner-based models), and administrative support functions.

Gem County

- **Emmett (Full-Service Satellite Office)**: The Emmett facility serves as the primary service location for Gem County and supports clinic services (limited schedule), WIC, environmental health (primarily delivered through centralized staff and field-based services), community health programming (limited or primarily delivered through centralized or partner-based models), and administrative support functions.

Owyhee County

- **Homedale (WIC Only – Shared)**: The Homedale site provides WIC services within a shared community facility.
- **Marsing Hub (Clinic – Shared Facility)**: The Marsing Hub operates as a partner-based, multi-tenant facility providing clinic services in coordination with other community providers. Services are delivered on a set schedule aligned with school hours, which supports access for school-based populations but may limit availability for other community members. This model supports integrated service delivery and local access in a rural setting.

Adams County

- **Council (WIC Only – Shared)**: The Council site provides WIC services on a limited schedule within a shared community facility.

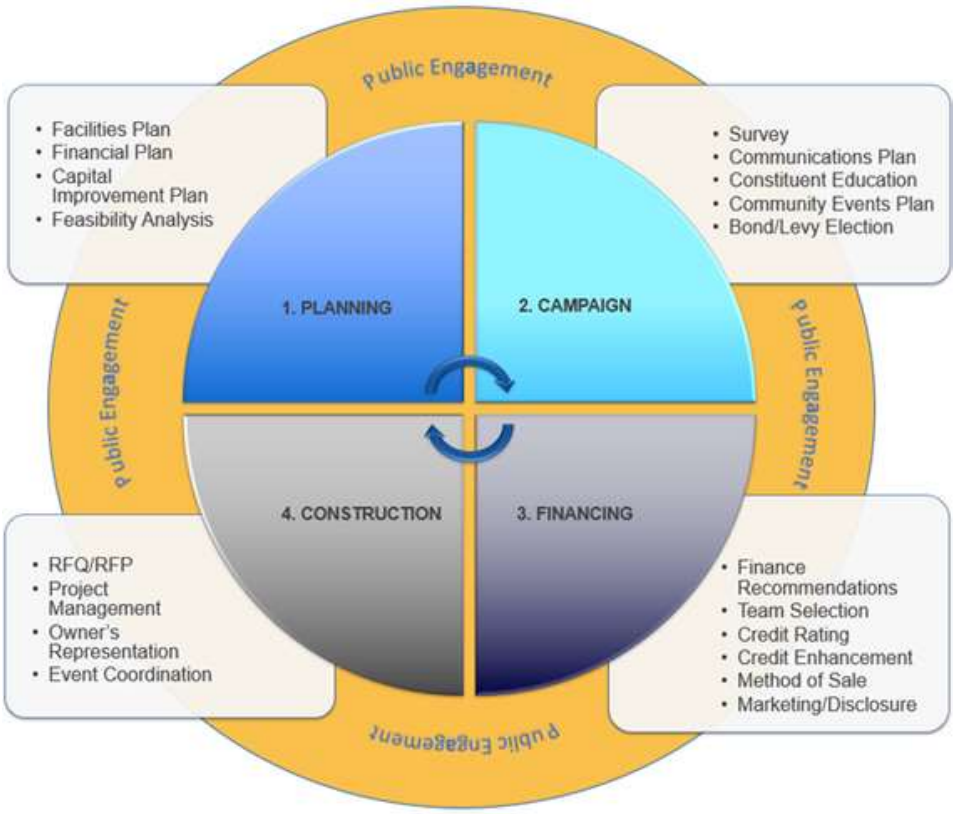
3. PROJECT OVERVIEW
(OUR PROCESS)

The Master Facilities Plan (MFP) and Comprehensive Financial Plan (CFP) process was initiated in February 2025 to provide Southwest District Health with a structured, data-informed framework for evaluating its long-term facility and financial needs.

The purpose of this process is to ensure that SWDH can continue to deliver required public health services across its six-county region in a manner that is operationally sustainable, fiscally responsible, and aligned with community needs. The effort evaluates both existing conditions and future considerations, recognizing that facilities, staffing capacity, and funding strategies must function together.

This planning effort was conducted in partnership with Clearwater Financial and followed a phased methodology designed specifically for public sector organizations.

Figure 1: The Comprehensive Process



Source: Clearwater Financial

3. PROJECT OVERVIEW (CONTINUED)

3.1 Master Facility Plan & Comprehensive Financial Plan Process

The MFP and CFP process follows a structured lifecycle that moves from initial alignment and data gathering to analysis, planning, and long-term implementation. The framework includes Initiation, Analysis, Planning, Recommendations, Implementation, and Ongoing Review.

- **Initiation** established project scope, assumptions, and key objectives through leadership interviews and document review.
- **Analysis** examined demographic trends, facility conditions, operational performance, and stakeholder input.
- **Planning** translated these findings into practical, phased facility strategies aligned with a 2040 planning horizon.
- **Recommendations** identified prioritized actions to guide decision-making and implementation.

This document captures the Initiation, Analysis, Planning, and Recommendations phases. Implementation and ongoing review will occur following Board direction.

3.2 Process Detail

The process began with a comprehensive review of the District's land and facility assets. Existing conditions were documented for owned properties, and available information was gathered for leased and shared locations. The consultancy conducted site visits to observe physical conditions, space utilization, workflow, and accessibility considerations.

Several leased or shared locations were not physically toured; however, department interviews and supporting documentation provided sufficient information to evaluate operational functionality and constraints.

Adjacency diagrams were developed to illustrate how departments interact and where functional relationships are strongest. These diagrams highlight operational dependencies and identify where physical layout may influence efficiency and service delivery. Public access was a key consideration in this evaluation.

The adjacency analysis identified the Caldwell facility as having the highest concentration of strong interdepartmental relationships. Clinic Services indicated the greatest number of strong adjacencies within a single division, while Community Health showed the broadest interaction across divisions. Administrative and support functions demonstrated connections across all program areas, reflecting their District-wide role.

Following facility review and adjacency analysis, structured interviews were conducted with District leadership, department heads, and staff. These discussions provided insight into operational conditions, space limitations, workflow constraints, and future needs.

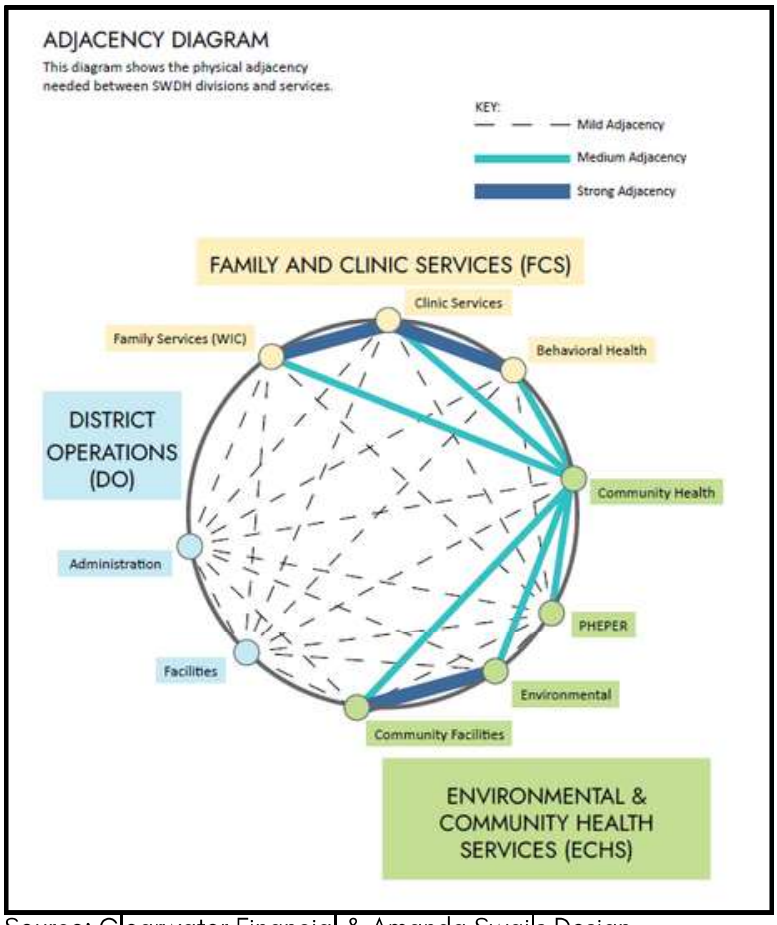
3. PROJECT OVERVIEW (CONTINUED)

Based on these findings, the planning team developed a phased set of facility strategies focused on improving functionality, supporting service delivery, and maintaining flexibility over time. These strategies emphasize renovation, reconfiguration, partnership opportunities, and phased implementation.

Where appropriate, order-of-magnitude cost ranges were developed to support planning-level comparison of potential improvements. These figures are intended to inform decision-making and will require refinement through future design and engineering work.

The process emphasized objective evaluation rather than predetermined outcomes. Facility planning considerations were assessed alongside operational realities and projected growth to support measured, long-term decision-making.

Figure 2: Adjacency Diagram



Source: Clearwater Financial & Amanda Swails Design

3. PROJECT OVERVIEW (CONTINUED)

3.3 Public Engagement

Public engagement was integrated throughout the MFP and CFP process to support transparency, gather input, and improve alignment between facility planning and community needs.

Engagement efforts were designed to inform stakeholders about the planning effort and provide structured opportunities for feedback. A detailed record of engagement activities, including meeting summaries and supporting materials, is included in the Appendices.

Key engagement components included:

- Social media communications
- Project information hosted on a dedicated SWDH webpage, including a project overview and ongoing updates
- Homepage banner placement to increase visibility and direct users to project information
- Press releases related to project initiation and the community survey
- Stakeholder interviews across the District's service area
- Citizens' Committee formation and meetings
- A district-wide community survey
- Survey promotion through multiple channels, including:
  - Flyers distributed at District facilities
  - Display of survey information on lobby monitors within SWDH locations
  - Inclusion in District communications and newsletters

Engagement efforts were implemented using a combination of digital communication, in-facility visibility, and direct stakeholder outreach. These strategies were designed to maximize participation within available resources while maintaining consistency with the District's communication practices.

Additional outreach strategies were identified and discussed throughout the planning process, including expanded partner-based distribution through schools, healthcare providers, and community organizations; broader institutional outreach across the District's service area; and increased use of digital and promotional channels to expand visibility. These strategies were evaluated in the context of available staff capacity, budget considerations, and coordination requirements. As a result, engagement efforts were prioritized toward approaches that could be implemented effectively within existing resources while still supporting meaningful community participation.

3. PROJECT OVERVIEW (CONTINUED)

Citizens' Committee

A Citizens' Committee was convened to provide community perspective and structured input throughout the MFP and CFP process. The Committee consisted of six members representing a range of geographic areas and professional backgrounds across the District's six-county region.

Members brought diverse experience from fields such as local government, healthcare, education, business, and community leadership. This range of perspectives helped ensure that discussions reflected both system-level considerations and community-level experience.

Committee members participated in facility tours, reviewed background materials, and engaged in guided discussions focused on service delivery, facility conditions, and long-term planning considerations.

The Committee played an important role in helping to contextualize technical findings and identify how facility and operational decisions may be experienced at the community level. Their input provided an additional layer of perspective to complement demographic analysis, facility assessments, and stakeholder engagement.

In addition to participating in the planning process, the Committee developed a formal recommendation letter for consideration by the Board of Health. The recommendations reflect the District's operational realities and align closely with the priorities identified in this Plan.

Key themes from the Committee's recommendations include:

- **Prioritizing service availability before facility expansion** The Committee emphasized expanding hours of operation and improving service consistency at existing locations before pursuing major facility investment. This reinforces the Plan's focus on maximizing existing assets and evaluating demand under more consistent operating conditions.
- **Strengthening public awareness and outreach** The Committee identified a need to improve communication regarding available services, locations, and hours of operation. Expanded outreach, including engagement with Spanish-speaking and Hispanic communities, was identified as an opportunity to improve access and utilization.
- **Addressing accessibility and facility access** The Committee highlighted the importance of improving ADA accessibility across District facilities, including building access, parking, and interior functionality. These observations support the Plan's emphasis on targeted facility improvements.
- **Expanding partnership-based service models** The Committee encouraged continued exploration of partnerships and co-location opportunities to improve access while maintaining a visible presence across communities. This aligns with the District's use of shared facility models and hub-based service delivery approaches.

3. PROJECT OVERVIEW (CONTINUED)

Citizens' Committee (continued)

The Committee also acknowledged the complexity of facility and service planning decisions and recognized that implementation will require ongoing evaluation and alignment with staffing capacity, service demand, and financial resources.

The alignment between Committee input and the Plan's recommendations reflects a consistent understanding of the District's priorities across stakeholders. The full Citizens' Committee recommendation letter is included in the Appendix.

Stakeholder Interviews

Stakeholder interviews were conducted with both internal staff and external partners to better understand how Southwest District Health is perceived, how services are delivered, and where opportunities exist to improve access, coordination, and long-term planning.

Internal interviews included staff and leadership across program areas and functional roles, while external interviews included representatives from local governments, healthcare providers, schools, nonprofits, and community organizations across the District's service area.

These interviews were designed to capture both operational insight and community perspective. Full summaries of internal and external stakeholder input are included in the Appendix 11.4. Across both internal and external interviews, several consistent themes emerged:

- **Limited public awareness of services** Stakeholders consistently noted that many residents associate the District primarily with environmental health and regulatory functions, such as inspections. Awareness of clinical services, behavioral health programs, and preventive health initiatives is more limited, and in some cases, residents are unclear about what services are offered and where they can be accessed. This lack of clarity contributes to uneven utilization across the District. Stakeholders indicated that some services may be underutilized not due to lack of need, but due to limited awareness or confusion about availability. This reinforces the importance of clear communication, targeted outreach, and consistent service delivery to ensure communities are able to fully access available services.
- **Behavioral and mental health as a critical and growing need** Both internal and external stakeholders identified behavioral health as one of the most significant gaps across the region. Demand is increasing across all age groups, particularly for youth, and is expected to remain a central focus for future service planning.
- **Facility limitations and inconsistencies across locations** Stakeholders described variation in facility conditions across the District, with outer clinics more frequently identified as constrained in terms of space, privacy, and accessibility. These observations align with facility assessment findings and support targeted improvements over time.

3. PROJECT OVERVIEW (CONTINUED)

Stakeholder Interviews

- **Geographic access and service availability challenges** The District's large service area creates barriers related to travel distance, transportation, and service availability. Stakeholders emphasized the importance of maintaining a distributed presence while exploring ways to improve access through expanded hours, partnerships, and flexible service delivery models.
- **Strong reputation with opportunity to improve visibility and coordination** Stakeholders consistently described the District as professional, responsive, and fiscally responsible. At the same time, many noted that communication with the public and partners could be more consistent and proactive, particularly in clarifying services, priorities, and long-term direction.
- **Communication and partner engagement opportunities** Several stakeholders noted limited awareness of service availability, referral processes, and points of contact. Feedback suggests an opportunity to strengthen communication through more regular updates, clearer points of contact, and more structured opportunities for coordination, such as partner meetings or direct, unsolicited outreach to key organizations. While communication currently occurs through emails, newsletters, and program-specific interactions, it was often described as inconsistent and primarily occurring after partners have initiated contact or established relationships.

3. PROJECT OVERVIEW (CONTINUED)

These themes, including access, awareness, service alignment, and communication, were consistent across both internal and external perspectives and closely align with the findings from demographic analysis, facility assessment, and operational review.

The alignment across stakeholder groups reinforces the key priorities identified in this Plan and provides additional validation for a phased, operationally grounded approach to facility and service planning.

While internal stakeholders emphasized operational and facility constraints, external stakeholders more frequently focused on access, awareness, and community experience, providing complementary perspectives that informed plan development.

Community Survey

In addition to stakeholder interviews, Southwest District Health conducted a community survey to gather input directly from residents across the District. The survey was open from April through October 2025 and received 394 responses from residents across all six counties. Survey participation in Spanish was limited relative to the District's demographic composition, indicating an opportunity to expand outreach and engagement efforts to better reach Spanish-speaking residents and improve awareness of available services.

The survey was designed to understand how residents access services, what services they value most, and what challenges they experience related to facilities, awareness, and service delivery. The full survey results are included in the Appendix 11.5.

Overall, survey responses reinforce many of the themes identified through stakeholder interviews, while also providing additional detail on community priorities and lived experiences. Key findings include:

- **Strong satisfaction with services, with opportunity to improve access and awareness** Respondents reported generally positive experiences with SWDH services. At the same time, lack of awareness and limited information were identified as barriers to access, reinforcing feedback from both internal and external stakeholders.
- **Core services are both the most used and most needed** The most frequently used and most requested services were consistent, including well water testing, septic systems, immunizations, and medical services. This alignment indicates that existing services remain highly relevant to community needs.
- **Behavioral health and preventive services identified as growing needs** Survey responses highlighted demand for mental health services, preventive care, and youth-focused programming, consistent with themes identified in stakeholder interviews.
- **Access challenges related to distance, hours, and scheduling** While many respondents reported no major barriers, others identified travel distance, limited hours, and scheduling challenges as key obstacles to accessing services. These findings support consideration of expanded service delivery models, including extended hours, mobile services, and telehealth.

3. PROJECT OVERVIEW (CONTINUED)

Community Survey (continued)

- **Facility experience varies by location** Respondents generally rated facilities positively, particularly the Caldwell main office, while smaller or more rural locations received lower or more varied ratings. These findings align with stakeholder input regarding inconsistencies across sites.
- **Awareness and communication remain key opportunities** Many respondents reported that they learn about services through social media, word of mouth, or healthcare providers, suggesting that communication strategies play a significant role in service utilization.
- **Opportunities to expand engagement across language groups** Survey participation in Spanish was limited, with only a small number of responses submitted in Spanish. Given the demographic composition of the District, this suggests an opportunity to expand outreach and engagement efforts to better reach Spanish-speaking residents and improve awareness of available services.

Taken together, the survey results reinforce the major themes identified through stakeholder engagement, particularly around awareness, access, behavioral health, and facility consistency. The alignment between qualitative and quantitative input provides a strong foundation for the priorities and recommendations outlined in this Plan.

The consistency across internal, external, and community input provides a high level of confidence in the priorities identified and supports a phased, data-informed approach to facility and service planning.

3.4 Data Limitations

At the time of this assessment, SWDH service utilization patterns are influenced by several structural factors that limit the ability to fully interpret true community demand. These include variability in operating hours across locations, differences in service availability by site, and known gaps in community awareness of available services.

Across the District, some services and locations report being consistently booked out, while others experience lower utilization. However, these patterns cannot be interpreted as direct indicators of demand without first addressing these structural inconsistencies.

Additionally, community engagement results indicate that awareness of SWDH services remains limited. This is particularly evident in populations with significant representation in the District, such as Spanish-speaking residents, who were minimally represented in survey responses despite comprising a meaningful portion of the population.

As a result, current utilization data should be understood as reflective of existing access conditions, not necessarily true underlying demand.



PART II:
Master Facilities Plan

4. DEMOGRAPHIC & SERVICE DEMAND CONTEXT

Southwest District Health serves a six-county region that has experienced sustained population growth over the past two decades. Projections indicate continued growth through 2040, with longer-term increases possible under higher-growth scenarios.

Understanding both the pace and distribution of this growth is essential to evaluating long-term facility adequacy and service delivery capacity. Population trends influence not only how much space is needed, but how services are delivered, where they are located, and how staffing is deployed across the District.

4.1 Regional Growth Trends

The table below summarizes projected population growth for each county within the District. The 2040 projection serves as the primary planning benchmark for facility evaluation. The 2060 projection is used as a longer-term reference to assess the durability of near- and mid-term planning decisions.

County	2020 Census	2040 Projection	2040 Increase (%)	2060 Projection	2060 Increase (%)
Adams	4,379	5,341	**22%**	6,304	**44%**
Canyon	231,105	336,028	**45%**	420,243	**82%**
Gem	19,123	24,202	**27%**	29,281	**53%**
Owyhee	11,913	13,821	**16%**	15,729	**32%**
Payette	25,386	31,544	**24%**	37,702	**49%**
Washington	10,500	11,845	**13%**	13,191	**26%**
District Total	302,406	422,782	**40%**	522,451	**73%**

4. DEMOGRAPHIC & SERVICE DEMAND CONTEXT

Population growth is not evenly distributed across the District. Canyon County is expected to continue experiencing the largest numeric growth, while Gem and Payette Counties are projected to see large increases relative to their population base. More rural counties may experience slower overall growth but will continue to face changing demographic patterns and service needs.

The 2040 planning horizon provides a practical timeframe for evaluating facility adaptation, renovation, and phased improvements. Longer-term projections are used to ensure that decisions made today remain viable under future growth conditions.

While percentage growth rates are highest in several smaller counties, total population increases remain concentrated in Canyon County due to its larger base population. As a result, even modest percentage growth in Canyon County represents a significantly larger number of residents compared to higher percentage increases in more rural counties.

These differences have important implications for service delivery and resource allocation. Larger population centers may require greater overall service capacity to meet demand, while smaller and more rural counties may require more targeted or flexible delivery approaches to maintain access despite lower population density.

Together, these factors reinforce the importance of balancing scale and equity in planning decisions, ensuring that resources are allocated in a way that both addresses the largest areas of demand and maintains appropriate access across all counties.

4. DEMOGRAPHIC & SERVICE DEMAND CONTEXT

4.2 County-Level Demographic Variation

Each county within the District presents unique characteristics that influence service demand and delivery.

- **Canyon County** continues to experience sustained population growth and urban expansion, increasing demand for clinical services, behavioral health, communicable disease response, and environmental health oversight.
- **Gem and Payette Counties** are projected to grow at moderate rates, placing additional pressure on existing satellite facilities and staffing capacity.
- **Washington, Adams, and Owyhee Counties** face more modest population growth but present rural access challenges. Travel distances, transportation limitations, and dispersed populations influence how services are delivered and where facility presence is most critical.

These variations reinforce the importance of a distributed service model while also highlighting differences in facility utilization, staffing needs, and service delivery strategies across the District.

4.3 Age Distribution and Service Implications

Changes in age distribution will also influence public health service demand. Growth among younger families affects demand for WIC services, immunizations, and early childhood programming. At the same time, aging populations influence needs related to chronic disease prevention, environmental health, and behavioral health services.

Stakeholder input consistently identified behavioral and mental health, particularly for youth, as a growing area of need across multiple counties.

These demographic trends affect how facilities are used. Planning must consider not only total space, but also room configuration, privacy requirements, exam room capacity, and flexibility to support evolving program priorities.

Age distribution patterns vary across the District's counties and should be considered alongside population growth and geographic access when evaluating service delivery models.

More urbanizing areas such as Canyon County are experiencing growth across both younger and older populations, requiring a broad range of services spanning maternal and child health, behavioral health, and chronic disease prevention. In contrast, more rural counties such as Owyhee and Adams exhibit characteristics associated with aging populations and lower population density, which may increase the importance of mobile services, periodic clinics, and targeted programming for older adults.

These differences reinforce that facility planning and service allocation strategies should be responsive to local demographic conditions rather than uniformly applied across all counties.

4. DEMOGRAPHIC & SERVICE DEMAND CONTEXT

4.4 Implications for Facility Planning

Population growth does not automatically require new construction. However, sustained increases in residents and shifting service patterns will influence how existing facilities function over time.

Facility planning must evaluate whether current buildings can support the projected demand by 2040 through reconfiguration, renovation, and operational adjustments. In many cases, service availability is influenced as much by staffing capacity and operating hours as by physical space.

Demographic changes may affect:

- Waiting area capacity and circulation
- Exam room utilization
- Behavioral health consultation space
- Confidential service delivery areas
- Administrative workspace needs
- Technology and infection control requirements

The purpose of this analysis is not to establish predetermined capital projects, but to determine whether the District's existing facilities can adapt to projected conditions while maintaining efficient and accessible service delivery.

The operational assessment that follows builds on this demographic context to evaluate how staffing, workflow, and service distribution interact with facility performance.

5. OPERATIONAL ASSESSMENT

Facility planning must be considered in the context of how services are delivered, how staff are deployed, and how residents access programs across the District's six-county region. Operational realities influence not only space needs, but also the effectiveness and sustainability of any facility strategy.

5.1 Service Delivery Model

Southwest District Health operates a distributed service model designed to maintain geographic access across both urban and rural communities. Services are delivered through a combination of:

- A central administrative and clinical hub in Caldwell
- Full-service satellite offices in select counties
- Program-specific locations, such as WIC sites
- Shared or partner facilities in rural areas

This model reflects both geographic necessity and operational practicality. Maintaining a physical presence across counties supports accessibility and community trust, particularly in rural areas.

At the same time, service demand varies by location based on population density, demographics, and transportation access. As a result, facility utilization and staffing patterns differ across sites.

This section describes the District's current service delivery model; recommendations related to service adjustments are addressed later in the report and are informed by considerations of data limitations, operating hours, and community awareness.

While maintaining a geographic presence across all counties is critical to accessibility and community trust, service delivery does not need to be uniform across all locations. Differences in population size, demand, staffing availability, and facility capacity require a flexible approach to how and where services are provided.

In higher-demand areas, this may include full-time service availability and expanded hours. In smaller or more rural communities, effective service delivery may be achieved through scheduled service days, shared facilities, mobile services, or regional coordination.

This approach allows the District to balance accessibility with operational efficiency, ensuring that all communities receive appropriate access to services while aligning service levels with demonstrated demand and available resources.

5. OPERATIONAL ASSESSMENT

5.2 Program Distribution and Workflow

The District's programs include clinic services, behavioral health, WIC, environmental health, epidemiology, emergency response, community health, and administrative functions.

Operational review and adjacency analysis indicate that certain programs maintain strong interdepartmental relationships, particularly within the Caldwell facility. Clinic Services and Community Health demonstrate frequent interaction with other divisions, while administrative and support functions operate across all program areas.

These relationships influence how space is used and how services can be delivered efficiently, particularly in facilities where multiple programs operate within limited square footage.

5.3 Service Demand Priorities (Behavioral Health and Clinic Services)

Stakeholder interviews and community survey results indicate that behavioral health and clinic services represent the most consistently identified areas of need across the District. While these categories are broad, the specific priorities within each are more clearly defined.

Behavioral health needs are most frequently associated with increasing access to crisis response and stabilization services, expanded youth mental health programming, and greater availability of ongoing counseling and support. Stakeholders also emphasized the importance of coordination with regional providers and community partners, particularly in rural areas where services are limited.

Clinic service priorities are primarily related to access and delivery rather than the expansion of service types. Key themes include improving access to primary care services, particularly for low-income and uninsured populations; addressing geographic barriers in rural communities; and increasing the consistency and predictability of service availability. Survey results further reinforce the importance of extended hours, improved scheduling, and alternative delivery models such as telehealth or mobile services.

These findings indicate that improving access, reliability, and distribution of existing services may have a greater impact than expanding the range of services offered.

5. OPERATIONAL ASSESSMENT

5.4 Staffing Capacity and Workforce Considerations

Workforce availability is a central factor in service delivery planning. While demographic projections indicate the potential for increased service needs, true demand is influenced by service availability, operating hours, and community awareness. As a result, staffing capacity ultimately determines how programs can expand or adjust.

Recruitment and retention challenges reflect broader healthcare workforce trends and affect the District's ability to increase service availability. Staffing levels directly influence:

- Clinic and exam room utilization
- Behavioral health appointment capacity
- Outreach and community programming
- Environmental health inspection scheduling
- Administrative and support functions

In many locations, service availability is constrained more by staffing capacity and operating hours than by physical facility size. Expanding space without corresponding staffing increases would not improve service delivery outcomes.

5.5 Geographic Presence and Service Demand

A central operational consideration for the District is balancing geographic presence with service demand.

Maintaining a physical presence in each county supports accessibility and community trust. However, service volume varies across locations, and not all services require a full-time, dedicated facility presence.

In some areas, services may be more effectively delivered through:

- Scheduled clinic days
- Shared or partner facilities
- Regional hub-based models

This balance requires ongoing evaluation of:

- Travel distances for residents
- Program utilization by location
- Staffing deployment efficiency
- Facility operating costs
- Opportunities for partnership and coordination

5. OPERATIONAL ASSESSMENT

In addition to geographic and operational considerations, the District must also account for the relationship between service availability and community need within each county. At present, variability in service offerings, operating hours, and facility capability across locations may not always align with differences in population size, demographics, and service demand. In some cases, communities with higher need may have more limited service availability, while other locations may offer services at a level that exceeds current utilization.

This dynamic creates potential misalignment between where services are offered and where they are most needed. Addressing this requires a more standardized and data-informed approach to service availability, combined with improved understanding of true demand following adjustments to hours, outreach, and facility capability. Over time, aligning service distribution with identified need will be critical to improving access, efficiency, and equity across the District.

In addition to geographic and operational considerations, the District must also account for the relationship between service availability, community understanding, and local need within each county. Stakeholder feedback consistently indicated that many residents primarily associate the District with environmental health and regulatory functions, with limited awareness of clinical, behavioral health, and preventive services.

This lack of clarity contributes to uneven utilization patterns across the system. In some cases, communities may not access available services due to limited awareness or confusion about what is offered and where. At the same time, variability in service offerings, operating hours, and facility capability across locations may not fully align with differences in population size, demographics, and service demand.

Together, these factors create potential misalignment between where services are offered and where they are most needed. Addressing this will require not only operational adjustments but also improved communication and outreach to ensure residents understand available services and how to access them.

5. OPERATIONAL ASSESSMENT

5.6 Operational Implications for Facility Planning

The operational assessment demonstrates that facility adequacy cannot be evaluated solely on square footage. Space configuration, workflow efficiency, privacy requirements, staffing capacity, operating hours, and overall facility capability are equally important factors.

Facilities across the District vary in terms of space, configuration, privacy, technology, and functionality. These differences directly influence the types of services that can be effectively delivered at each location. For example, some sites lack enclosed spaces necessary for confidential clinical or behavioral health services, while others have limited capacity to support concurrent programming or specialized equipment. As a result, not all locations are equally suited to provide the full range of public health services.

As population and service needs evolve, the District must evaluate:

- Whether existing facilities can be adapted to support changing program needs
- Whether service hours and staffing adjustments can improve access before physical expansion is considered
- Whether certain services should remain centralized or distributed based on both demand and facility capability
- Whether shared or partner facility models can improve efficiency and access
- Whether targeted investments in privacy, equipment, or interior reconfiguration are needed to support service delivery

Facility performance is also influenced by building systems and technology infrastructure. Reliable IT systems, standardized meeting spaces, and functional building systems support both internal coordination and service delivery. Variability in these systems across facilities may affect efficiency, particularly as services increasingly rely on virtual communication, data systems, and coordinated program delivery.

Facility planning decisions should prioritize operational effectiveness and flexibility. In many cases, improving how space is used, how services are delivered, and how facilities are equipped will provide greater benefit than expanding physical infrastructure.

The facility assessment that follows builds on this operational context to evaluate how each location supports current operations and future service needs.

6. FACILITIES & SCENARIOS

The facility assessment and operational review identified several consistent themes across the District's service footprint. Based on these findings, a range of potential facility scenarios were developed to explore opportunities for improvement, adaptation, and long-term sustainability.

While some facilities require minimal adjustment, others present opportunities for targeted renovation or operational refinement. The considerations outlined in this section reflect a combination of observed conditions, staff input, and projected service needs.

6.1 Facility Inventory & Conditions Assessment

Facility planning must be grounded in a clear understanding of how each building currently functions and how it supports service delivery across the District's six-county region. This section evaluates each facility based on site observations, space utilization, staff input, and operational workflow, and considers how those conditions align with projected service demand through 2040.

The evaluation focuses on how well each facility supports current operations, its ability to adapt to changing service needs, and its role within the District's overall service delivery model. This section is intended to inform decision-making and does not assume a predetermined outcome for any individual site.

Facility conditions referenced in this section are informed by the Land and Facility Report (Appendix 11.1), which includes a standardized evaluation of building condition, functionality, and site characteristics. This assessment framework provides a consistent basis for comparing facilities across the District and identifying priority considerations for future planning.

6.2 Facility Typology Overview

Southwest District Health operates a distributed network of facilities designed to support service delivery across its six-county region. This network includes:

- A central hub (Caldwell), which houses the majority of administrative, clinical, and support services
- Full-service satellite offices (Payette, Weiser, Emmett), which provide a range of services within their respective counties
- Program-specific sites, primarily focused on WIC service delivery in targeted locations
- Shared or partner facilities, where services are delivered within multi-tenant or collaborative environments

Each facility type serves a distinct role within the District's service delivery model. The following assessment considers both the geographic context of each site and how effectively it supports current and future operational needs.

Across multiple locations, service availability is influenced not only by facility capacity but also by operating hours. In several cases, expanding hours of operation may improve access and utilization prior to consideration of facility expansion.

6. FACILITIES & SCENARIOS

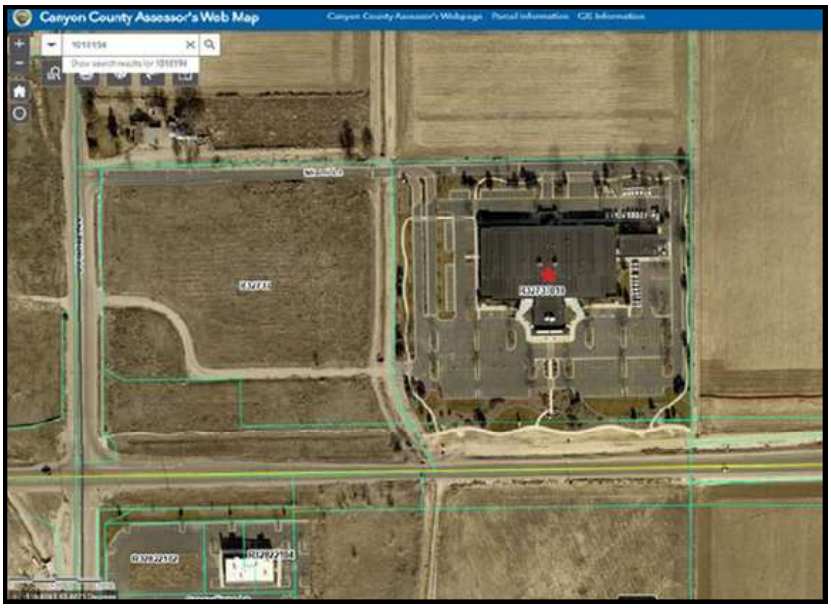
6.3 Canyon County

Canyon County is the District's primary population center and includes both the central hub and multiple satellite service locations supporting a broad range of programs.

Caldwell (Main Office – District Hub)

The Caldwell facility serves as Southwest District Health's primary administrative and clinical hub. As the District's largest and most comprehensive site, it supports all major service divisions and functions as the central point of coordination for operations across the six-county region.





Facility Overview

The Caldwell facility is approximately 51,900 square feet and houses Clinic Services, Behavioral Health, WIC, Environmental Health, Epidemiology, Emergency Preparedness, Community Health, and Administration.

The building is functionally organized to support both public-facing and internal operations. Clinical Services and WIC are located along the primary public access areas, while administrative and environmental health functions are positioned in areas with more limited public interaction. Community Health and Epidemiology functions are centrally located, supporting coordination across divisions.

Overall, the facility is appropriately sized for its role as the District's operational hub and has the ability to accommodate internal reconfiguration as staffing and service needs evolve.

6. FACILITIES & SCENARIOS

Services Provided

- Clinic Services
- Behavioral Health
- Women, Infants, and Children (WIC)
- Environmental Health
- Epidemiology and Emergency Preparedness
- Community Health Programming
- Administration and District Operations

Operating Hours

Service Type	Days	Hours
Building Hours	Monday–Friday	8:00 AM – 5:00 PM
Clinic Services	Monday–Wednesday	7:30 AM – 6:30 PM
	Thursday-Friday	8:00 AM – 5:00 PM
Behavioral Health	Monday–Thursday	8:30 AM – 5:30 PM
WIC	Monday–Friday	8:00 AM – 5:00 PM

Facility Observations & Considerations

The Caldwell facility functions effectively as the District's central hub and provides sufficient overall capacity to support current operations. Its size and layout offer flexibility to accommodate future staffing growth through internal reconfiguration rather than expansion.

In addition to interior functionality, site conditions and building systems influence long-term facility performance.

The Caldwell facility is located outside of the City core and is primarily accessible by private vehicle, with limited pedestrian connectivity and no direct access to public transit. While this location supports operational functions and centralized service delivery, it may present access considerations for certain populations.

6. FACILITIES & SCENARIOS

Building systems and lifecycle considerations should also be incorporated into future planning. The roofing system is approaching the end of its useful life and will require replacement within the near term. The existing HVAC system relies on distributed heat pump units, which can be labor-intensive to maintain and may present long-term efficiency challenges. Additional considerations include localized plumbing issues, site maintenance related to tree root impacts on pavement, and inconsistencies in technology infrastructure across meeting and service areas.

These factors suggest that future planning for the Caldwell facility should consider not only space reconfiguration, but also phased investment in building systems, site improvements, and technology standardization to support long-term operational efficiency.

Opportunities exist to improve functionality and long-term adaptability. These include conversion of an existing exam room to support infectious disease response, as well as continued reconfiguration of workstations and office space to align with evolving staffing needs.

As behavioral health demand continues to increase, the facility has the ability to support additional services through reallocation of existing space. Future adjustments to workstation configurations within Environmental Health and Epidemiology may also be warranted as those divisions grow.

Overall, the Caldwell site represents a strong long-term asset for the District, with the ability to adapt to changing service delivery needs through targeted improvements rather than major structural changes.

The Caldwell facility is also situated within proximity to key partner organizations, including behavioral health and community service providers. These relationships support coordination of care and may present opportunities to further integrate partnership-based service delivery into the facility's long-term role as the District's central hub.

6. FACILITIES & SCENARIOS

Caldwell Facility Condition Assessment

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.

Source: Land and Facility Report (Appendix 11.1)

6. FACILITIES & SCENARIOS

Nampa (WIC Only – Leased Satellite Office)

The Nampa site provides WIC services within a leased space at the Idaho Hispanic Community Center. This location supports access to services within a high-demand area of Canyon County and provides a community-based setting for program delivery.



The Nampa site operates within a shared, multi-tenant environment and is configured specifically for WIC service delivery. The location benefits from strong community visibility and accessibility; however, the space presents functional limitations related to confidentiality and layout.

While visual privacy is generally achievable, the lack of fully enclosed consultation rooms creates challenges for sound privacy during appointments. The current configuration limits the ability to conduct multiple consultations simultaneously and may affect overall service efficiency.

Services Provided

- Women, Infants, and Children (WIC)

Operating Hours

Service Type	Days	Hours
WIC Services	Monday, Tuesday, Thursday, Friday	9:00 AM – 4:00 PM

Facility Observations & Considerations

The Nampa site plays an important role in providing geographically accessible WIC services within Canyon County, particularly in a high-demand service area. The shared facility model supports community-based delivery but introduces limitations related to privacy and dedicated program space.

Service delivery at this location is currently limited to four days per week (Monday, Tuesday, Thursday, and Friday from 9:00 AM to 4:00 PM), which constrains overall availability for clients. While physical space limitations are a consideration, current utilization should be evaluated alongside operating hours. Expanding service availability through increased hours may improve access and program reach prior to consideration of facility expansion or relocation.

Opportunities exist to improve service delivery through either enhanced privacy within the existing space or transition to a configuration that provides enclosed consultation rooms. Any future facility considerations should be evaluated in conjunction with service demand, hours of operation, and the role of this site within the broader Canyon County service strategy.

6. FACILITIES & SCENARIOS

Idaho Hispanic Community Center 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.

Source: Land and Facility Report (Appendix 11.1)

Note: This facility is leased and a facility assessment was not completed.

6. FACILITIES & SCENARIOS

Farmway (Former Leased Location – Services Relocated to Shared Location)

WIC services in the Farmway area are currently provided within a shared location at the Farmway Village Community Center following the discontinuation of the prior leased location. This transition maintains service presence within the community while utilizing a shared facility model.



Services are provided on a limited schedule:

- 1st Monday of the month, 9:00 AM – 4:00 PM
- 3rd Thursday of the month, 9:00 AM – 4:00 PM

This model supports geographic access within a rural area but operates with limited frequency and without dedicated, full-time space.

Facility Observations & Considerations

The transition from the previous Farmway site reflects the flexibility of shared and leased facility arrangements within the District's service model. While the physical location has changed, service continuity within the community has been maintained.

As with other limited-schedule locations, service availability is constrained by operating frequency. Continued evaluation of service hours and location within the Farmway area will help ensure that access remains aligned with community need. Expanding service availability through increased hours, where feasible, should be considered prior to establishing a permanent or expanded facility presence.

Farmway Village Community Center Facility Information

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.

Source: Land and Facility Report (Appendix 11.1)

***Note**: This facility was leased and a facility assessment was not completed.*
***Additional Note:** During this process the lease at the Farmwaywas not renewed and a tour of the new facility at Farmway Village was not conducted.*

6. FACILITIES & SCENARIOS

6.4 Payette County

The Payette facility serves as a full-service satellite office for Payette County, providing local access to a range of public health services within a centralized community location.

City of Payette (Full-Service Satellite Model)

Facility Overview

The Payette facility is approximately 5,000 square feet and supports multiple service areas, including clinic services, WIC, environmental health, and administrative functions. The building functions effectively as a satellite office model and is appropriately sized for current operations.



The layout generally supports service delivery; however, opportunities exist to improve space utilization and better align the interior configuration with current program needs. Storage areas, reception space, and internal circulation present opportunities for reorganization to enhance efficiency and client experience. The facility also has the potential to accommodate additional functions, such as behavioral health services and community-based programming, through targeted improvements.

The facility also includes space occupied by the Payette County Office of Emergency Management (OEM), reflecting a shared-use environment that supports coordination with local emergency response functions.



6. FACILITIES & SCENARIOS

Services Provided

- Clinic Services (limited)
- Women, Infants, and Children (WIC)
- Environmental Health
- Community Health Programming (limited)
- Administrative Support Functions

Operating Hours

Service Type	Days	Hours
Building Hours	Monday–Friday	8:00 AM – 5:00 PM
Clinic Services	Thursday (rotating schedule)	9:00 AM – 5:00 PM
WIC	Monday, Wednesday, Friday	8:00 AM – 5:00 PM

Facility Observations & Considerations

The Payette facility functions as an effective satellite office and is a strong model for localized service delivery. The building has sufficient capacity to support expanded services through interior reconfiguration rather than physical expansion.

Clinic services are currently offered on a limited schedule (approximately one to two days per month on a rotating basis), which significantly constrains access to care within the County. While facility improvements, such as the addition of behavioral health offices, reconfiguration of storage areas, and development of a community room, would enhance functionality, current service availability should be evaluated alongside operating hours. Expanding clinic hours and service frequency may improve access and utilization prior to consideration of facility expansion.

Opportunities exist to improve the facility through targeted upgrades, including an ADA-compliant reception area, improved space utilization, and the addition of flexible program space. With these improvements, the Payette site has the potential to support a broader range of services and serve as a long-term anchor location for Payette County.

The site currently provides approximately 18 on-site parking spaces, including standard and ADA-accessible spaces. While this is below current zoning requirements, the existing parking configuration is considered adequate for current operations, with additional street parking available in the surrounding area. The site's parking condition reflects legacy development patterns and is not anticipated to constrain near-term service delivery.

6. FACILITIES & SCENARIOS

Payette Facility Condition Assessment

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.	

Source: Land and Facility Report (Appendix 11.1)

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.

6. FACILITIES & SCENARIOS

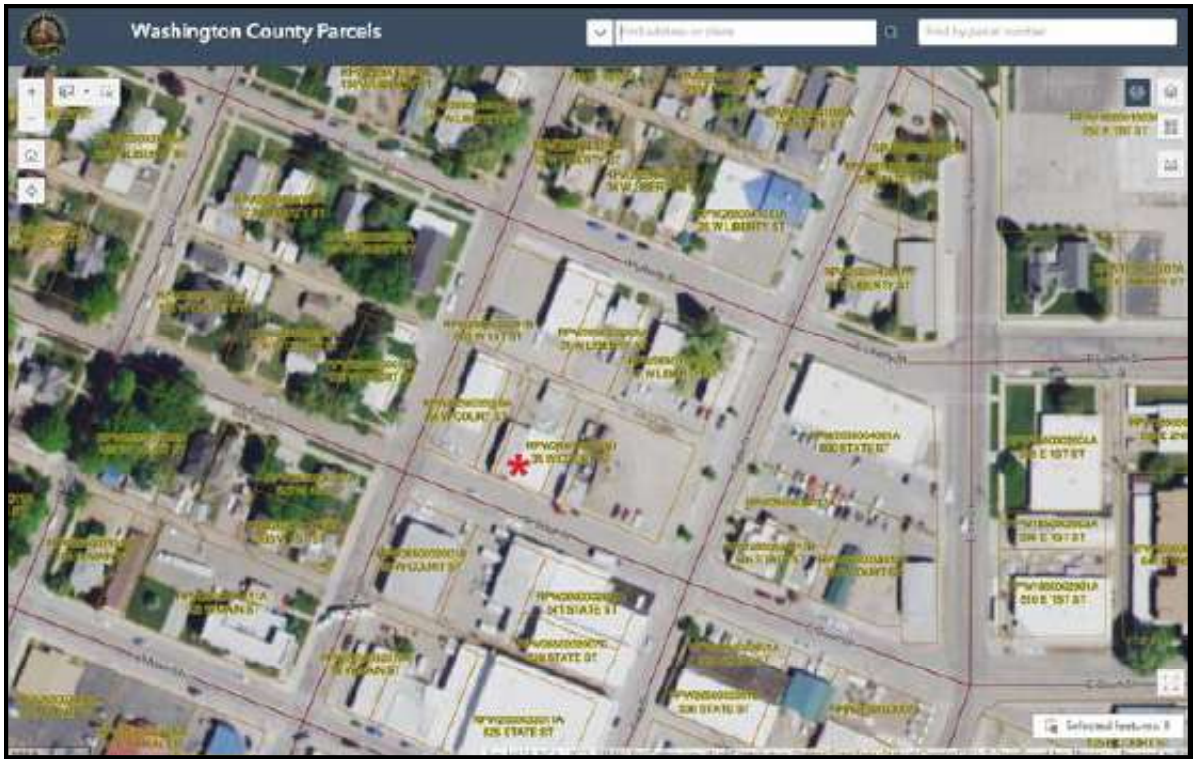
6.5 Washington County

The Weiser facility serves as the full-service satellite office for Washington County, providing local access to core public health services within a compact facility.

Weiser Office (Full-Service Satellite Model)



The Weiser facility is approximately 2,200 square feet and supports clinic services, WIC, environmental health, and administrative functions. As a full-service satellite office, the site plays an important role in maintaining a local presence and supporting access to services within Washington County. The building's limited size presents challenges related to space allocation, circulation, and overall functionality. The current layout constrains the ability to support multiple services simultaneously and limits flexibility for future program growth.



6. FACILITIES & SCENARIOS

Services Provided

- Clinic Services (limited)
- Women, Infants, and Children (WIC)
- Environmental Health
- Community Health Programming (limited)
- Administrative Support Functions

Operating Hours

Service Type	Days	Hours
Building Hours	Monday–Friday	8:00 AM – 5:00 PM
Clinic Services	Thursday (rotating schedule)	9:00 AM – 5:00 PM
WIC	Thursday	8:00 AM – 5:00 PM

Facility Observations & Considerations

The Weiser facility provides essential local access to services but presents notable space limitations that affect functionality, privacy, and long-term adaptability. The building's size and configuration restrict the ability to support multiple services simultaneously and limit flexibility for future program growth, particularly for behavioral health and co-located programming.

The current interior layout also presents circulation challenges. Several rooms function as pass-through spaces, requiring movement through program areas to access other parts of the building. This configuration results in inefficient and, at times, disruptive circulation patterns that can affect both client experience and staff workflow.

ADA compliance has also been identified as a key consideration. Certain elements of the facility do not meet current ADA requirements, particularly related to parking and the reception area. These issues represent required improvements and should be addressed as part of any near-term facility upgrades.

Service delivery at this location is currently limited, with clinic services offered on a rotating schedule and WIC services available one day per week. This level of service availability constrains access for residents and should be evaluated alongside physical facility limitations. Expanding service hours and frequency may improve access and utilization prior to consideration of major facility investment.

Given the constraints of the existing building, the District may consider a range of long-term strategies, including targeted improvements, expansion on or adjacent to the current site, or relocation to a facility better suited to support full-service operations. Any future direction should balance geographic access, service demand, and the cost-effectiveness of improving versus replacing the existing facility.

6. FACILITIES & SCENARIOS

Weiser Facility Condition Assessment

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.

Source: Land and Facility Report (Appendix 11.1)

6. FACILITIES & SCENARIOS

6.6 Gem County

The Emmett facility serves as the full-service satellite office for Gem County, providing local access to core public health services within a centrally located community setting.

Emmett Office (Full-Service Satellite Model)



The Emmett facility is approximately 2,500 square feet and supports clinic services, WIC, environmental health, and administrative functions. The site is appropriately located to serve the community and functions effectively as a local service point within the District's broader network.

The building layout generally supports current operations; however, the facility is constrained by its size and limited flexibility. As service demand increases, the existing configuration may limit the ability to expand programming, particularly for behavioral health and community-based services.



6. FACILITIES & SCENARIOS

Services Provided

- Clinic Services (limited schedule)
- Women, Infants, and Children (WIC)
- Environmental Health
- Community Health Programming (limited)
- Administrative Support Functions

Operating Hours

Service Type	Days	Hours
Building Hours	Monday–Friday	8:00 AM – 5:00 PM
Clinic Services	Thursday (rotating schedule)	9:00 AM – 5:00 PM
WIC	Tuesday	8:00 AM – 5:00 PM

Facility Observations & Considerations

The Emmett facility provides an important local presence for Gem County and supports delivery of core services; however, space limitations affect the building's ability to fully accommodate evolving service needs. Opportunities exist to improve the interior layout to better support privacy, workflow, and program delivery.

In addition to functional considerations, code-related improvements have been identified. Certain elements of the facility do not meet current ADA and applicable building code (IBC) requirements, particularly in client-facing areas and circulation, such as the entrance ramp and reception area. These issues represent required improvements and should be addressed as part of any near-term facility upgrades.

Service delivery at this location is currently limited, with clinic services offered on a rotating schedule and WIC services available one day per week. This level of availability constrains access for residents and should be evaluated alongside physical space considerations. Expanding service hours and frequency may improve access and utilization prior to consideration of facility expansion or relocation.

Over time, the District may consider targeted improvements to the existing facility or evaluate alternative configurations that better support a full-service satellite model. Any future approach should balance community access, operational needs, and the cost-effectiveness of improving the current facility relative to other options.

6. FACILITIES & SCENARIOS

Emmett Facility Condition Assessment

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	

Source: Land and Facility Report (Appendix 11.1)

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.

6. FACILITIES & SCENARIOS

6.7 Owyhee County

The Homedale site provides WIC services within a shared community facility, supporting access to services for residents in Owyhee County.

Homedale (WIC only – Shared Satellite Office)



The Homedale site operates within shared space at a community facility and is configured specifically for WIC service delivery. This model allows the District to maintain a local presence in a rural area; however, the shared environment limits the ability to fully control layout, privacy, and scheduling.

The current configuration presents challenges related to both visual and sound privacy, as the space does not include fully enclosed consultation rooms. These limitations affect the ability to conduct confidential appointments and may constrain the number of clients that can be served at one time.

Services Provided

- Women, Infants, and Children (WIC)

Operating Hours

Service Type	Days	Hours
WIC Services	Tuesday, Thursday	9:00 AM – 4:00 PM

Facility Observations & Considerations

The Homedale site plays an important role in maintaining geographic access to WIC services within Owyhee County, particularly given the rural nature of the service area. The shared facility model supports this presence but introduces limitations related to privacy, scheduling, and dedicated program space.

Service delivery at this location is currently limited to two days per week (Tuesday and Thursday from 9:00 AM to 4:00 PM), which constrains overall accessibility for residents. While facility conditions are a contributing factor, current utilization should be considered alongside operating hours. Expanding service availability through increased hours may improve access and program reach prior to consideration of facility expansion or relocation.

Opportunities exist to improve service delivery through enhanced privacy within the existing space or transition to a configuration that provides enclosed consultation rooms. Any future considerations should balance the need for continued local access with the operational efficiency of shared versus dedicated space.

6. FACILITIES & SCENARIOS

Homedale 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.

Source: Land and Facility Report (Appendix 11.1)

6. FACILITIES & SCENARIOS

6.7 Owyhee County

The Marsing Hub operates as a shared, partner-based facility model and provides clinic services within a collaborative, community-centered environment in Owyhee County.

Marsing Hub (Clinic Only – Shared Facility Satellite Office)



The Marsing Hub is a multi-tenant facility that brings together multiple service providers in a single location. Within this model, the District delivers clinic services alongside partner organizations, allowing for coordinated service delivery and increased community access.

This shared approach supports operational efficiency by leveraging existing infrastructure while maintaining a local presence in a rural area. The co-location of services enhances convenience for residents and creates opportunities for collaboration across providers.

Services Provided

- Clinic Services (delivered in partnership setting)
- Coordinated access to partner-provided services (varies by provider)

Operating Hours

Service Type	Days	Hours
Clinic Services	Monday–Friday (aligned with school schedule)	School Hours

Facility Observations & Considerations

The Marsing Hub represents a successful example of a shared facility model that supports both service accessibility and operational efficiency. By co-locating services with community partners, the District is able to provide clinic services in a manner that would be more difficult to achieve in a standalone facility within a rural setting.

This model demonstrates the potential benefits of partnership-based service delivery, including shared infrastructure, increased visibility, and improved convenience for residents. It also allows the District to maintain a presence in Owyhee County without the need for a fully dedicated facility.

While service delivery is aligned with school hours, which may limit availability for some populations, the model itself provides a strong foundation for expanding services in coordination with partners. Where feasible, adjustments to service hours could be considered to broaden accessibility.

The Marsing Hub may serve as a model for future facility planning in rural areas, particularly where population density and service demand may not support a traditional standalone facility. Continued evaluation of partnership opportunities could help expand this approach in other areas of the District.

6. FACILITIES & SCENARIOS

Marsing Hub 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.

Source: Land and Facility Report (Appendix 11.1)

6. FACILITIES & SCENARIOS

6.8 Adams County

The Council site provides WIC services within a shared community facility, a limited but important level of service access for residents in Adams County.

Council (WIC Only – Shared Satellite Office)

The Council site operates within shared space at a community facility and is used to deliver WIC services on a scheduled basis. This approach allows the District to maintain a presence in a geographically remote area without the need for a dedicated facility.



As with other shared locations, the District has limited control over the configuration of the space, which may affect privacy, scheduling flexibility, and overall service delivery.

Services Provided

- Women, Infants, and Children (WIC)

Operating Hours

Service Type	Days	Hours
WIC Services	Scheduled by appointment	Typically less than one (1) day per month

Facility Observations & Considerations

The Council site provides a minimal but important level of service access within Adams County, particularly given the rural and low-density nature of the area. The current model reflects a balance between maintaining geographic presence and aligning service delivery with population size and demand.

Service availability at this location is extremely limited, with WIC services provided on an infrequent, scheduled basis. While this approach supports basic access, it may constrain utilization and limit flexibility for clients. As with other limited-availability locations, operating hours and service frequency should be considered alongside facility needs. Expanding service availability, where feasible, may improve access prior to consideration of any dedicated facility investment.

The shared facility model remains appropriate for this location given current demand; however, periodic evaluation of service levels, scheduling, and delivery approach will help ensure continued alignment with community needs.

Across multiple locations, service availability is influenced not only by facility capacity but also by operating hours and staffing levels. In several cases, operational adjustments may improve access and utilization prior to consideration of physical expansion.

6. FACILITIES & SCENARIOS

Council 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.

Source: Land and Facility Report (Appendix 11.1)

6. FACILITIES & SCENARIOS

6.9 Summary of Facility Themes and Cross-Cutting Observations

The facility assessment and operational review identified several consistent themes across the District's service area.

The District's distributed service model supports geographic access and community presence across all six counties. Full-service satellite offices provide localized access to a range of programs, while program-specific and shared sites maintain service reach in more rural areas.

Space configuration and flexibility vary by location. While the Central Hub in Caldwell provides capacity for internal reconfiguration and phased adjustment, several satellite facilities operate within more compact footprints. In those locations, concurrent programming, privacy requirements, and circulation patterns influence operational efficiency.

Shared and leased facilities provide geographic flexibility but limit long-term control over configuration and continuity. Periodic reevaluation of lease arrangements and shared-use agreements is necessary to maintain operational stability.

Across multiple locations, service availability is influenced not only by facility capacity but also by operating hours and staffing levels. In several cases, expanding service hours or adjusting staffing patterns may improve access and utilization prior to consideration of facility expansion.

Modernization and accessibility improvements may be warranted at select locations over time. These considerations relate to interior configuration, technology infrastructure, privacy standards, and long-term adaptability rather than structural viability.

Projected population growth through 2040 suggests that continued adaptability will be important across the system. Longer-range projections reinforce the importance of flexibility in facility planning decisions made in the near term.

Building systems, lifecycle, and technology infrastructure are emerging considerations in addition to space configuration, several facilities, particularly the Caldwell main office, present considerations related to building system lifecycle, including roofing, HVAC, and technology infrastructure. These factors influence long-term maintenance costs, operational efficiency, and service delivery capabilities, particularly as reliance on virtual services and interdepartmental coordination increases.

The findings in this section do not establish predetermined facility actions. Rather, they provide the factual foundation for evaluating potential scenarios and phased strategies in the sections that follow.

7. SCENARIO DEVELOPMENT

Resource prioritization reflects both total population demand and the need to maintain equitable access across the District. The facility assessment and operational review identified a range of opportunities to improve service delivery, accessibility, and long-term adaptability across the District.

This section outlines a phased facility Plan organized by County and time horizon. The Plan emphasizes practical, incremental actions that align with operational capacity, staffing considerations, and projected service needs.

These actions are not mandates. Rather, they provide a structured framework to guide decision-making, sequencing, and prioritization over time. Service priorities identified in this section reflect stakeholder and community input and are further described in Section 5.

Systemwide Implementation Priorities and Sequencing

To support a clear and actionable approach to facility planning, the District should prioritize implementation based on a consistent order of operations across all locations. This sequencing reflects operational urgency, impact on service delivery, and alignment with available resources.

Detailed facility-specific actions supporting these priorities are provided in the Appendix and are reflected in the county-level scenarios that follow.

Priority 1 – Code Compliance, Safety, and Accessibility

- ADA improvements (reception, parking, restrooms, access)
- Life safety/code issues (ramps, railings, entrances)
- Immediate building repairs

Priority 2 – Privacy and Confidential Service Delivery

- Partition walls, sound mitigation
- Enclosed spaces for clinical/behavioral health
- Reception and waiting area privacy

Priority 3 – Low-Cost, High-Impact Reconfiguration

- Repurpose rooms (storage → program space)
- Improve circulation and workflow
- Behavioral health room creation

Priority 4 – Operational Adjustments

- Expand/standardize hours
- Adjust staffing
- Increase outreach and awareness

Priority 5 – Strategic Reconfiguration and Expansion

- Larger renovations or additions
- Expansion based on demonstrated need
- Shared/partner models

Actions within each priority may be implemented across multiple facilities concurrently based on readiness, funding, and operational capacity.

7. SCENARIO DEVELOPMENT

7.1 Canyon County – Caldwell (Central Hub)

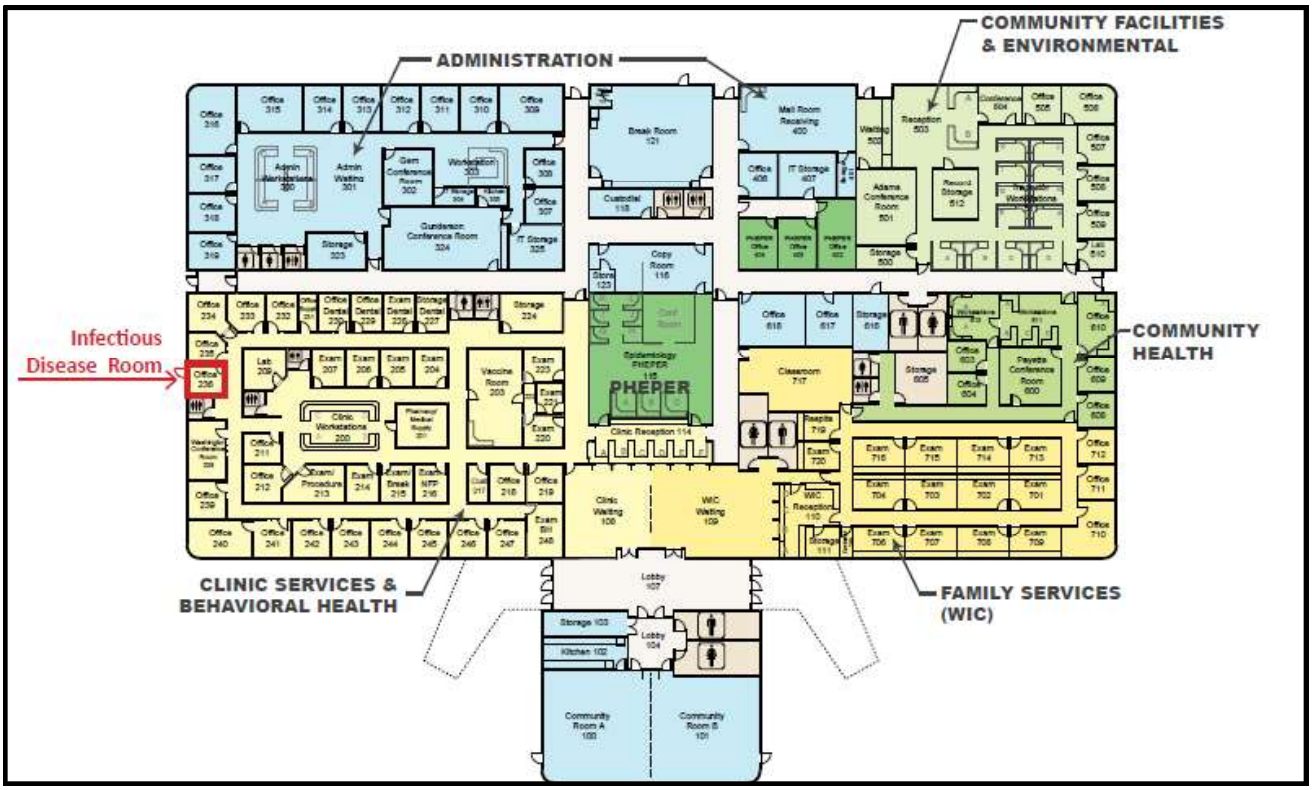
Near-Term (0–5 Years)

- Convert Room 236 into a dedicated infectious disease room, including exterior access and appropriate ventilation improvements
- Reallocate existing clinic office space to support expanded behavioral health offices
- Address near-term building system needs, including roof replacement planning, HVAC maintenance strategy, and technology standardization across meeting and service spaces
- Behavioral health and clinic services should be prioritized, with a focus on expanding access to youth mental health, counseling, and primary care capacity, as well as improving scheduling and extended hours to meet demand with increased staffing.
- Establish a Community Partnership Manager position to lead coordination and expansion of hub-based and co-located service models
- Expand public awareness and utilization of services provided at the Caldwell facility through targeted outreach and communication efforts

Mid-Term (5–10 Years)

- Reconfigure and reduce workstation sizes to accommodate future staffing increases and improve space efficiency
- Optimize use of space within administrative areas to improve workflow and adaptability
- Reallocate existing space to support continued expansion of behavioral health services

7. SCENARIO DEVELOPMENT



Long-Term (10+ Years)

- Implement phased modernization of interior systems, including technology infrastructure, infection control enhancements, and general interior upgrades
- Perform periodic reassessment of space utilization relative to staffing growth and service demand

7. SCENARIO DEVELOPMENT

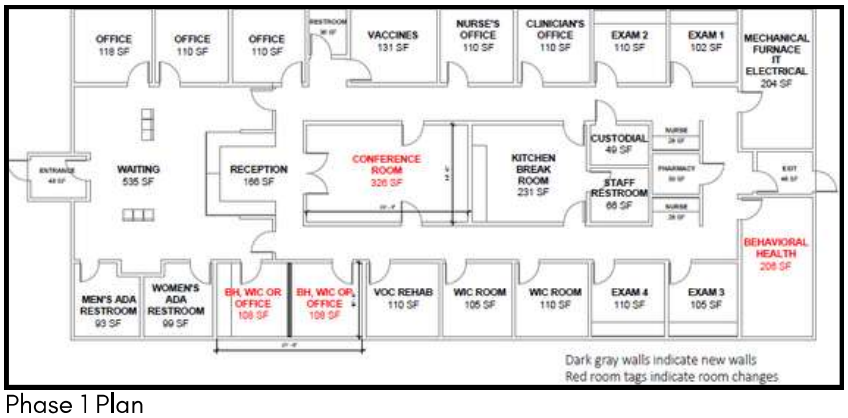
7.2. Payette County – Full-Service Satellite Office

Near-Term (0–5 Years)

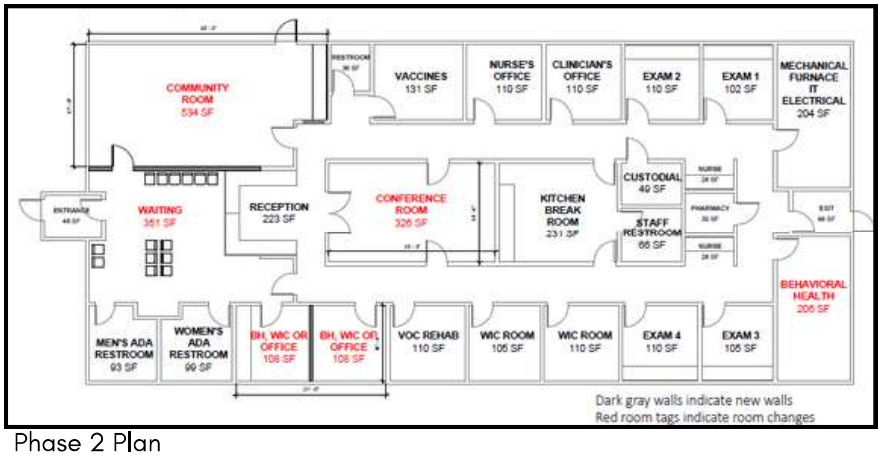
- Increase service availability by expanding clinic hours and service frequency, as staffing capacity allows
- Improve public awareness of available services to increase utilization
- Evaluate staffing needs to support access to crisis response and increase consistency and availability of clinic services to reduce travel and scheduling barriers.
- Implement ADA-related improvements, including lowering reception desk height and providing required knee space.

Mid-Term (5–10 Years)

- Reconfigure interior layout to improve privacy, workflow, and concurrent service delivery, including conversion of existing storage and conference space to support behavioral health services
- Create additional consultation or program space through interior reorganization
- Evaluate development of a flexible community room to support programming and public use



Phase 1 Plan



Phase 2 Plan

Long-Term (10+ Years)

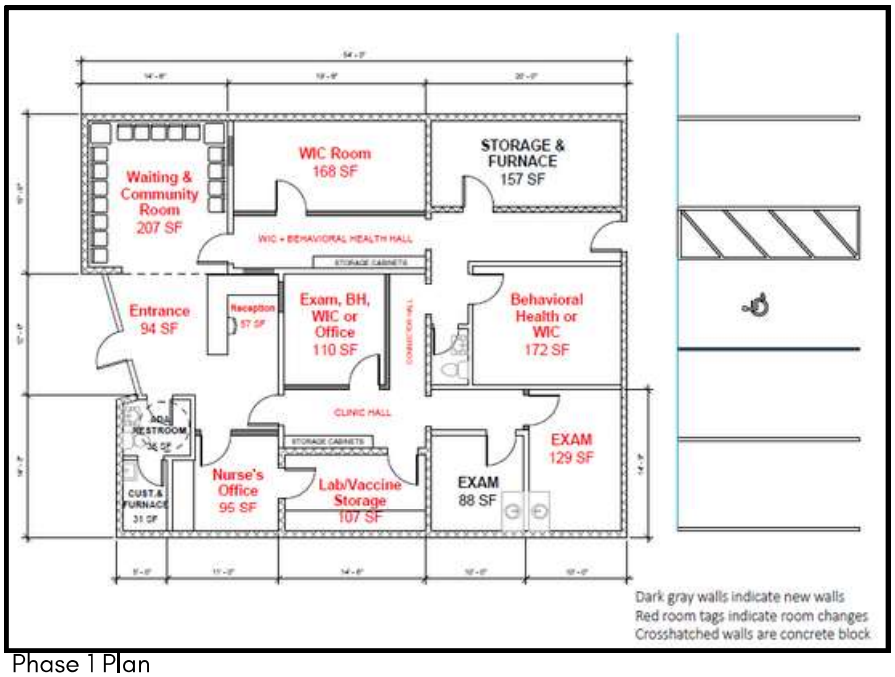
- Evaluate feasibility of modest expansion if increased service demand and utilization are sustained
- Maintain the Payette site as a long-term anchor facility within Payette County

7. SCENARIO DEVELOPMENT

7.3 Washington County – Weiser

Near-Term (0–5 Years)

- Increase service hours and frequency to improve access
- Evaluate staffing needs to support expanded clinic and behavioral health services
- Improve public awareness of available services
- Implement interior renovations to improve the functional layout with new hallways to reconfigured rooms
- Implement ADA-related improvements, including the development of accessible parking and accessible reception desk



Phase 1 Plan



Phase 2 Plan

Mid-Term (5–10 Years)

- Relocate the reception desk to face the entrance door to improve circulation and client interaction
- Reconfigure clinic, WIC, and office space to improve circulation and service delivery
- Expand or reconfigure exam room space

Long-Term (10+ Years)

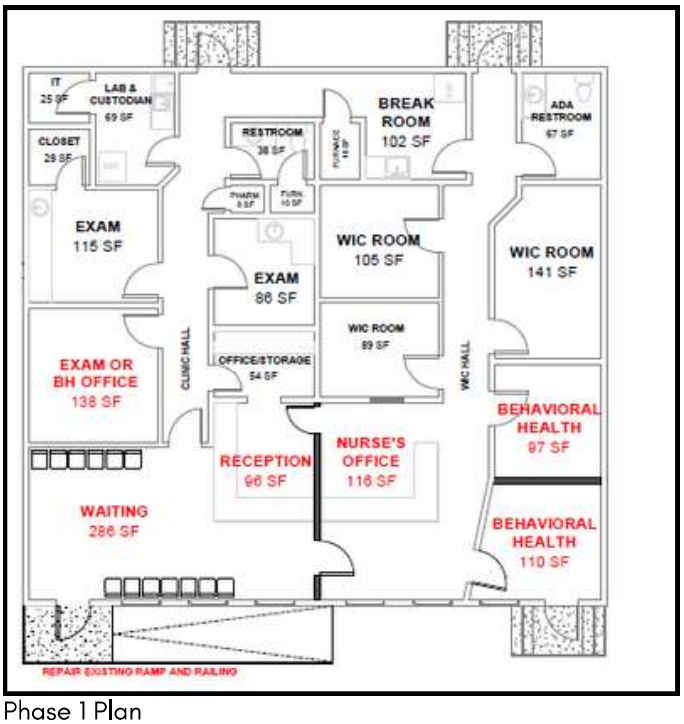
- Evaluate expansion or relocation options to better support full-service operations
- Consider partnership or shared facility models if they improve flexibility and cost efficiency

7. SCENARIO DEVELOPMENT

7.4 Gem County – Emmett

Near-Term (0–5 Years)

- Increase service hours and frequency to improve availability or access
- Evaluate staffing needs to support expanded service delivery
- Improve public awareness and utilization
- Implement ADA-related improvements, including upgrades to the restroom sink and reception desk
- Repair or replace exterior ramp and railings to improve safety and code compliance



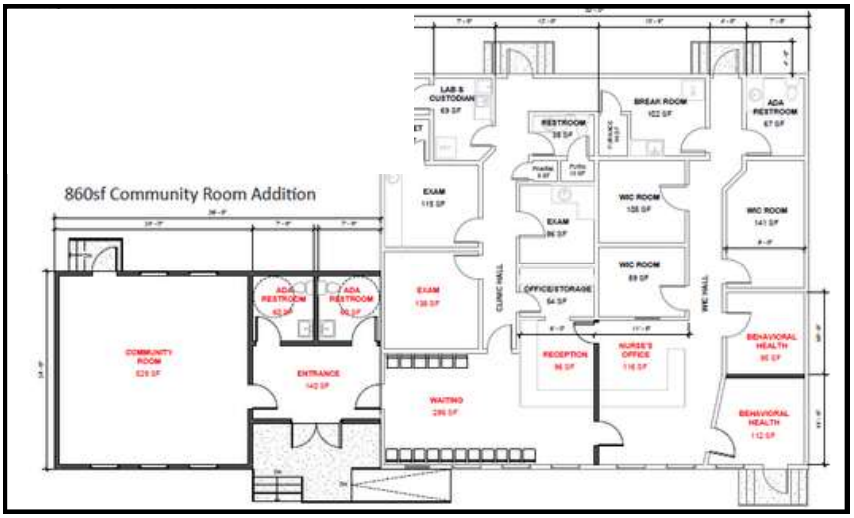
Phase 1 Plan

Mid-Term (5–10 Years)

- Implement interior and site improvements to enhance functionality and circulation
- Reconfigure interior space to support behavioral health and clinic services
- Evaluate development of a community room addition to support programming and after-hours use

Long-Term (10+ Years)

- Evaluate modest expansion or alternative facility configurations
- Explore shared or co-located service models where appropriate



Phase 2 Plan

7. SCENARIO DEVELOPMENT

7.5 Owyhee County – Distributed / Shared Model

Near-Term (0–5 Years)

- Maintain and strengthen existing shared facility arrangements, including the Marsing Hub
- Expand service hours where feasible to improve availability or access
- Improve coordination with facility partners and service providers
- Increase public awareness of available services
- Improve privacy at WIC service locations through use of partitioning, screening, or sound mitigation strategies

Mid-Term (5–10 Years)

- Improve privacy, scheduling efficiency, and program coordination within shared spaces, including enhanced partitioning or reconfiguration where feasible
- Expand partnership-based service delivery models where appropriate





Source: Marsing School District

Long-Term (10+ Years)

- Continue refinement of hub-based and shared facility models
- Evaluate opportunities to expand partnership-driven service delivery in rural areas

7. SCENARIO DEVELOPMENT

7.6 Adams County – Limited-Service Presence

Near-Term (0–5 Years)

- Maintain existing shared-service model for WIC delivery
- Improve scheduling coordination and service consistency
- Increase awareness of available services
- Improve visual and sound privacy through use of partitions, screens, or sound mitigation strategies



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

Mid-Term (5–10 Years)

- Monitor utilization trends and adjust service frequency as needed
- Evaluate opportunities to improve privacy and service delivery within shared space

Long-Term (10+ Years)

- Reassess service model based on population growth and demand
- Maintain flexibility in approach to avoid unnecessary capital investment

7. SCENARIO DEVELOPMENT

7.7 Comparative Observations

The Facility Plan shows several consistent themes, across all counties, that inform prioritization and sequencing of actions.

The Central Hub in Caldwell provides the greatest flexibility for internal reconfiguration within its existing footprint. Planned actions at this site focus on targeted improvements, staffing alignment, and phased modernization rather than structural expansion.

Full-service satellite offices in Payette, Weiser, and Emmett demonstrate varying degrees of spatial constraint. In these locations, interior reconfiguration, improved space utilization, and operational adjustments are prioritized, with modest expansion considered only where supported by sustained service demand.

Shared and distributed service models in Owyhee and Adams Counties provide geographic presence with limited dedicated infrastructure. In these areas, the Plan emphasizes operational refinement, partnership-based service delivery, and continued evaluation of service levels rather than capital investment.

Across all locations, service availability is influenced not only by facility capacity but also by operating hours and staffing levels. Expanding service hours and aligning staffing capacity are key considerations that may improve access and utilization prior to pursuing facility expansion.

Phased implementation remains a consistent approach across the system. Facility and operational adjustments should be sequenced to maintain continuity of services and align with experienced demand, staffing capacity, and financial conditions.

These observations provide a framework for the District's prioritized recommendations in the following section.

ADA compliance is a challenge with several facilities, and the District should ensure any shared facilities are ADA compliant.

8. TIMELINE OVERVIEW RECOMMENDATIONS

The phased Facility Plan identifies a range of actions across locations and time horizons. The recommendations below summarize the District's highest priorities to guide near- and mid-term decision-making.

These priorities are intended to improve service delivery, increase utilization, and support long-term adaptability while maintaining fiscal responsibility. Implementation should be phased and aligned with staffing capacity, demonstrated service demand, and available financial resources.

1. Increase Public Awareness and Utilization of Services
The District should prioritize efforts to improve public awareness and understanding of available services across all counties. Many locations currently operate below potential utilization due in part to limited visibility.

Targeted outreach, community engagement, and clear communication of available services should be expanded to increase utilization, particularly in rural areas and at satellite locations.

Partner Communication and Coordination
In addition to public-facing outreach, the District should strengthen communication with partner organizations. Stakeholder feedback indicates that partner communication is often reactive, with information frequently shared after a partner has initiated contact or through an existing relationship, rather than through a consistent and proactive communication approach.

To improve coordination and awareness, the District should consider establishing a recurring partner communication process, such as a monthly or quarterly group update, to share information on:

- available services and program updates
- changes in service hours or locations
- emerging public health issues and trends
- District priorities, initiatives, and partnership opportunities

The District should also consider maintaining a current partner contact list, clarifying points of contact for key program areas, and creating periodic opportunities for direct coordination with healthcare providers, schools, local governments, and community organizations. Strengthening partner communication will improve service awareness, support referrals, and increase coordination across the District.

8. TIMELINE OVERVIEW RECOMMENDATIONS

2. Establish a Community Partnership Manager Role
The District should establish a dedicated Community Partnership Manager position to lead development and coordination of partnership-based service models.

This role would support expansion of hub and co-located service approaches, similar to the Marsing Hub, and serve as a central point of coordination for relationships with schools, community organizations, and partner agencies. The position would also support identification of new partnership opportunities to expand access in underserved areas. Compliance review, including ADA, would be incorporated into this role.

3. Expand and Standardize Service Hours and Availability
The District should prioritize expanding and standardizing service hours and frequency across multiple locations as a foundational step in improving access and informing future service decisions.

In several cases, service availability is constrained more by limited and inconsistent operating hours than by physical facility capacity. Variability in hours and service schedules across locations creates barriers to access and reduces the reliability of utilization data. Without consistent availability, it is difficult to determine whether low utilization reflects a lack of demand, limited community awareness, access challenges, or a combination of these factors.

Expanding and standardizing hours, particularly for clinic and WIC services, will:

- Improve accessibility and predictability for residents
- Increase utilization of existing services and facilities
- Provide more accurate and comparable utilization data across sites
- Enable the District to better assess service demand by location and service type

This Plan does not recommend the discontinuation of specific services at this time. Given current limitations in utilization data, driven by inconsistent hours, uneven service availability, and gaps in community awareness, it is premature to determine whether services should be continued, reduced, or discontinued in specific communities.

Instead, the District should take a phased, data-informed approach:

- Standardize and expand operating hours and service availability across sites
- Expand community awareness and outreach efforts, with a focus on underrepresented populations
- Reassess utilization and demand patterns after these improvements are implemented
- Evaluate service delivery models (e.g., centralized, shared, scheduled, or mobile) based on updated data

8. TIMELINE OVERVIEW RECOMMENDATIONS

Efforts should also consider potential misalignment between current service availability and community need within counties, ensuring that service distribution is evaluated and adjusted based on standardized operations and improved demand data.

By first establishing consistent access and improving awareness, the District will be better positioned to make informed, equitable, and data-driven decisions about future service delivery and facility planning.

4. Increase Staffing Capacity in Key Service Areas
The District should prioritize staffing increases in behavioral health, clinic services, and rural service delivery.

Staffing capacity is a primary driver of service availability and should be aligned with any planned expansion of hours or programs. Increased staffing will also support more effective use of existing facilities and improve service continuity across the District.

5. Prioritize Targeted Facility Improvements and Align Services with Facility Capability
Facility improvements should focus on targeted, high-impact upgrades that improve functionality, service delivery, and alignment between facility capability and program needs.

Facilities across the District vary in terms of space, configuration, privacy, technology, and overall functionality. These differences directly influence the types of services that can be delivered at each location. As a result, not all sites are equally suited to provide the full range of public health services. Future planning should align service delivery with facility capability, ensuring that:

- Services requiring private, enclosed spaces (e.g., clinical and behavioral health) are delivered in appropriately equipped locations
- Sites with space or configuration limitations utilize alternative models such as scheduled services, shared facilities, or partnerships
- Targeted investments in privacy, equipment, and interior reconfiguration are prioritized where they will enable expanded or improved service delivery

8. TIMELINE OVERVIEW RECOMMENDATIONS

Key improvement priorities include:

- Improving privacy and confidentiality in clinical and WIC service areas
- Enhancing ADA accessibility, including entrances, circulation, and service counters
- Reconfiguring interior space to improve circulation and accommodate behavioral health services
- Addressing deferred maintenance and safety-related improvements
- Incorporating building system lifecycle planning (roofing, HVAC, and technology infrastructure) into near-term capital and maintenance planning

Aligning services with facility capability will improve efficiency, protect client confidentiality, and ensure that resources are invested where they can have the greatest impact.

6. Continue Development of Partnership-Based Service Models

The District should continue to expand partnership-based and shared facility models, particularly in rural areas where standalone facilities may not be cost-effective.

The Marsing Hub provides a strong example of this approach. Continued investment in partnership-driven models can improve access, increase efficiency, and reduce the need for additional capital investment.

7. Maintain a Phased and Flexible Implementation Approach

All facility and operational improvements should be implemented in phases and adjusted over time based on performance and need.

Decisions should be guided by service demand, staffing capacity, and financial conditions. This approach allows the District to remain responsive to changing community needs while minimizing risk associated with premature capital investment.



PART III:
Comprehensive Financial Plan

9. COMPREHENSIVE FINANCIAL FRAMEWORK

The Comprehensive Financial Plan (CFP) provides a framework for aligning facility planning, service delivery, and financial capacity over time. It is intended to support informed, phased decision-making rather than define specific capital projects or funding commitments.

This section builds directly on the facility Plan and operational assessment, translating identified priorities into financial considerations. The focus is on how the District can implement improvements in a manner that is fiscally responsible, operationally sustainable, and responsive to community needs.

The purpose of this financial framework is not to prescribe specific funding strategies, but to provide a structured basis for evaluating tradeoffs. Decisions should consider operational effectiveness, community access, staffing capacity, and long-term financial sustainability in combination, rather than in isolation

9.1 Financial Approach and Guiding Principles

A central principle of this Plan is that operational investments should precede capital expansion. In many cases, service availability is constrained more by staffing capacity and operating hours than by physical space.

As a result, expanding service hours, increasing staffing in key program areas, and improving utilization of existing facilities are prioritized before consideration of new construction or major expansion.
The District's financial approach is grounded in three key principles:

- **Maximize Existing Assets First**
  - Existing facilities should be fully utilized and, where appropriate, reconfigured or renovated to support evolving service needs before pursuing expansion.
- **Align Investments with Demonstrated Demand**
  - Facility and operational investments should be phased based on verified service demand, utilization patterns, and staffing capacity.
- **Maintain Flexibility in Delivery Models**
  - The District's distributed service model (including satellite offices, shared facilities, and partnership-based approaches) provides flexibility in how services are delivered and should continue to be supported where cost-effective.

These principles provide the foundation for evaluating both operational and capital investments throughout the planning horizon.

9. COMPREHENSIVE FINANCIAL FRAMEWORK

9.2 Financial Context and Stability

Southwest District Health maintains a stable financial position supported by diversified revenue sources and consistent financial oversight. The District's operating model relies on a combination of federal and state grants, County contributions, service fees, and other intergovernmental sources.

While this structure supports core operations, it also introduces variability and limitations. A significant portion of funding is program-specific, and certain revenue streams may not be available to support long-term capital investment.

Long-term financial planning must balance:

- Capital improvement needs
- Workforce stability
- Grant dependency and reimbursement cycles
- Reserve preservation
- Multi-county equity considerations

Staffing represents the primary ongoing cost driver for the District. Investments in behavioral health, clinic services, and rural service delivery will require sustained funding commitments and should be evaluated alongside any proposed changes to service hours or facility use.

9.3 Capital Investment Categories

Potential facility investments generally fall into three categories:

1. **Interior Reconfiguration and Modernization** Improvements within existing building footprints to enhance workflow, privacy, and adaptability.
2. **Modest Additions or Site Enhancements** Targeted expansion to address spatial constraints or program growth.
3. **Shared or Co-located Facility Arrangements** Collaborative models leveraging shared infrastructure to maintain geographic access and reduce capital cost.

Each category carries a different financial scale and risk profile. Interior renovation strategies typically require lower capital commitment, shorter implementation timelines, and reduced long-term financial exposure.

For this reason, renovation-first strategies generally present lower fiscal risk while preserving future flexibility.

9. COMPREHENSIVE FINANCIAL FRAMEWORK

9.4 Order-of-Magnitude Cost Considerations

To support implementation planning, this section provides order-of-magnitude cost considerations for potential facility improvements. These estimates are intended to illustrate the relative scale of investment associated with different types of projects and to support phased decision-making over time.

Consistent with the approach outlined in this Plan, these costs are presented in today's dollars and are not intended to represent project budgets or funding commitments. Rather, they provide a planning-level framework to evaluate timing, prioritization, and financial feasibility of potential improvements.

Planning-level cost ranges indicate:

- **Renovation and reconfiguration**: approximately $150 to $175 per square foot
- **New construction**: approximately $350 to $375 per square foot

Projects located in more rural or remote areas, including portions of Washington and Owyhee Counties, may experience additional cost premiums, typically in the range of 5 to 10 percent, due to labor availability, transportation, and site conditions.

To provide context for potential Phase I improvements, order-of-magnitude estimates have been developed using current-dollar assumptions. These estimates are intended for planning purposes only and reflect preliminary scope based on identified facility needs.

Estimated renovation costs below reflect planning-level estimates based on conceptual scopes identified in this report. These estimates include a range of improvement types, from targeted interior reconfiguration (Phase I) to broader facility renovation scenarios.

Costs are intended for comparative and long-term planning purposes only and do not represent project budgets or funding commitments. They do not include soft costs (e.g., design, permitting, project management), escalation, or potential site-specific conditions that may affect final costs.

9. COMPREHENSIVE FINANCIAL FRAMEWORK

Estimated Phase I renovation costs include:

- **Weiser (Full Facility Renovation):**
  - Approximately 2,200 square feet at $175 per square foot
    → **Estimated cost: ~$385,000**

- **Emmett (Full Facility Renovation):**
  - Approximately 2,500 square feet at $175 per square foot
    → **Estimated cost: ~$437,500**

- **Payette (Targeted Interior Reconfiguration – Phase I):**
  - Approximately 800 square feet of impacted space associated with reception improvements, conference room reconfiguration, and conversion of storage space
    → **Estimated cost: ~$140,000**

These estimates reflect renovation-focused improvements and do not include escalation, soft costs, or potential site-related adjustments.

Actual project costs will be determined at the time of implementation and will depend on:

- Final scope and programming
- Architectural design development
- Competitive bidding conditions
- Market pricing and material costs at the time of procurement

These cost considerations reinforce the importance of prioritizing lower-cost, high-impact improvements before pursuing more capital-intensive solutions.

9. COMPREHENSIVE FINANCIAL FRAMEWORK

9.5 Cost Drivers and Operational Considerations

The District's primary cost drivers are operational rather than structural. Key cost drivers include:

- Staffing capacity across behavioral health, clinic services, and rural delivery
- Service hours and program availability
- Facility operations, maintenance, and targeted improvements
- Geographic distribution of services across multiple counties

In many cases, expanding service hours and staffing capacity represents a more effective and lower-cost approach to improving access than expanding physical space.

Facility investments should therefore be evaluated in the context of how they support operational efficiency, service delivery, and long-term sustainability.

9.6 Funding Strategy Considerations

If facility improvements are pursued, the Board may consider a range of funding tools available under Idaho law. The appropriateness of any mechanism would depend on project scale, timing, and long-term fiscal impact.

As a public health district without independent taxing authority, the District's ability to pursue certain financing mechanisms is limited. As a result, capital funding strategies should prioritize approaches that align with statutory authority and historical financing models. Potential approaches include:

- **Phased Use of Reserves** Allocation of existing fund balances over multiple budget cycles for smaller projects.
- **Annual Capital Allocations** Establishment of a dedicated capital line item within the annual budget.
- **State or Federal Capital Grants** Competitive funding opportunities aligned with program objectives.
- **Intergovernmental Cost Participation** Cost-sharing agreements for facilities serving multiple counties.
- **Lease or Partnership Models** Shared-use or co-located facilities to reduce upfront capital requirements.
- **State-Supported and Debt Financing Mechanisms** The District may consider financing capital improvements through bank loans or lease-revenue structures supported by state-level entities, such as the Idaho State Building Authority or similar programs, subject to statutory requirements limiting debt beyond the current year.
- **Partnership-Based Capital Investments** Co-location or shared facility models may allow capital costs to be distributed across multiple entities, reducing the need for District-led financing.

9. COMPREHENSIVE FINANCIAL FRAMEWORK

9.7 Phasing and Fiscal Stewardship

Phased implementation provides the District with the greatest financial flexibility. Sequencing improvements over time allows the Board to:

- Align capital commitments with known service demand
- Protect operational stability
- Monitor demographic trends before advancing to larger projects
- Preserve reserve levels appropriate for a grant-dependent organization

A renovation-first approach reduces long-term financial exposure while maintaining adaptability for future growth.

9.8 Ongoing Financial Review

The Board may consider incorporating facility planning into routine financial review cycles. Periodic reassessment ensures that capital decisions remain aligned with:

- Updated demographic projections
- Program utilization trends
- Workforce capacity
- Revenue stability

This approach supports continuous alignment rather than one-time capital commitments.



PART IV:
Conclusion

10. IMPLEMENTATION

The recommendations within this Plan are designed to be implemented in measured phases, aligned with operational needs, financial capacity, and Board direction.

Implementation should prioritize strategies that:

- Maximize use of existing assets
- Improve functional efficiency
- Preserve fiscal flexibility
- Maintain service continuity

A phased, renovation-first approach provides the most adaptable and fiscally responsible starting point for implementation.

10.1 Phase I – Operational Optimization and Facility Refinement

The first phase of implementation focuses on optimizing existing facilities and improving operational performance without expanding building footprint.

This phase reflects the Plan's core principle that operational improvements, particularly those related to staffing, service hours, and workflow, should precede capital expansion.

Typical Phase I actions may include:

- Interior space reallocation to improve departmental adjacencies
- Modifications to enhance privacy, confidentiality, and client flow
- Targeted mechanical, lighting, and technology upgrades
- Improvements that address workflow inefficiencies
- Minor code, accessibility, or life-safety updates

These improvements generally require lower capital investment, shorter implementation timelines, and reduced financial exposure compared to structural expansion.

The recommendations within this Plan are designed to be implemented in measured phases, aligned with operational needs, financial capacity, and Board direction.

Implementation should prioritize strategies that:

- Maximize use of existing assets
- Improve functional efficiency
- Preserve fiscal flexibility
- Maintain service continuity

A phased, renovation-first approach provides the most adaptable and fiscally responsible starting point for implementation.

10. IMPLEMENTATION

10.1.A Facility-Specific Phase I Actions

Caldwell (District Hub)

- Convert Room 236 into an Infectious Disease Room
- Reallocate existing clinic office space to accommodate Behavioral Health services
- Reconfigure workstation layouts to improve efficiency and support future staffing needs
- Optimize use of administrative space to improve workflow and capacity

Payette

- Reorganize space to incorporate a dedicated Behavioral Health room within existing footprint
- Improve ADA accessibility at reception by lowering counter height and adding knee clearance

Weiser

- Improve site accessibility, including ADA-compliant parking and accessible entry enhancements
- Upgrade reception area to meet ADA requirements
- Relocate and reorganize select functions (e.g., immunization storage, lab) within existing rooms to improve workflow

Emmett

- Address immediate ADA and code-related deficiencies, including ramp railing, steps, and restroom upgrades
- Improve reception and waiting area layout to enhance workflow and client experience

WIC and Shared Sites (Nampa, Homedale, Council, Farmway)

- Improve visual and acoustic privacy through installation of partition systems or sound mitigation strategies

10. IMPLEMENTATION

10.2 Phase II – Targeted Capacity Adjustments

Following completion and evaluation of Phase I improvements, the Board may assess whether targeted capacity adjustments are warranted at select locations.

These adjustments are intended to respond to community need and may include:

- Modest square footage additions
- Site-level improvements
- Expansion of programmable space where demand has increased

Advancement beyond Phase I should be supported by:

- Documented increases in service utilization
- Evaluation of operational performance following Phase I improvements
- Updated demographic analysis
- Review of fiscal impact and funding feasibility

This stepwise approach ensures that expansion decisions are data-informed and aligned with actual service demand rather than projected need alone.

Changes to service delivery should be accompanied by clear communication and outreach to avoid unintended reductions in utilization or community trust.

Targeted capacity adjustments differ from comprehensive facility replacement and are intended to preserve flexibility while addressing specific operational constraints.

10.2.A Facility-Specific Phase II Considerations

Payette

- Reconfigure interior layout to:
  - Create a dedicated Conference Room
  - Add Behavioral Health rooms through subdivision of existing space
- Convert underutilized office areas into a larger Community Room to support programming and outreach
- Evaluate expanded clinical capacity if utilization increases following Phase I improvements

10. IMPLEMENTATION

Weiser

- Reconfigure interior layout to improve clinical flow and service delivery, including:
  - Creation of a defined clinic corridor
  - Addition of office and nurse workspaces
  - Expansion and reconfiguration of WIC and Behavioral Health areas
- Increase exam room size and improve layout to support clinical use
- Evaluate additional site or facility improvements based on sustained demand

Emmett

- Reconfigure interior spaces to expand clinical and behavioral health capacity, including:
  - Subdivision of existing rooms into additional service areas
  - Repurposing of underutilized space to support program growth
- Construct a Community Room addition to support expanded programming and potential after-hours use

These targeted adjustments differ from comprehensive facility replacement and are intended to preserve flexibility while addressing specific operational constraints.

10.3 Phase III – Long-Term Planning and System Adaptability

Facility planning within a public health district must account for long time horizons. Buildings and capital investments often span multiple decades, while population growth, service demand, and funding conditions may evolve more rapidly.

The District has evaluated projected population trends through 2040 as the primary planning horizon, with extended projections used to assess long-term system adaptability under varying growth conditions.

Long-term planning should include:

- Monitoring population growth patterns across the region
- Evaluating changes in service utilization and program demand
- Reviewing regulatory and programmatic requirements
- Assessing facility performance and functional adequacy

Long-term adaptability requires coordination between physical space, staffing capacity, and program funding. Expansion of square footage without corresponding operational capacity may not result in improved service delivery.

Maintaining flexibility and avoiding premature structural commitments allows the District to adapt responsibly as conditions evolve.

10. IMPLEMENTATION

10.4 Governance and Ongoing Review

Facility planning should be integrated into routine governance and financial oversight processes rather than treated as a one-time initiative.

As service demand, funding conditions, and operational priorities evolve, facility strategy should be annually reviewed to ensure continued alignment with District goals and statutory responsibilities. Integrating facility planning into annual budgeting and strategic review cycles allows the Board to:

- Evaluate capital needs alongside operational priorities
- Address maintenance proactively
- Monitor facility performance relative to service demand
- Adjust implementation sequencing based on financial capacity
- Maintain transparency in long-term planning decisions

A structured review process supports measured decision-making, reduces long-term financial risk, and ensures that facility investments remain responsive to changing conditions.

This Plan is intended to guide implementation over time. Continued integration into governance processes will help ensure that facility decisions remain aligned with service delivery, fiscal stewardship, and community needs.

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Appendix 11.0
Demographic Report

2025

Southwest District Health Demographic Report Summary

PREPARED FOR SOUTHWEST DISTRICT HEALTH

AUGUST 2025

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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

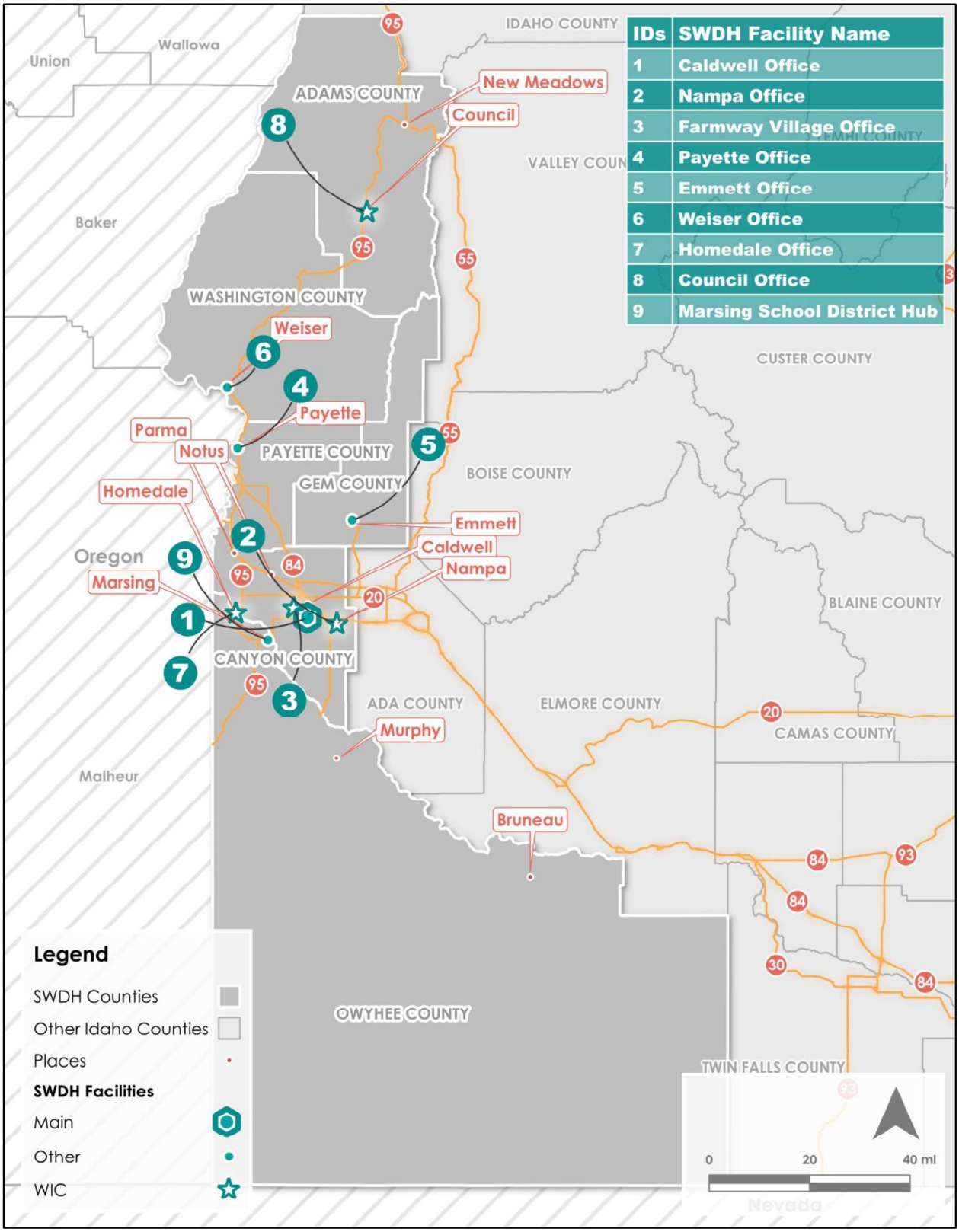


Figure: Southwest District Health, ACS Population by Block Group and Comparative City Populations

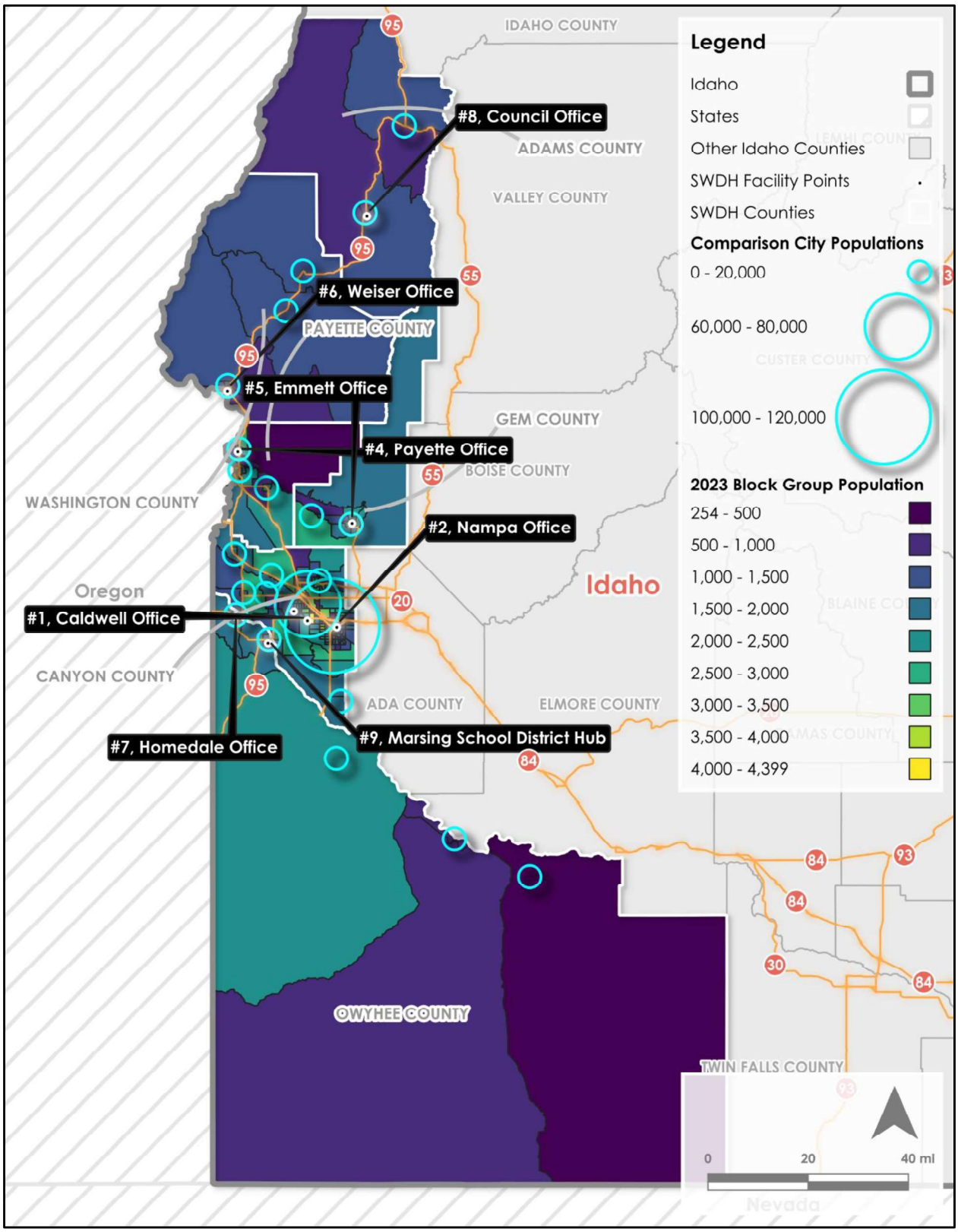
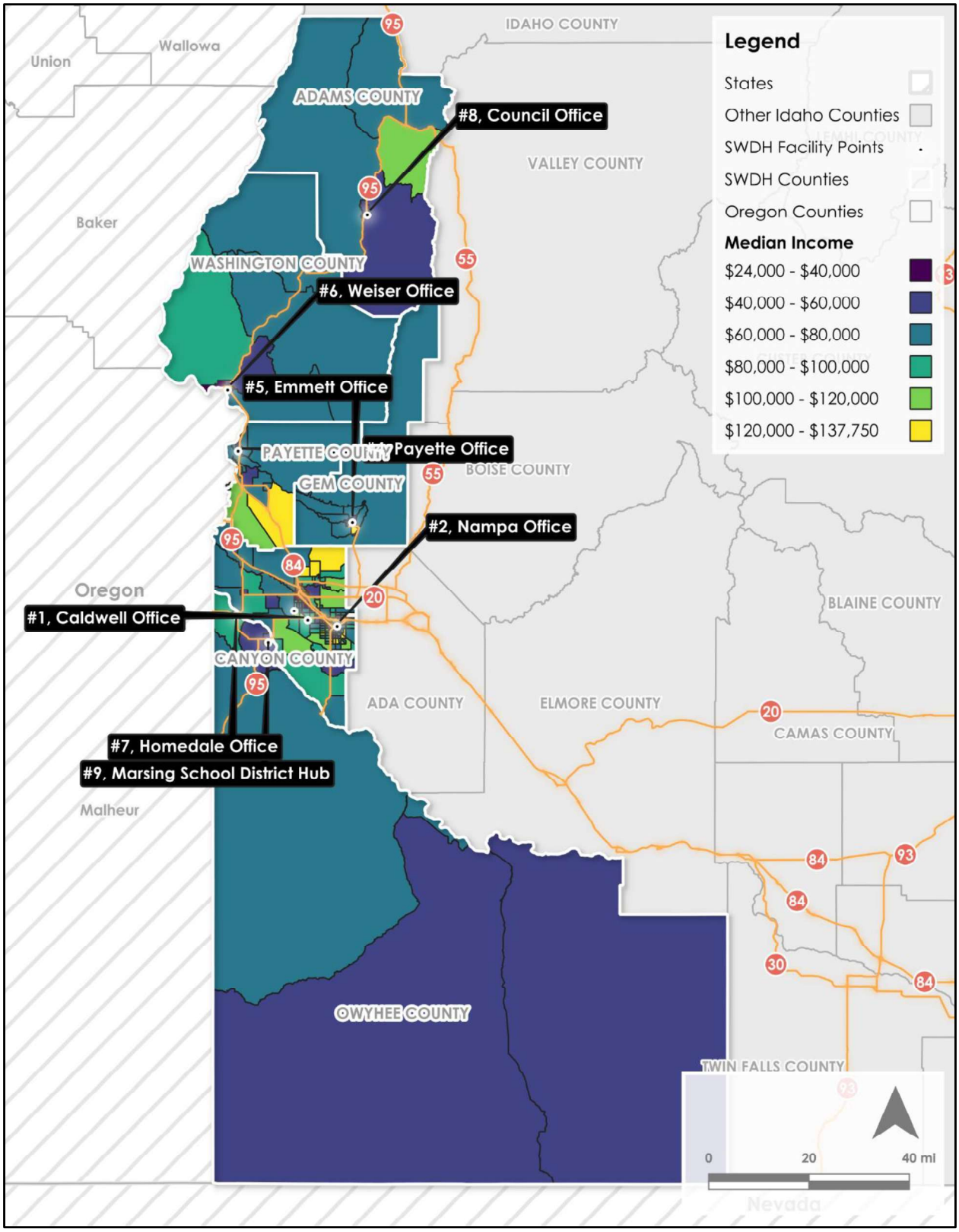


Figure: Southwest District Health, ACS Median Income by Block Group



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

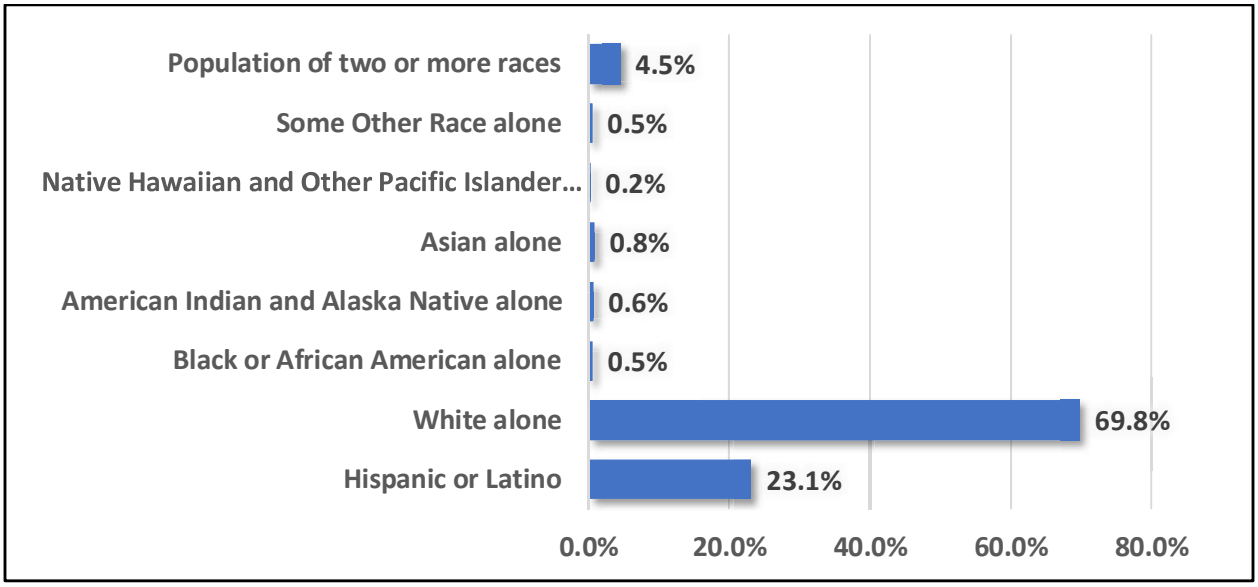
According to 2020 Decennial Census data (U.S. Census Bureau, 2025), most individuals in the Southwest District Health (SWDH) service area identified as belonging to a single race. A more detailed breakdown is provided below:

- **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

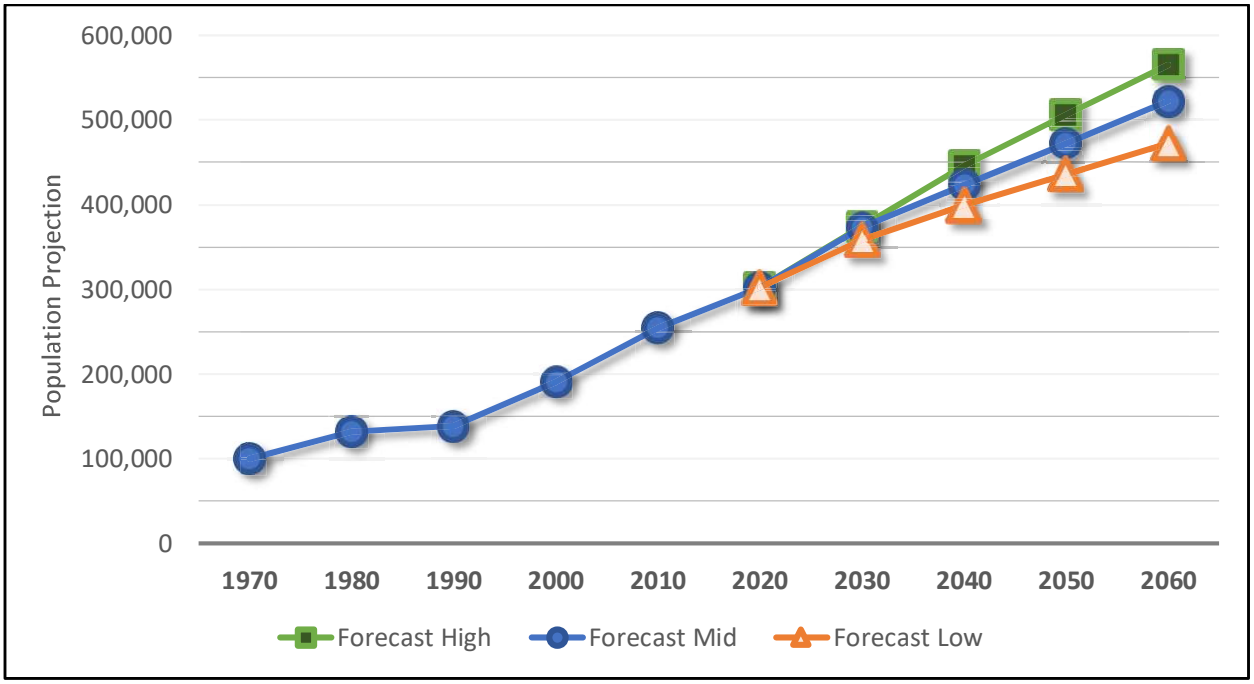


Table: Southwest District Health, Population Forecast

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

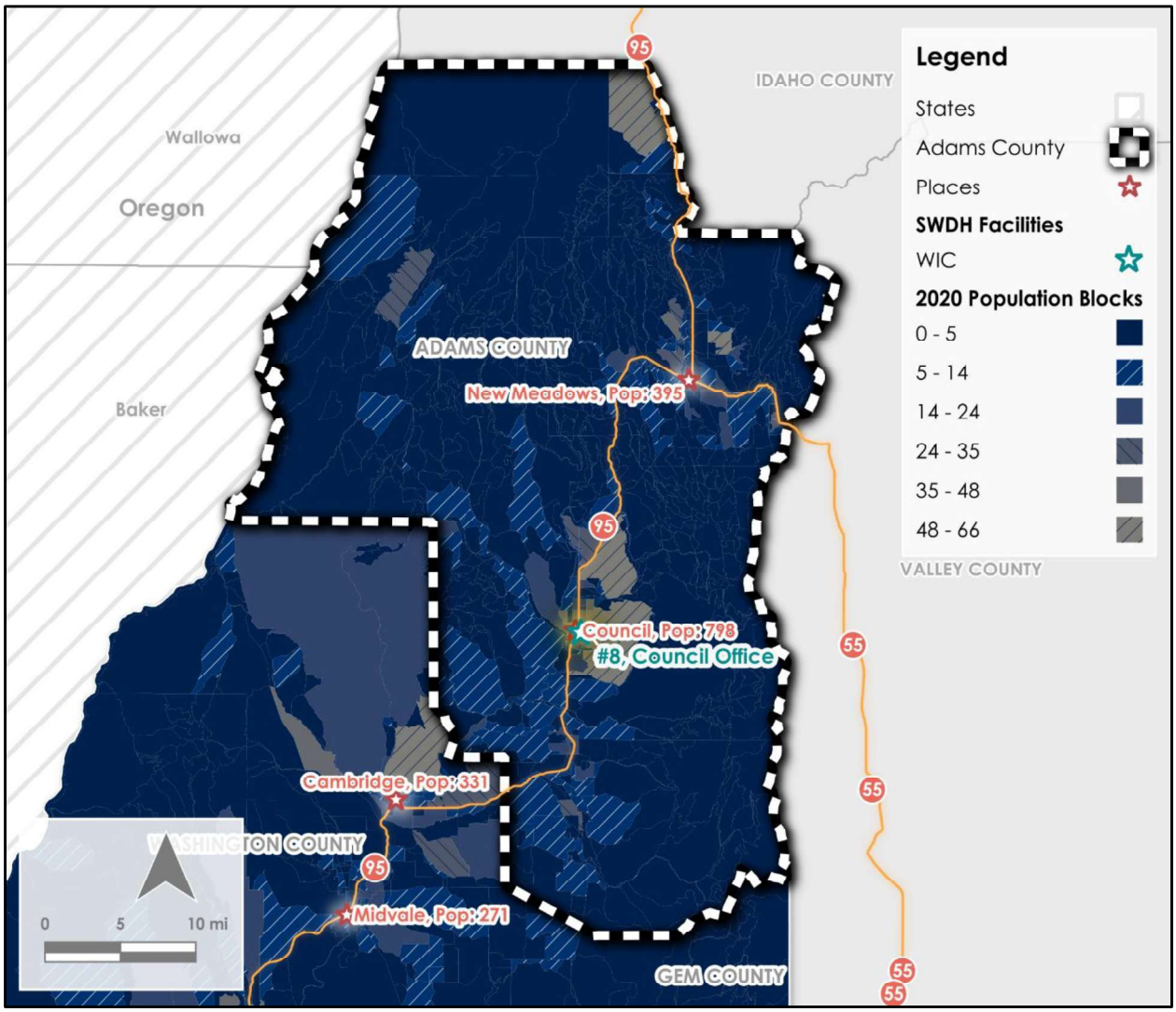
According to the latest 5-year ACS estimates (2019–2023), veteran status is reported for individuals aged 18 and older who have served in the U.S. Armed Forces, regardless of service period or discharge type.

- 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)

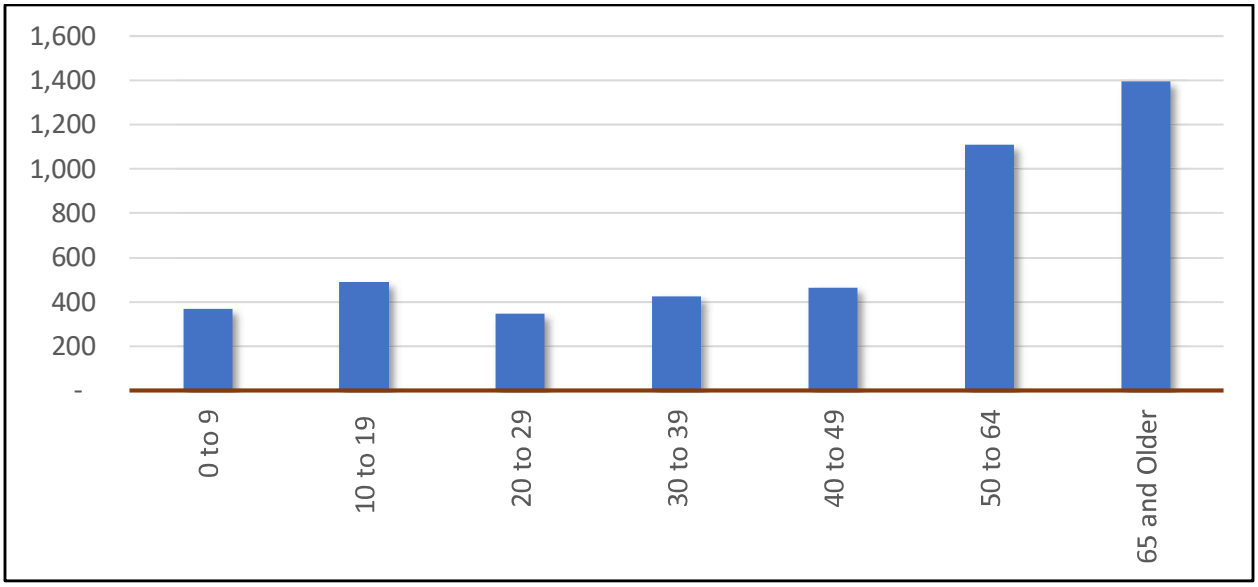


Figure: Adams County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)

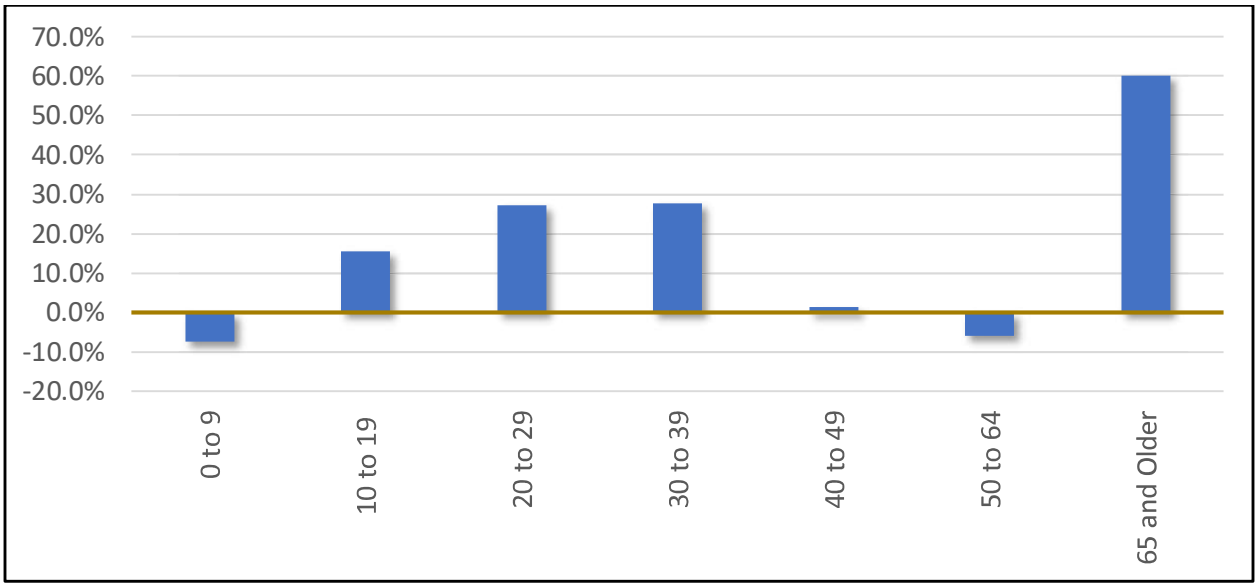


Table: Adams County, ACS Change in Population Age Groups

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%

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

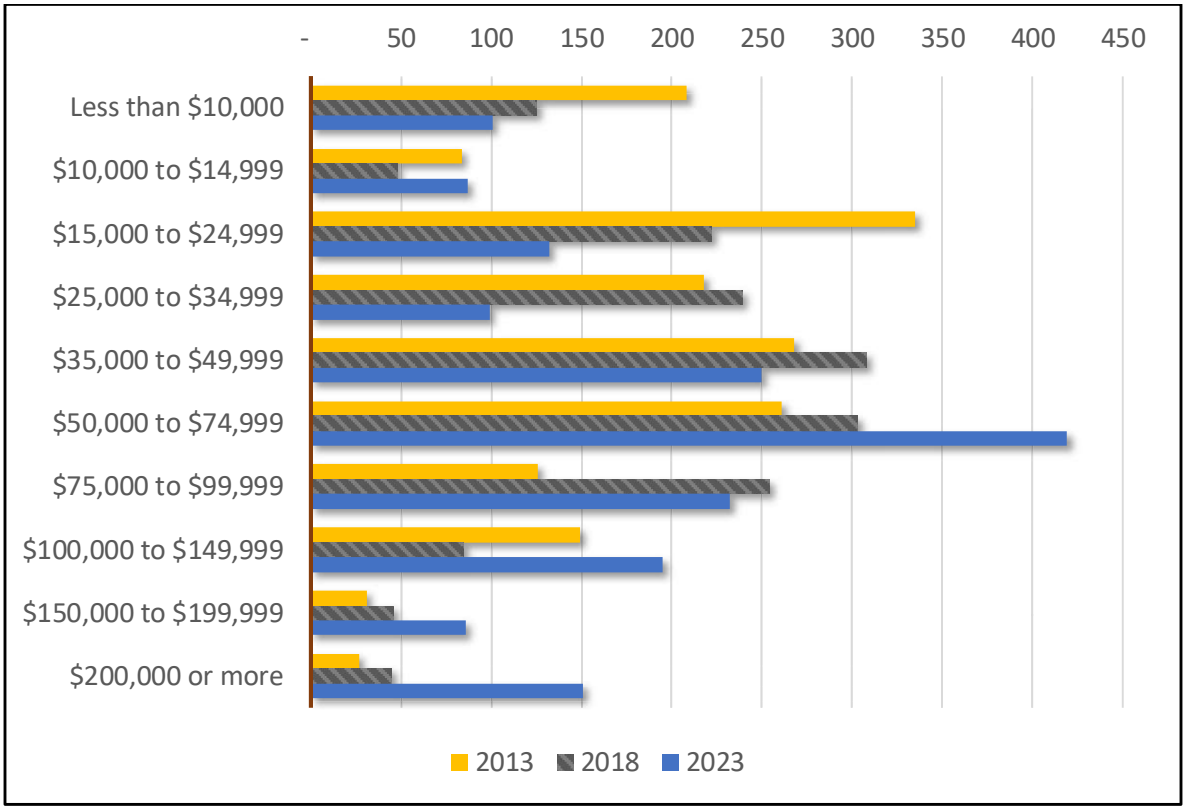
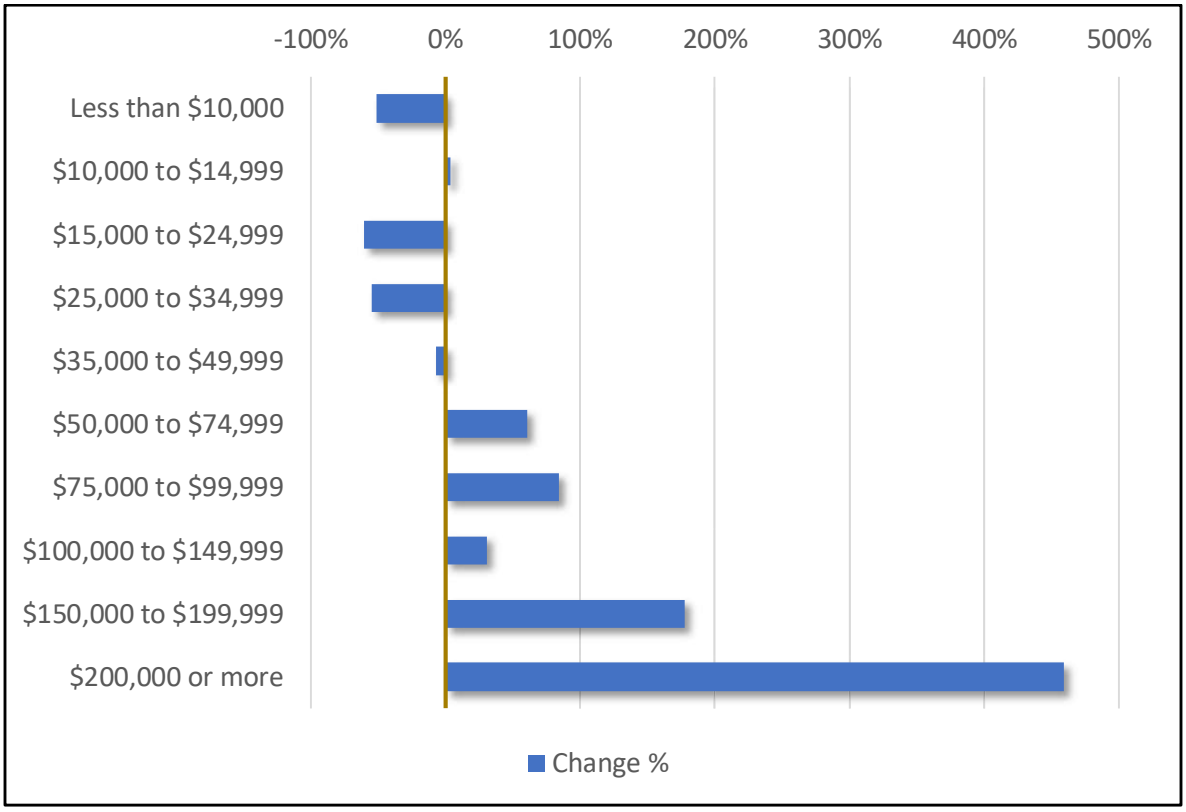


Figure: Adams County, ACS Changes to Household Income by %, 2013 to 2023



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

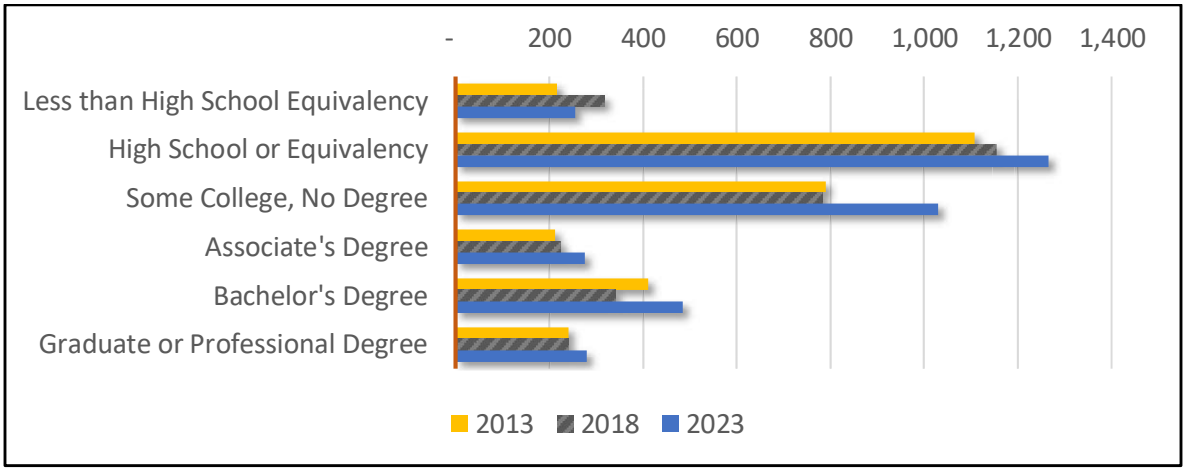


Figure: Adams County, ACS % Change to Educational Attainment, 2013 to 2023

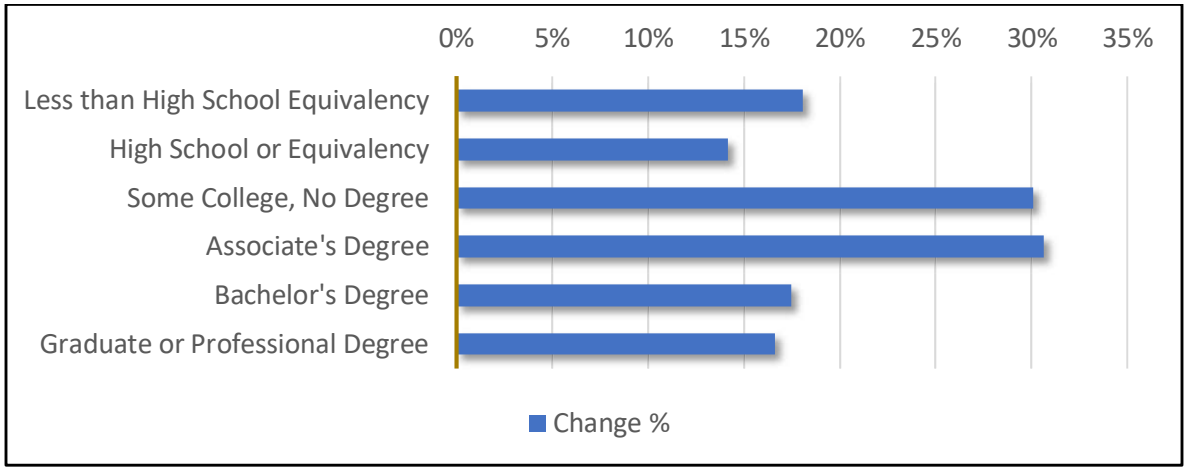
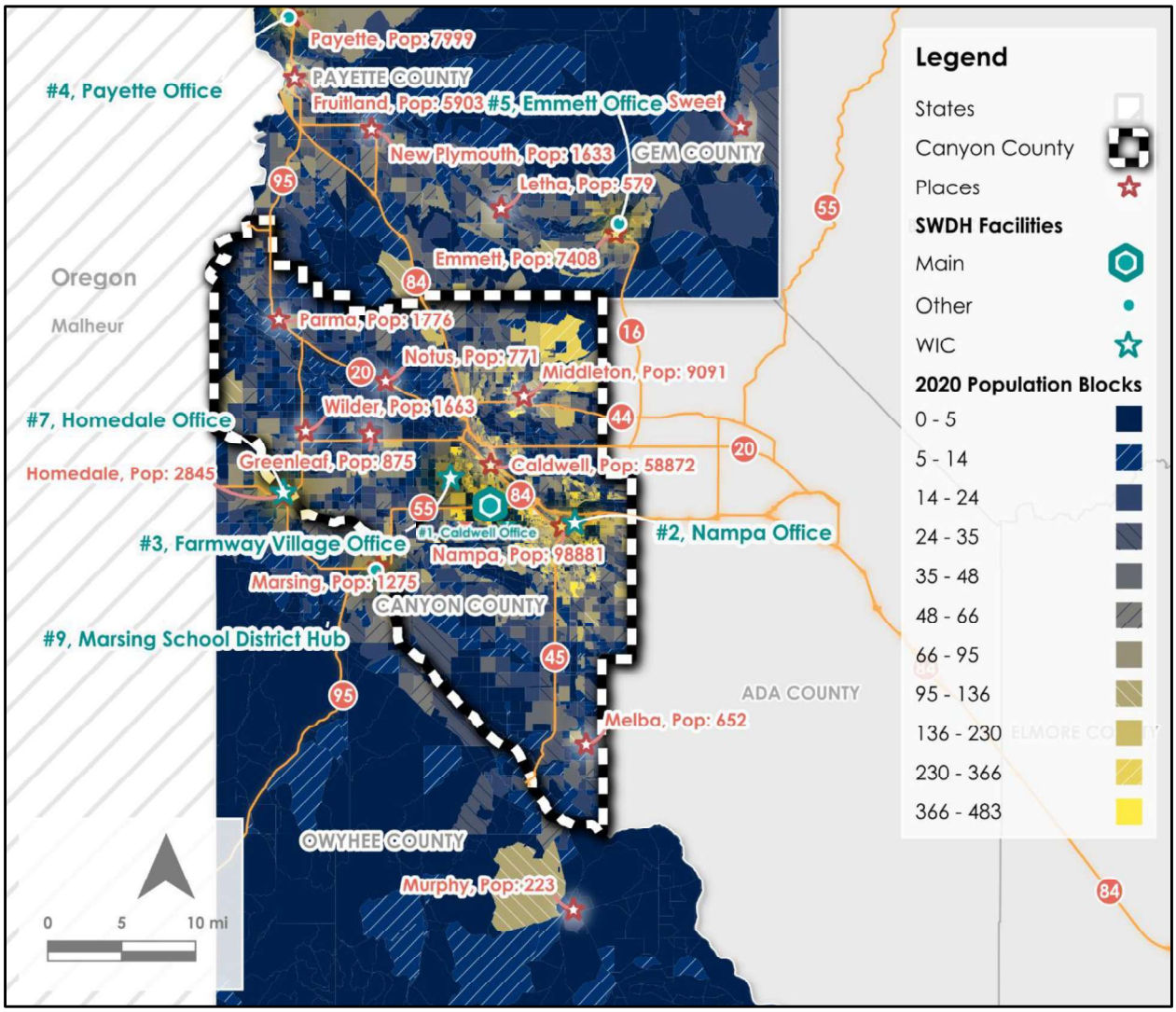
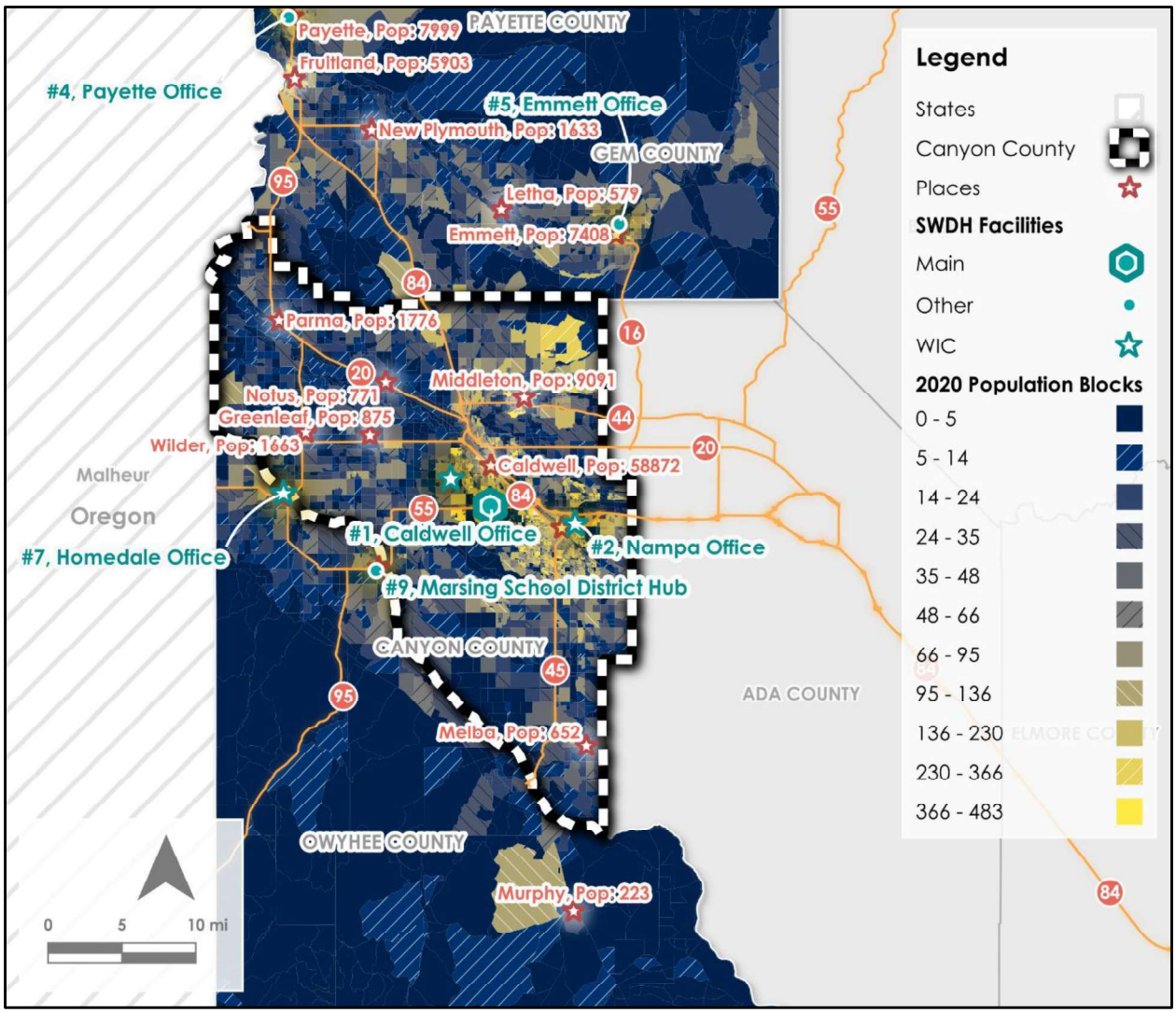


Table: Adams County, ACS Change in Educational Attainment 2013 to 2023

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)

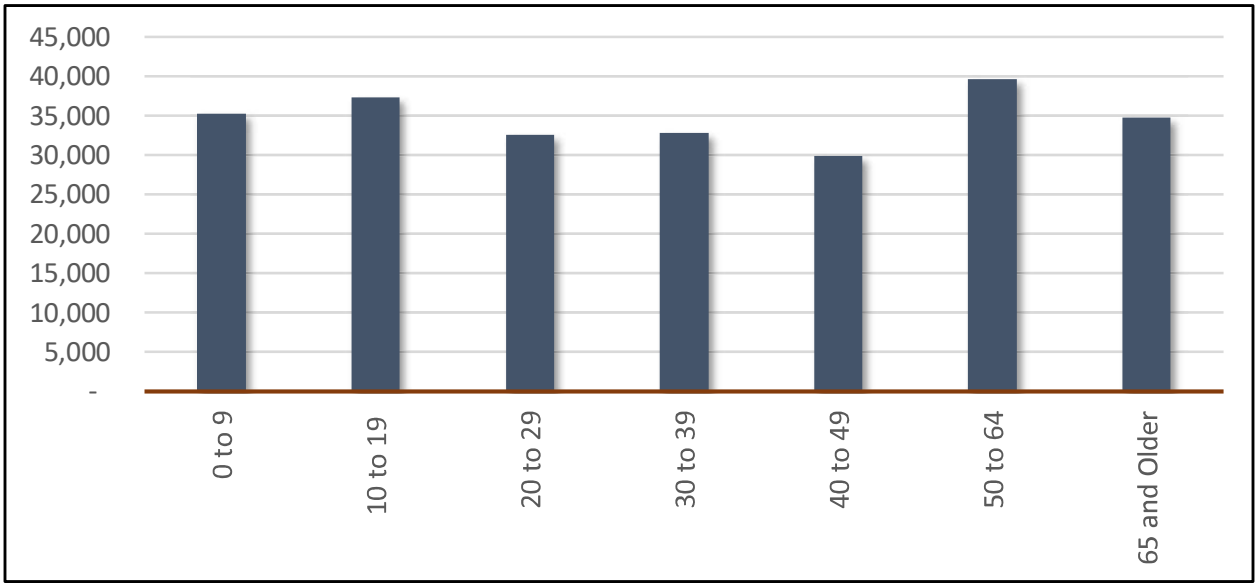


Figure: Canyon Change in Population Age Groups by % (2009-2013 to 2019-2023)

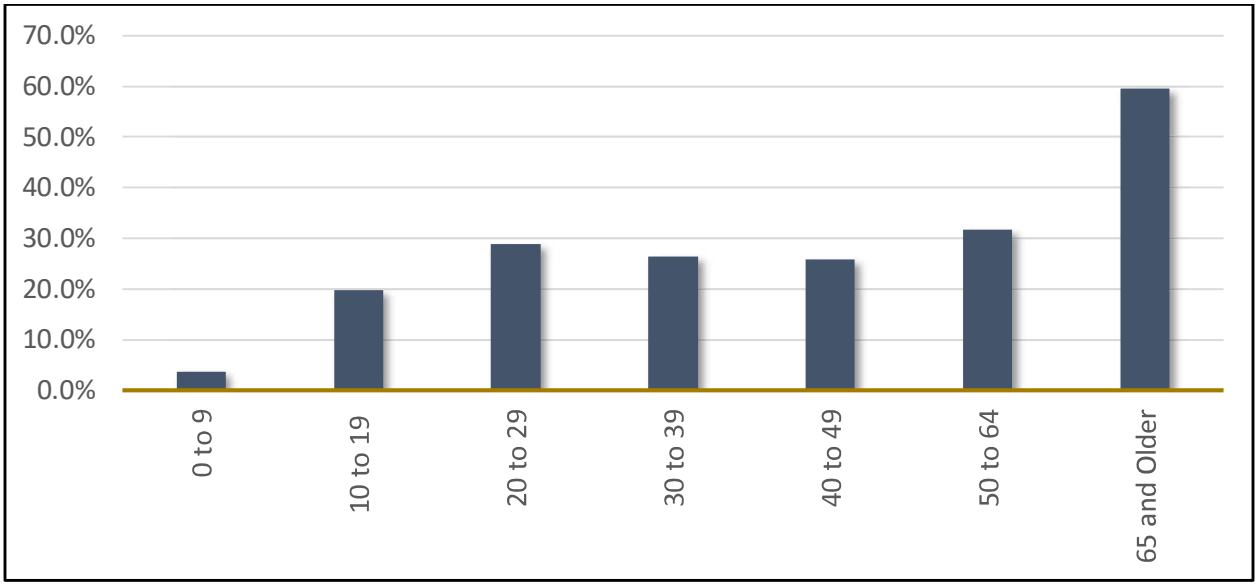


Table: Canyon County, ACS Change in Population Age Groups

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

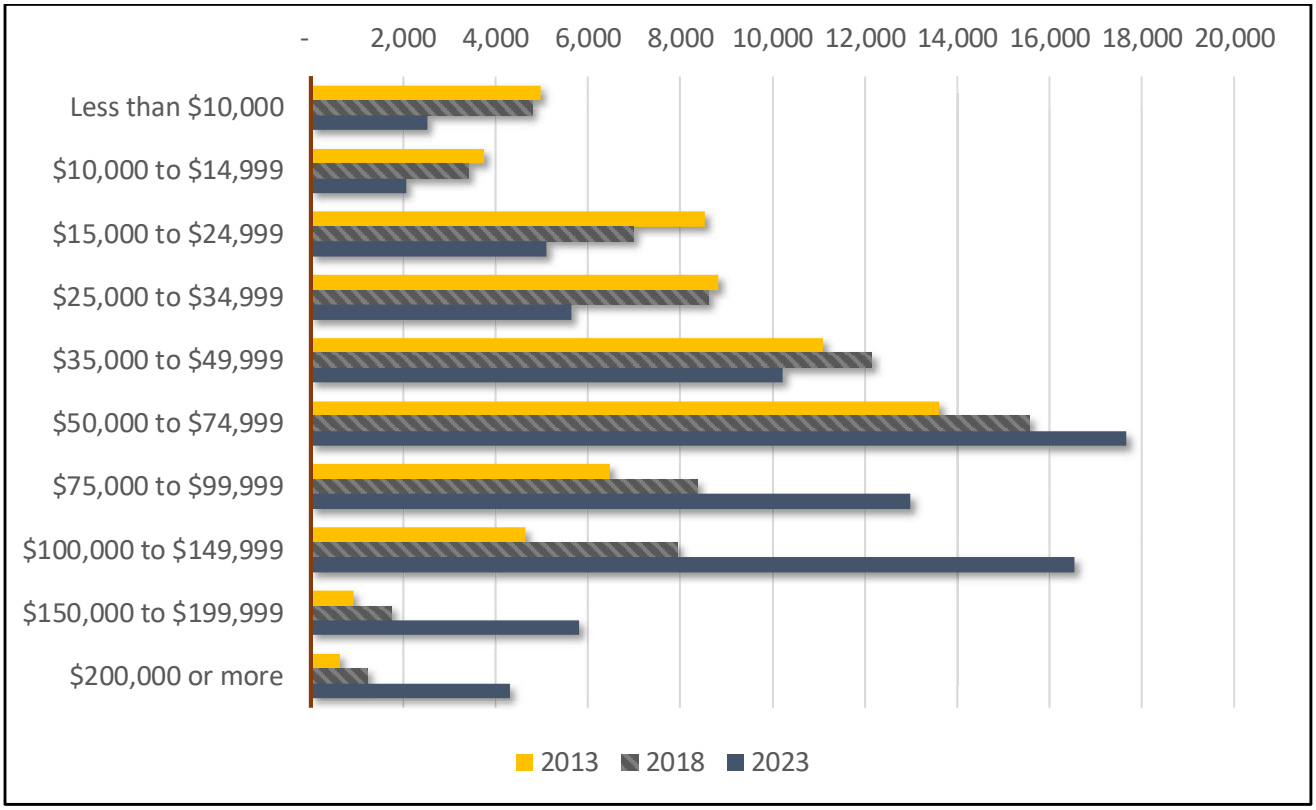
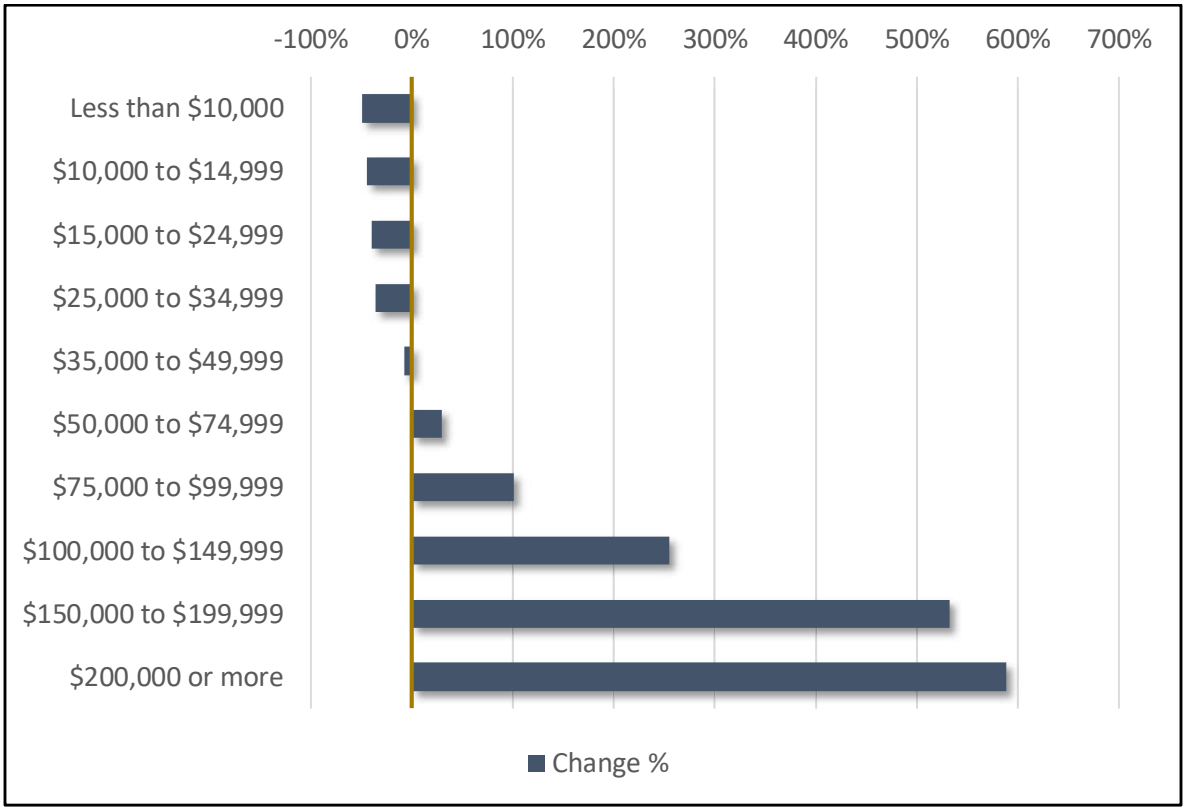


Figure: Canyon County, ACS Changes to Household Income by %, 2013 to 2023



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

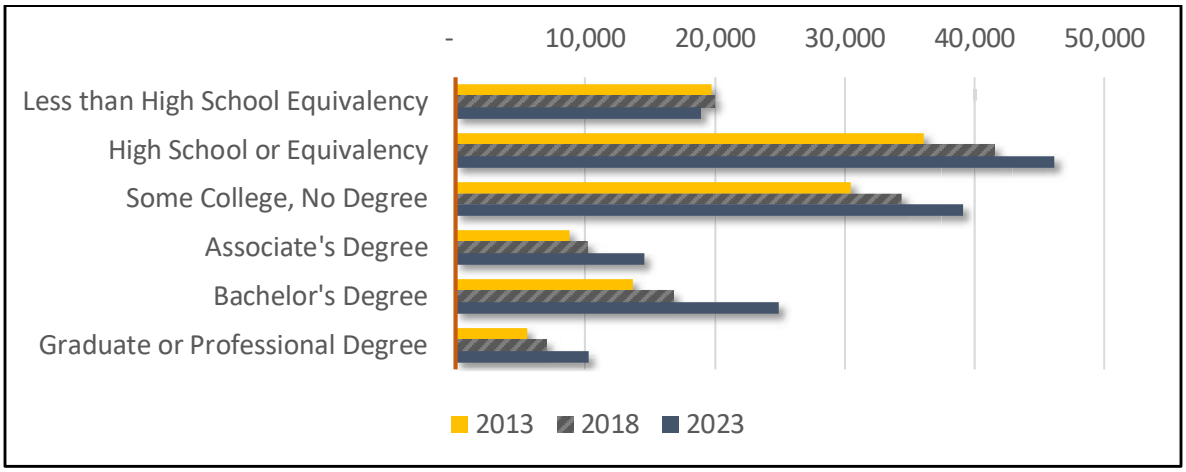
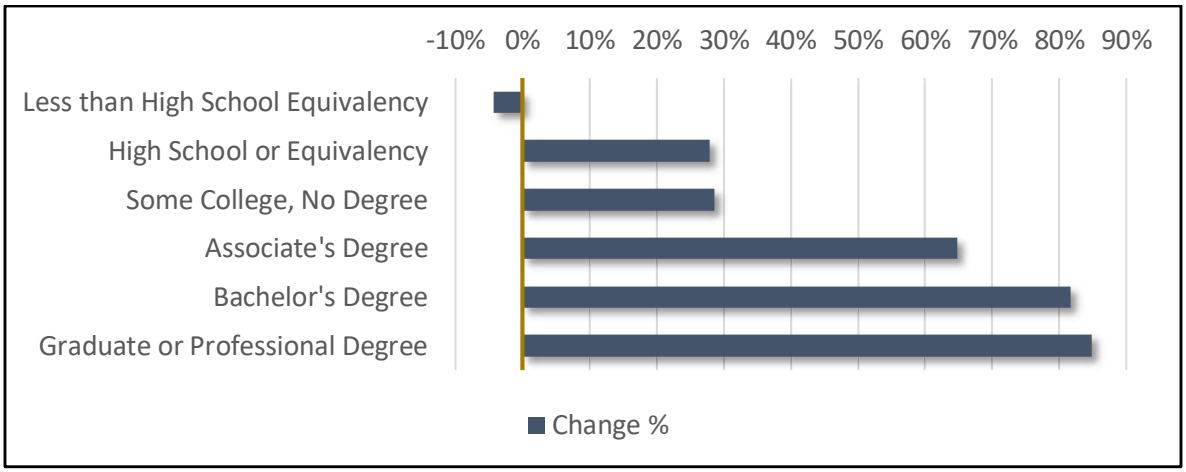
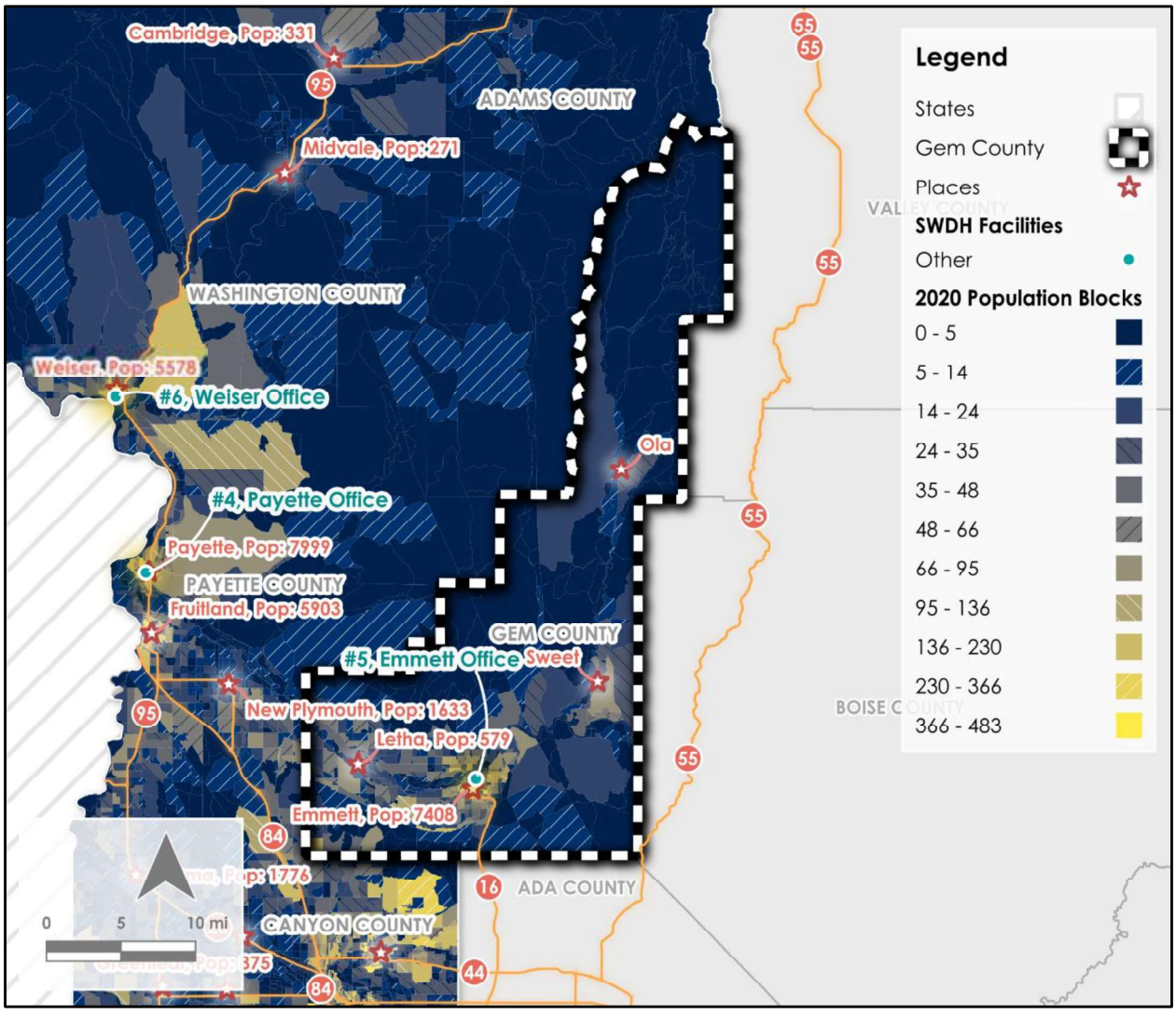


Figure: Canyon County, ACS % Change to Educational Attainment, 2013 to 2023



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)

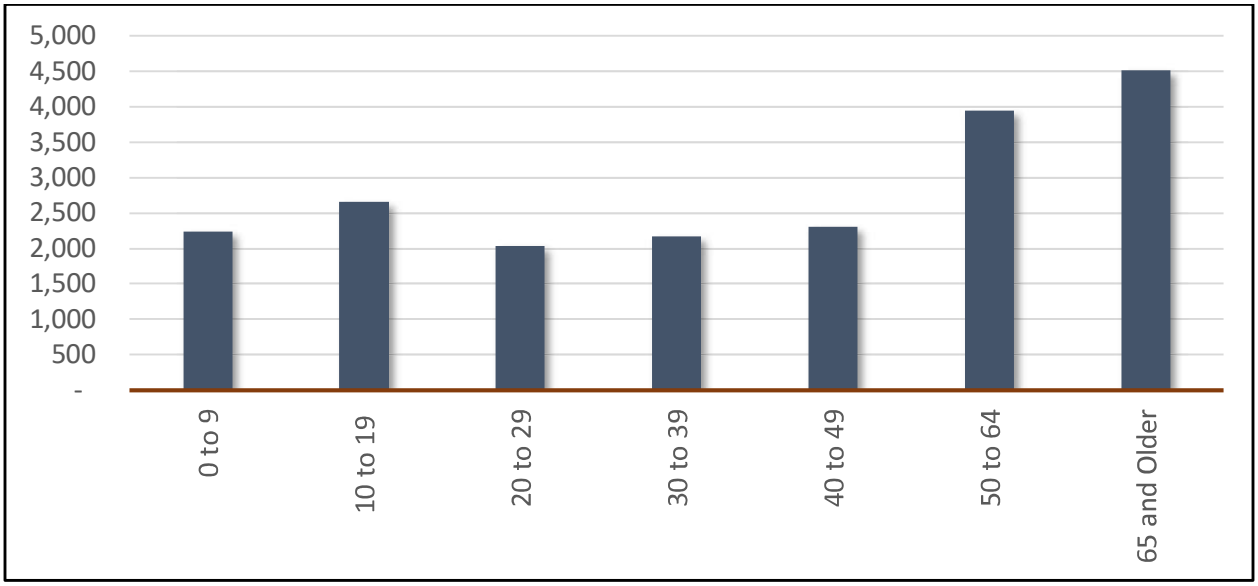
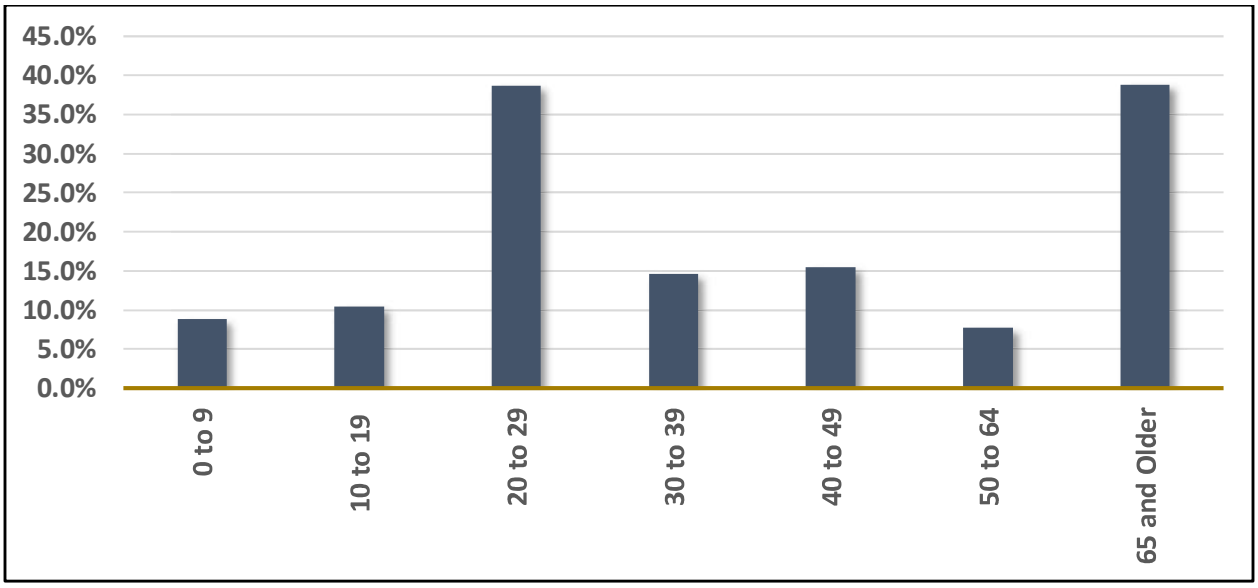


Figure: Gem County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



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

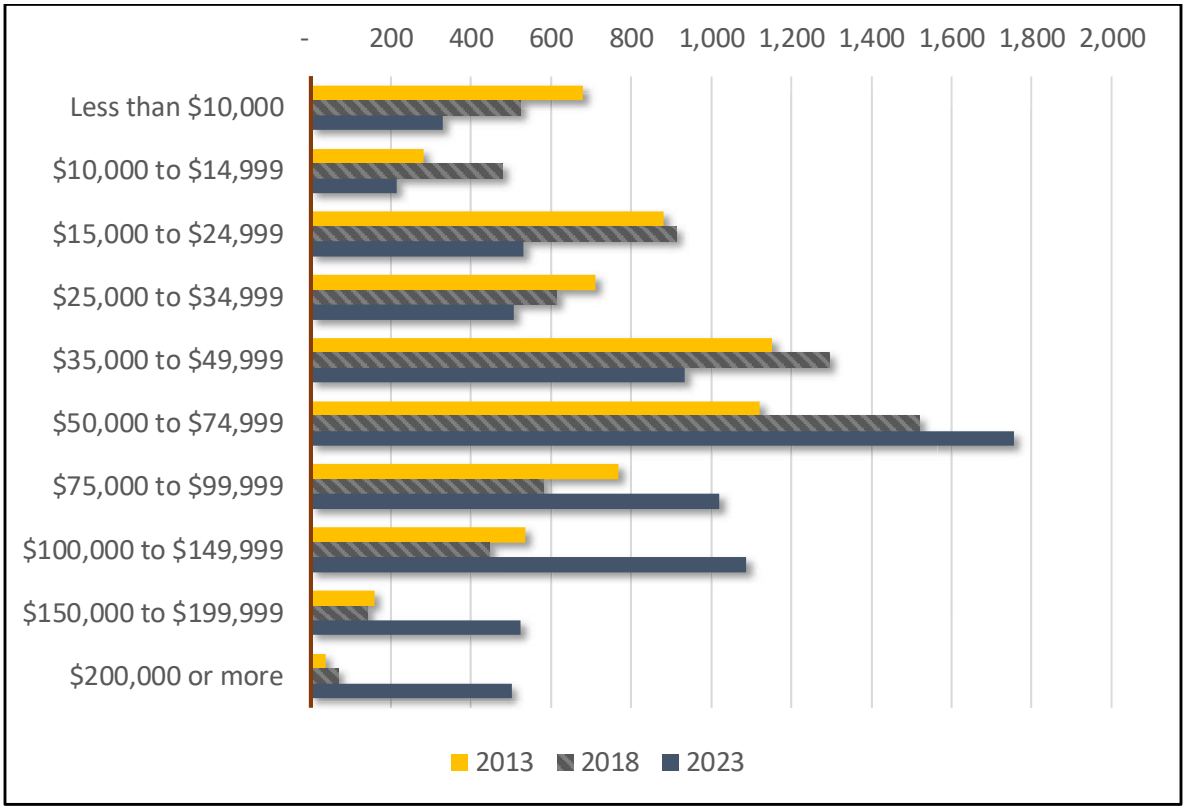
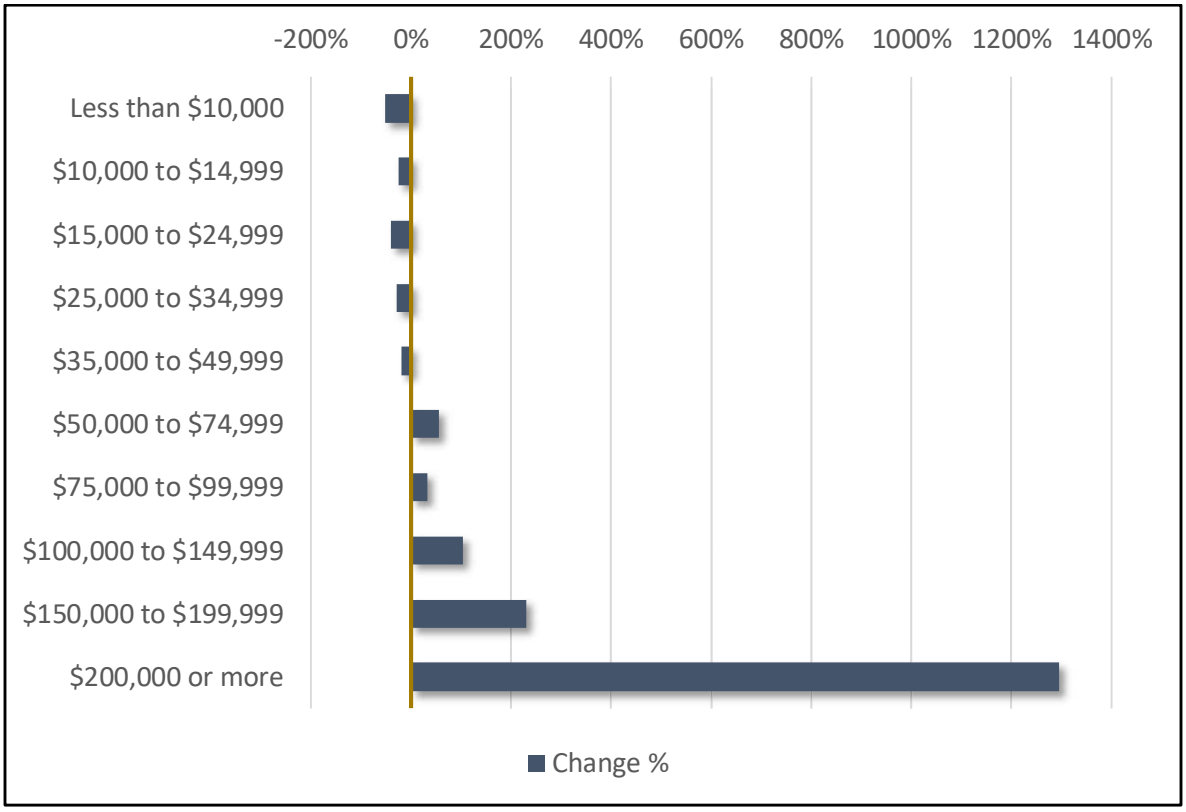


Figure: Gem County, ACS Changes to Household Income by %, 2013 to 2023



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

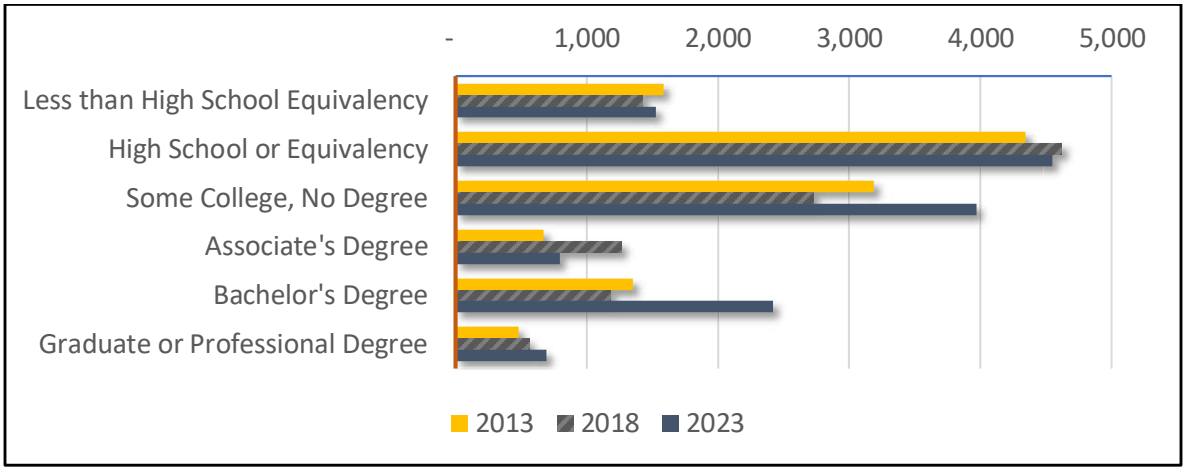
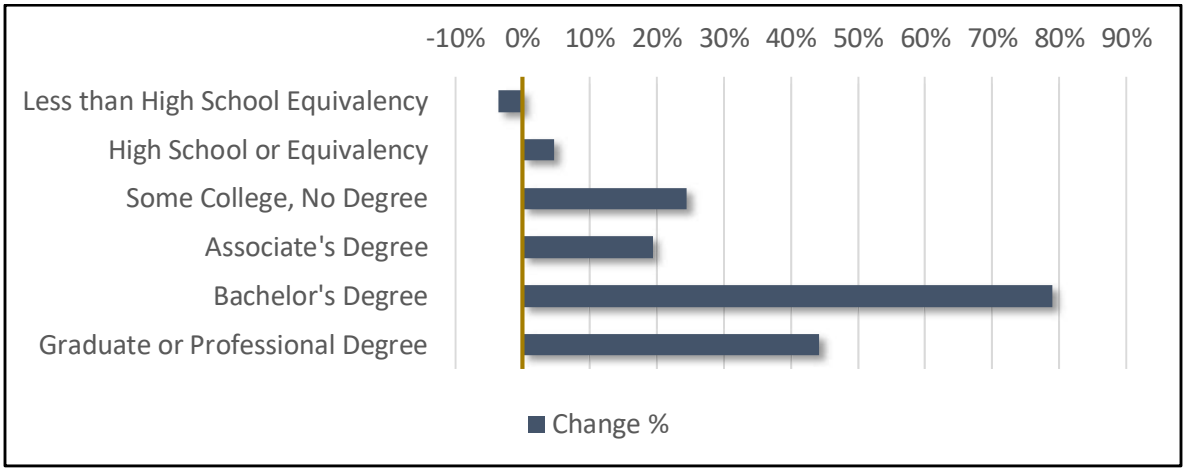
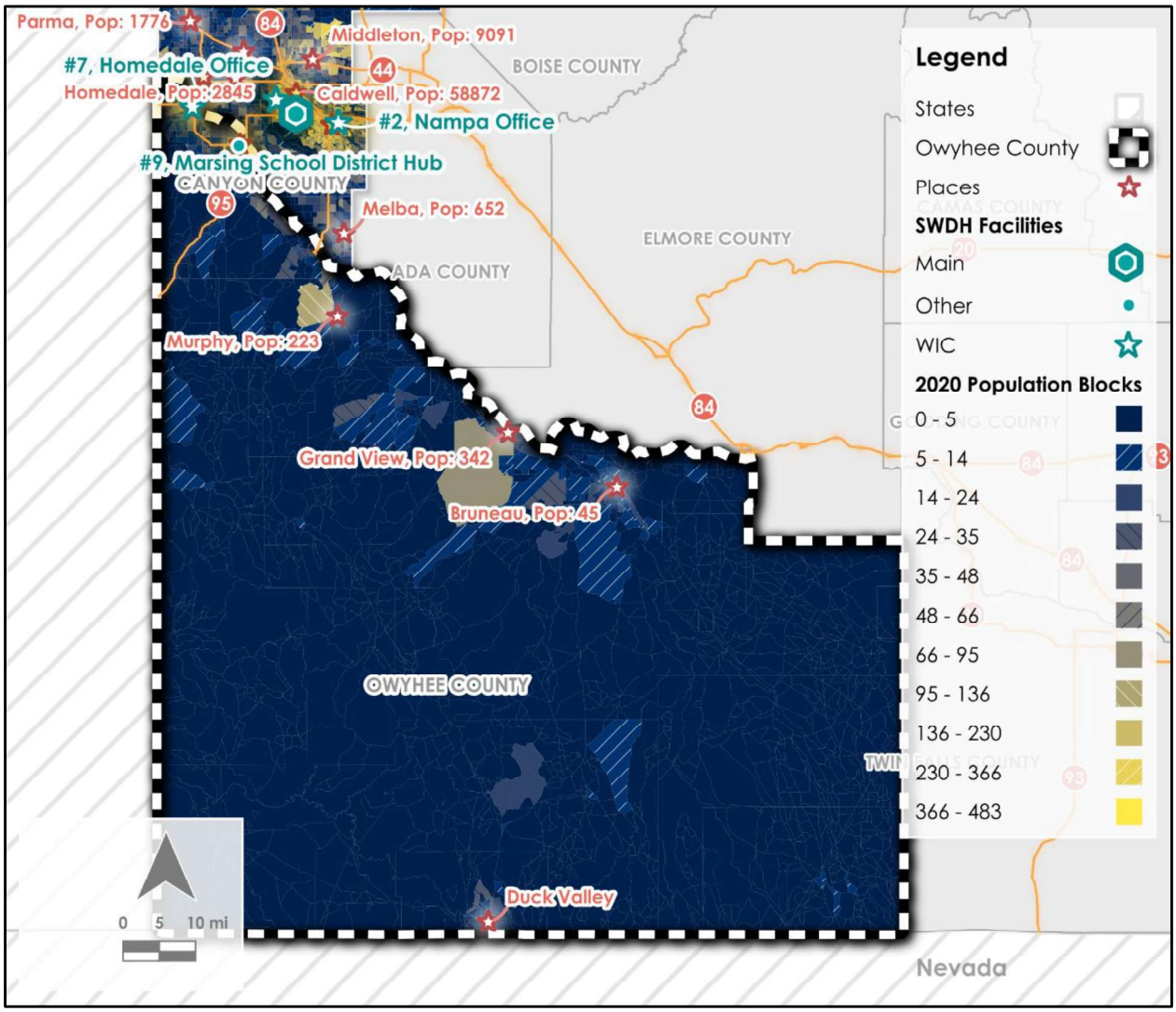


Figure: Gem County, ACS % Change to Educational Attainment, 2013 to 2023



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)

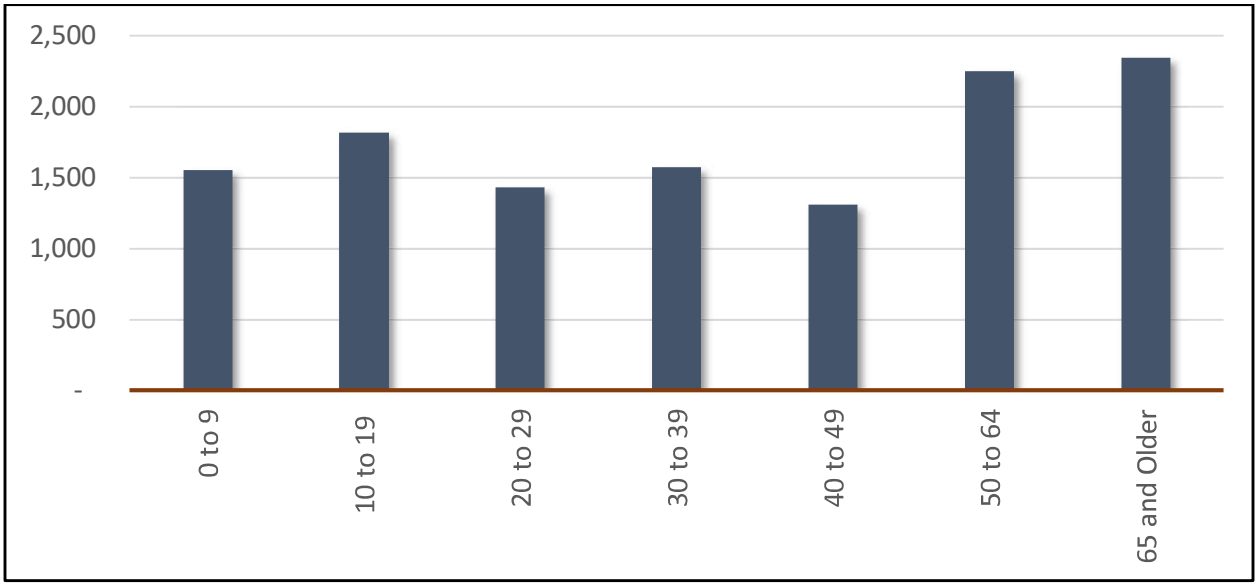
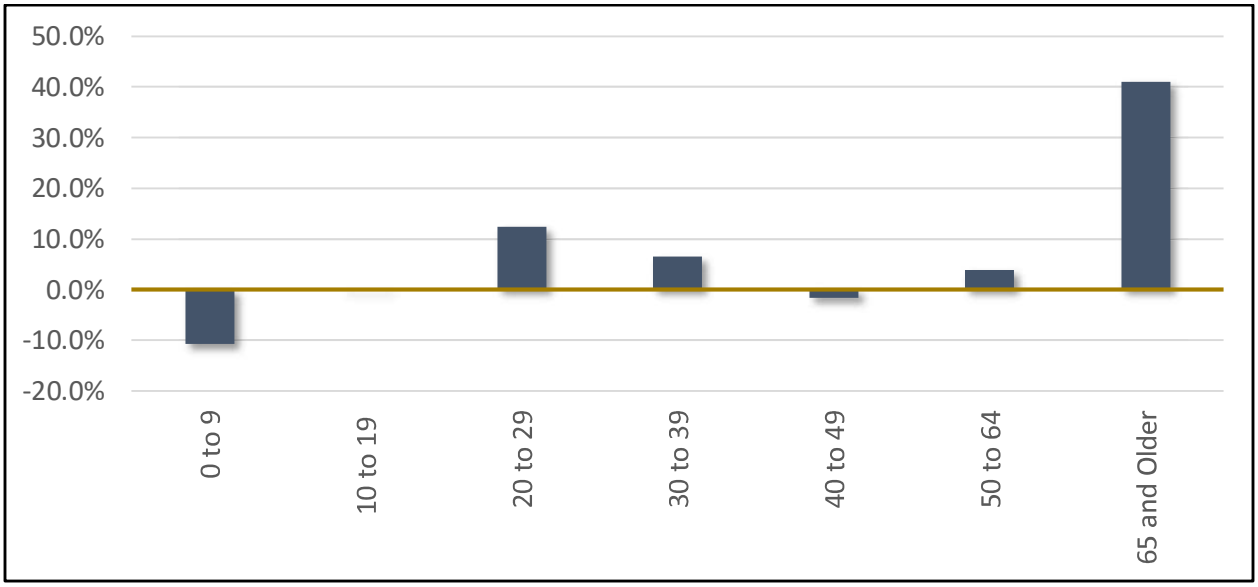


Figure: Owyhee County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



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

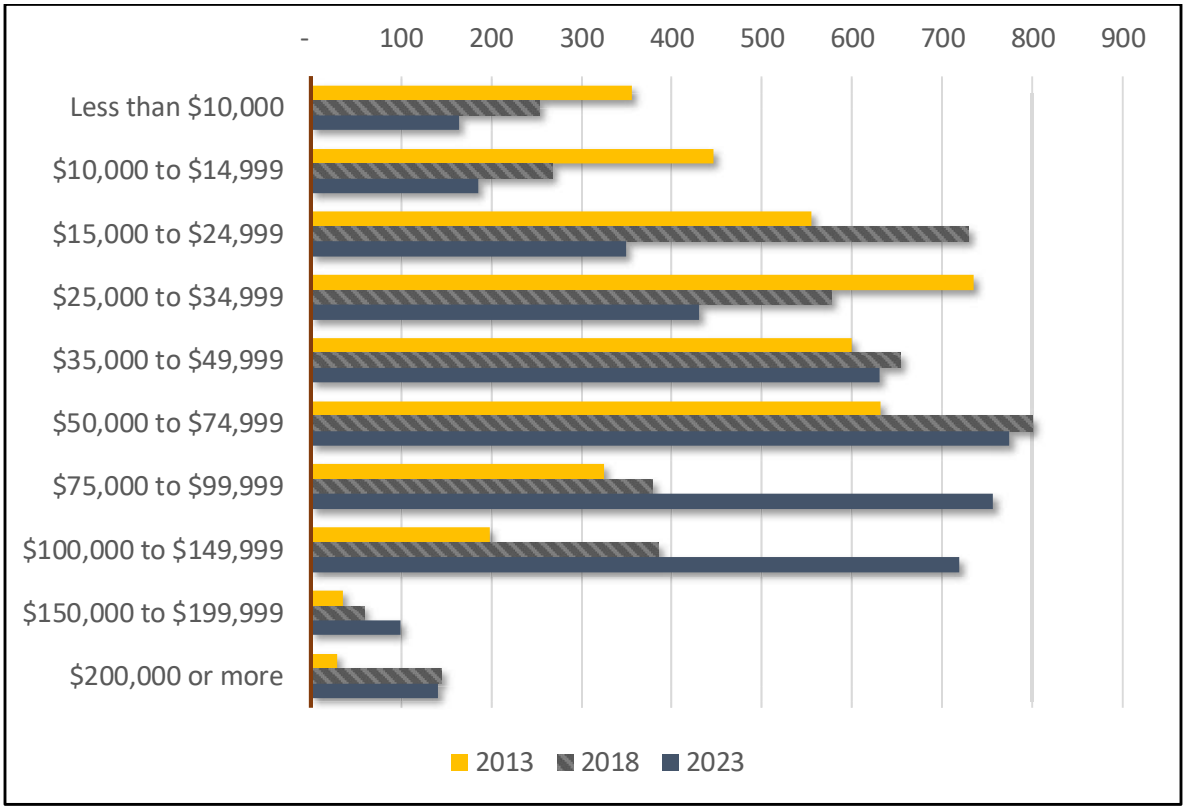
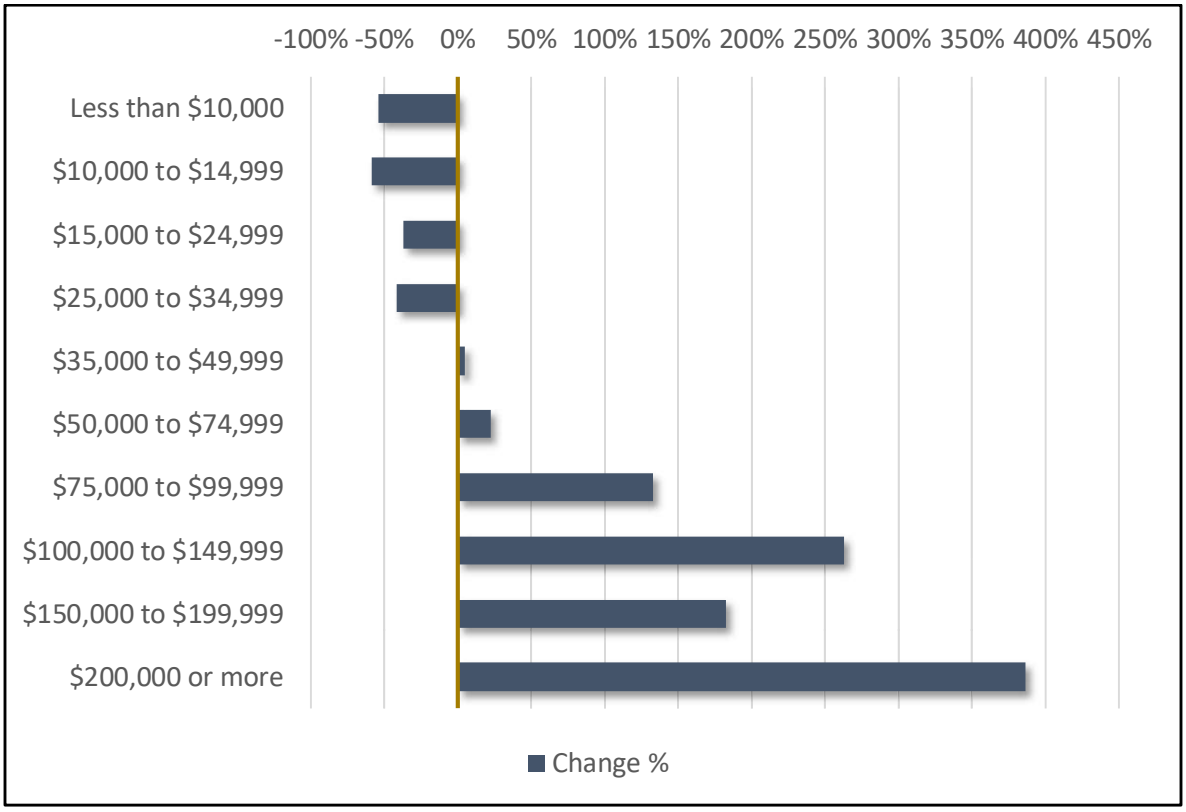


Figure: Owyhee County, ACS Changes to Household Income by %, 2013 to 2023



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

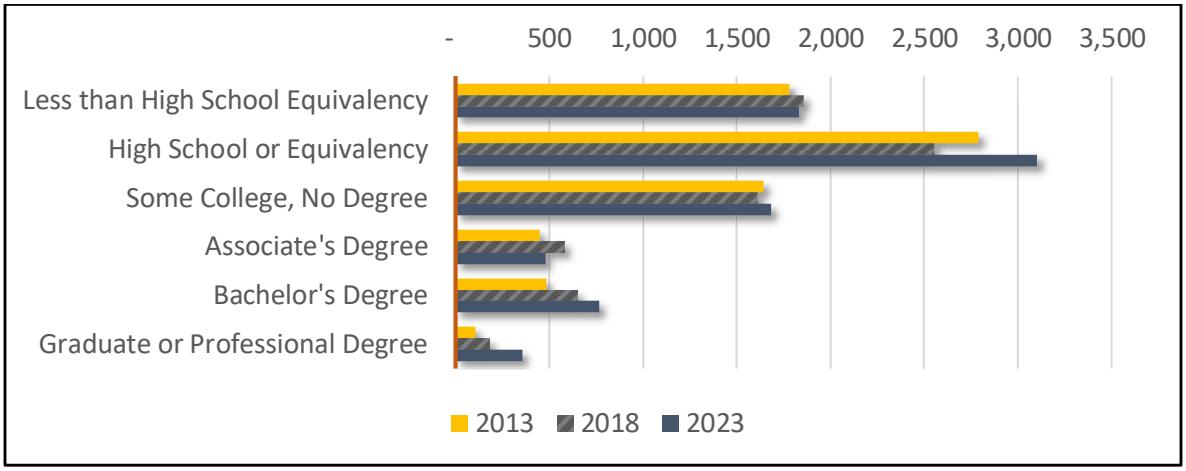
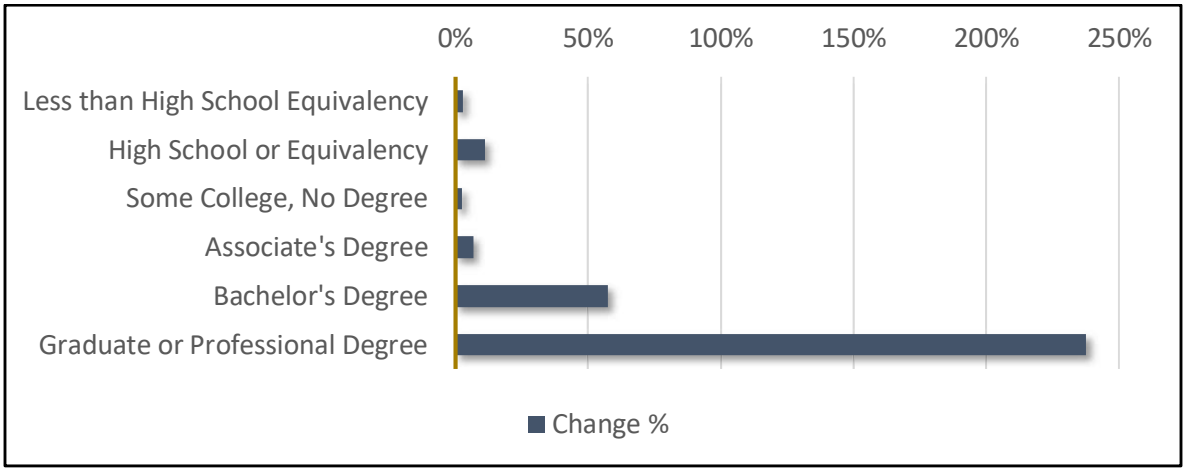
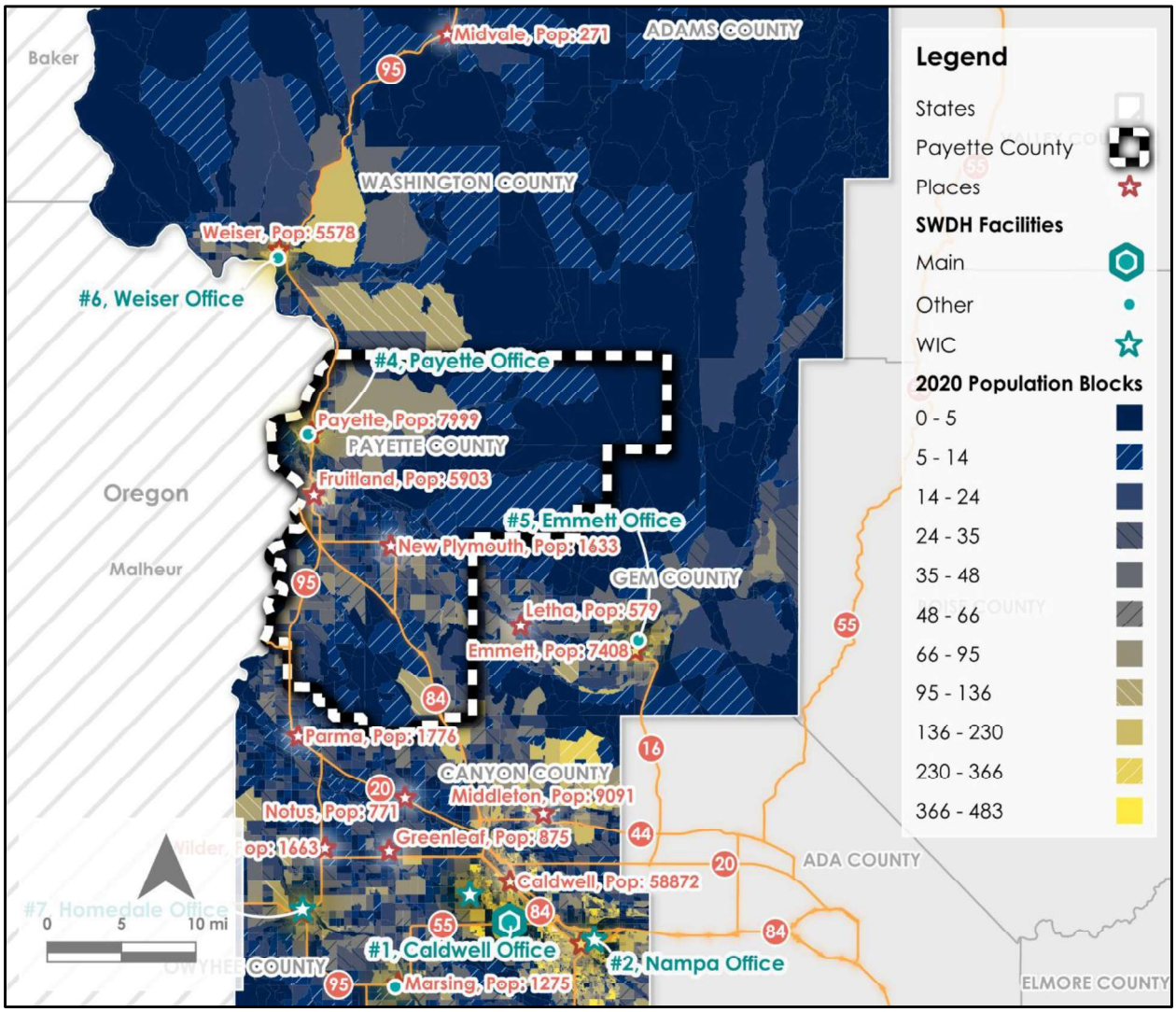


Figure: Owyhee, ACS % Change to Educational Attainment, 2013 to 2023



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)

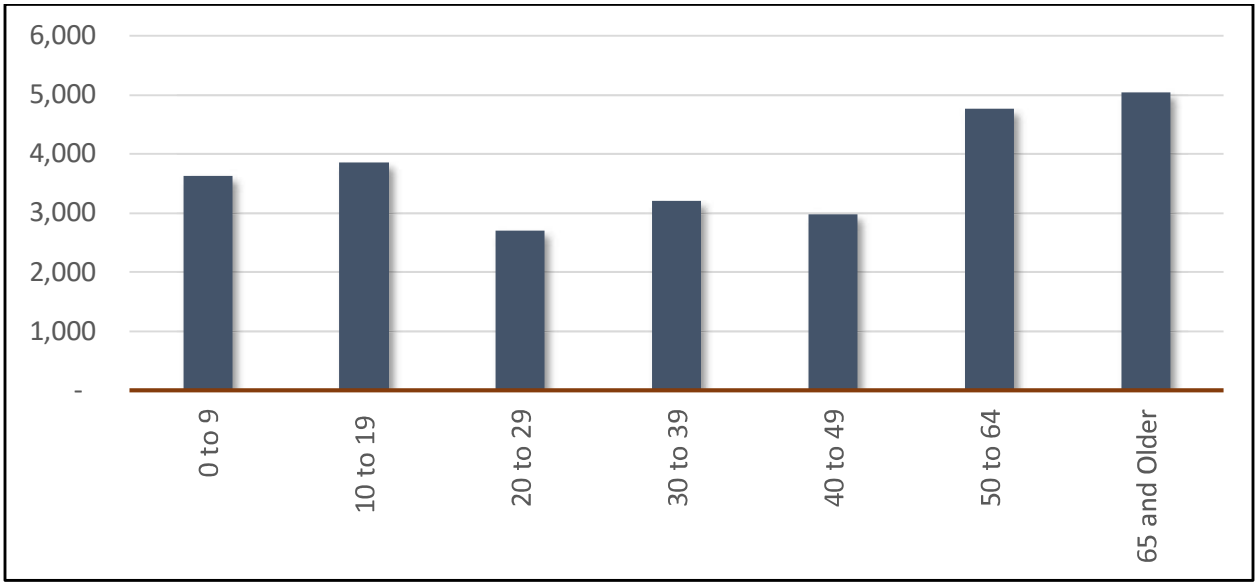
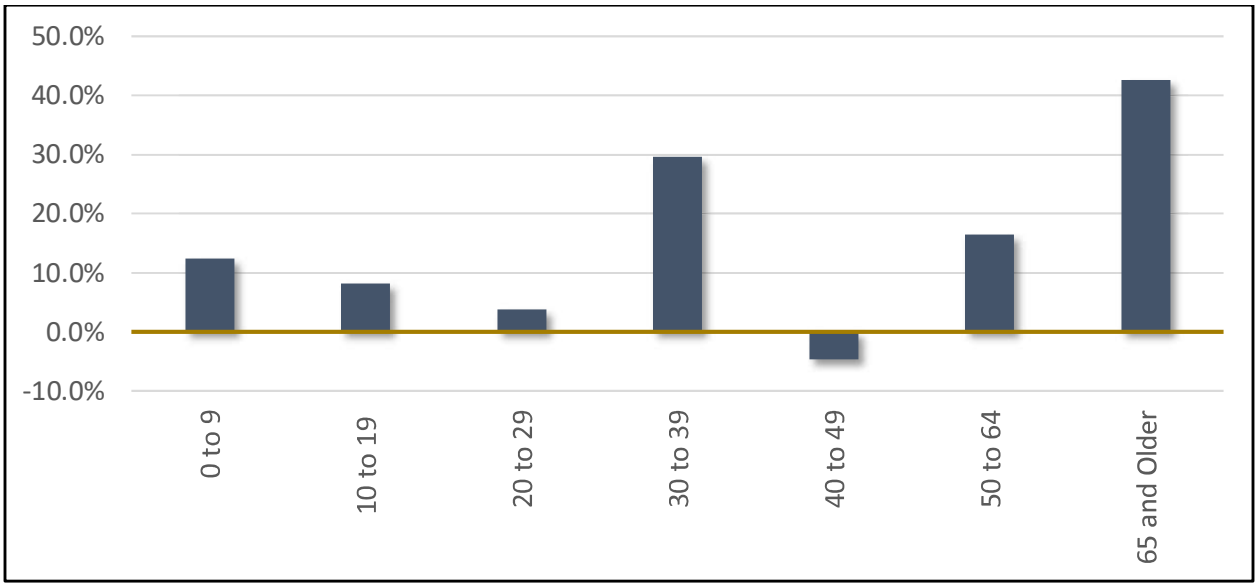


Figure: Payette County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



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

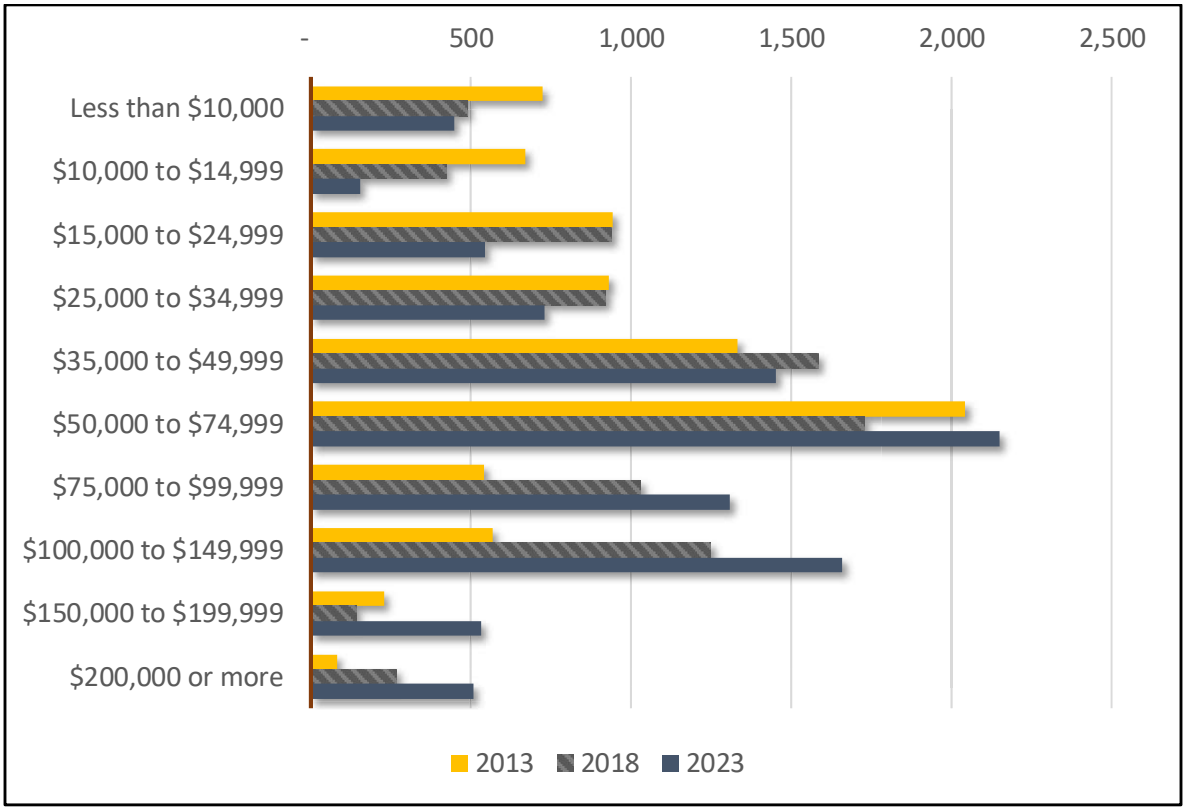
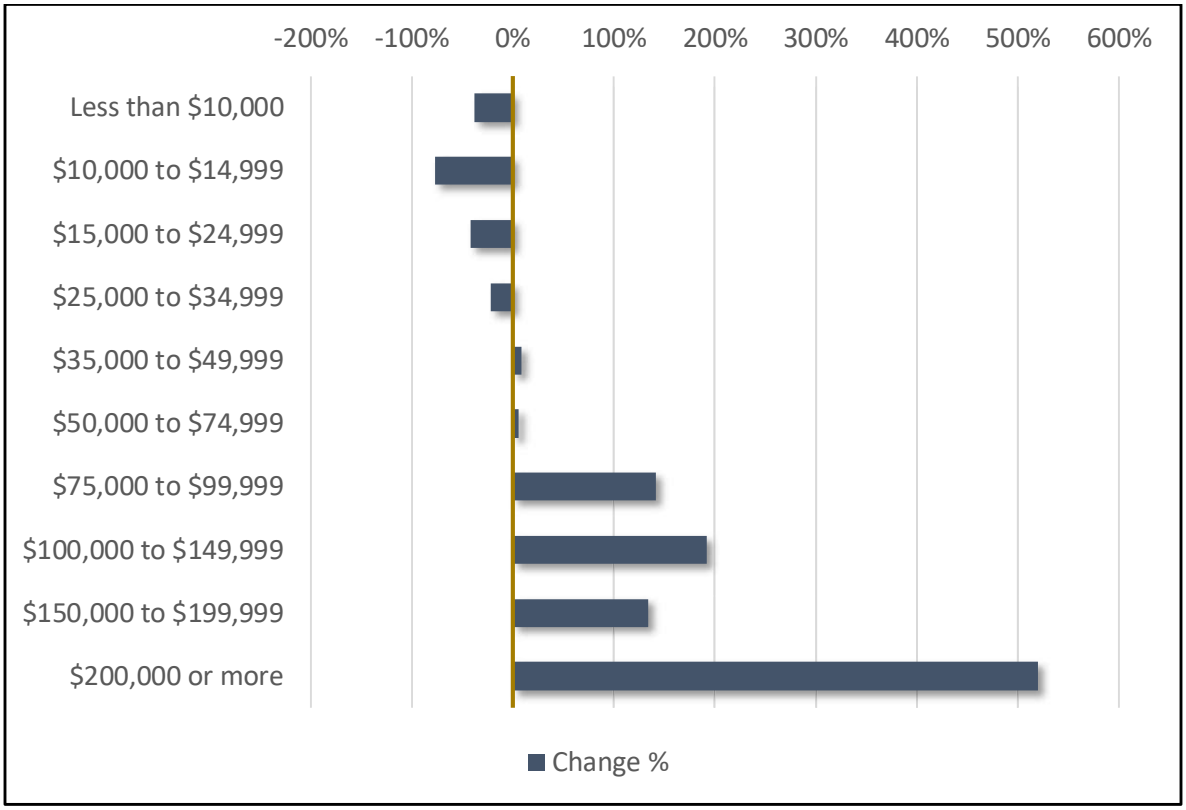


Figure: Payette County, ACS Changes to Household Income by %, 2013 to 2023



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

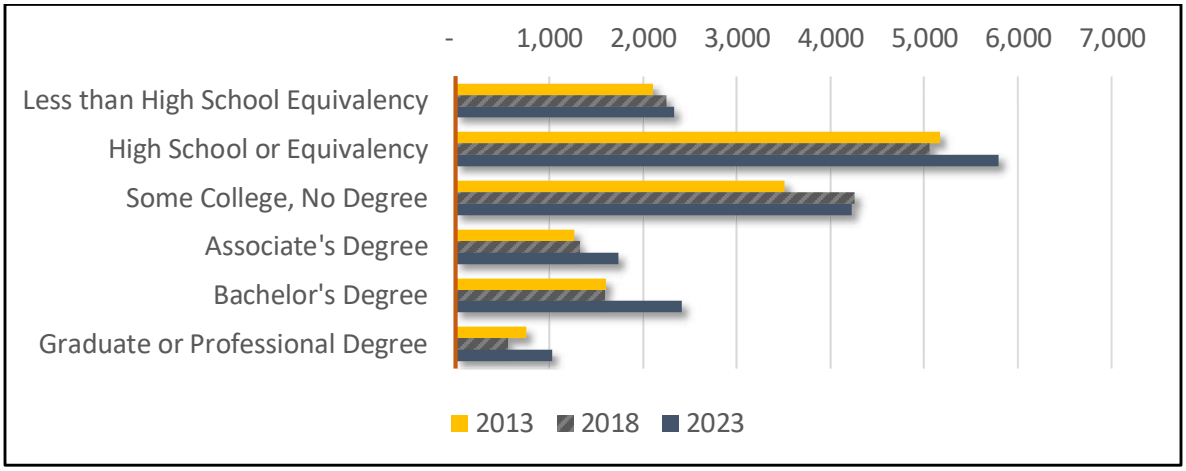
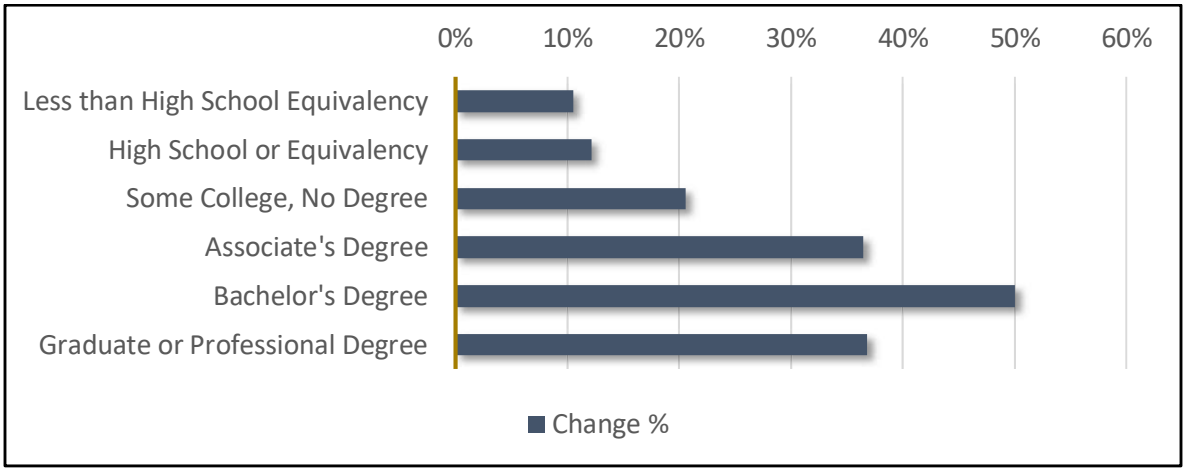
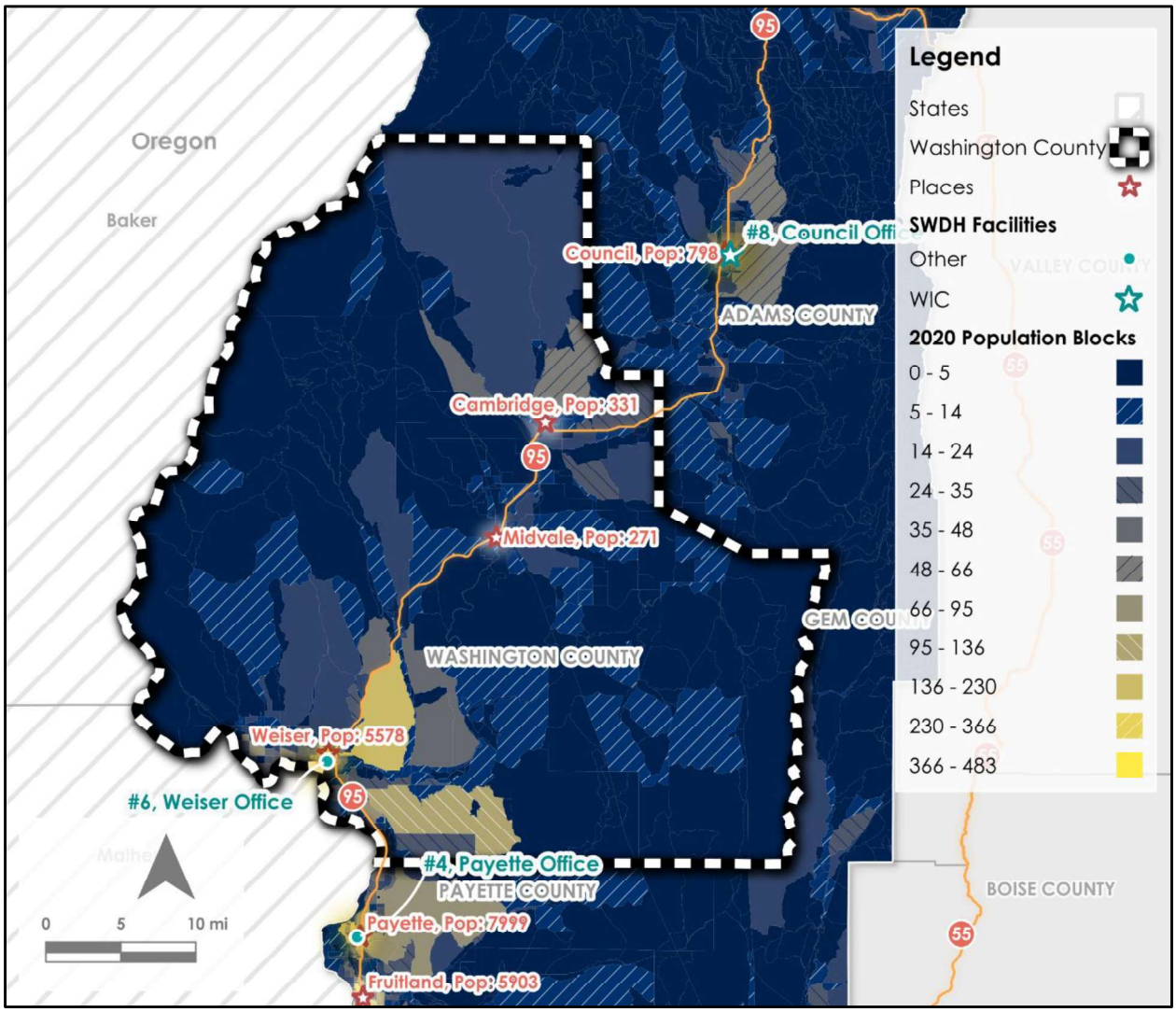


Figure: Payette County, ACS % Change to Educational Attainment, 2013 to 2023



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)

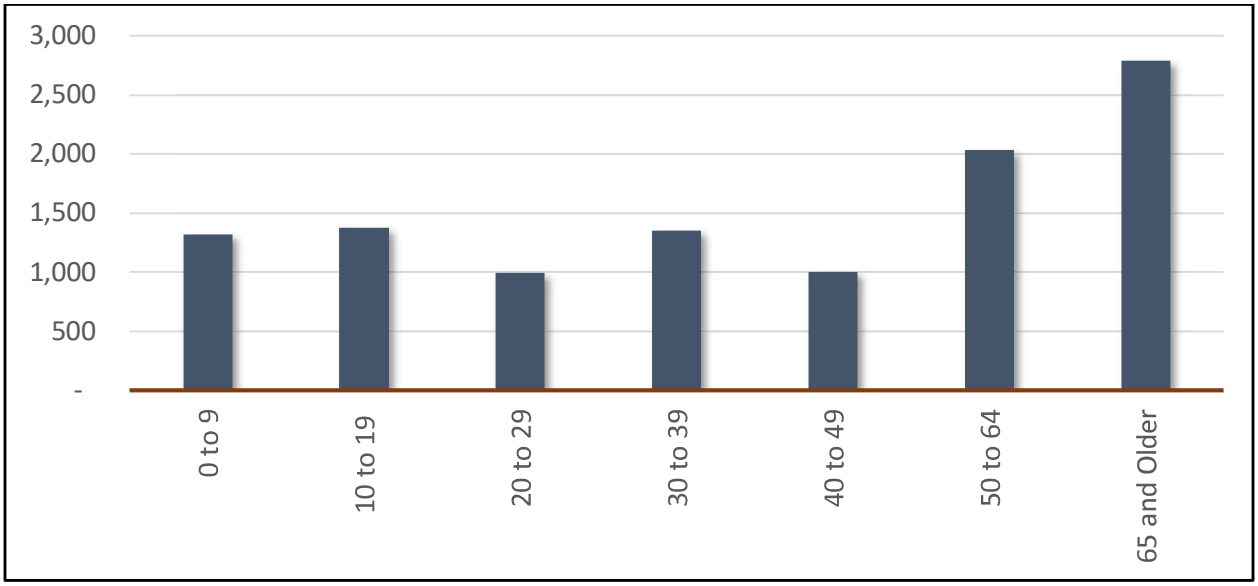
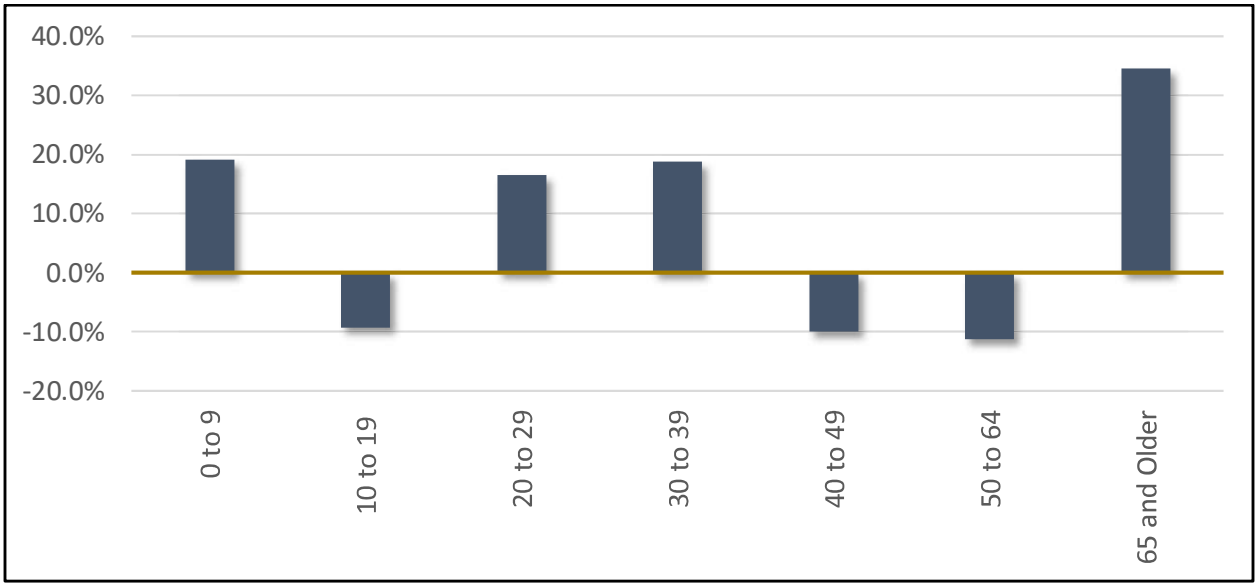


Figure: Washington County, ACS Change in Population Age Groups by % (2009-2013 to 2019-2023)



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

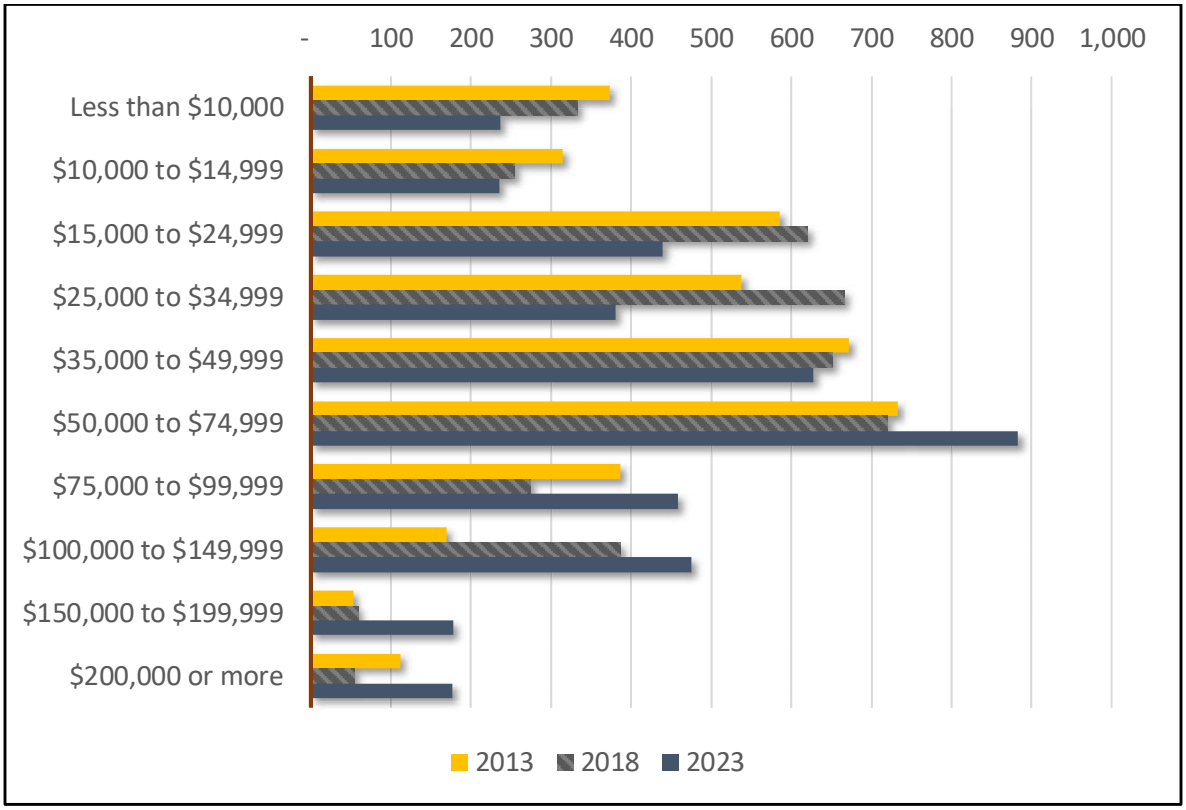
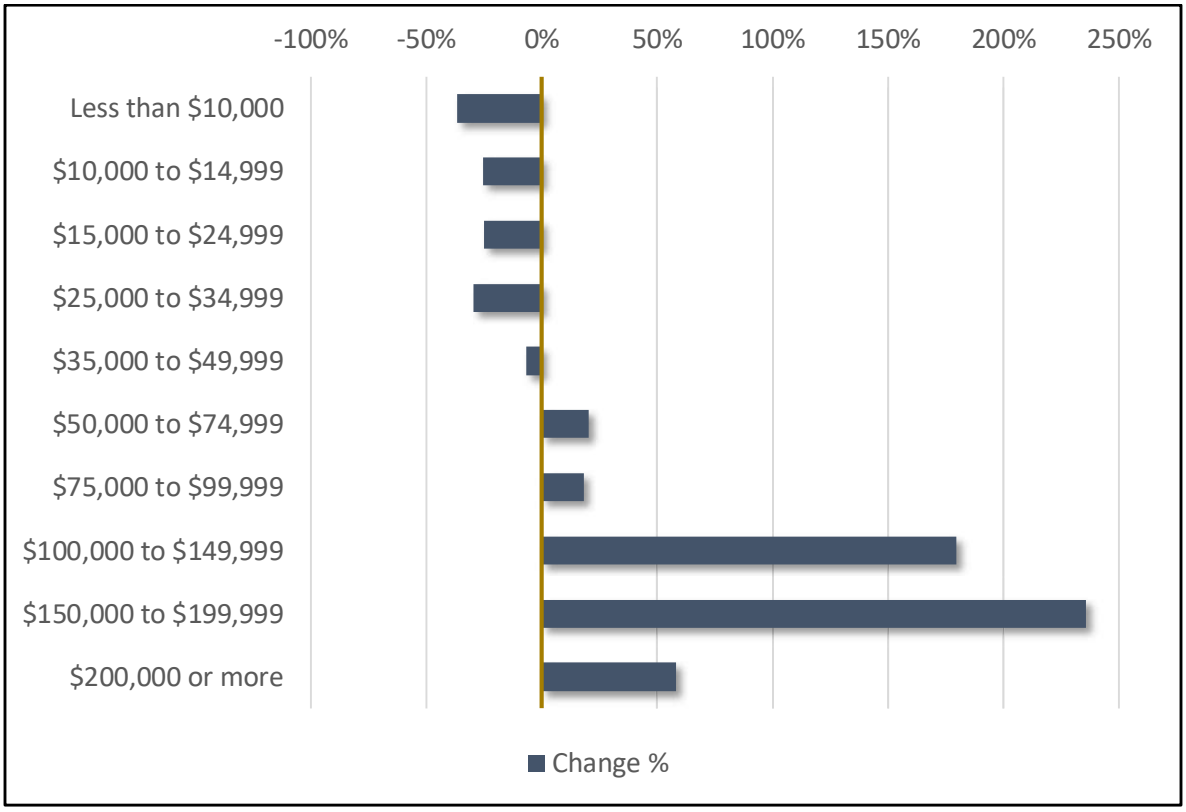


Figure: Washington County, ACS Changes to Household Income by %, 2013 to 2023



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

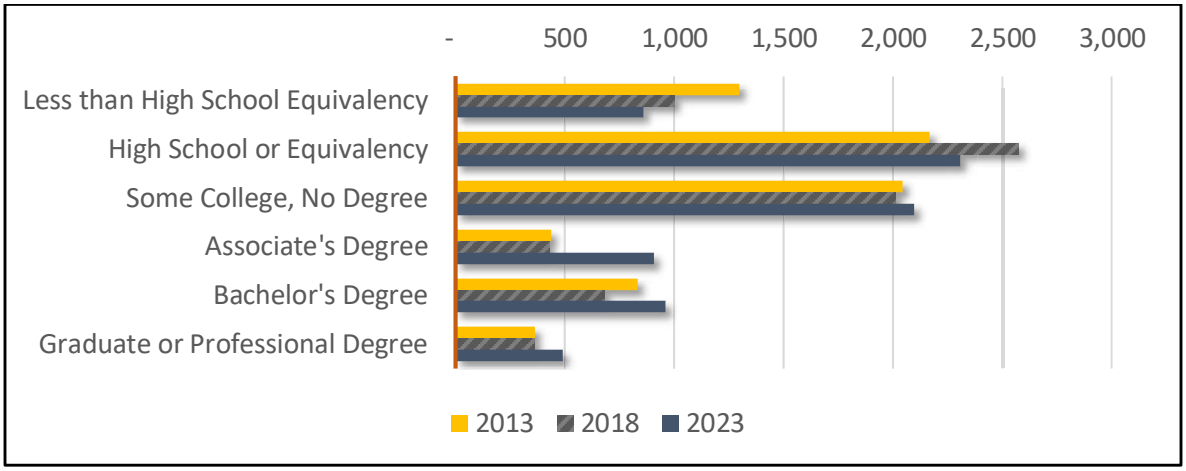
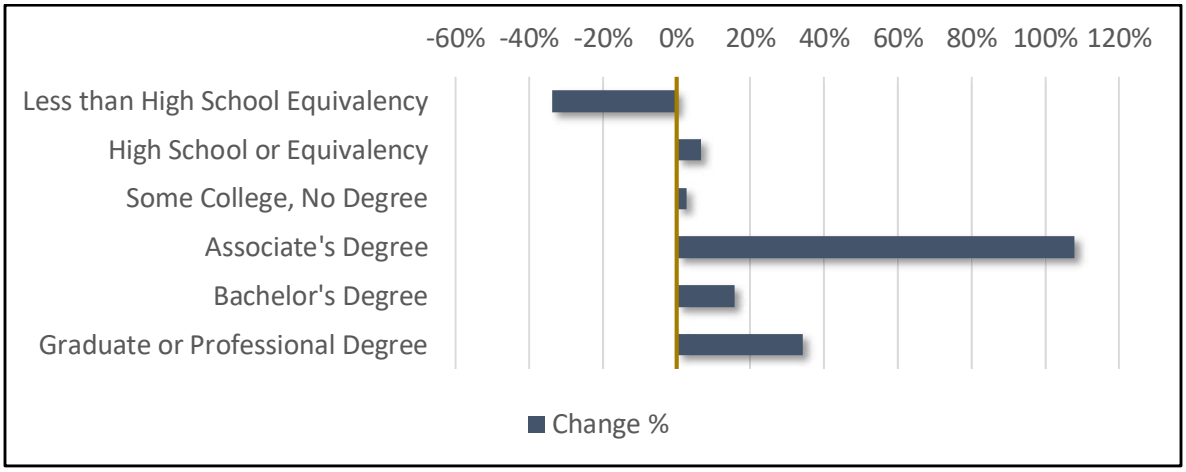


Figure: Washington County, ACS % Change to Educational Attainment, 2013 to 2023



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.

References

Bureau of the Census. (1981). *1980 Census of Population, Idaho.* U.S. Department of Commerce.

Bureau of the Census. (1992). *1990 Census of Population, Idaho, General Population Characteristics.* U.S. Department of Commerce, Economics and Statistics Administration.

U.S. Census Bureau. (2023, May 16). *Census Bureau: Poverty*. Retrieved from About Poverty in the U.S. Population: https://www.census.gov/topics/income-poverty/poverty/about.html

U.S. Census Bureau. (2025, February). *2010 and 2020 DEC ReDistricting Data PL 94:171; p1 Race; H1 Occupancy Status*. Retrieved from Explore Census Data: https://data.census.gov

U.S. Census Bureau. (2025, March 24). *Census Bureau: Data and Maps*. Retrieved from 2020 Census Demographic and Housing Characteristics File (DHC): https://www.census.gov/data/tables/2023/dec/2020-census-dhc.html

U.S. Census Bureau. (2025, February). *DP03: Selected Industry Charactersistics*. Retrieved from Explore Census Data: https://data.census.gov/

U.S. Census Bureau Census Bureau. (2024, November 24). *Census Bureau: Disability*. Retrieved from Guidance for Disability Data Users: https://www.census.gov/topics/health/disability/guidance.html

U.S. Census Bureau, Via TidyCensus. (2025, February). *Available API's*. Retrieved from Data & Maps: https://www.census.gov/data/developers/data-sets.html

U.S. Census Bureau, Via TidyCensus. (2025, April). *Available API's*. Retrieved from Data & Maps: https://www.census.gov/data/developers/data-sets.html

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



Appendix 11.1
SWDH Land & Facilities Report

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

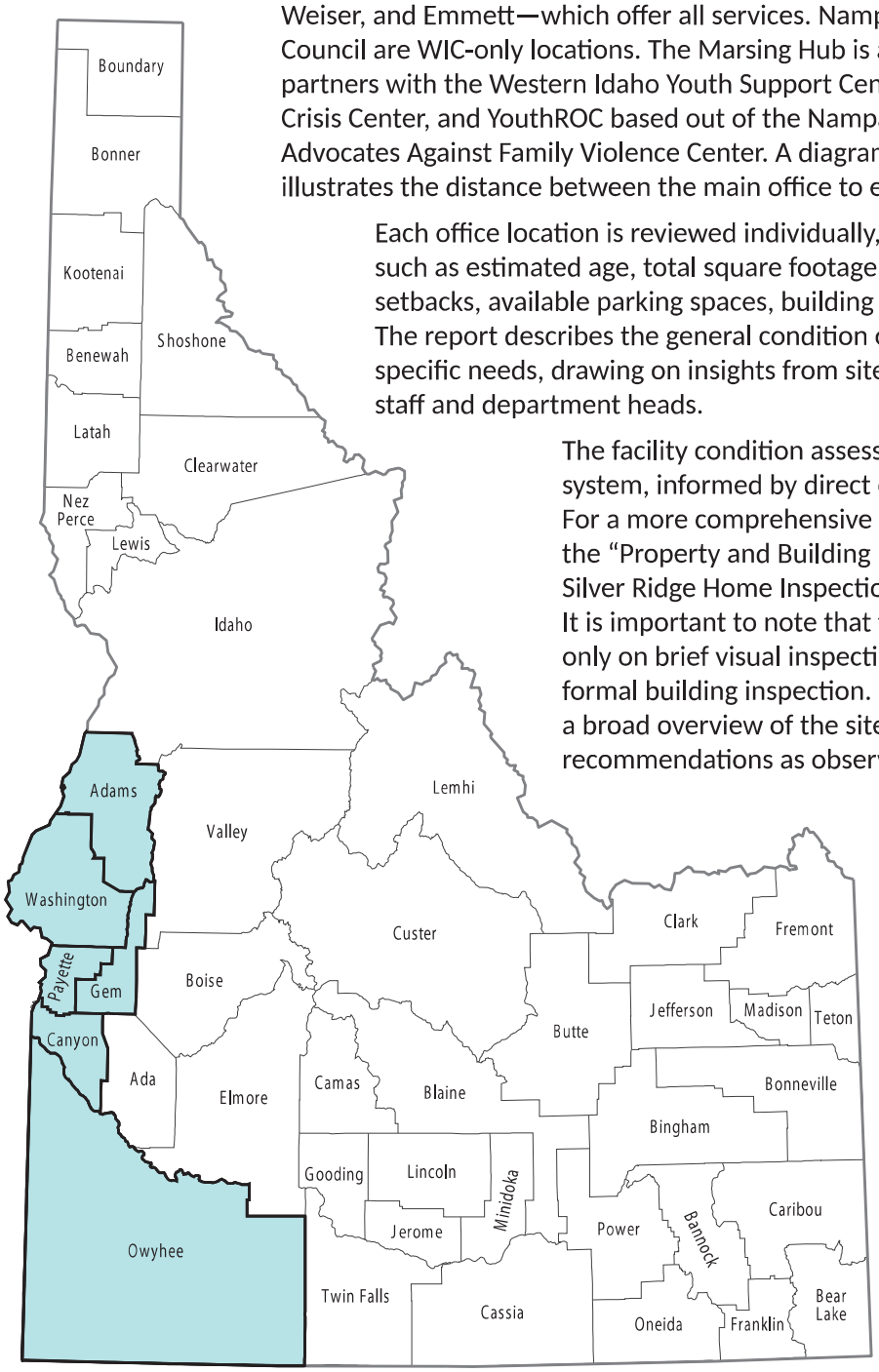
Introduction

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.

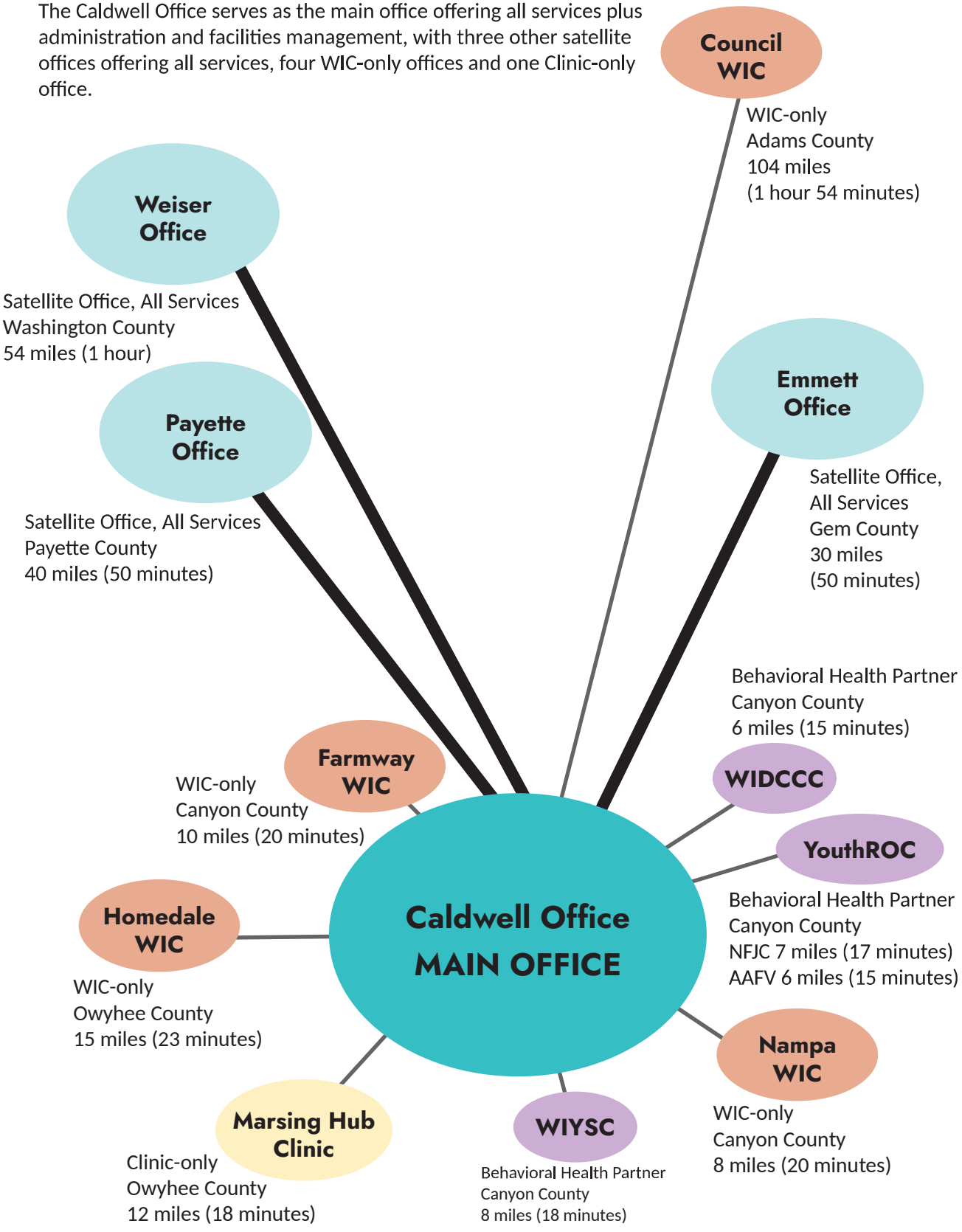


Counties served by SWDH shown shaded

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

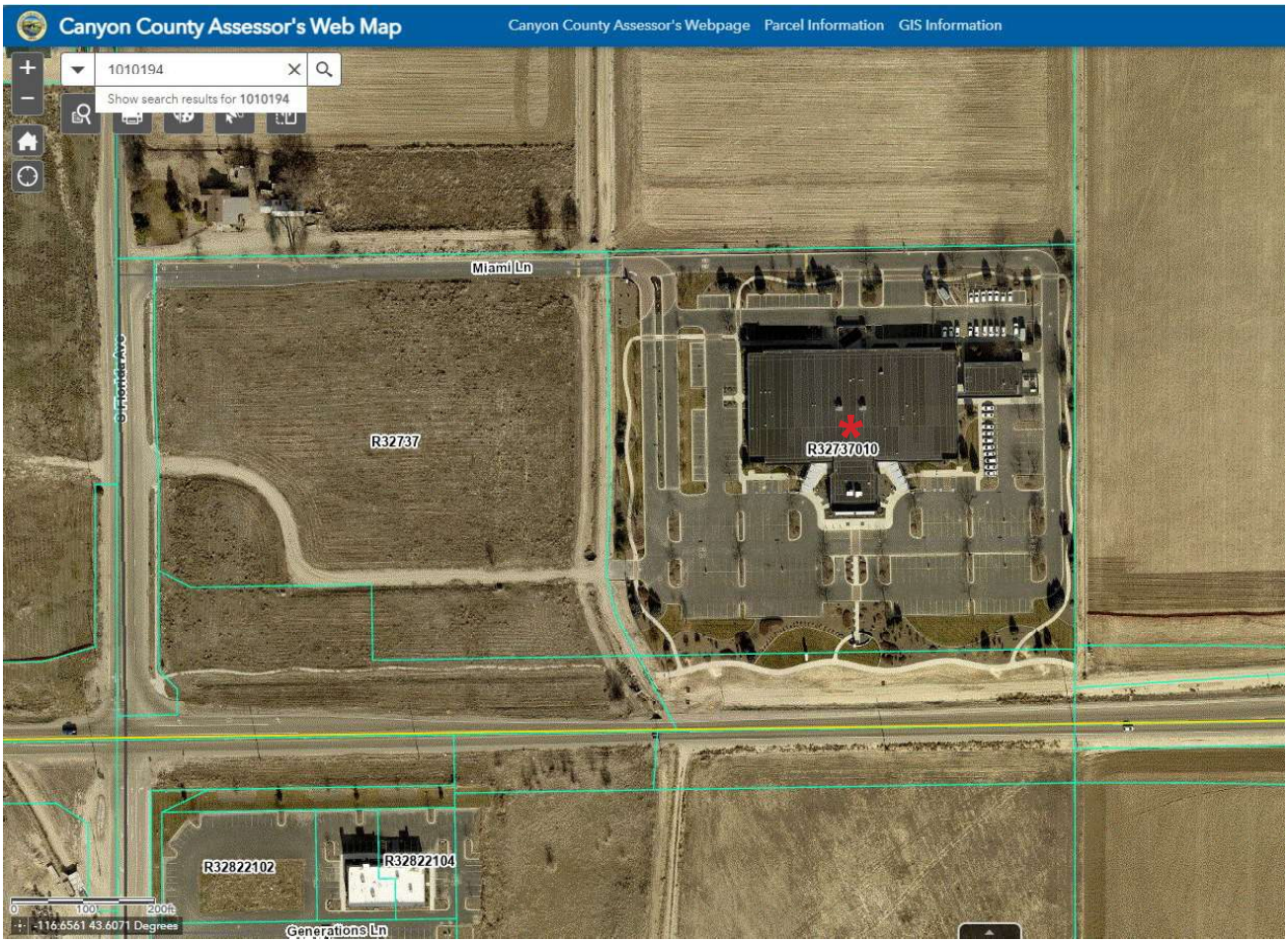
Name:	Address:	County:	Services:
Caldwell Office (Main Office)	13307 Miami Lane Caldwell, ID 83607	Canyon	All Services Main Office
Payette Office (Satellite Office)	1155 3rd Ave North Payette, ID 83661	Payette	All Services
Weiser Office (Satellite Office)	46 West Court St Weiser, ID 83672	Washington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

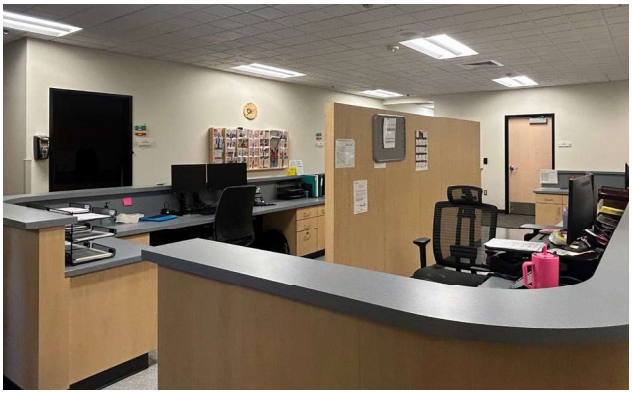
CALDWELL OFFICE

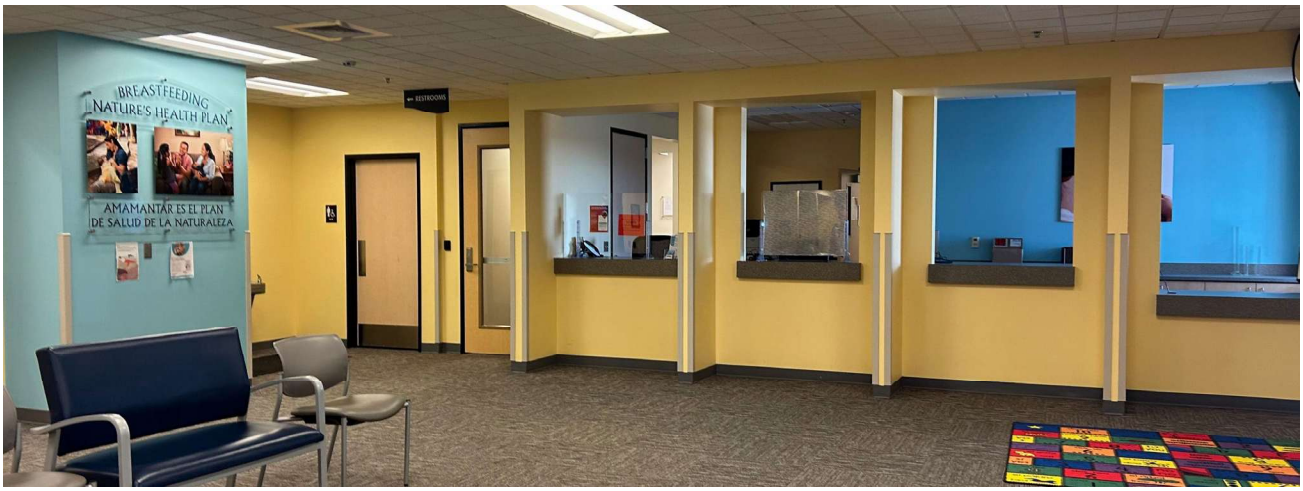
SWDH Main Office
All SWDH Services - Canyon County
13307 Miami Lane
Caldwell, ID 83607

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

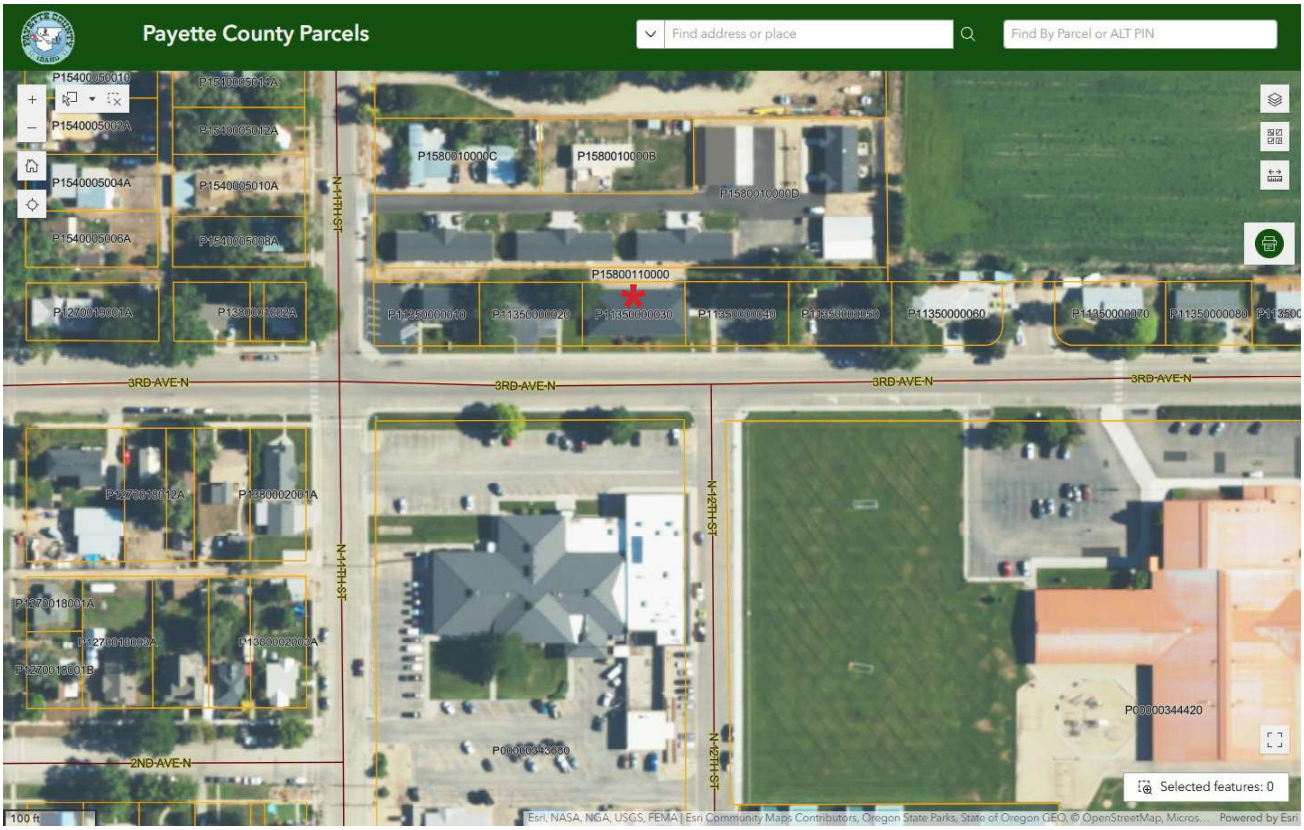
5 – Excellent: Only routine maintenance required.
4 – Good: Minor repairs may be needed; system functions properly.
3 – Fair: Occasional major and frequent minor repairs; sometimes fails.
2 – Poor: Major repairs needed, worn, outdated, limited function, or not up to code.
1 – Bad: Needs major repair 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	16
Existing ADA Parking Spaces	2
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

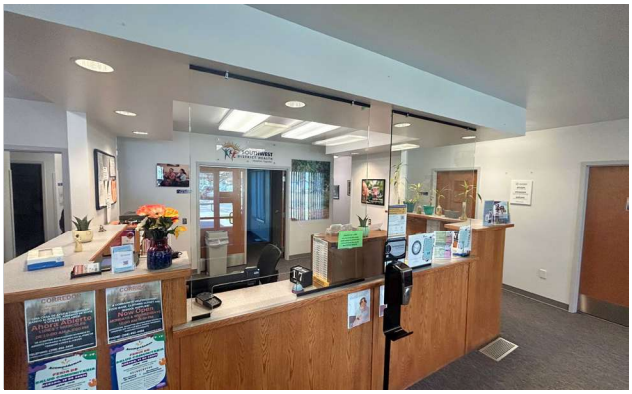
Structural Framing:	Wood frame
Siding Material:	Vinyl, Brick
Basement/Crawl Space/Slab:	Crawl Space
Roofing Material:	Fiberglass/Asphalt
Attic Ventilation Type:	Ridge Vents
HVAC Type:	Forced Air
Electrical Service Supply:	200 amp
Water Source:	Public
Sewer:	Public

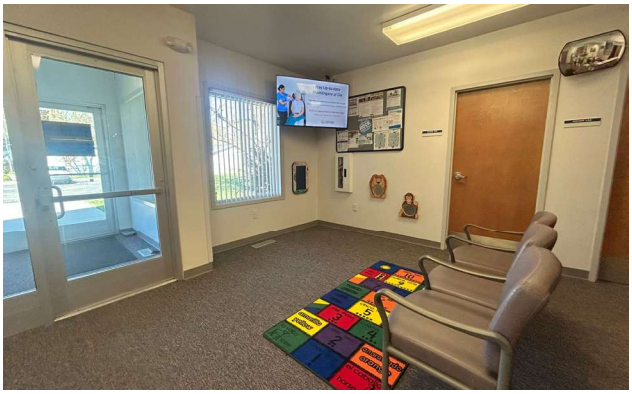
PAYETTE OFFICE

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

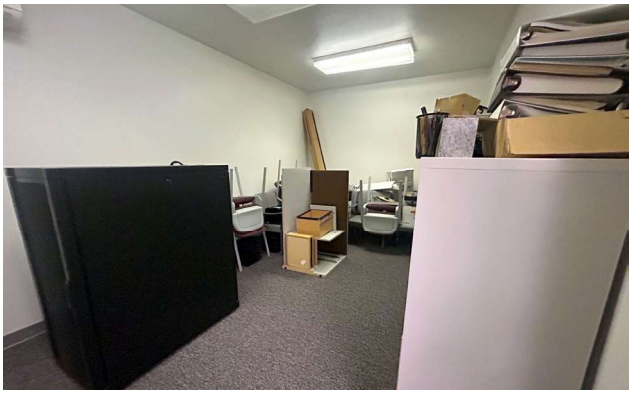
Open Weekdays 8am - 5pm
WIC Mon/Wed/Fri 8am - 5pm











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

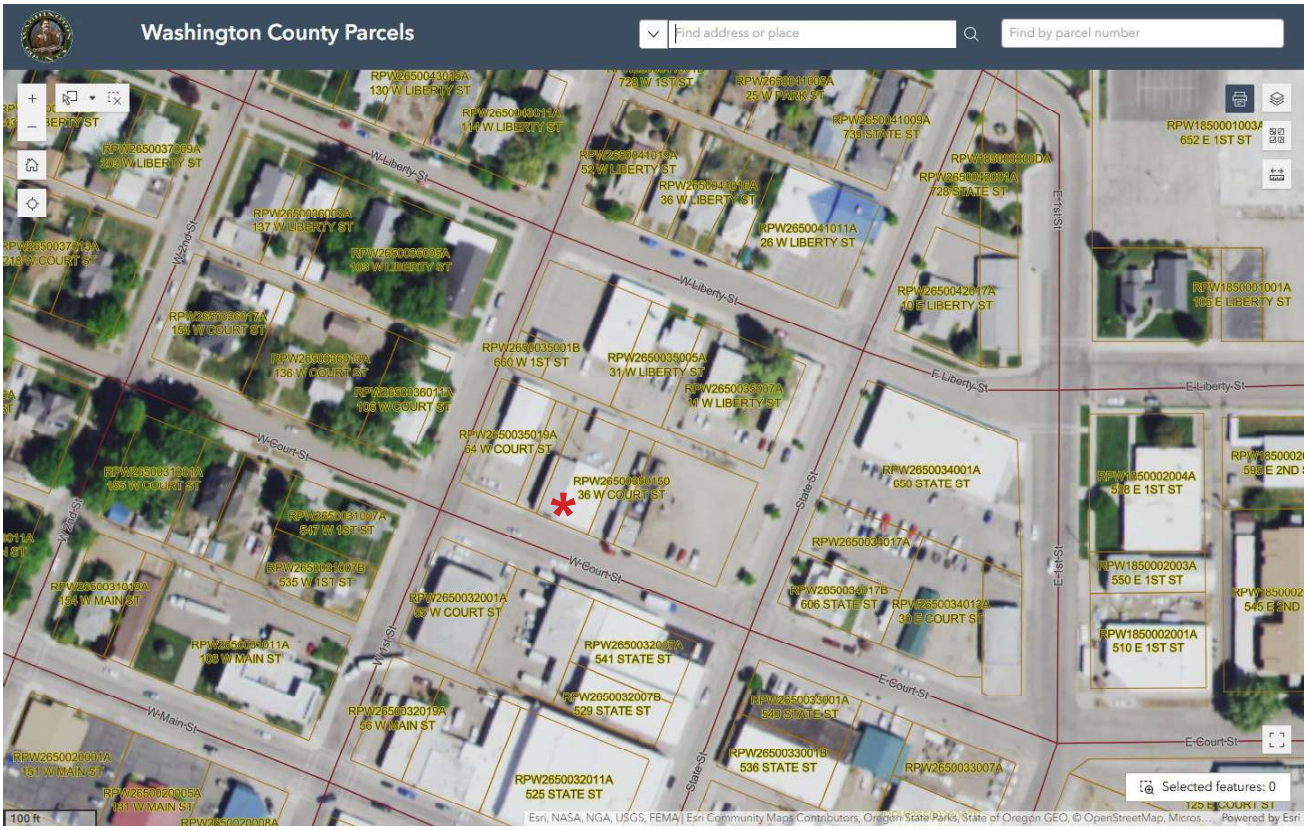
5 – Excellent: Only routine maintenance required.
4 – Good: Minor repairs may be needed; system functions properly.
3 – Fair: Occasional major and frequent minor repairs; sometimes fails.
2 – Poor: Major repairs needed, worn, outdated, limited function, or not up to code.
1 – Bad: Needs major repair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

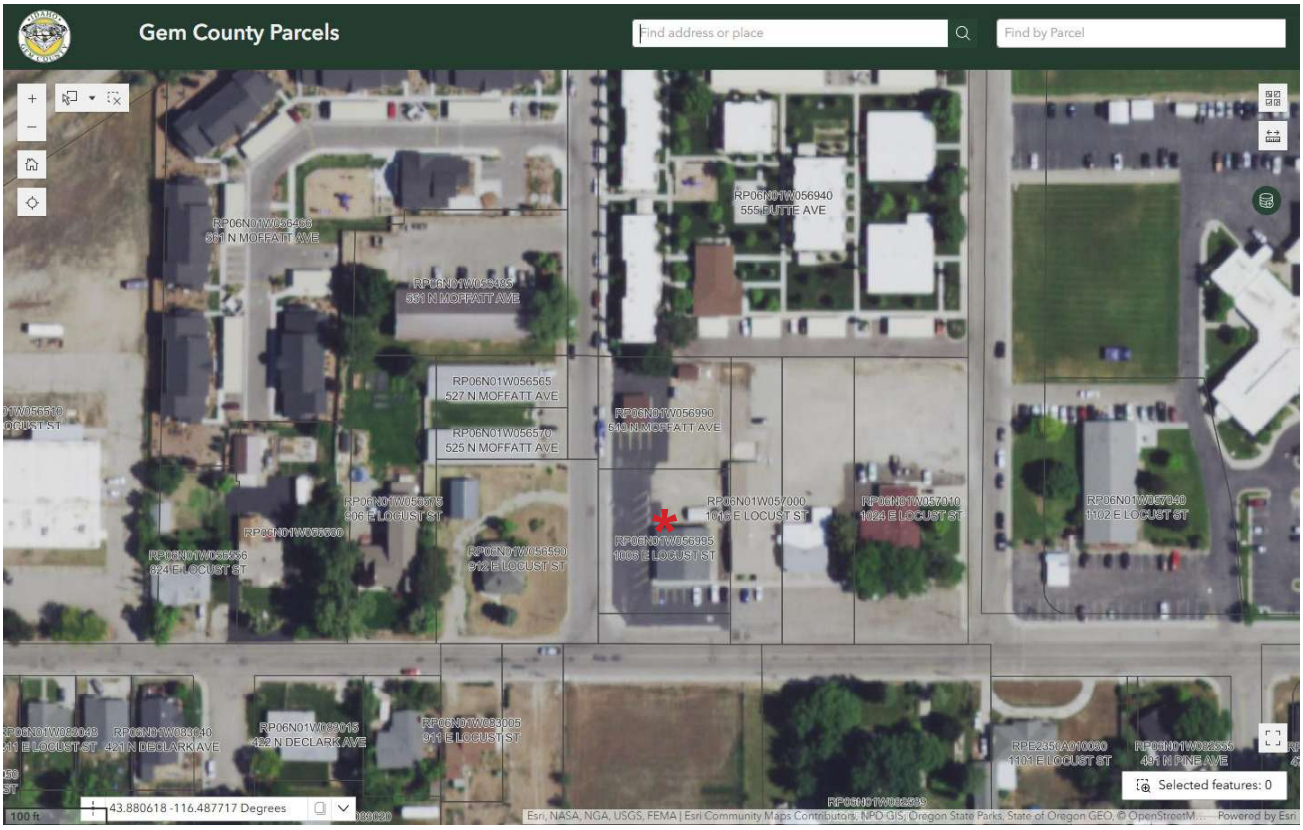
EMMETT OFFICE

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


Gem County Parcels
Find address or place
Find by Parcel
RP06N01W056940
555 BUTTE AVE
RP06N01W056565
527 N MOFFATT AVE
RP06N01W056570
525 N MOFFATT AVE
RP06N01W057000
1015 E LOCUST ST
RP06N01W057010
1024 E LOCUST ST
RP06N01W057040
1102 E LOCUST ST
RP06N01W056995
1005 E LOCUST ST
RP06N01W056990
912 E LOCUST ST
RP06N01W056556
824 E LOCUST ST
RP06N01W056575
906 E LOCUST ST
RP06N01W056990
913 N MOFFATT AVE
RP06N01W056565
531 N MOFFATT AVE
RP06N01W056570
525 N MOFFATT AVE
RP06N01W056556
824 E LOCUST ST
RP06N01W056575
906 E LOCUST ST
RP06N01W056990
912 E LOCUST ST
RP06N01W057000
1015 E LOCUST ST
RP06N01W057010
1024 E LOCUST ST
RP06N01W057040
1102 E LOCUST ST
RP06N01W056995
1005 E LOCUST ST
RP06N01W056990
913 N MOFFATT AVE
RP06N01W056565
531

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

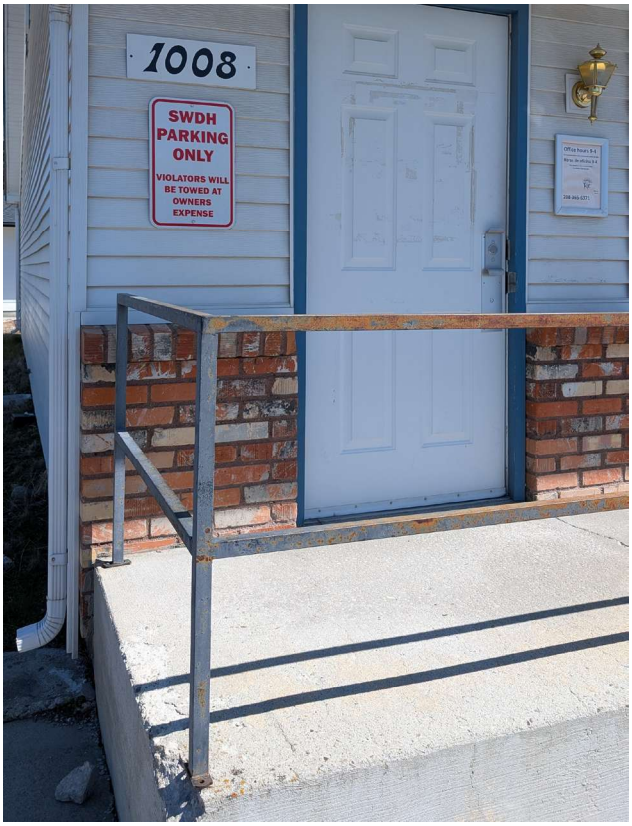
Open Weekdays 8am - 5pm
WIC Tuesdays 8am - 5pm



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.

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
Caldwell, ID 83607
Open 1st Monday of month 9am-4pm,
3rd Thursday of month 9am-7pm



FACILITY INFORMATION

Owned, Leased or Shared:	Shared, reserved space in the Farmway Community Center
Year of SWDH Occupation:	2007
Leased Square Footage:	unknown
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 in Farmway Village, which is operated by the Caldwell Housing Authority—the largest rural housing authority in the country. The building also houses Terry Reilly (behavioral health) and the Farmway Community Center, which is a small event space. SWDH previously leased separate office space within the building, but their lease ended. WIC services are now provided in the Farmway Community Center on a shared, reserved basis.

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.



Appendix 11.2
SWDH Adjacency Report

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.

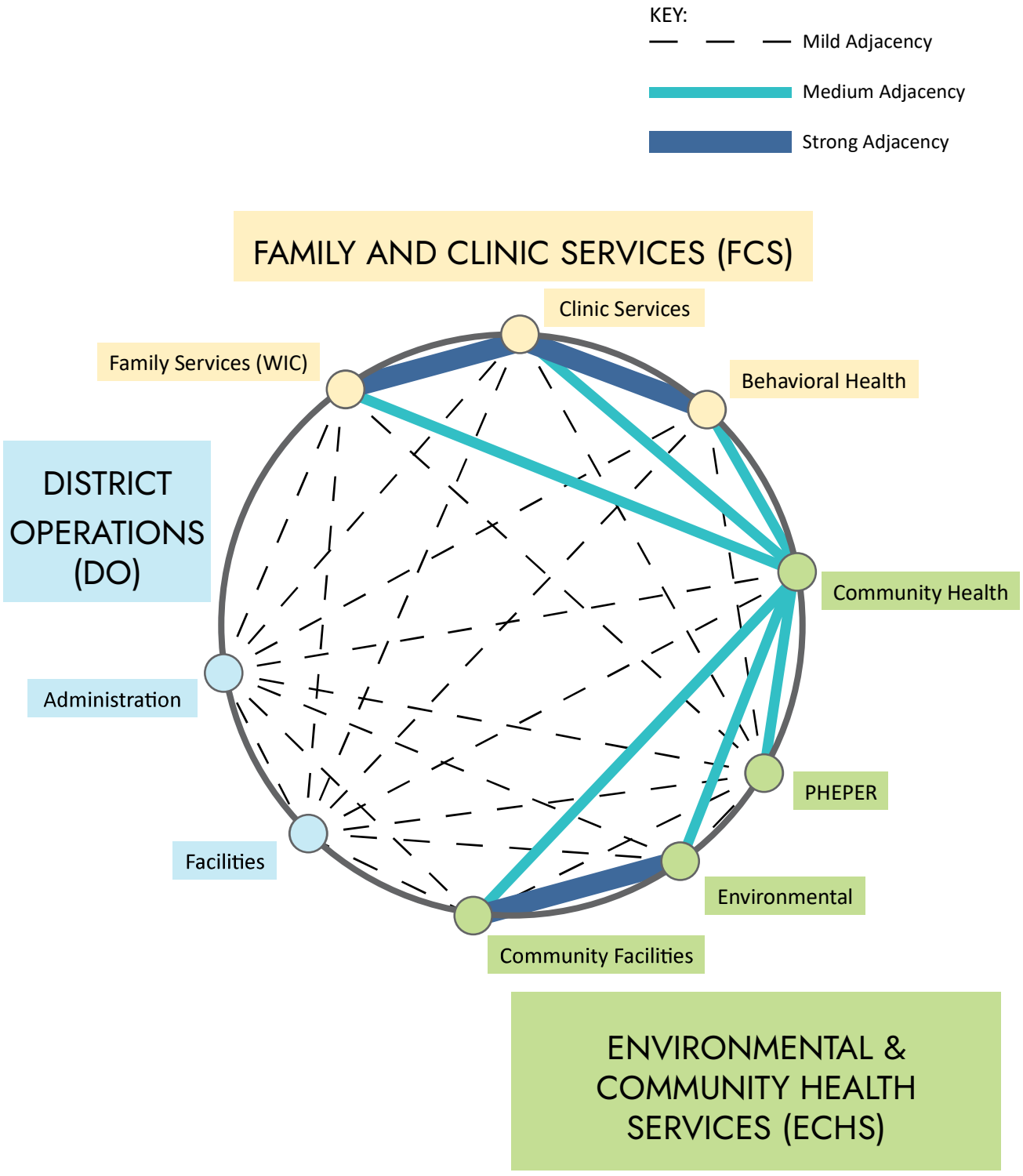
District Operations (DO) ensures the smooth functioning of SWDH, handling administration, finance and procurement, organizational development, information technology, human resources, customer service, and the maintenance of facilities.

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.

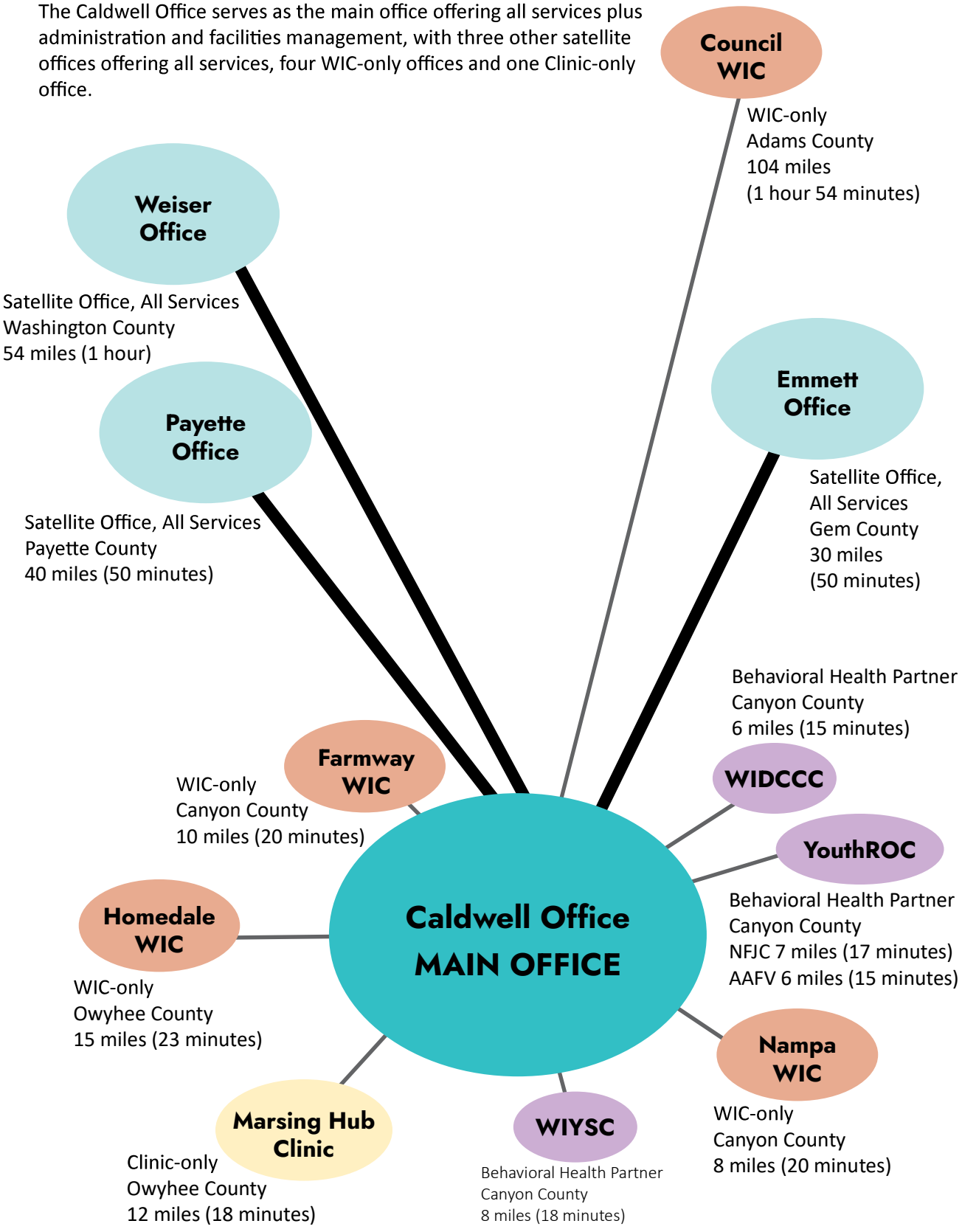
ADJACENCY DIAGRAM

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

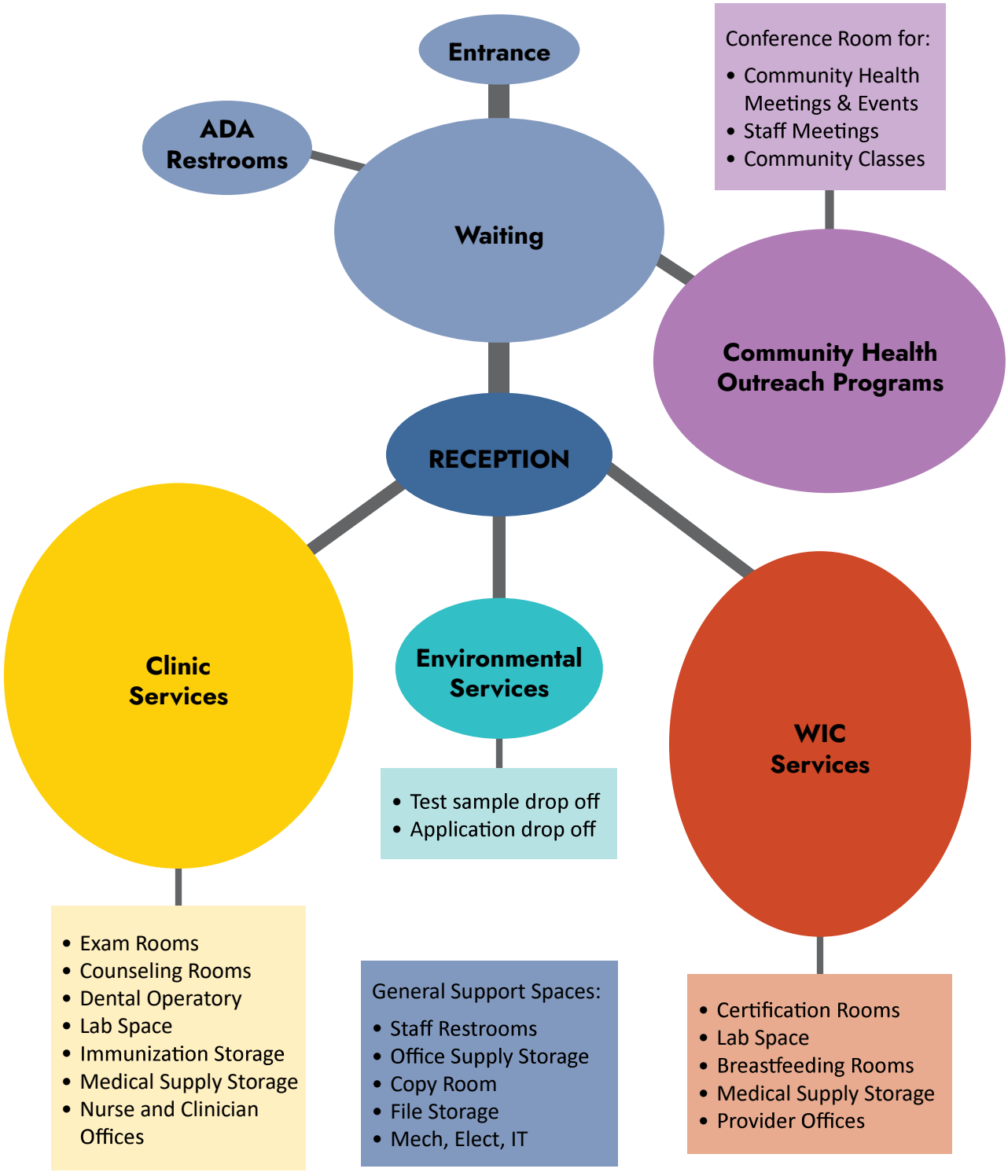
This table outlines the services provided at each physical location. Please note, District Operations (DO) and PHEPER operate out of the Caldwell Office but support each location remotely. Payette, Weiser and Emmett Offices are considered "all services" even though DO and PHEPER are not based there.

		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.





Appendix 11.3
SWDH Space Allocation Report

2025

Southwest District Health Space Allocation Report

PREPARED FOR SOUTHWEST DISTRICT HEALTH
AUGUST 2025

SOUTHWEST DISTRICT HEALTH

CLEARWATER FINANCIAL

amanda swails DESIGN

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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

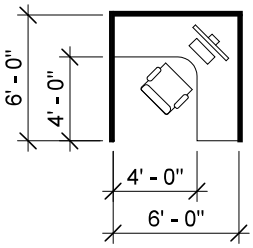
The "State of Idaho Office Space Standards" further specifies office size limits based on the type of employee, as detailed in their table below. In defining room types, this report does not consider the employee's job title occupying the room. This report assigns room types according to the existing 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]

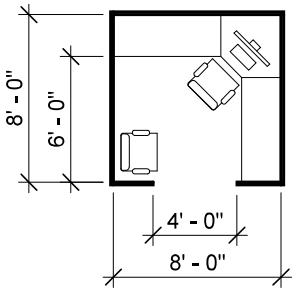
OFFICE FLOOR PLANS

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



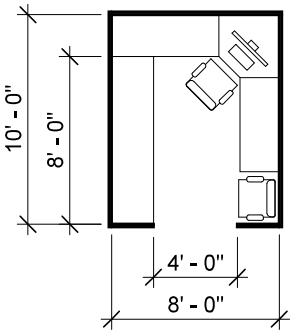
Open Office
Small Cubicle
36 nsf

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



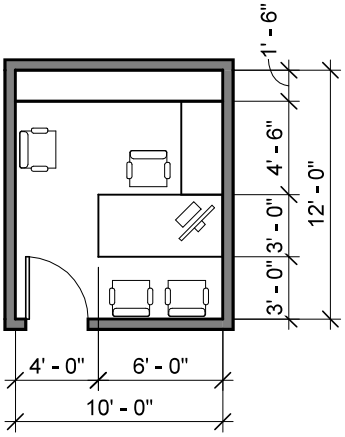
Open Office
Medium Cubicle
64 nsf

For typical employees, single occupant.



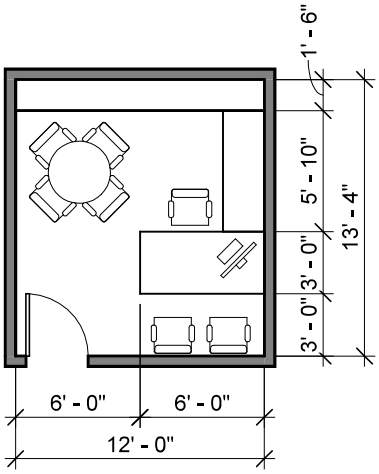
Open Office
Large Cubicle
80 nsf

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



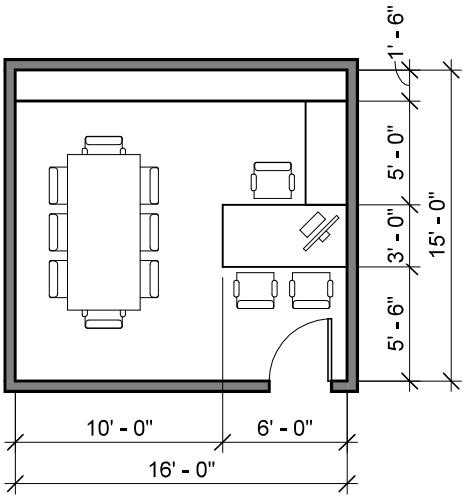
Private Office Small
120 nsf

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



Private Office Medium
160 nsf

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

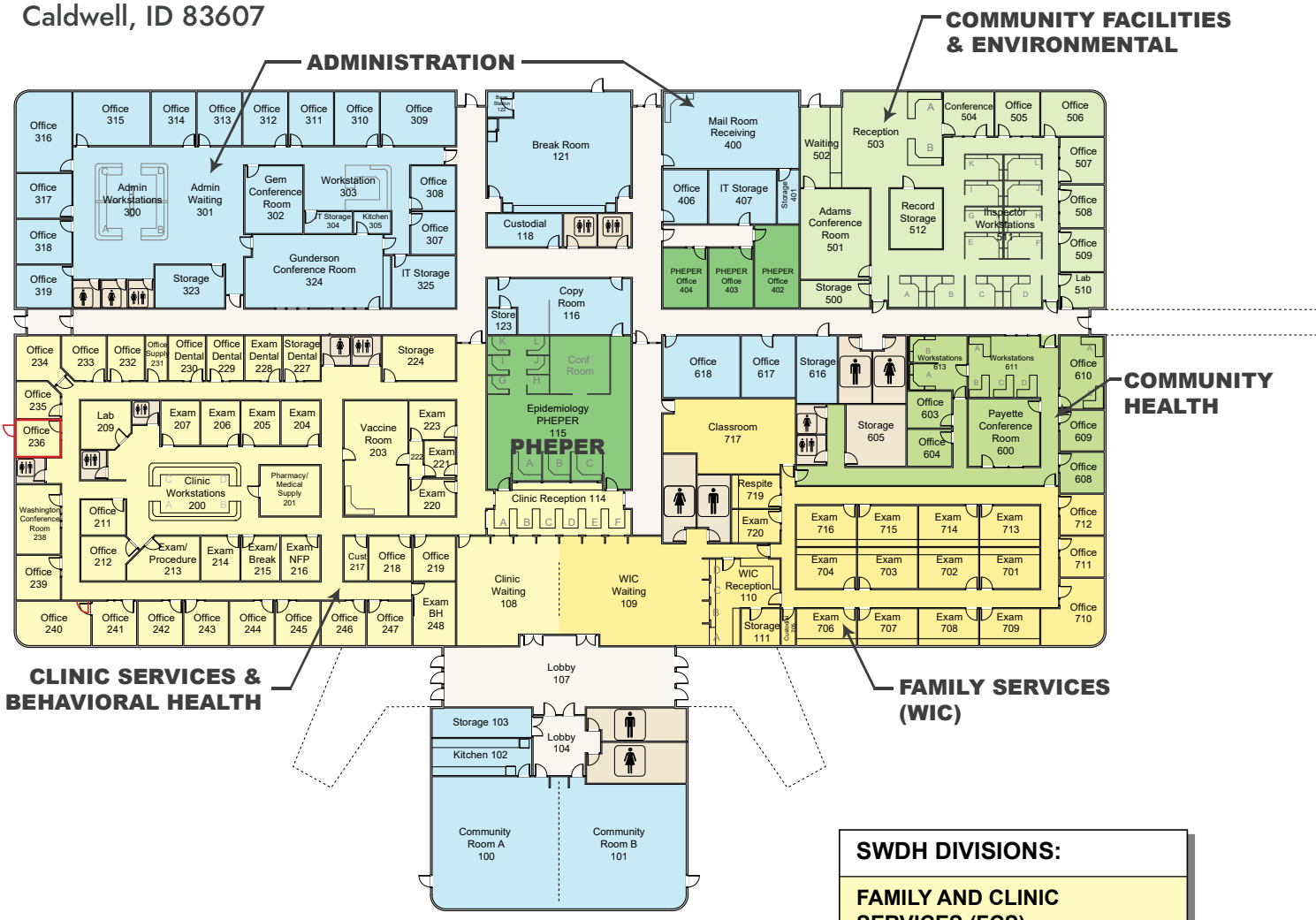


Private Office Large
240 nsf

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:

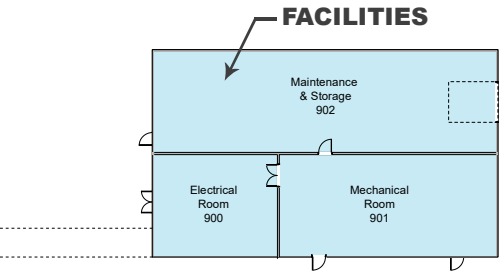
FAMILY AND CLINIC SERVICES (FCS)
- Family Services (WIC)
- Clinic Services
- Behavioral Health

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.

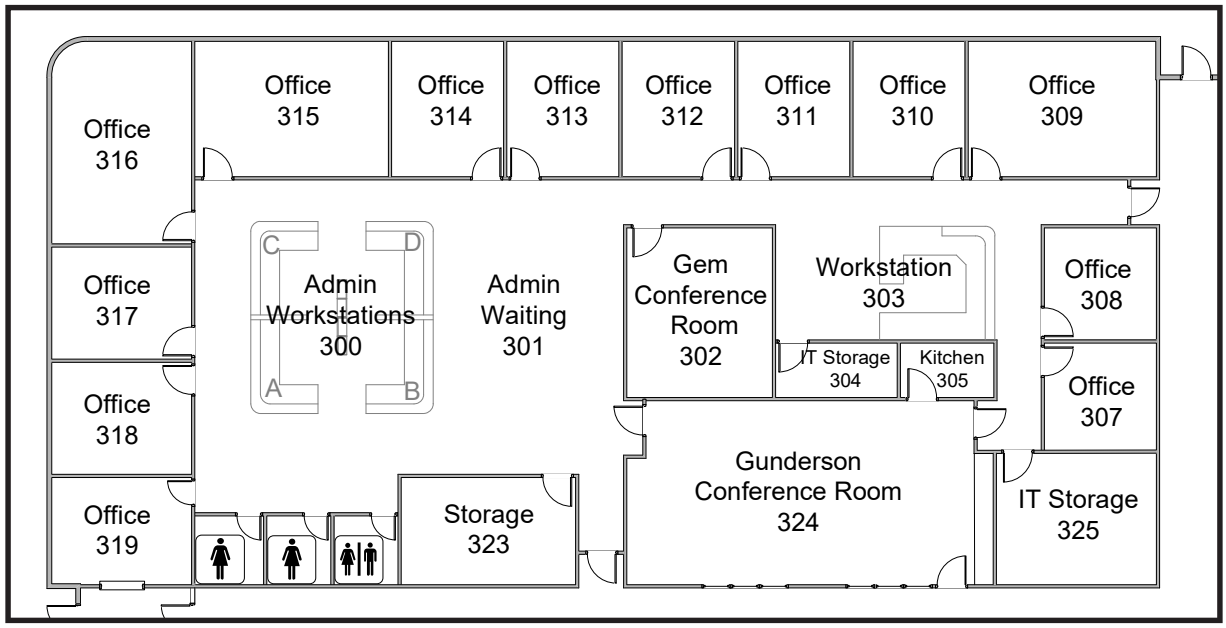
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ADMINISTRATION SPACE ALLOCATION

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]

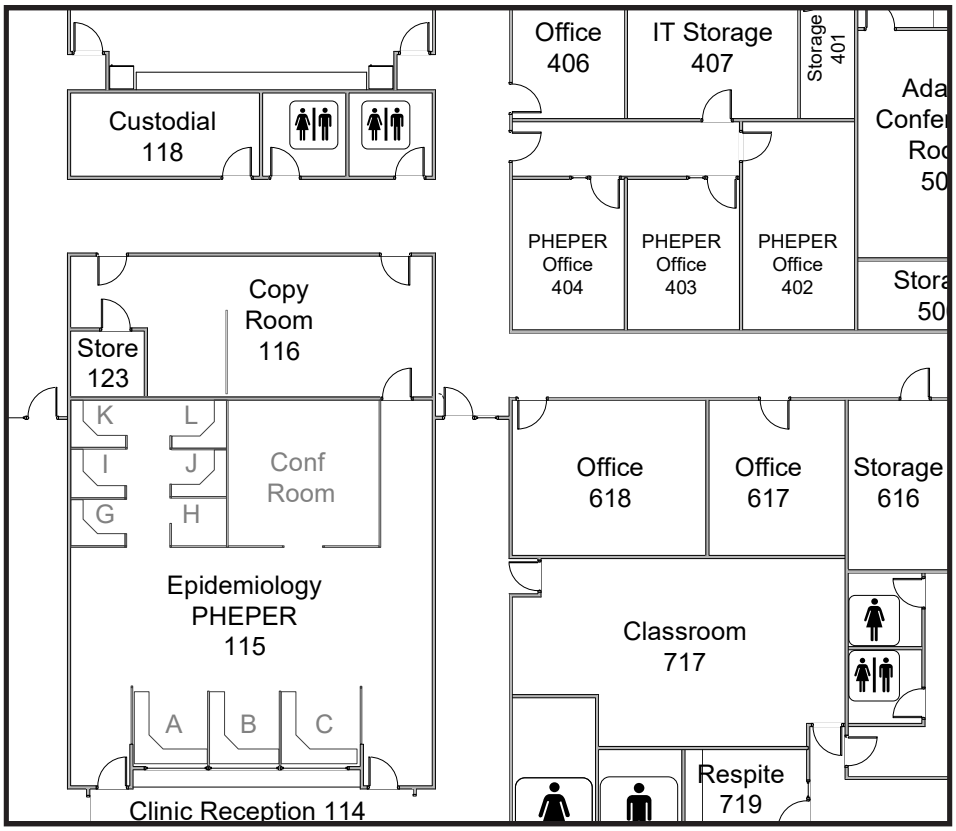


EPIDEMIOLOGY (PHEPER) SPACE ALLOCATION

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]

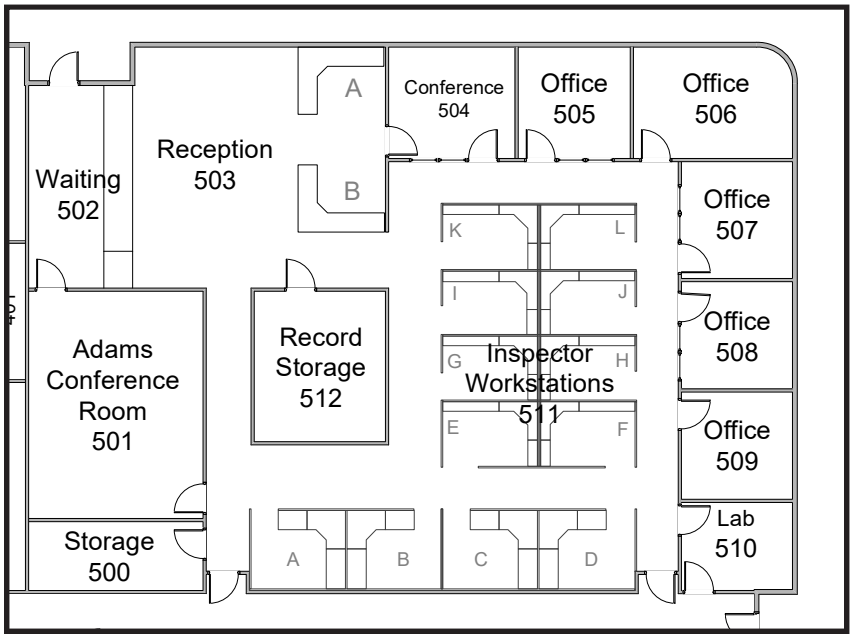


COMMUNITY FACILITIES & ENVIRONMENTAL SPACE ALLOCATION

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]

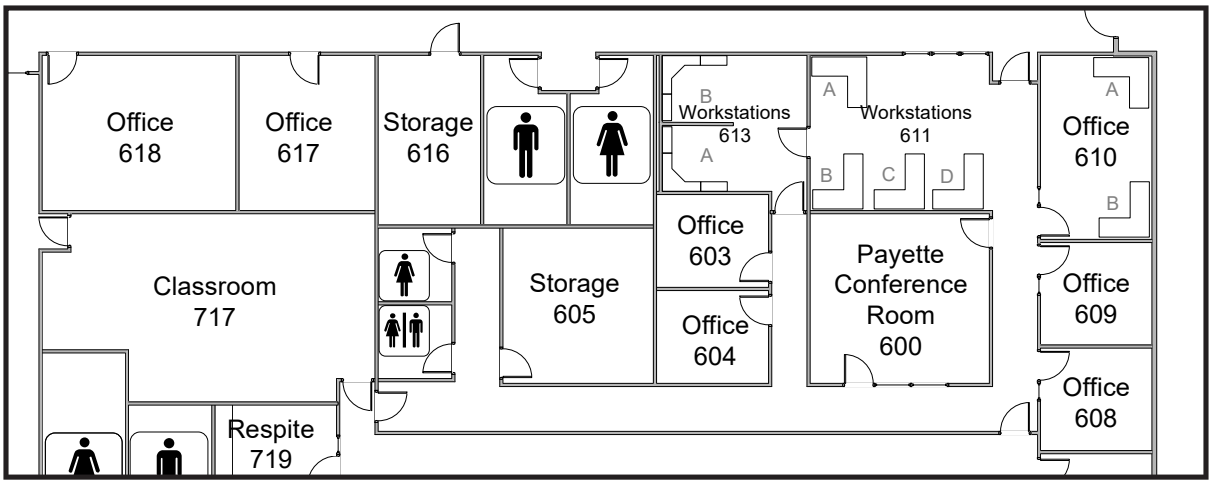


COMMUNITY HEALTH SPACE ALLOCATION

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]

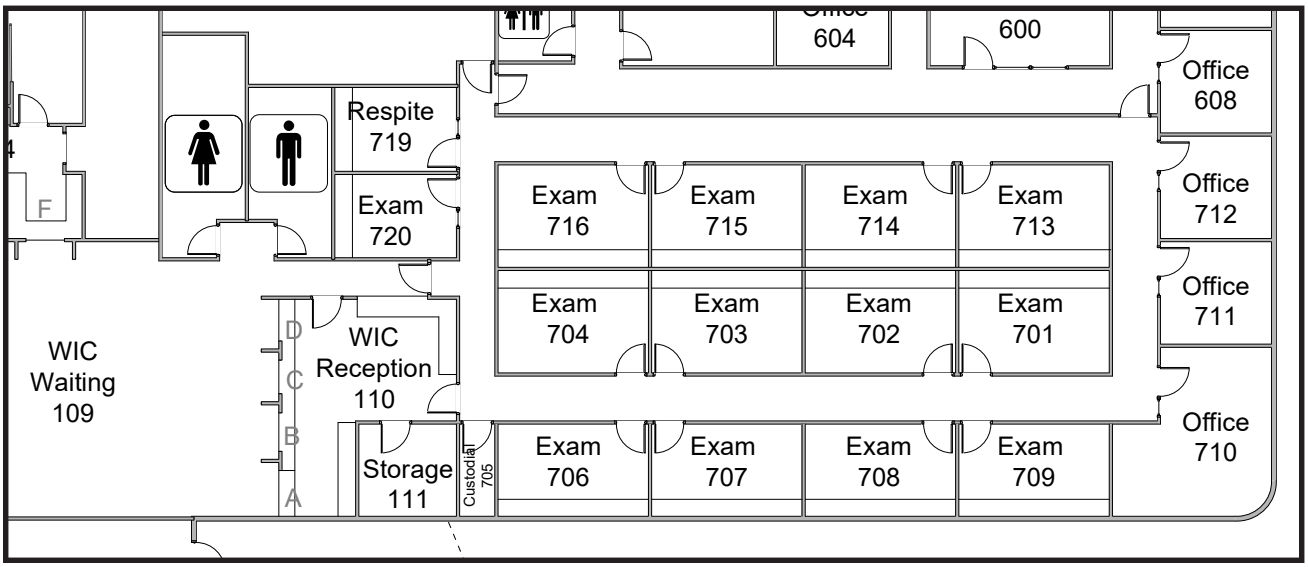


FAMILY SERVICES (WIC) SPACE ALLOCATION

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

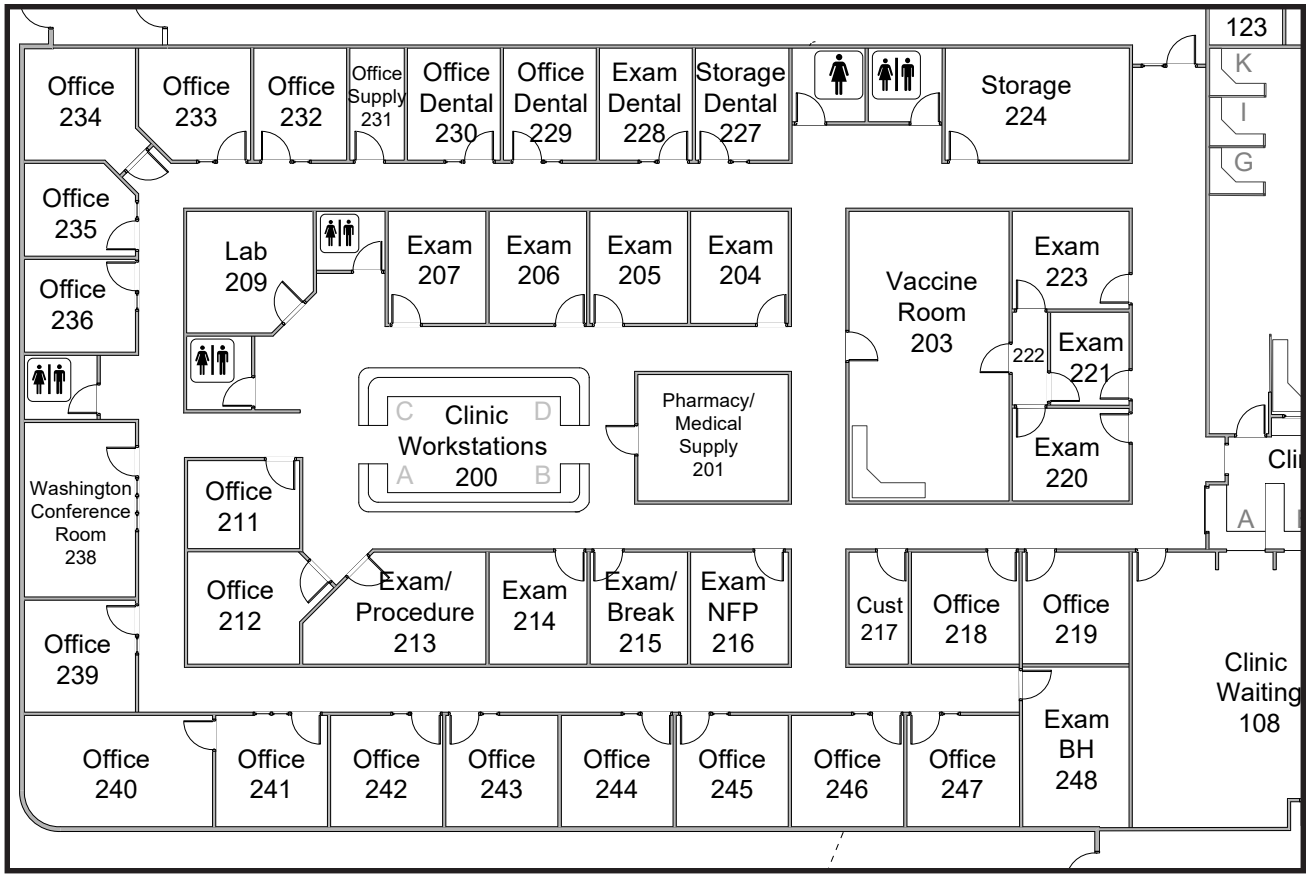
The Clinic Services and Behavioral Health area encompasses a wide range of services within its walls. This office includes standard medical examination rooms, behavioral health facilities, dental services, and several home visiting programs tailored for young families.

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

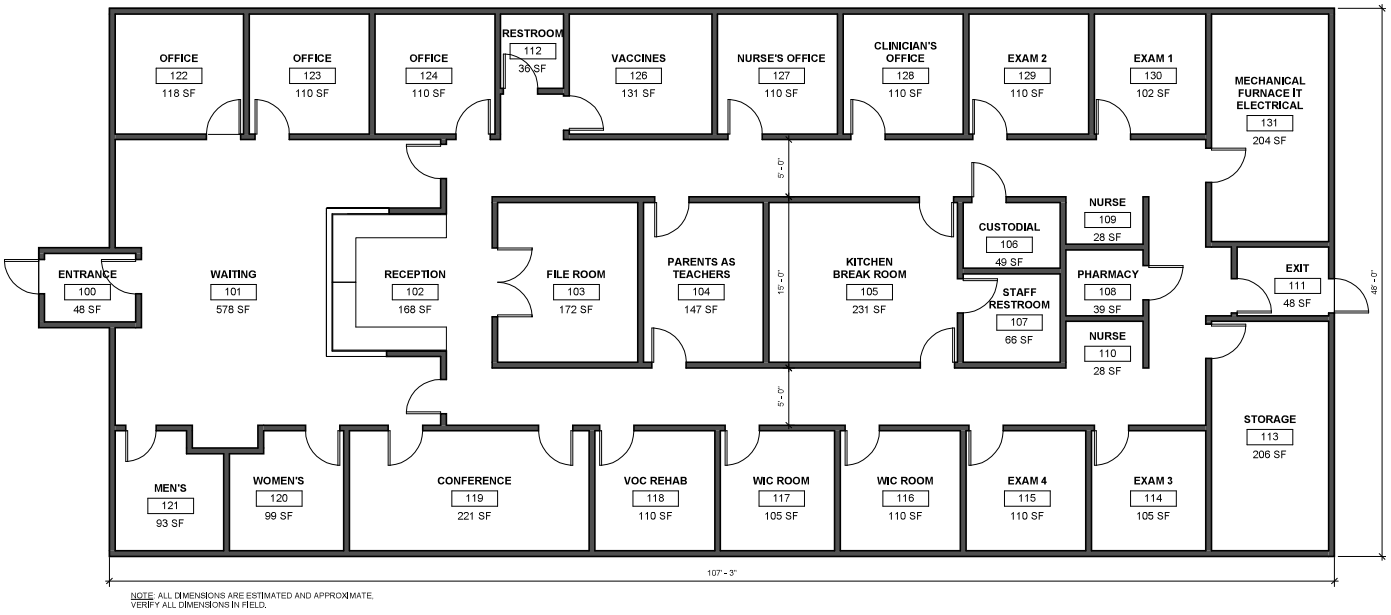
Office 239	144 SF	NFP, 1 staff	120	Private Office Small	+24 sf
Office 240	228 SF	Division Administrator	240	Private Office Large	-12 sf
Offices 241	140 SF	FCS, 1 staff	120	Private Office Small	+20 sf
Office 242	140 SF	BH Program Manager, 1 staff	120	Private Office Small	+20 sf
Office 243	140 SF	BH Project 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



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 Office of Emergency Management (OEM) 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.

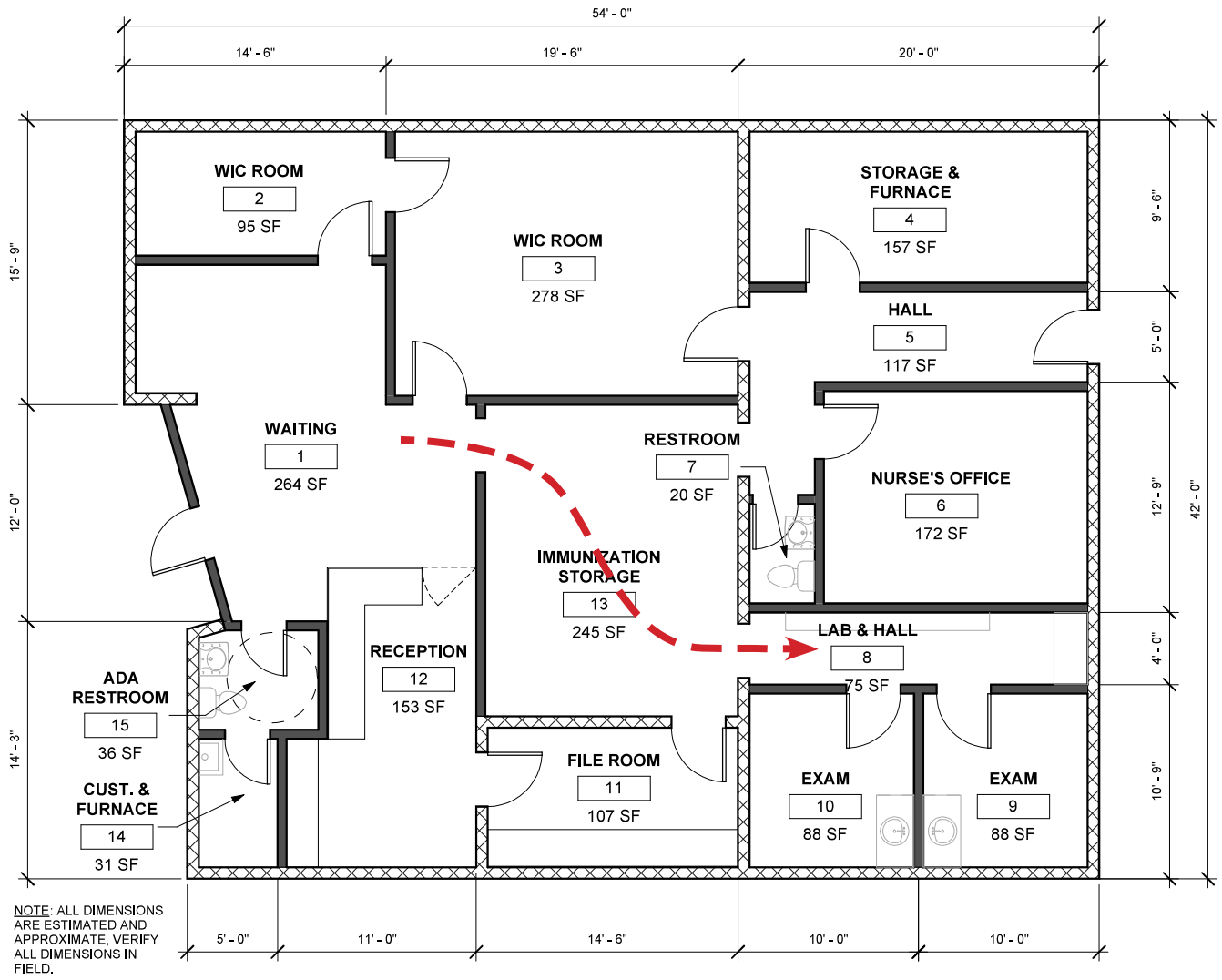
PAYETTE OFFICE

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 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.

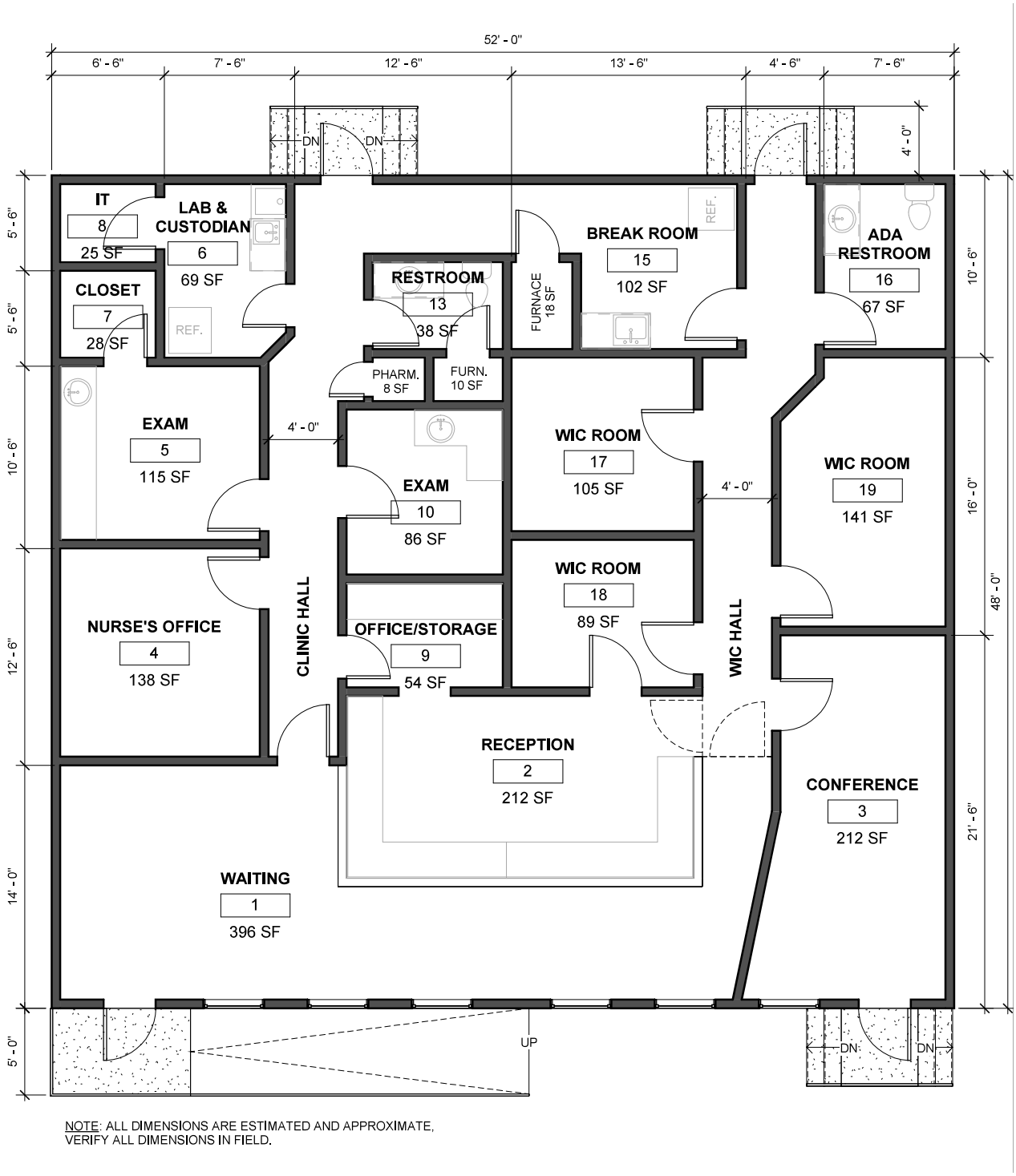
A narrow hallway outside the exam rooms doubles as the nurse's station, with a slim lab counter and supply storage. Some areas are tight, while others, like a WIC room and the nurse's office in the back, are oversized but awkwardly divided or poorly located.

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.

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
Caldwell, ID 83607



FACILITY SPACE ALLOCATION

The Farmway Office provides WIC-only services in Farmway Village. SWDH previously leased office space within the building, but their lease ended. WIC services are now provided in the Farmway Community Center on a shared, reserved basis. WIC services are provided mostly by appointment, with occasional walk-ins. Terry Reilly (behavioral health) also occupies a portion of the building.

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.

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.



Appendix 11.4
Internal & External Stakeholder Summaries

2025

Southwest District Health
Internal Stakeholder Summary

CLEARWATER FINANCIAL

SOUTHWEST DISTRICT HEALTH

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Introduction

Southwest District Health (SWDH) undertook a series of internal stakeholder interviews to better understand the organization's strengths, challenges, and priorities for the future. Twelve interviews were conducted with staff and board representatives across a range of programs and functions. Each conversation followed a structured interview guide, covering services, resources, facilities, communication, and long-term priorities, while also allowing space for broader reflections.

This report presents a thematic synthesis of those interviews. To ensure candor and protect anonymity, no individual comments are attributed by name, title, or department. Instead, perspectives are grouped into themes that emerged across multiple participants. The analysis is organized in alignment with the internal stakeholder interview guide, followed by a review of emergent themes not explicitly included in the guide. The report concludes with cross-cutting patterns, areas of convergence and divergence, and neutral considerations for leadership. The purpose is not to provide recommendations, but to highlight perceptions and insights that may inform future planning discussions.

Executive Summary

The interviews revealed consistent recognition of the breadth of services offered by Southwest District Health, spanning both clinical care and broader community programs. Many stakeholders noted that this variety is not always visible, either to the public or even to staff outside specific programs, which limits awareness of the District's impact.

A recurring theme was the need for expanded behavioral and mental health services. Nearly all participants identified this as a pressing and unmet community need. Stakeholders also raised concerns about facilities and infrastructure. While the Caldwell site was generally viewed as functional, outer clinics were described as outdated, with issues of privacy, space, ventilation, and ADA compliance, which serve as barriers to both staff effectiveness and public access.

Resource allocation generated mixed perspectives. Some felt programs were appropriately resourced, while others pointed to gaps in staffing and funding, particularly in grant-dependent programs. The sustainability of services was a common worry, with several noting that grant funding, while useful in starting initiatives, often left programs vulnerable when external support ended.

Communication and public awareness also surfaced as important themes. Internally, most staff felt reasonably well informed, though some wanted more consistent updates. Externally, the public does not always understand or take advantage of available services, leading some programs to be underutilized.

Areas of convergence included urgency around behavioral health, improving outer clinic facilities, and strengthening community partnerships. Divergence was most evident in views on resources and allocation. Taken together, the interviews highlight both the strengths of SWDH, its breadth of services and commitment to community health, and the challenges it faces in sustaining and expanding efforts amid aging infrastructure, uneven resources, and growing public health demands.

Findings Organized by Interview Guide

Services & Clients

Internal stakeholders consistently described Southwest District Health's services as broad, diverse, and vital to the communities it serves. Programs range from direct clinical services, such as immunizations, prenatal and postnatal care, and treatment for tuberculosis and sexually transmitted infections, to environmental health functions like restaurant and septic inspections, landfill oversight, and water quality. Staff also pointed to counseling services, prevention programs, and a variety of partnerships with schools, counties, and other community organizations.

Several participants remarked that the true scope of SWDH's services is often underrecognized, even by staff themselves. Some shared that they only came to understand the full breadth of the District's responsibilities after joining the organization. This perception highlighted a broader theme: the work of the District touches many facets of community health, but its visibility remains limited outside of immediate program users.

The populations served by SWDH are as varied as the programs themselves. Depending on the service, primary clients may include individual patients, families, schools, businesses, county agencies, or community partners. Many interviewees called attention to the growing demand for behavioral and mental health services cuts across nearly every client group. Others reflected on how reliance on grant-funded programs has allowed the District to expand its reach but has also created challenges when those funding sources are not renewed, sometimes leaving communities without services they had come to rely upon.

One participant summarized this perspective by noting, "I didn't realize until joining how many different services we actually provide, from clinics to inspections to prevention programs." This sentiment was echoed across interviews, reinforcing the view that SWDH's services are broad, impactful, and often underappreciated in their scope.

Service Delivery Methods

When discussing how services are delivered, internal stakeholders emphasized that in-person care remains the cornerstone of SWDH's approach. Most programs rely on face-to-face interactions at clinics, where staff provide preventive care, treatment, education, and follow-up support. Several participants described this model as effective for building trust with clients and ensuring care is accessible to those who may be less comfortable with technology.

At the same time, many interviewees highlighted the growing role and potential of telehealth. While still limited in practice, telehealth was described as particularly valuable for clients who face barriers such as lack of transportation, inflexible work schedules, or long travel distances to clinics. Staff observed that expanding virtual options could help address inequities in access, especially in rural parts of the District, though it would require additional infrastructure and consistent investment to become a regular part of service delivery.

Home visits were mentioned as another method of reaching clients, though these were less common and typically associated with specific programs. Where they occur, home visits were viewed as highly

beneficial, particularly for families with young children or clients with mobility challenges. However, stakeholders noted that staff capacity limits the extent to which these services can be offered consistently across the District.

As one participant explained, *"Right now it's mostly in person at the clinics. I'm trying to get more telehealth going, because some patients just can't get here or take time off work."* This reflects a broader recognition that while the current delivery system is grounded in in-person care, future growth in virtual and flexible service options will likely be essential to meet community needs.

Resources (Available and Needed)

Stakeholders offered varied perspectives on the resources available to them in carrying out their work. Some described feeling generally well supported by the tools, equipment, and staffing needed to meet day-to-day demands. Others, however, painted a more challenging picture, pointing to persistent shortages of personnel and an overreliance on short-term grant funding that undermines program stability.

Several participants noted that staffing was particularly strained in outer clinics, where the same expectations must often be met with fewer people and less supportive infrastructure. In these locations, staff described "stretching" to cover needs that would be handled by larger teams in more centralized offices. This not only created operational pressure but, in their view, placed limits on the District's ability to grow or innovate.

The reliance on grant funding was another common theme. While grants were praised for enabling innovation and expansion of services, many stakeholders worried that they create vulnerabilities when funding cycles end. Programs that communities had come to depend on were sometimes discontinued due to lack of sustainable funding, which left both staff and clients frustrated. As one participant put it, *"You can use grants to start a program, but if the money runs out, you can't keep it going."*

Partnerships were described as a partial counterbalance to resource gaps. Many staff highlighted positive relationships with counties, schools, and other agencies, which helped supplement District capacity. Even so, participants emphasized that partnerships alone cannot offset the need for stable, long-term investments in staffing and operational support.

In sum, while some internal stakeholders felt resourced to deliver their services effectively, many others described gaps in staffing and sustainability that limit the District's ability to fully meet community needs.

Resource Allocation

Perspectives on resource allocation within Southwest District Health varied widely, often depending on program area and physical location. Some stakeholders expressed confidence that resources are distributed fairly and strategically across the organization. These individuals emphasized that leadership makes careful decisions in balancing priorities and that, from their vantage point, essential needs are generally met.

Others, however, conveyed a sense of unevenness, particularly when comparing central facilities with outer clinics. Several participants described differences in how resources are experienced across the

District. Some noted that certain sites operate with fewer supplies, less support, or more limited equipment, even though service expectations remain consistent across locations. These differences were said to create frustrations for staff and, in some cases, leave communities feeling they have fewer options for accessing care.

Perspectives on resource allocation reflected a divide between those who felt that funding decisions were generally sound and equitable, and others who described the experience of working with fewer resources. Some participants emphasized that the District strives to distribute funding fairly, while others noted that certain locations operate with more limited tools and support compared to larger sites. One stakeholder explained it this way: *"Overall, resources seem to be allocated fairly, but some clinics don't have access to the same tools and equipment as others."*

Overall, while there was no consensus on whether resources are fully adequate, the interviews revealed a shared awareness that allocation decisions have a direct and visible impact on both staff and community experience, and that differences between central and outer facilities remain a persistent source of concern.

Facilities & Technology

Facilities emerged as one of the most prominent areas of concern in the internal stakeholder interviews. While some staff described the Caldwell site as largely functional, the outer clinics were repeatedly characterized as outdated, cramped, and poorly equipped to support the services being provided. Interviewees highlighted issues ranging from a lack of privacy in exam rooms to inadequate ventilation, limited storage, and restroom facilities that do not meet ADA standards. In certain cases, rooms were described as so small or poorly laid out that staff struggled to see patients comfortably or maintain confidentiality during visits.

Several participants also pointed to the absence of basic infrastructure in some clinics, such as sinks in exam spaces or sterilization equipment that would be standard in more modern facilities. Others noted challenges with heating and cooling systems, which they said impacted both patient comfort and the ability to provide services safely. These concerns were particularly acute in the outer sites, which were described as carrying the same expectations as the central office but with far fewer resources.

Technology was raised less frequently but was not absent from the conversation. Some stakeholders noted that while the District has made strides in electronic records and digital systems, there remain inconsistencies across sites. Outdated computers or insufficient connectivity in certain locations were identified as barriers to efficiency. At the same time, participants acknowledged that these issues were not as urgent as the more pressing structural and space-related challenges.

As one staff member explained, *"In one clinic room, there's no privacy - if the door opens, people in the hall can see directly into the exam space."* This comment reflects the broader theme that facility shortcomings directly affect both staff capacity and patient experience.

Taken together, the interviews suggest that while technology is an area of incremental improvement, facilities, particularly at outer clinics, represent a significant challenge that stakeholders believe must be addressed to ensure equitable and effective service delivery.

Public Awareness of Services

Concerns about public awareness surfaced consistently across the internal stakeholder interviews. Many participants felt that a significant portion of the community remains unaware of the full range of services offered by Southwest District Health. This lack of awareness was described as a contributing factor to underutilization of certain programs and clinics, particularly in smaller or more rural locations such as Payette.

Several interviewees suggested that misperceptions also play a role. Some community members assume that District services are only available to individuals without private insurance, while others simply do not understand which services are offered locally versus those provided by hospitals or private clinics. Staff observed that these misunderstandings can prevent residents from accessing services they may benefit from, leading to gaps in preventive care and treatment.

Efforts to raise awareness have been made, but stakeholders acknowledged that communication and outreach are complicated by the cultural and political context of the region. Some expressed that promoting public health services can be a sensitive undertaking in conservative communities, requiring a careful balance between visibility and community trust.

One stakeholder described the challenge by saying, *"The clinic might be underutilized because people don't know it's there, or they assume they should go elsewhere."* This perspective highlights both the need for better outreach and the difficulty of achieving it in environments where public health messaging can sometimes be met with skepticism.

Overall, while staff recognized the importance of improving awareness and communication, they also emphasized that doing so effectively would require thoughtful strategies tailored to the values and expectations of the communities SWDH serves.

Missing Opportunities (Services, Outreach, Partnerships)

Internal stakeholders identified several areas where they believe Southwest District Health is not fully capitalizing on opportunities to expand or strengthen its role. The most frequently mentioned gaps involved outreach and partnerships, particularly in relation to emergency services, behavioral health, and community engagement.

Many interviewees emphasized that the District could benefit from stronger connections with emergency managers, zoning and planning departments, and ambulance providers. These relationships were seen as critical to ensuring that public health considerations are integrated into broader community planning and emergency response efforts. Yet, staff noted that such partnerships remain uneven across the District, with some counties demonstrating strong collaboration while others operate more independently.

Behavioral health was again raised as an area where opportunities are being missed. Several participants pointed out that the need for counseling and support services continues to grow, but the District's capacity to respond is constrained. They suggested that additional partnerships with schools, nonprofits, and other providers could help address this gap, but that sustained funding and staffing would be necessary to make such collaborations meaningful.

Funding was a recurring theme in this discussion. Stakeholders acknowledged that while opportunities exist, the ability to act on them often "comes down to money." As one participant observed, *"There could be more connection with emergency services and ambulance providers, but it always comes down to money."* This sentiment underscores the tension between recognition of potential and the practical limitations imposed by available resources.

In summary, internal voices indicated that SWDH could extend its impact by building stronger relationships with community partners and investing more intentionally in behavioral health, outreach, and emergency preparedness. However, they also cautioned that without reliable funding, these opportunities are likely to remain aspirational rather than achievable.

Program Adjacencies

When reflecting on how different programs relate to one another, stakeholders described a mixture of strong linkages and areas where closer alignment could improve service delivery. One example that was frequently mentioned involved the natural connections between environmental health and planning and zoning. Staff explained that these relationships are essential because land-use and development decisions often intersect with public health concerns such as septic systems, water quality, and sanitation. In this context, coordination with planning and zoning was described as both frequent and necessary, since permitting decisions routinely require District input to ensure community health and safety standards are met.

At the same time, interviewees highlighted gaps in adjacency where services overlap but collaboration is less developed. Emergency management and emergency medical services were cited as examples of areas where stronger ties could create efficiencies and enhance preparedness. Several participants observed that, while cooperation exists, these connections are not always systematic or consistent across counties.

The theme of adjacency extended beyond program structures to how staff perceive their own work within the larger District. Some described feeling well integrated with colleagues in complementary programs, while others felt isolated or siloed, lacking opportunities to share resources or coordinate efforts.

As one participant noted, *"Planning and zoning works with the District a lot, that adjacency matters for local issues."* This observation underscores how some program linkages are viewed as critical to daily operations, while others remain underdeveloped and present opportunities for strengthening.

Overall, stakeholders conveyed that while important adjacencies are already in place, there is room to expand and formalize collaboration between programs, particularly in areas where public health intersects with emergency response and community infrastructure.

Use of Shared Spaces

Stakeholders spoke less about shared spaces than they did about broader facility challenges, but when the topic did arise, it often underscored the ways in which physical layouts can complicate service delivery. Some staff described the availability of meeting rooms and public areas as limited, with scheduling conflicts occasionally creating difficulties for both internal operations and community-facing

activities. Others mentioned that certain shared spaces were not designed with their current uses in mind, resulting in inefficiencies or discomfort.

Several participants raised concerns about restroom access, noting that in some facilities, public restrooms are either limited in number or not fully accessible. As a result, staff restrooms are sometimes used to accommodate patients, which blurs the intended boundaries between staff and public spaces. While not universally described as a daily barrier, this issue was cited as an example of how space limitations can ripple into patient experience and staff workflow.

One stakeholder explained, *"Patients sometimes end up using staff bathrooms because the public ones aren't accessible."* Although offered as a practical observation, this comment illustrates how seemingly small constraints in shared spaces can affect both perceptions of service quality and the functionality of a facility.

In general, while shared spaces were not portrayed as the most critical challenge, their use reflected the broader theme that SWDH facilities are often stretched beyond their intended design. These constraints were most acute in smaller or older clinics, where space limitations force staff to make compromises in how areas are allocated and used.

Work at Other District Sites

Many internal stakeholders described traveling to or working at multiple District sites beyond their primary location. This rotation was seen as necessary to provide coverage across the District's service area, but it also introduced a range of logistical and operational challenges. Staff noted that while the expectation to support multiple sites is well understood, the resources and conditions available at each location can vary significantly.

Several participants explained that outer clinics in particular often lack the same equipment, space, or staffing levels as the central office. This meant that when staff rotated into these facilities, they had to adapt quickly to different environments, sometimes improvising to make up for gaps in supplies or infrastructure. For some, this created frustration, as it meant that the quality and efficiency of their work could differ depending on the site.

Despite these difficulties, some interviewees described working at different sites as an opportunity to better understand the range of community needs within the District. Exposure to varied populations and service contexts was seen as beneficial for building perspective, even if the practical challenges of inconsistent resources remained.

Several participants described the experience of working across multiple District sites, noting that each location presents its own challenges with equipment, space, or support. This perspective reflected a broader theme in the interviews: while staff remain committed to providing services throughout the District, differences in facility conditions can complicate their work and create inconsistencies in how services are delivered.

Challenges for Public Access (Parking, Signage, ADA, etc.)

Internal stakeholders frequently pointed to barriers that the public encounters when trying to access services at District facilities. Parking was raised as a practical concern, with some clinics offering limited

or inconvenient spaces for patients. In a few cases, staff noted that parking shortages cause stress for clients who may already feel anxious about seeking care.

Signage and wayfinding also emerged as challenges. Several interviewees observed that buildings are not always easy to navigate, particularly for first-time visitors. Confusion over entrances or the absence of clear directional signs was described as creating frustration for patients and occasionally delaying appointments.

Accessibility was a particularly significant theme. Multiple stakeholders explained that some facilities do not fully meet ADA standards, citing restrooms that are too small for wheelchair users or clinic rooms that are difficult to access for those with mobility challenges. These limitations were viewed not only as compliance issues but also as obstacles that undermine the District's goal of equitable service delivery.

One participant explained, *"Some bathrooms aren't ADA compliant, and that makes it harder for patients."* While stated plainly, this comment reflects the larger concern that the physical environment itself can become a barrier to care.

Overall, these access challenges were described as part of the broader facility issues facing the District. Stakeholders emphasized that addressing them will be essential for improving both patient experience and the overall accessibility of SWDH's services.

Communication & Information Flow

When reflecting on communication within Southwest District Health, most internal stakeholders described the flow of information as functional but uneven. Many staff reported that they typically receive updates about District-wide plans and changes in a timely manner, and several expressed appreciation for leadership's efforts to keep them informed. However, there were also repeated observations that communication is not always consistent across sites or programs.

Some interviewees felt that information tends to circulate more effectively at the central office than at outer clinics, where staff may not be as closely connected to leadership. This sometimes left those working in remote sites feeling a step behind or less engaged in District-wide initiatives. A few participants also commented that communication from the District to its governing board and county representatives could be improved, with more regular updates desired to maintain alignment and trust.

Despite these concerns, there was a general sense that communication channels are in place and functioning, but that they could be strengthened to ensure greater consistency. The tone of these comments was not one of dissatisfaction as much as recognition that the District's geographic spread and varied programs require deliberate effort to maintain clear and equitable communication.

Some participants observed that communication across different audiences, whether staff, governing bodies, or community partners, is not always consistent. They expressed a desire for more regular and uniform updates to ensure that everyone connected with the District has the same information and feels equally engaged in its work.

Future Priorities (5–10–20 years)

When asked to reflect on the future, nearly all internal stakeholders identified behavioral and mental health as the most urgent priority for Southwest District Health. Participants consistently described

growing community needs in this area, noting that gaps in services already exist and are expected to widen as populations increase. Many voiced concern that without significant expansion of counseling, prevention, and treatment programs, the District will struggle to meet its mission over the coming decades.

Facility improvements were also described as a critical priority. Stakeholders emphasized that outdated and inadequate clinic spaces, particularly in outer locations, limit both the effectiveness of staff and the experience of patients. Several commented that planning for future growth will require not only maintaining current facilities but also rethinking how clinics are designed and equipped to support modern models of care.

In addition to behavioral health and facilities, participants pointed to broader themes such as preparing for population growth, improving community outreach, and ensuring financial sustainability. Many acknowledged that the District has successfully launched innovative programs through grant funding but warned that reliance on short-term grants is not a viable long-term strategy. They suggested that stable, predictable funding streams will be necessary to support future expansion and to ensure continuity of services.

One staff member summarized the sentiment by saying, *"The need for mental health support is urgent everywhere - it should be a top priority for the future."* This perspective captures the overwhelming emphasis that stakeholders placed on behavioral health as a building block of the District's long-term planning.

Overall, the interviews revealed that internal stakeholders envision a future where SWDH is better equipped, both through facilities and resources, to meet the evolving needs of the community, with behavioral health at the center of that vision.

Emergent Themes (Not in the Interview Guide)

In addition to the structured topics from the interview guide, several themes surfaced organically across conversations that highlight broader dynamics shaping the work of Southwest District Health.

One of the most frequently mentioned emergent themes was the influence of state and local politics on the District's ability to operate effectively. Multiple stakeholders reflected on the pressures public health has faced since the COVID-19 pandemic, noting that skepticism of government institutions has carried into perceptions of the District. These participants explained that political climates at both the state and county level sometimes constrain what services can be offered or how they are presented to the public. This was not always expressed in frustration, but often as a practical reality that requires the District to be strategic in how it communicates and engages with communities.

Closely tied to this was a theme of trust and communication. Several interviewees described the pandemic as a pivotal moment that strained relationships between public health agencies and the public. While they acknowledged that progress has been made in rebuilding credibility, they also emphasized that trust remains fragile and requires deliberate investment. Stronger partnerships, greater transparency, and consistent outreach were all identified as ways to continue strengthening that trust over time. As one participant put it, *"We had to rebuild trust after COVID, and that happens through communication and relationships."*

Another theme that emerged was the need to balance innovation with sustainability. Stakeholders praised the District's ability to launch new initiatives, often through grants, but cautioned that frequent changes in funding streams can create instability. This was echoed in discussions of resources but surfaced independently here as a broader concern about organizational resilience and the ability to plan for the long term.

Together, these emergent themes suggest that beyond immediate service delivery and facility needs, SWDH faces ongoing challenges in navigating political realities, strengthening community trust, and ensuring that its programs are sustainable well into the future.

Cross-Cutting Patterns

Several themes emerged across multiple sections of the interviews, suggesting challenges and opportunities that cut across program areas and functions.

Foremost among these was the recurring emphasis on behavioral and mental health needs. Regardless of whether participants were discussing services, partnerships, resources, or long-term priorities, the demand for expanded behavioral health programming surfaced again and again. This consistency indicates that stakeholders view behavioral health not as a single programmatic gap but as a systemic issue that affects the entire District's capacity to serve its communities.

Facilities were another cross-cutting concern. From questions about how services are delivered, to challenges with shared spaces, to barriers in public access, the physical condition of SWDH's sites repeatedly shaped stakeholders' experiences. In particular, outer clinics were described as limiting staff efficiency and patient comfort, underscoring that facility challenges are interconnected with service quality, equity, and long-term planning.

Finally, funding emerged as a unifying thread across resource discussions, allocation, and emergent themes. While grants have enabled innovation, stakeholders consistently raised concerns about sustainability and the disruptions caused when funding sources expire. This reliance on temporary resources intersects with nearly every other challenge identified - from staffing shortages to missed opportunities for partnerships - and was viewed as a major factor influencing the District's ability to meet future demands.

Taken together, these cross-cutting patterns suggest that behavioral health, facilities, and sustainable funding are not isolated issues but interconnected priorities that will shape how Southwest District Health evolves over the next decade and beyond.

Areas of Convergence and Divergence

Across the interviews, there was strong convergence on several key themes. Nearly all stakeholders agreed that behavioral and mental health should be a top priority for Southwest District Health moving forward. This need was described as urgent, growing, and deeply embedded in the communities the District serves. There was also widespread agreement that facility improvements, particularly in outer clinics, are necessary to ensure equitable access and effective service delivery. Stakeholders consistently emphasized that current spaces are inadequate for both staff and clients, and that upgrading these facilities will be essential for future growth.

Convergence was also evident in the recognition of public awareness as a barrier. Many stakeholders pointed out that residents either do not know about available services or misunderstand who is eligible to receive them. While the perspectives differed in detail, there was a shared sense that outreach and communication are critical challenges that must be addressed if the District is to expand its reach.

Divergence appeared most clearly in perceptions of resources and allocation. Some participants described resource distribution as fair and appropriate, with leadership making sound decisions that balance competing priorities. Others, particularly those working in smaller or more remote sites, emphasized shortages in staffing, equipment, and supplies that they felt left them at a disadvantage compared to the central office. This divide reflected not only different experiences but also differences in perspective between leadership and frontline staff.

There was also divergence in how staff described the District's internal communication. While some expressed satisfaction with the frequency and clarity of updates, others, especially those in outer clinics, felt less connected to decision-making processes and desired more consistent information.

Overall, the interviews revealed a strong alignment to the broad priorities facing the District, particularly in behavioral health, facilities, and public engagement. At the same time, they highlighted important differences in how resources and communication are experienced across roles and locations, highlighting the complexity of managing a geographically and programmatically diverse organization.

Considerations for Leadership

The themes raised by internal stakeholders suggest several areas where Southwest District Health's leadership may wish to reflect and explore options. These considerations are framed as questions to guide future discussion and decision-making.

First, given the near-universal emphasis on behavioral and mental health, leadership may wish to consider how the District can best define its role in this area. What mix of direct services, partnerships, and community outreach would most effectively address the growing need, and what funding strategies could ensure sustainability over the long term?

Second, the concerns raised about facilities invite further examination. How should the District prioritize investments in outer clinics to ensure that patients and staff experience consistent quality of care and access? What criteria will be most useful for determining which facility improvements should be addressed first?

Third, the issue of public awareness raises important questions about outreach and communication. What strategies can the District use to improve visibility of its services in ways that resonate with communities, particularly in areas where skepticism of public health persists? How can messaging be tailored to both inform residents and strengthen trust?

Finally, questions of resources and allocation suggest a need for ongoing dialogue. How can the District ensure that resource distribution feels equitable across sites, while also accounting for differences in population, demand, and programming requirements? What mechanisms might strengthen communication so that staff across all locations feel connected and informed?

By considering these questions, the Board of Health and leadership team can use the insights gathered from internal stakeholders to inform planning, strengthen organizational resilience, and ensure that Southwest District Health is positioned to meet the evolving needs of its communities.

Conclusion

The internal stakeholder interviews provided a valuable window into how Southwest District Health is experienced from within. SWDH's internal stakeholders consistently described the District as broad in scope, essential to the communities it serves, and committed to public health. At the same time, the conversations underscored persistent challenges, most notably, unmet behavioral health needs, aging facilities, uneven resource allocation, and limited public awareness of services.

These findings highlight both strengths and vulnerabilities. The organization's diversity of programs and dedicated workforce remain clear assets, while the reliance on short-term funding, facility disparities between central and outer sites, and gaps in communication reflect structural issues that merit attention. Importantly, the convergence around behavioral health and facility improvements suggests areas where internal consensus may guide future priorities.

As the District considers its next steps, the voices of internal stakeholders offer both caution and opportunity: caution in acknowledging the barriers that could limit effectiveness, and opportunity in the shared vision for stronger behavioral health services, modernized facilities, and clearer communication. Taken together, these insights provide a foundation for leadership discussions and future planning aimed at ensuring Southwest District Health remains resilient, equitable, and responsive to the communities it serves.

2025

Southwest District Health
External Stakeholder Summary

CLEARWATER FINANCIAL

SOUTHWEST DISTRICT HEALTH

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Introduction

Southwest District Health (SWDH) invited external stakeholders to share their perspectives on the District's work, its facilities, and the needs they see in their communities. Over the course of twenty conversations, people from across the region and from a variety of sectors spoke about their experiences with SWDH and their views on what the District does well and where it could grow.

Participants represented a broad cross-section of the region. County and city officials from Canyon, Gem, Owyhee, Payette, and Washington Counties offered local government perspectives, while representatives from planning organizations such as COMPASS and law enforcement contributed insights on growth, transportation, and public safety. Leaders from nonprofits and service providers shared experiences supporting families, youth, and vulnerable populations, including behavioral health and recovery programs. Healthcare providers and hospital partners reflected on collaborative efforts in clinical and emergency preparedness contexts. The interviews also included voices from education, public safety, and community-based organizations, ensuring that urban and rural geographies across the District were represented.

These interviews were designed to listen directly to community voices and partner organizations, with the goal of understanding how SWDH is perceived and what priorities matter most for the future. The report that follows summarizes what we heard. It is organized around the external stakeholder interview guide while also noting additional themes that emerged naturally in the conversations.

Executive Summary

External stakeholders described Southwest District Health as an important presence in the region, responsible for both protecting community health and providing direct services. Many expressed appreciation for the professionalism of staff and the District's commitment to serving a wide geographic area. At the same time, they highlighted challenges that affect how the public understands and accesses services.

One of the strongest themes was limited awareness of SWDH's role. Stakeholders repeatedly noted that community members often do not know what services the District provides or assume that programs are only available to certain groups. This lack of visibility was seen as a barrier to both trust and use of services.

Behavioral and mental health was identified as a critical gap, echoing concerns raised by internal stakeholders but voiced here from the perspective of community need. Stakeholders emphasized the importance of building capacity in this area, particularly for youth and underserved populations. Other frequently mentioned needs included transportation support, expanded partnerships, and more flexible or accessible clinic hours.

Facilities were also a concern. While participants did not focus on operational challenges, they described the community's experience of facilities in terms of convenience, accessibility, parking, and adequacy of space. Several noted that the District will need to modernize and expand its physical presence to keep pace with population growth.

When asked about finances, most described SWDH as fiscally responsible, though a few expressed a desire for more visibility into priorities and long-term plans. Looking ahead, stakeholders encouraged

investment in facilities, outreach, and innovation, including greater use of technology such as telehealth to reduce barriers for rural residents.

While there is overlap with themes raised by internal stakeholders, especially around behavioral health and facilities, the external voices focused more on community awareness, accessibility, and expectations of service. Together, the two sets of interviews provide complementary perspectives that reinforce the urgency of certain issues while offering a fuller picture of how SWDH is viewed both inside and outside the organization.

Location Within the District

Stakeholders often framed their perspectives in terms of geography. Many spoke about the challenges of serving a large, multi-county district where communities differ significantly in size, resources, and accessibility. Travel distances were repeatedly noted as a barrier, particularly for residents in rural areas who must go farther to reach services compared to those closer to central facilities.

These differences were seen as shaping both access and perception. While the District works to provide consistent services, several participants observed that the experience can feel uneven depending on where someone lives. At the same time, many emphasized that having a regional health district provides a level of coordination that would be difficult for individual counties to achieve on their own. One participant summed this up by noting that, *"It's a big district with a lot of different communities. That makes it hard, but it also means there's one place people can look to for public health."*

Interface with the District

Stakeholders described a wide range of ways they interact with Southwest District Health, reflecting the District's dual role as both a regulator and a community health partner. For some, the primary connection was through environmental health services such as inspections and permitting. Others engaged through clinical programs, including immunizations, WIC, or family health. Still others interacted through collaborative efforts, ranging from emergency preparedness to community health initiatives.

Partnerships emerged as a consistent theme. Hospitals described longstanding ties through infection prevention committees and community health needs assessments, noting that SWDH epidemiologists are valued participants in those conversations. Physicians pointed to joint efforts to increase WIC enrollment and expand STD testing outreach in clinical settings. Broader collaborative work was also highlighted, with SWDH serving as the backbone organization for the Western Idaho Community Health Collaborative, which brings together health systems, nonprofits, and community groups to address social determinants of health.

Partnerships were also described in the context of public health emergencies, where strong coordination across agencies was seen as essential. Several participants noted past experiences where SWDH worked alongside community partners to manage high-stakes situations, and they emphasized the importance of keeping those connections active through future emergency planning.

In addition to these established collaborations, stakeholders suggested new approaches for partnership, including the idea of creating more flexible or shared spaces within SWDH facilities. Such spaces could be used by employers, insurers, or other organizations seeking to connect with residents, particularly in areas where access to services is limited.

While many participants described SWDH as responsive and collaborative, a few noted that their interactions still feel transactional at times, limited to inspections or compliance. These stakeholders expressed interest in broadening the relationship beyond regulatory touchpoints to include more joint projects that address community health needs.

Overall Perception of the District

External stakeholders generally described Southwest District Health as an important and stabilizing presence in the region. Many characterized the District as a trusted public health partner that provides consistency across multiple counties. Several participants emphasized the professionalism and responsiveness of staff, noting that they valued having a central organization dedicated to public health functions.

At the same time, there were comments reflecting the complexity of how the District is viewed. Some stakeholders said that SWDH is often associated more with regulatory functions, such as inspections and permitting, than with its broader community health role. Others noted that community members may not fully understand the scope of services offered, which can limit both awareness and trust.

When discussing improvements, participants pointed to opportunities to strengthen visibility and outreach. Examples included increasing public education about available services, making clearer distinctions between SWDH's role and that of hospitals or clinics, and creating more visible connections with schools and community-based organizations. Several participants suggested that expanding SWDH's presence at community events or through shared initiatives with local partners could help reinforce the District's role beyond regulation.

One stakeholder captured this balance by reflecting, *"They're good at what they do, but a lot of people just don't know the District is more than inspections and permits."* This perspective illustrates how SWDH is seen as competent and valuable but also highlights the need for greater public understanding of its broader mission.

Familiarity with Services

Stakeholders varied significantly in their familiarity with the services offered by Southwest District Health. Some programs, such as WIC, immunizations, and environmental health inspections, were mentioned frequently and appeared to be well understood by both community members and partner organizations. These services were seen as visible, either because people interact with them directly or because they are tied to everyday needs such as food safety and school requirements.

In contrast, several other areas generated less recognition. Behavioral and mental health services were repeatedly identified as a community priority, but many stakeholders said they were unclear about what SWDH currently provides in this space. Emergency preparedness and crisis response were also less familiar, with only a few participants noting direct involvement. Similarly, broader prevention and education initiatives were not consistently recognized, with some stakeholders associating the District almost exclusively with inspections and permitting.

Participants suggested that SWDH focus future outreach on raising visibility around these lesser-known programs. Ideas included highlighting prevention and education efforts through community events and

schools, making behavioral health resources more prominent in public materials, and ensuring that emergency preparedness roles are explained clearly to both local officials and the public.

As one stakeholder observed, *"Everyone knows about inspections and WIC, but beyond that, a lot of people don't know what the District does."* This reflects the broader theme that while some services are highly visible, others remain less understood, creating opportunities for targeted communication.

Public Health Service Needs

When asked about unmet needs in their communities, stakeholders consistently pointed to behavioral and mental health as the most pressing gap. Nearly all participants emphasized that demand for counseling, crisis response, and long-term support services is outpacing what is currently available. Several noted that youth and school-aged populations are particularly underserved, with schools often struggling to meet student needs on their own. Others mentioned adults and families facing stress, addiction, or limited access to behavioral health providers.

Transportation was also described as a major barrier that compounds other health needs. Stakeholders explained that many residents, especially in rural areas, lack reliable transportation to clinics or must travel long distances to reach services. Some suggested that mobile or satellite options could help bridge this gap, while others recommended expanded partnerships with local transportation providers.

A number of participants also raised the need for stronger health education and outreach in the community. They emphasized that residents often lack clear information about available services, preventive care, and eligibility requirements. In their view, increasing visibility and improving communication could prevent small health issues from becoming larger problems.

As one participant reflected, *"Mental health is the biggest issue we hear about everywhere, and right now, the resources just aren't enough."* This sentiment captured the consensus that while multiple health needs exist, behavioral health is at the forefront of community concern.

Other needs that surfaced included oral health services for children, more accessible immunization clinics, and expanded support for vulnerable populations such as seniors and migrant workers. Several stakeholders noted that while hospitals and private providers play important roles, there are gaps they cannot fill, which they see as opportunities for SWDH to step in or coordinate solutions.

Geographic Access & Inconveniences

Stakeholders consistently described geography as one of the greatest challenges for residents seeking services from Southwest District Health. The District's large, multi-county footprint means that many rural communities are located far from clinic sites, requiring long travel times that can deter people from seeking care. Several participants noted that while Caldwell is relatively accessible to more urban populations, residents in outlying areas face a very different experience, with fewer nearby options and longer commutes.

Transportation was closely tied to this issue. Stakeholders explained that many residents, particularly low-income families, seniors, and those in rural areas, lack reliable transportation to reach appointments. In some cases, people must rely on friends, family, or county transportation services,

which are not always available when needed. These barriers were seen as limiting not only preventive care, such as immunizations or screenings, but also timely response to urgent health needs.

Participants suggested several potential solutions. Some recommended expanding the use of mobile or satellite clinics to bring services closer to rural communities. Others emphasized the importance of adjusting clinic hours to better accommodate people who cannot travel during the workday. A few suggested that SWDH could strengthen partnerships with local transportation providers or advocate for broader transit solutions that connect rural communities with health services.

One stakeholder summarized the challenge by saying, *"If you live in Caldwell, it's easy. But if you're in a small town miles away, you may not even try to make the trip."* This is indicative of a broader theme that while services exist, physical access to them is uneven across the District, and solutions will need to address both distance and transportation barriers.

Facilities & Locations

When discussing SWDH facilities, external stakeholders focused on accessibility, convenience, and the adequacy of buildings to meet community needs. The Caldwell office was frequently described as central and relatively well equipped, though several participants noted that even this site will need to grow and modernize to keep pace with rising demand.

By contrast, facilities in smaller towns such as Weiser and Homedale were more often described as outdated. Stakeholders pointed to limited space, lack of privacy, and older layouts that do not reflect the way health services are delivered today. Payette was also mentioned, though here the concern centered more on convenience and parking rather than the interior condition of the facility itself.

As one stakeholder explained, *"The services are good, but the buildings don't always keep up, especially in the smaller towns."* This reflects the broader theme that while SWDH's programs and staff are valued, facilities are uneven, and investments will be needed to modernize sites across the District.

Despite these challenges, participants consistently emphasized the value of maintaining multiple sites across the District, saying that this structure allows more residents to access at least some services closer to home. Looking ahead, many suggested that population growth will require SWDH not only to expand capacity at Caldwell but also to reinvest in outer clinics to ensure consistent quality across locations. Ideas included updating aging facilities, ensuring full ADA compliance, and designing more flexible spaces that could adapt to multiple service needs.

District Performance: Strengths & Areas for Improvement

External stakeholders generally described Southwest District Health as a reliable and professional organization. Many highlighted staff responsiveness as one of the District's greatest strengths. They noted that when questions or issues arise, SWDH staff are approachable, knowledgeable, and willing to help. Several participants also emphasized that the District provides a consistent presence across multiple counties, which gives communities confidence that core public health services will be delivered regardless of location.

Partnerships were another area where stakeholders felt SWDH performs well. They cited examples of collaboration in areas such as community health assessments, nutrition and WIC programs, food safety

oversight, and participation in community coalitions. These relationships were seen as essential for connecting public health with schools, hospitals, nonprofits, and local governments.

At the same time, participants identified several areas where performance could be strengthened. Many felt that public awareness of SWDH's role remains too limited, and that residents often only encounter the District through inspections or compliance activities rather than community health programs. Some suggested that greater visibility at community events or stronger outreach through schools and local organizations could help balance this perception.

Facilities and access were also mentioned as areas for improvement. While Caldwell was generally described as adequate, stakeholders stressed that outer locations like Weiser and Emmett need upgrades to create a more consistent experience across the District. Participants also said that transportation barriers must be addressed if services are to be truly accessible for rural residents.

Finally, a few stakeholders noted that SWDH could improve communication with partners by sharing information more proactively and more clearly outlining long-term priorities. As one participant reflected, *"The staff are great to work with, but the public doesn't always know what the District does. More visibility would help."*

Overall, external stakeholders conveyed strong confidence in the dedication and professionalism of SWDH staff, while also pointing to opportunities to expand visibility, modernize facilities, and strengthen community connections.

Communication Preferences

When asked how they prefer to receive information from Southwest District Health, stakeholders offered a range of responses that reflected both organizational and community-level needs. Many emphasized the importance of direct, clear communication from the District to partner agencies. Email was the most frequently mentioned tool, with participants noting that it allows them to quickly share updates across their own teams. Some also described conference calls, newsletters, or regular check-ins as useful for keeping relationships active.

At the community level, participants highlighted the need for broader and more accessible outreach. Several observed that residents often rely on social media for updates and suggested that SWDH strengthen its presence on platforms, such as Facebook. Others recommended more consistent use of local newspapers, radio, and community events to ensure that people without regular internet access are also reached.

A recurring theme was the need for consistent, proactive communication. While stakeholders generally described SWDH as responsive when contacted, some said that updates can feel irregular, leaving them unsure about current programs or priorities. A few suggested that a standardized communication calendar, such as quarterly updates or recurring community briefings, could help keep partners and residents better informed.

Several participants also recommended tailoring messages to highlight services in everyday terms. They explained that the public may not always recognize technical program names but respond more readily when services are described through practical examples, such as food safety, child health, or emergency readiness.

As one stakeholder put it, *"When we hear from the District, it's helpful, but sometimes we go too long without an update. More consistency would make it easier for us to stay connected."*

Fiscal Responsibility

External stakeholders generally described Southwest District Health as fiscally responsible. Many said they believed the District manages its resources carefully and avoids unnecessary spending, which helped build confidence in its stewardship of public funds. Several participants mentioned that, compared to other agencies, SWDH is viewed as operating within its means while still maintaining essential services.

At the same time, a few stakeholders admitted they were not familiar with the details of SWDH's budget or financial processes, which made it difficult for them to assess how funds are prioritized. This lack of visibility led some to suggest that the District could strengthen trust by more clearly communicating its long-term financial planning and explaining how investments are tied to service needs.

A number of participants linked fiscal responsibility to facilities and infrastructure. They noted that while SWDH appears to be careful with taxpayer dollars, visible investment in updating and expanding facilities will be necessary as the region grows. In their view, explaining the connection between budgets, facilities, and community health outcomes would help residents better understand why new resources may be required.

One stakeholder summarized this perspective by saying, *"I think they're good with money, but it's not always clear what the priorities are. People want to know how decisions get made."*

Budget Priorities (Next 20 Years)

When asked about long-term budget priorities, stakeholders emphasized the importance of investing in facilities and infrastructure to keep pace with population growth. Many observed that while services are valued, the buildings that house them must be modern, accessible, and flexible enough to adapt to changing needs. Several participants pointed specifically to the need for updating or expanding outer clinics so that residents in rural areas have access to facilities comparable to those in more central locations.

Behavioral and mental health was also highlighted as a priority area for future funding. Stakeholders consistently described the lack of behavioral health resources as one of the greatest community needs and stressed that sustained financial investment will be required to build capacity in this area. Some suggested that long-term planning could include partnerships with schools, health systems, or nonprofits to leverage resources and broaden impact.

As one participant noted, *"Facilities and mental health are where the dollars will need to go. If the District doesn't keep up in those areas, the gaps will just get bigger."*

In addition, participants noted the importance of preparing for emerging public health challenges. They recommended that SWDH budget for flexible spaces and technology that could support telehealth, mobile services, or rapid response during emergencies. A few stakeholders also mentioned the need to strengthen communication and outreach efforts, explaining that ongoing investment in public education and awareness campaigns will be critical for ensuring services are fully utilized.

Anticipated Growth Needs (Organization/Community)

Stakeholders consistently emphasized that rapid population growth across the region will put increasing pressure on Southwest District Health in the years ahead. Many pointed to the steady pace of residential development in both urban centers and rural towns, noting that more people will translate directly into higher demand for clinical services, inspections, and public health programs. Several participants expressed concern that the District's current staffing and facilities may not be sufficient to keep up if growth continues at its current pace.

Behavioral and mental health once again surfaced as a central theme. Stakeholders warned that as the population expands, unmet needs in this area will only become more visible and more urgent. Some stressed the importance of planning now for services that can support both youth and adult populations, including crisis response, school-based programs, and long-term counseling resources.

Participants also mentioned the need to anticipate infrastructure demands tied to growth. For example, more housing developments will increase the need for environmental health services such as septic approvals and water safety oversight. At the same time, stakeholders said SWDH should consider how to expand preventive programs, such as immunizations, health education, and maternal-child health services, to reach larger populations without creating bottlenecks.

As one stakeholder put it, *"The growth isn't slowing down, so services have to grow with it. Otherwise, the District will always be trying to catch up."*

Technology was another area of emphasis. Several participants suggested that telehealth, mobile clinics, or virtual education platforms could help address gaps in access, especially in rural areas where growth may not bring new facilities right away. Others recommended that SWDH plan for flexible spaces that can adapt as needs shift over the next two decades.

Future Services & Facilities (20-Year Perspective)

Looking further ahead, stakeholders described a clear expectation that Southwest District Health will need to expand both the scope and the physical footprint of its services to keep pace with population growth. Many said the District should anticipate not only larger numbers of clients but also a wider variety of health needs, requiring facilities that are more modern, adaptable, and strategically located.

Several participants pointed out that existing outer clinics, particularly in rural towns, will require significant reinvestment if they are to remain viable over the next two decades. They emphasized that without upgrades, these facilities may not be able to accommodate the demand generated by expanding populations. Others suggested that SWDH should explore new facility models, such as multipurpose spaces that can flex between clinical services, education, and community engagement.

Stakeholders also highlighted the need for facilities that integrate technology and support telehealth. They noted that many residents will continue to face transportation barriers, and virtual options could help extend the District's reach without requiring every client to travel long distances. In addition, several participants encouraged SWDH to consider incorporating community meeting areas into future facilities, both to increase visibility and to create spaces where the District can connect directly with residents.

While most agreed that Caldwell will remain a central hub, there was also strong interest in ensuring that rural communities are not left behind. As one participant observed, *"If growth only means bigger buildings in Caldwell, the outlying towns will still struggle."* This reflects a shared concern that investments in future facilities should be distributed across the District to ensure ease of access.

Role of Virtual Services

Stakeholders frequently highlighted virtual services as a key part of the District's future. Many saw telehealth and digital platforms as essential tools for overcoming transportation barriers, particularly for residents in rural areas who may not be able to regularly travel to Caldwell or other central locations. They emphasized that virtual care could extend access to counseling, health education, and even some clinical consultations, helping to reduce gaps where physical facilities are limited.

Several participants also noted that the pandemic expanded public comfort with telehealth, making it a more viable option today than in the past. They described it as an area where SWDH could continue building capacity, particularly in behavioral health and preventive services. A few suggested that virtual programs could also support training for community partners and outreach to schools, broadening the District's influence without requiring additional physical sites.

At the same time, stakeholders acknowledged the limitations of virtual services. They pointed out that broadband access remains inconsistent in parts of the District, which can make telehealth difficult for some households. Others emphasized that not all services can be delivered effectively online, and that virtual options should supplement, rather than replace, in-person care.

Additional Observations

In addition to the structured questions, stakeholders shared a variety of observations about how Southwest District Health could strengthen its role in the community. A recurring theme was the importance of visibility. Several participants noted that many residents do not fully understand what SWDH does and suggested that the District look for ways to be more present at community events, in schools, and through partnerships with local organizations. They emphasized that greater visibility could help counter misconceptions that services are limited to specific populations.

Some stakeholders also raised the topic of partnerships with the private sector. They pointed out that as hospitals, clinics, and nonprofits expand their own services, there are opportunities for SWDH to position itself as a convener or coordinator, ensuring that public health gaps are not overlooked. One participant suggested that the District could host roundtables with healthcare providers and community organizations to identify duplication and opportunities for collaboration.

A few participants also encouraged SWDH to think creatively about facility use. Ideas included offering community meeting rooms, expanding educational programming, or developing flexible spaces that could host pop-up clinics or serve as hubs for local partnerships. These suggestions were framed as ways to make facilities more welcoming and more directly connected to the communities they serve.

Finally, some stakeholders noted that communication about emergency preparedness could be strengthened. While they acknowledged SWDH's role in this area, they felt that clearer, more proactive outreach could help residents understand how the District contributes to planning and response.

Taken together, these additional observations reinforced many of the themes already raised in the interviews: the need for visibility, stronger partnerships, modernized facilities, and effective communication. They also pointed to opportunities for SWDH to build new connections and demonstrate its value in ways that go beyond compliance and regulatory functions.

Expectations of Public Health Services

Stakeholders often framed their expectations of Southwest District Health in terms of both access and breadth of services. Many said they see the District as a core provider of preventive and public health programs, and they expect it to ensure that all residents, regardless of income, location, or insurance status, have access to essential services.

Behavioral and mental health once again surfaced as the clearest expectation. Participants repeatedly emphasized that the community looks to SWDH to play a role in filling gaps left by private providers, particularly for counseling, crisis response, and youth-focused services. They acknowledged that hospitals and clinics offer some support but stressed that demand far exceeds supply, and they see public health as having a responsibility to help meet that need.

Participants also expressed expectations around public education. Several said they view SWDH as the entity responsible for providing clear, accurate information on health topics ranging from immunizations to nutrition to environmental health. They stressed that the District should be a trusted source for reliable information, especially at a time when misinformation can spread quickly.

Other expectations included ensuring equitable service across the District's geography, supporting vulnerable populations such as seniors and migrant workers, and preparing for emerging health issues like substance use or new disease outbreaks. Some participants linked these expectations to facilities, noting that residents expect clean, modern, and welcoming spaces that reflect the importance of the services being provided.

As one stakeholder explained, *"People expect public health to be there when no one else is, especially in the gaps that the private sector doesn't fill."* This sentiment reflected the broader theme that while SWDH is already valued, the community expects it to be both a safety net and a leader in advancing public health.

Potential Duplication with the Private Sector

When asked whether Southwest District Health's services duplicate those offered by private providers, most stakeholders said they did not view duplication as a major concern. Instead, they emphasized that SWDH often plays a complementary role, filling gaps that the private sector either cannot or does not address. For example, public health programs like WIC, immunizations for uninsured populations, and environmental health oversight were consistently described as areas where the District provides unique value.

A few participants acknowledged that there may be some overlap in limited areas, such as preventive screenings or health education, where both SWDH and healthcare providers are engaged. However, these stakeholders generally felt that duplication was not problematic when the need in the community is so great. They explained that in many cases, the private sector cannot fully meet demand, and having multiple avenues for residents to access care only increases the likelihood that needs will be met.

Several participants suggested that where potential overlap does occur, SWDH could strengthen its role as a coordinator. They said the District is well positioned to bring partners together, identify gaps, and help ensure that resources are used efficiently. One stakeholder explained, *"Even if there's some overlap, it's better than a gap. The District can help make sure services aren't missed just because providers aren't talking to each other."*

Overall, stakeholders saw SWDH as an essential partner to the private sector rather than a competitor, with its greatest value lying in its ability to reach underserved populations and provide services that are not financially sustainable for private organizations.

Opportunities for Innovation

Stakeholders expressed interest in seeing Southwest District Health pursue new and innovative approaches to reach residents more effectively. A recurring theme was the use of mobile and pop-up clinics. Several participants suggested that temporary or traveling service sites could help bring immunizations, health screenings, or educational programs directly into rural communities where distance and transportation barriers limit access.

Technology was also highlighted as an area for innovation. Stakeholders noted that the pandemic accelerated adoption of telehealth and virtual platforms, and they encouraged SWDH to expand digital offerings for behavioral health counseling, health education, and even some preventive services. Some also suggested exploring virtual training for community partners, which could extend the District's reach without requiring additional physical infrastructure.

As one stakeholder commented, *"It doesn't always have to be a new building. Sometimes it's about meeting people where they are or trying new ways of using what you already have."*

Facility design was another area where participants encouraged innovation. They proposed creating flexible, multipurpose spaces within clinics that could host community meetings, provide space for partner organizations, or accommodate a variety of service needs. These kinds of shared spaces were seen as ways to both increase visibility and foster collaboration.

A number of stakeholders also encouraged SWDH to explore stronger community partnerships as part of an innovative approach. They suggested more formal collaboration with schools, nonprofits, and local employers to address social determinants of health, expand education efforts, and connect residents to preventive care before problems escalate.

Additional Questions Suggested

At the end of the interviews, some stakeholders reflected on what they wished had been asked or discussed in greater depth. A few suggested that future conversations should include more attention to youth health and wellness, noting that schools are seeing increasing needs around mental health, nutrition, and preventive care, and that it would be valuable to understand expectations of public health in this space more directly.

Others recommended asking more about workforce and staffing, both within SWDH and across the healthcare sector. They observed that staffing shortages affect the availability of services and partnerships, and they felt this was an important factor to explore more explicitly.

Several participants also suggested that future questions could address emerging health risks. They noted that issues such as substance use, vaping, and the long-term effects of growth on housing and sanitation will shape public health demands over time, and they encouraged SWDH to anticipate these needs.

Finally, a few stakeholders reflected that more emphasis could be placed on communication strategies. They recommended that future interviews probe not only what messages are effective, but also how information could best reach different audiences, including rural residents, seniors, and non-English-speaking communities.

These suggestions underscored the value stakeholders placed on being heard and involved in shaping SWDH's future. They also reflected a desire for the District to continue asking questions that reach beyond current operations to anticipate what communities will need in the years ahead.

Emergent Themes

Beyond the structured interview questions, several themes emerged organically during conversations with external stakeholders.

One of the most consistent was housing and growth pressures. Multiple participants linked population growth not only to healthcare demand but also to broader issues such as housing availability, sanitation, and infrastructure. They noted that rapid development in both urban and rural areas is creating new challenges for environmental health and community well-being, suggesting that SWDH may need to consider these intersections more directly in long-term planning.

Another emergent theme was the importance of addressing health equity. Stakeholders emphasized that certain populations, including migrant workers, low-income families, and seniors, face particular barriers to care. They encouraged SWDH to be mindful of how services are distributed and to ensure that vulnerable groups are not overlooked in planning for facilities, staffing, or outreach.

Community trust and visibility also surfaced as a recurring topic. Some participants explained that residents are more likely to use services when they clearly understand SWDH's role and see the District present in their communities. This theme connected to earlier discussions of communication and outreach but was framed here more broadly as an issue of building lasting trust and recognition.

Finally, several stakeholders raised the idea of regional coordination. They noted that public health challenges often cross county lines and require collaboration with other governmental and nonprofit entities. While SWDH already participates in some regional initiatives, participants encouraged further strengthening these relationships to avoid duplication, pool resources, and present a united front in addressing community health priorities.

These emergent themes suggest that stakeholders see SWDH's role as extending beyond direct service delivery. They envision the District as both a provider and a convener, with responsibilities that include anticipating community change, ensuring equity, and fostering collaboration across systems.

Cross-Cutting Patterns

Several themes cut across multiple sections of the stakeholder interviews, reinforcing their importance to the community's perception of Southwest District Health.

Behavioral and mental health was the most consistent cross-cutting issue. It surfaced when stakeholders were asked about unmet needs, budget priorities, expectations of public health, and anticipated growth. Whether framed in terms of youth support, adult services, or crisis response, nearly all participants emphasized that behavioral health is central to community well-being and requires expanded investment.

Facilities and geography also emerged as overlapping concerns. Stakeholders repeatedly tied service access to the adequacy and condition of SWDH's physical locations, with Caldwell often viewed as relatively strong while outer clinics such as Weiser and Homedale were seen as outdated or less convenient. These facility issues were consistently linked to broader concerns about service accessibility as rural residents were perceived to have fewer options despite facing the same needs.

Awareness and communication appeared in nearly every section of the interviews. Whether discussing familiarity with services, community perceptions, or areas for improvement, stakeholders emphasized that many residents simply do not know what SWDH does. They described communication as inconsistent and underlined the need for more proactive, visible outreach across diverse platforms and communities.

Finally, the importance of partnerships was woven throughout the conversations. Stakeholders described collaboration with schools, hospitals, nonprofits, and local governments as critical to achieving public health goals. They also encouraged innovation in partnerships, including shared spaces, pop-up clinics, and stronger regional coordination, as ways to expand impact without duplicating services.

Taken together, these patterns illustrate that while stakeholders discussed many different aspects of SWDH, the themes of behavioral health, facilities and access, communication, and partnerships form the backbone of their collective feedback.

Areas of Convergence and Divergence

Across the interviews, there was strong convergence around several themes. Stakeholders overwhelmingly agreed that behavioral and mental health is the greatest unmet need in the region. They also consistently emphasized that facilities in smaller towns such as Weiser and Homedale require reinvestment, and that transportation barriers make access to care uneven across the District. Nearly all participants agreed that SWDH staff are professional and responsive, with many describing this as one of the District's greatest strengths.

There was also broad alignment on the issue of community awareness. Stakeholders frequently said that residents are not well informed about what SWDH does, with many assuming the District's role is limited to inspections or compliance. The consensus was that visibility and communication must be improved to ensure services are fully utilized and the District's broader mission is understood.

At the same time, perspectives diverged in a few areas. While most stakeholders described SWDH as fiscally responsible, some admitted they did not have enough visibility into financial priorities to form a clear opinion. There were also differences in how stakeholders perceived SWDH's role in partnerships. Some described the District as collaborative and deeply engaged, while others felt their interactions were limited and more transactional. Similarly, while Caldwell's facility was generally viewed positively, opinions varied on whether it was already strained by growth or still adequate for current needs.

These areas of convergence and divergence suggest that while external stakeholders share a common view of SWDH's importance and professionalism, they differ in the depth of their understanding and experiences. Where alignment was strongest — behavioral health, facilities, communication, and staff — the message was clear and consistent. Where perspectives varied, it often reflected differences in stakeholders' points of contact with the District.

Considerations for Leadership

The interviews with external stakeholders surfaced a number of questions that the Board of Health and leadership may wish to consider as part of future planning. One of the strongest themes was behavioral and mental health, which stakeholders repeatedly described as a pressing gap in the region. This raises the question of what role SWDH should play in expanding behavioral health services, particularly for youth and underserved populations, and how the District might partner with schools, healthcare providers, or nonprofits to build greater capacity in this area.

Facilities and access were also recurring topics of discussion. Stakeholders emphasized that while the Caldwell site is central and relatively strong, outer locations such as Weiser, Homedale, and Payette face challenges related to space, modernization, and accessibility. This prompts reflection on how the District might balance investments between central and rural facilities to ensure equity of access. At the same time, the issue of transportation was described as a barrier for many residents, leading to questions about whether strategies such as mobile clinics, satellite offices, or partnerships with local transit providers could help bridge the gap.

Awareness and communication represented another area of emphasis. Many stakeholders said that residents do not clearly understand the full scope of SWDH's role and suggested that greater visibility is needed. This raises the question of what communication approaches could most effectively build public understanding and how the District might establish more consistent, proactive communication with both partners and the community at large.

Partnerships and innovation also emerged as opportunities. Some stakeholders described SWDH as highly collaborative, while others felt their engagement was more limited. This suggests the value of examining how the District can strengthen or expand partnerships with schools, hospitals, nonprofits, and local governments. Stakeholders also suggested new models such as pop-up clinics, shared spaces, and regional collaborations as ways to extend impact without duplicating services.

Finally, stakeholders generally perceived SWDH as fiscally responsible, but some said they lacked visibility into budget priorities and long-term planning. This points to the question of whether greater transparency could help reinforce public trust. It also highlights the need to weigh trade-offs as the District considers investments in facilities, technology, and service expansion over the next 20 years.

Taken together, these considerations are not recommendations but questions that reflect the themes and divergences voiced by external stakeholders. They offer leadership a set of issues to explore as SWDH prepares for the future.

Conclusion

The external stakeholder interviews offered a candid and thoughtful view of how Southwest District Health is seen across its service area. While participants identified challenges, particularly around

behavioral health, facilities, access, and awareness, they also expressed consistent appreciation for the District's role and the dedication of its staff. What emerged most strongly was a sense that SWDH is an essential institution, one that provides stability and leadership in public health while navigating the complexities of a large and growing region.

The findings in this report do not prescribe solutions but reflect the perspectives of those who engage with SWDH from outside the organization. They are intended to inform ongoing planning, spark dialogue, and guide leadership as it weighs future priorities. In this way, the interviews serve as both affirmation of the District's value and a reminder of the opportunities ahead to strengthen connections and expand impact.



Appendix 11.5
Community Survey Results

SOUTHWEST DISTRICT HEALTH
Facility Survey

Educate, Listen, Learn

Survey Results
April 23 - October 3, 2025

Total Respondents To-Date: 394

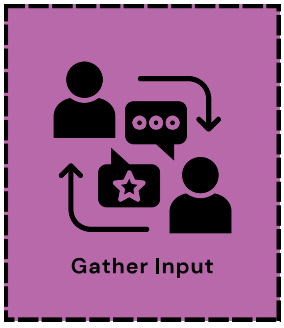
CLEARWATER FINANCIAL

SOUTHWEST DISTRICT HEALTH

Survey Purpose

The Southwest District Health Community Survey was developed to hear from **residents** about their **experiences** and **priorities** related to the **services** and **facilities** of the District. Responses provide valuable insight into **community needs** and highlight **strengths** and **challenges** across District facilities. This input will help **guide planning** for future facilities, **improve service delivery**, and ensure **resources are aligned** with the needs of the communities being served.









Survey Development



Collaborative Planning

- Discussion, planning with District leadership
- Establishment of timeline and key focus areas
- Development of initial questions, feedback & edits, finalization
- Deployment April 2025



Outreach & Participation

- Stakeholder interviews
- Social media outreach and website promotion
- Inclusion in multiple newsletters (e-newsletter, News You Can Use)
- Flyers placed in three (3) outer clinics + main office check-in booths
- Press release

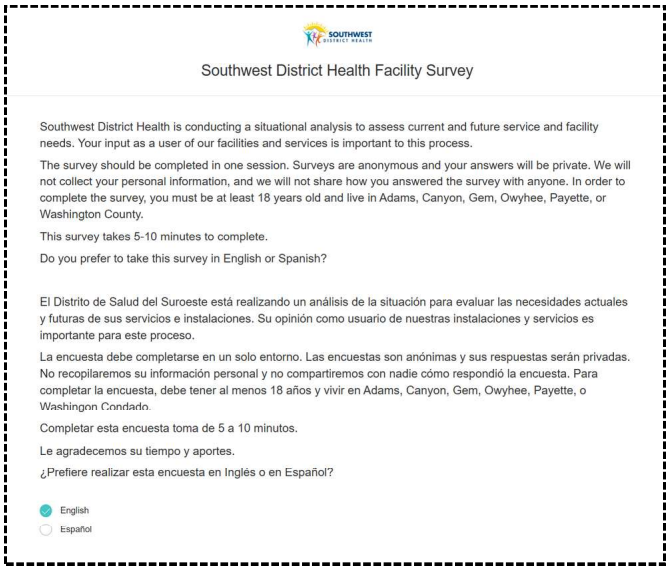


Shaping the Path Forward

- Community input reviewed for patterns, concerns, and priorities
- Results used to inform District planning and next steps

Survey

- Services ✓
- Facilities ✓
- Accessibility ✓
- Challenges ✓
- Parking ✓



Southwest District Health Facility Survey

Southwest District Health is conducting a situational analysis to assess current and future service and facility needs. Your input as a user of our facilities and services is important to this process.

The survey should be completed in one session. Surveys are anonymous and your answers will be private. We will not collect your personal information, and we will not share how you answered the survey with anyone. In order to complete the survey, you must be at least 18 years old and live in Adams, Canyon, Gem, Owyhee, Payette, or Washington County.

This survey takes 5-10 minutes to complete.

Do you prefer to take this survey in English or Spanish?

El Distrito de Salud del Suroeste está realizando un análisis de la situación para evaluar las necesidades actuales y futuras de sus servicios e instalaciones. Su opinión como usuario de nuestras instalaciones y servicios es importante para este proceso.

La encuesta debe completarse en un solo entorno. Las encuestas son anónimas y sus respuestas serán privadas. No recopilaremos su información personal y no compartiremos con nadie cómo respondió la encuesta. Para completar la encuesta, debe tener al menos 18 años y vivir en Adams, Canyon, Gem, Owyhee, Payette, o Washington Condado.

Completar esta encuesta toma de 5 a 10 minutos.

Le agradecemos su tiempo y aportes.

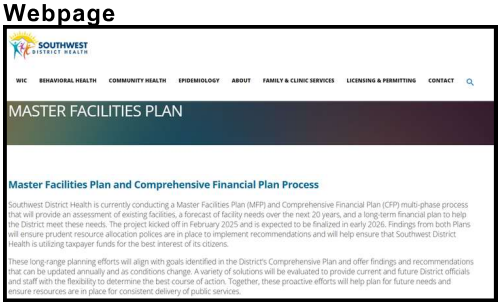
¿Prefiere realizar esta encuesta en Inglés o en Español?

English
Español

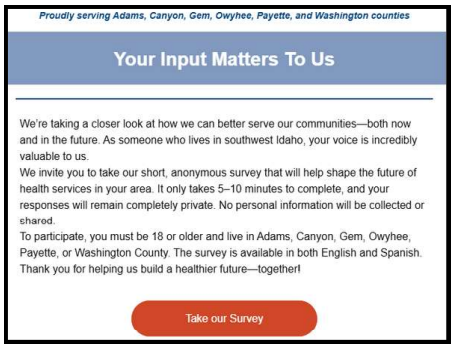
- ✓ Unnecessary Services
- ✓ Missing Services
- ✓ Awareness
- ✓ Communication
- ✓ Demographics

OUTREACH

Webpage



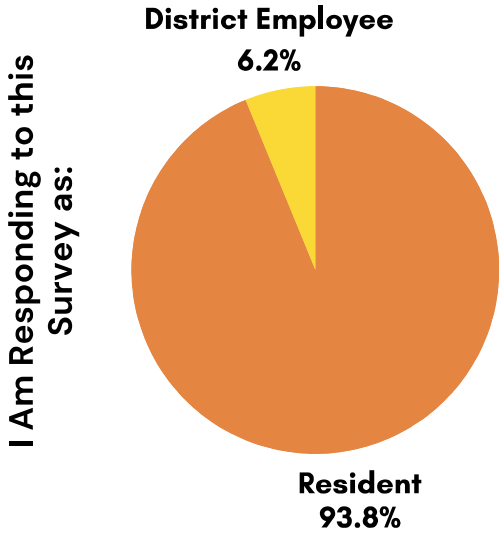
Newsletter



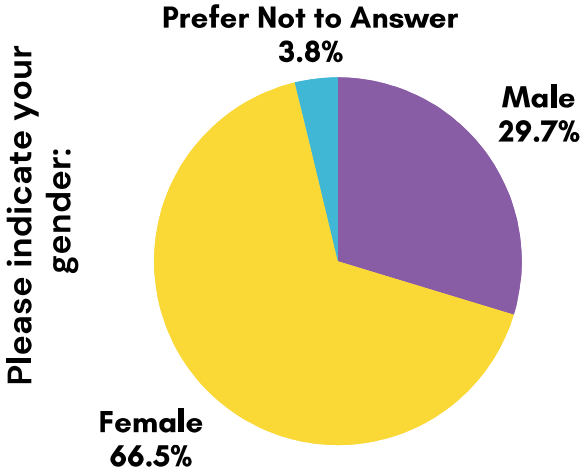
Social Media Posts



Who Took the Survey?

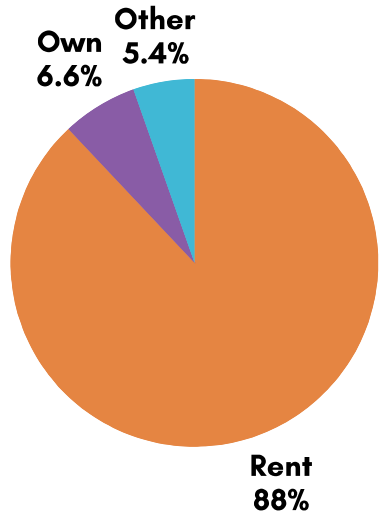


# of Responses: 241

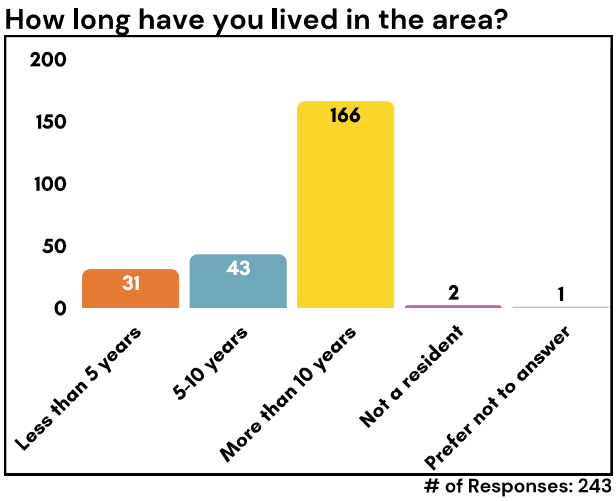


# of Responses: 241

Who Took the Survey?



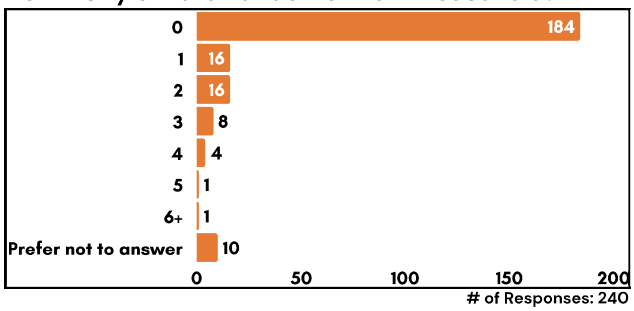
# of Responses: 241



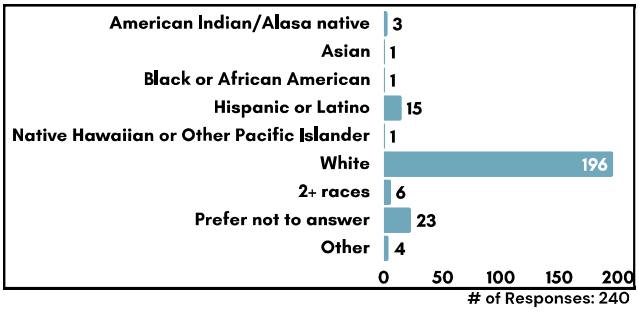
# of Responses: 243

Who Took the Survey?

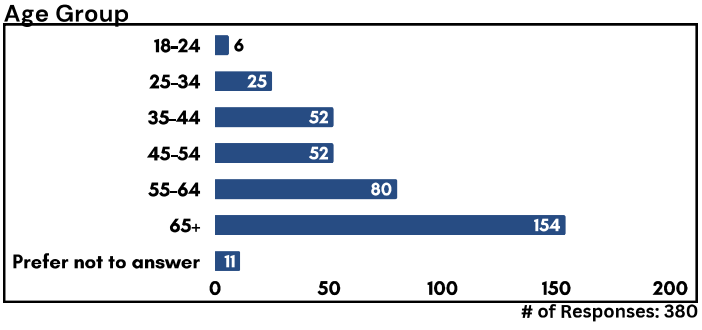
How many children under 18 live in household?



Race

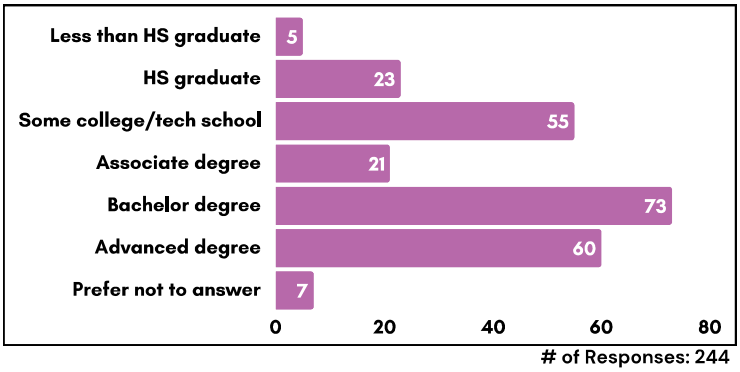


Age Group



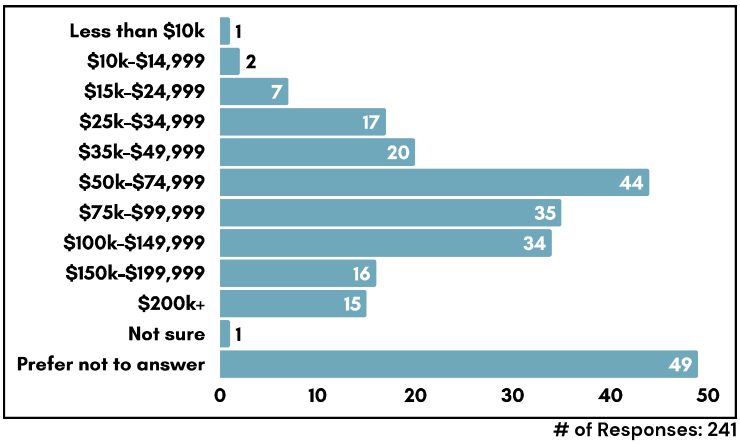
Who Took the Survey?

Education



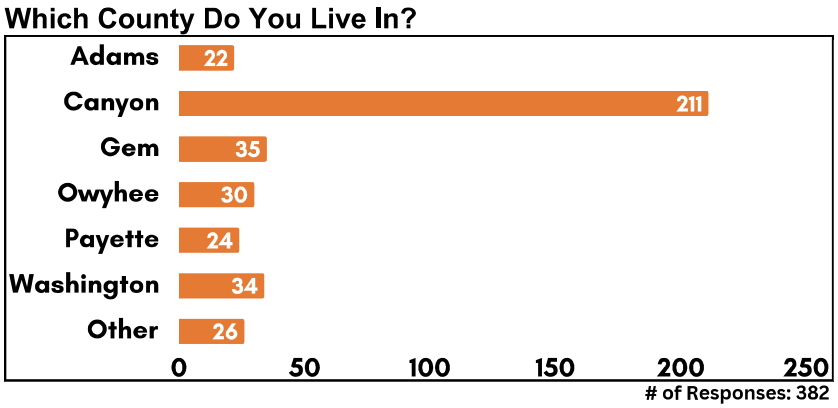
# of Responses: 244

Income



# of Responses: 241

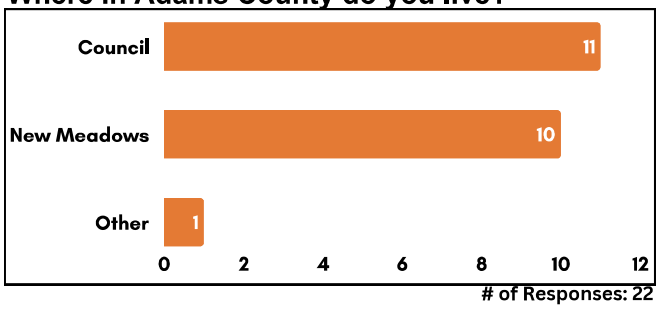
Location



"Other" Counties (26)

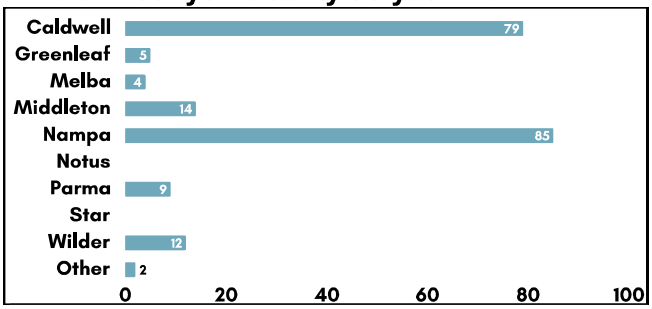
- Ada County: 22
- Elko County, NV: 1
- Idaho County, ID: 1
- Malheur County, OR: 1
- Caldwell: 1

Where in Adams County do you live?



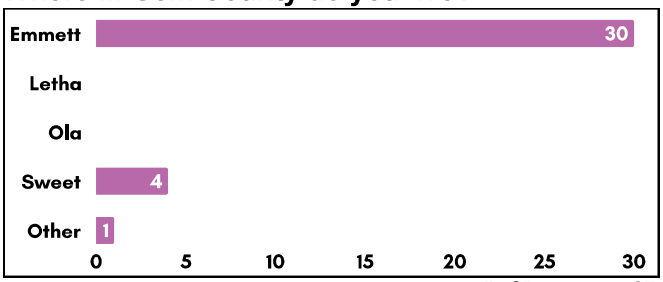
# of Responses: 22

Where in Canyon County do you live?



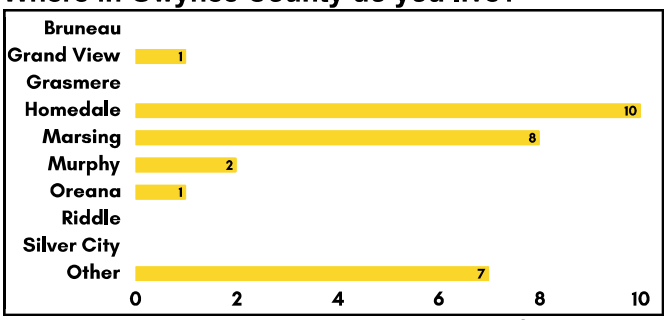
# of Responses: 210

Where in Gem County do you live?



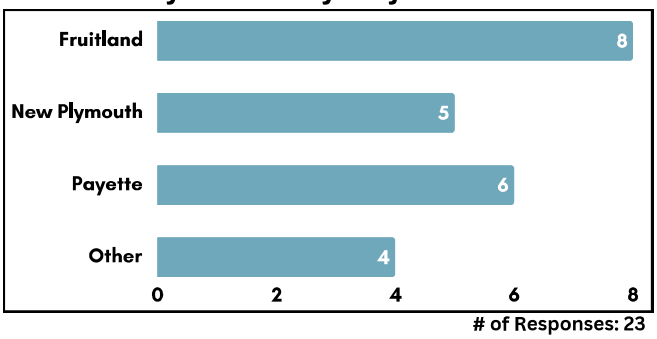
# of Responses: 35

Where in Owyhee County do you live?



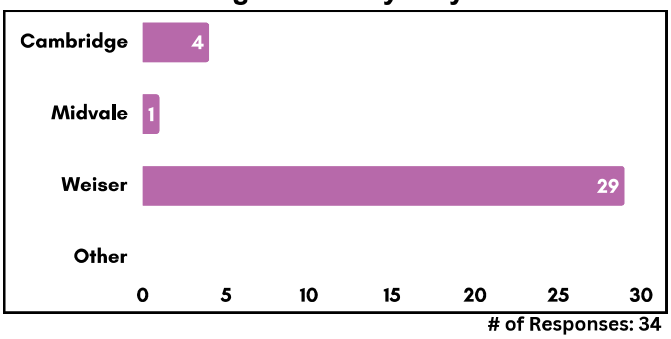
# of Responses: 29

Where in Payette County do you live?



# of Responses: 23

Where in Washington County do you live?



# of Responses: 34

What Is Your Home Zip Code?

# of Responses: 365

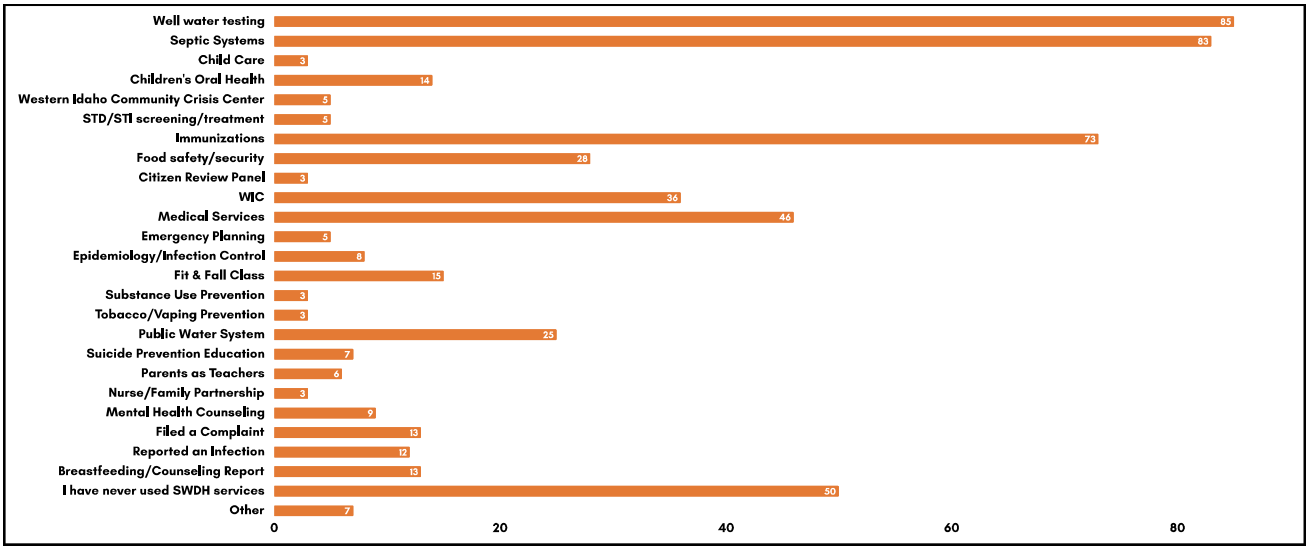
- Over half of all respondents were from **Canyon County** (203).
  - Nampa (79) and Caldwell (78) made up the largest share.
- **Emmett** (30) and **Weiser** (28) provided strong participation from **Gem** and **Washington** counties.
- Other notable counties:
  - **Owyhee** (23)
  - Ada (22)
  - **Adams** (21)
  - **Payette** (15)

- **Smaller** contributions from **Middleton** (12), **Marsing** (11), **Parma** (11), Wilder (11), and **Council** (11).
- **Minimal** out-of-area responses from **Boise**, **Oregon**, **Nevada**, and **Washington State** (<5 combined).

SERVICES

Which SWDH services have you or a member of your household used?

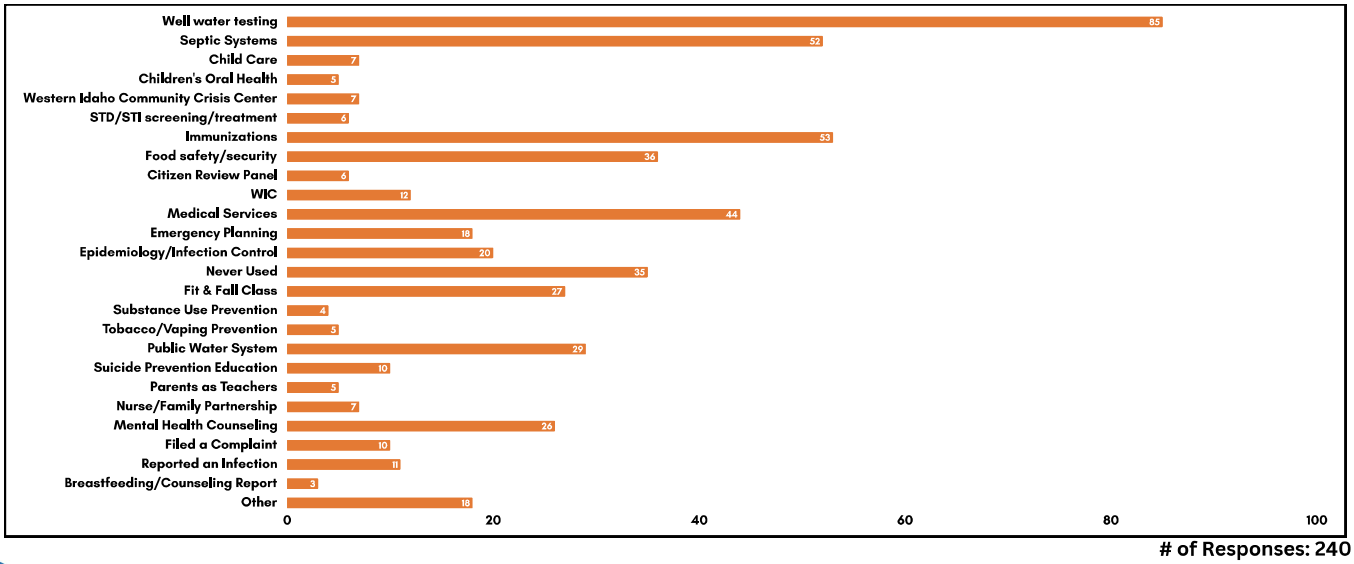
(Select all that apply)



# of Responses: 262

Which of the following services do you or your family need most from SWDH?

(Select up to 3)



# of Responses: 240

“Other” Comments

Which of the following services do you or your family need most from SWDH?

- **None / No unmet needs / Don’t need services – 9 responses**
  - “None” (3)
  - “none” (1)
  - “None at the moment” (1)
  - “I have no unmet needs” (1)
  - “i don't need SWDH services at this time. I volunteer for a non profit which partners with SWDH.” (1)
  - “My family no longer needs services” (1)
  - “My children are grown now so we haven't used any of SWDH services in about 15 years.”
- **Water system concerns – 2 responses**
  - “Homedale water system needs attention” (1)
  - “I benefit from the regulation of restaurants and grocery stores. As well as supervision for the Nampa water supply.” (1)

- **Health information/services – 3 responses**
  - “information about diseases occurring in our community” (1)
  - “Husband has bvFTD. Would help if nursing staff came back to assess changes to assist me. I am his 24/7 caregiver.” (1)
  - “Senior resources” (1)
- **Permits / regulation – 1 response**
  - “temporary food permit”
- **Not specified – 2 responses**
  - “Not specified” (2)
- **Community commentary – 1 response**
  - “My family need all the greedy moving to id. To go home.”

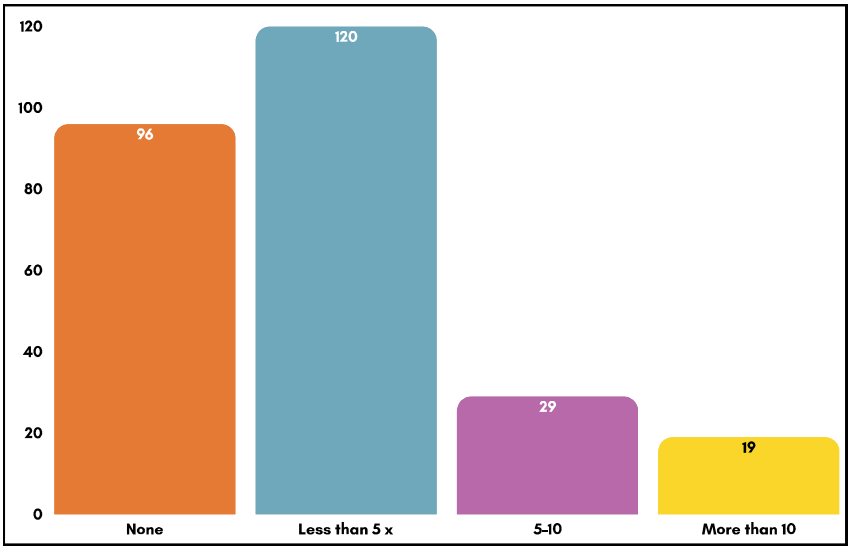
Which SWDH services have you or a member of your household **used**? (Select all that apply)

- **Most frequently used**:
  - Well water testing (32%),
  - Septic systems (32%),
  - Immunizations (28%), and
  - Medical services (18%)
- **Other notable use**
  - WIC (14%),
  - Food safety/security (11%), Children's oral health (5%), and
  - Fit and Fall Proof (6%)
- **~19%** reported **never using** SWDH services

Which of the following services do you or your family **need most** from SWDH? (Select up to 3)

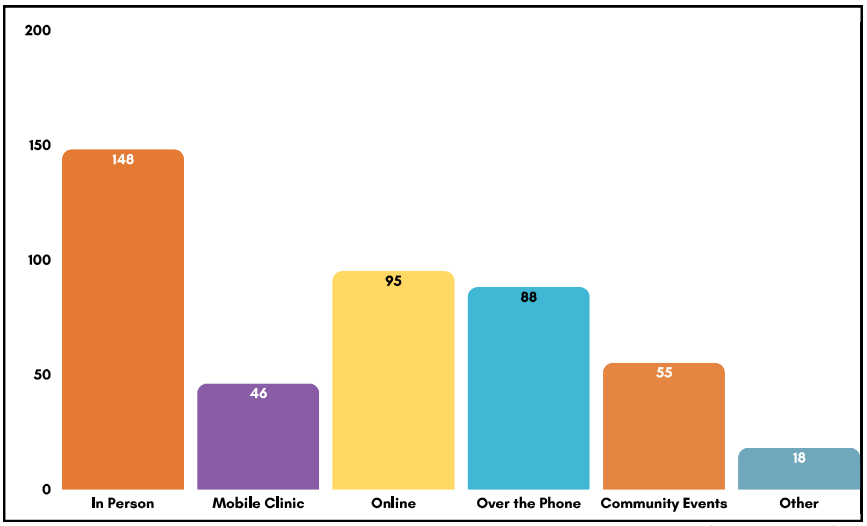
- **Top needs:**
  - Well water testing (35%),
  - Immunizations (22%),
  - Septic systems (22%), and
  - Medical services (18%)
- **Other priorities**:
  - Food safety/security (15%),
  - Mental health counseling (11%), and
  - Fit and Fall Proof classes (11%)
- **~15%** indicated they **don't need** SWDH services

In the past 5 years, how often has your family used SWDH services?



# of Responses: 264

How would you prefer to access SWDH services?
(Select all that apply)



# of Responses: 254

"Other" (18)

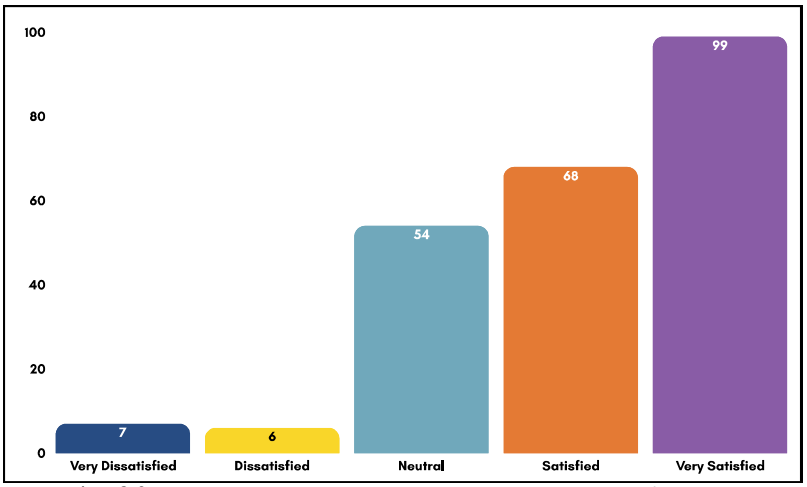
- Mail / Email / Internet (5)
- All of the above (3)
- Unspecified/blank (2)
- Unaware of services (1)
- In-home visit (1)

- "I would really like if they came to Adams County Health Center more for WIC etc."
- "Since the septic tank is the only thing that is covered by your services that we use, rather not have to talk to you at all."
- "Would prefer not to."
- "Defund. No need. DEQ or Health and Welfare should administer relevant programs."

**Does not reflect all comments*

How satisfied are you with the quality of services you have received from SWDH?

(0: Very Dissatisfied; 1: Dissatisfied; 2: Neutral; 3: Satisfied; 4: Very Satisfied.)



Avg. Rating: 3.05 # of Responses: 234

Please share more details about why you are satisfied with the services.
# of Responses: 74

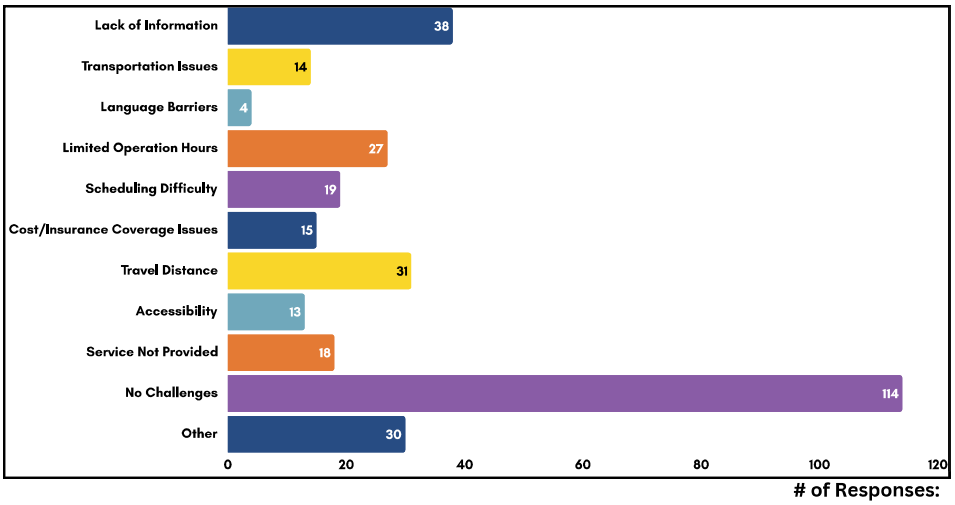
- Staff **helpfulness** and **professionalism** frequently cited.
- **Positive outcomes** and **peace of mind** from services like **water testing**, **immunizations**, and **WIC**.
- **Accessibility** of **information** and **resources** are a benefit

Please share more details about why you are dissatisfied with the services.
# of Responses: 10

- Only a **small set of comments** (10 responses).
- **Concerns** included: **limited hours**, **scheduling challenges**, and **service availability gaps**.
- **Distance** or **travel** difficulty as a barrier

What challenges have you faced when trying to access SWDH services?

(Select all that apply)

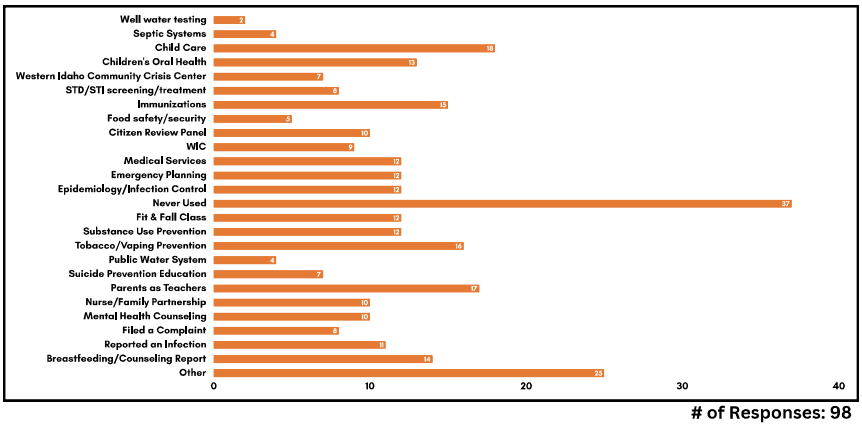


# of Responses: 233

- **No challenge/Not used –** 9
- **Access & communication issues –** 8
- **Service gaps & location barriers** – 3
- **Policy/program critiques** – 7
- **Total:**
  - 27 unique comments (some respondents selected “Other” but wrote “None/Not specified,” which inflates the 30 total).

Are there any SWDH services you believe are no longer needed in your community?

(Select all that apply)



# of Responses: 98

Top Service Responses

- Never Used – 37
- Other – 25
- Child Care – 18
- Parents as Teachers – 17
- Tobacco/Vaping Prevention – 16

"Other Comments"

- **Neutral / Uncertain Responses** (8 total)
- **All Services Are Needed** (7 total)
- **Service-Specific Mentions** (3 total)
  - WIC is the only thing I know of being utilized in my community. (1)
  - Water system in Homedale needs immediate attention (1)
  - Mosquito abatement (2 mentions, counts as 2)
- **Conditional Comments** (2 total)
- **Negative Comments** (2 total)

**All comments not displayed. Source list shows 25; some are duplicates.*

Please share more details about why you think these services are no longer needed.

# of Responses: 51

- **Mixed feedback**: some pointed to **low usage** or **duplication** with other providers.
- Services mentioned most often:
  - **Childcare** (18%),
  - **Children's oral health** (13%),
  - **Immunizations** (15%),
  - **Parents as Teachers** (17%), and
  - **Tobacco/vaping prevention** (16%)
- **37%** selected "I have never used SWDH services", suggesting **unfamiliarity** with service provision.

Are there specific health services you feel are missing in your community that SWDH should consider providing?

# of Responses: 65

Preventive/affordable care – interest in **screenings**, **wellness**, and services at **lower cost.**

Youth-focused programs – suggestions included **teen mental health**, **prevention** services, and **family support** programs.

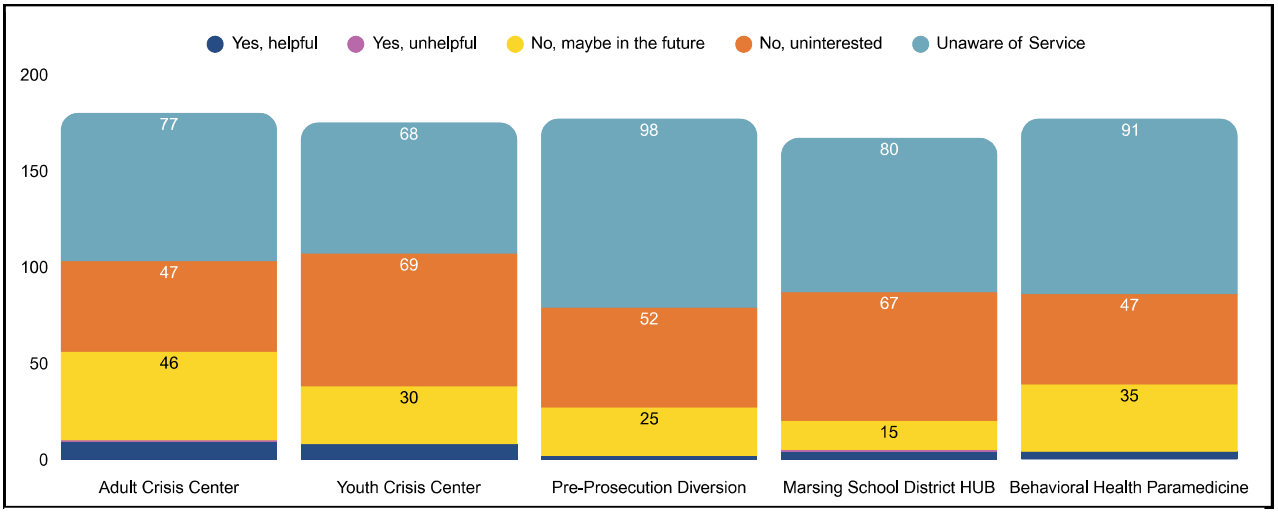
Mobile and telehealth services – requested to address barriers related to **travel**, **scheduling**, and **distance**.

Mental health services – frequent mentions of counseling, crisis intervention, and expanded behavioral health support.

Access to urgent/primary care – requests for **more medical providers** in **rural areas**, including same-day or walk-in care.

Dental care – noted as an **unmet need,** particularly **affordable options** for **families** and **children.**

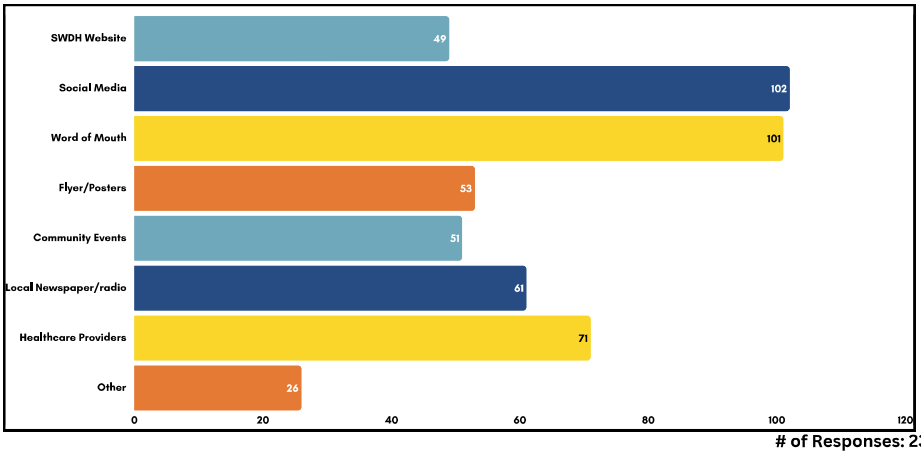
The District also supports services that are not directly provided by the District. Have you or someone in your household used any of the following services, which are supported by the District but not directly provided? If so, how would you rate your experience?



# of Responses: 188

How do you usually find out about health services in your community?

(Select all that apply)



# of Responses: 234

Other

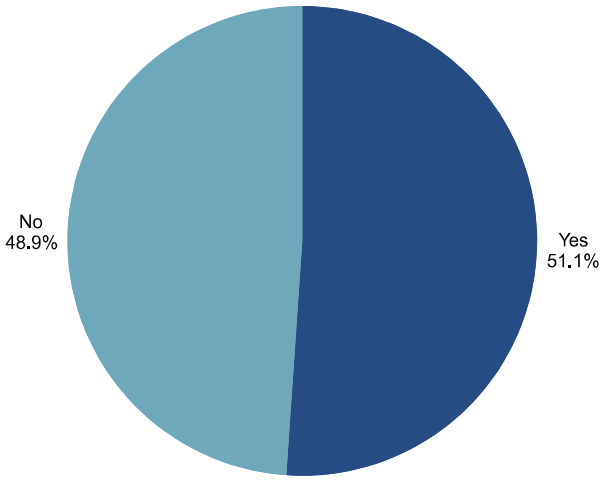
- Search engines / online lookups – 6
- Email / direct communication – 5
- Traditional / local media – 4
- Community / local institutions – 3
- Miscellaneous unique items – 3
- Word of mouth / networks – 2
- Social media comments – 2
- Not specified – 2

Main Office

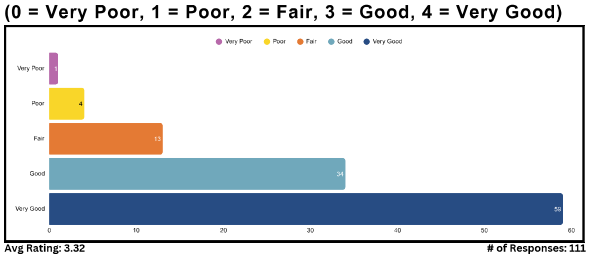
Have you visited the SWDH Main Office?

(13307 Miami Ln, Caldwell, ID 83607)

# of Responses: 251

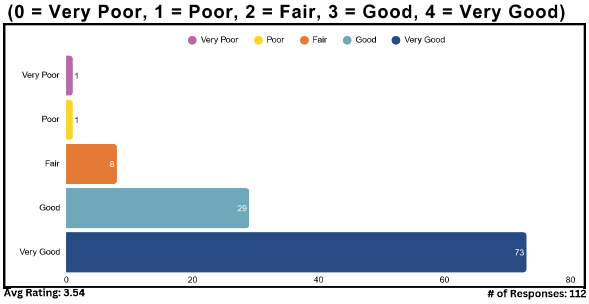


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



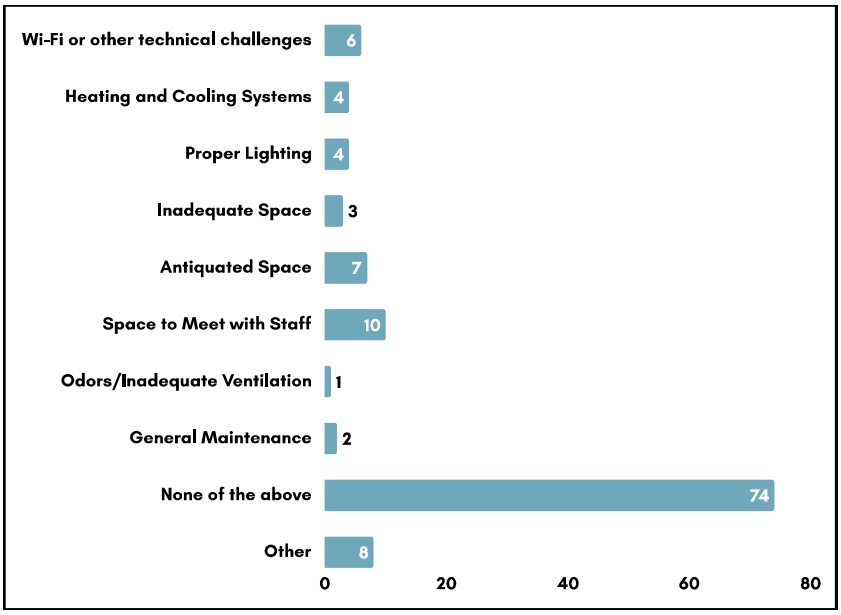
Avg Rating: 3.32 # of Responses: 111

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.54 # of Responses: 112

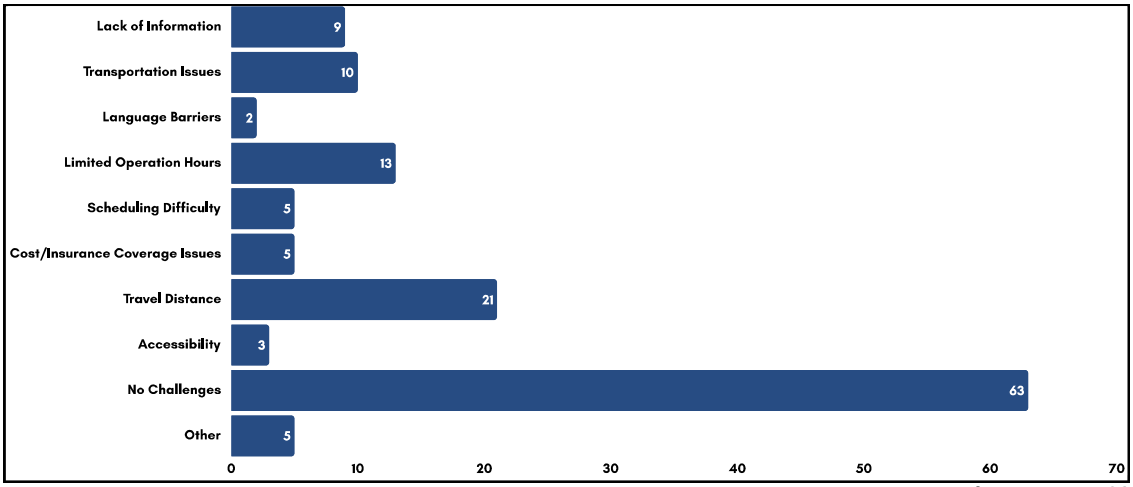
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 98

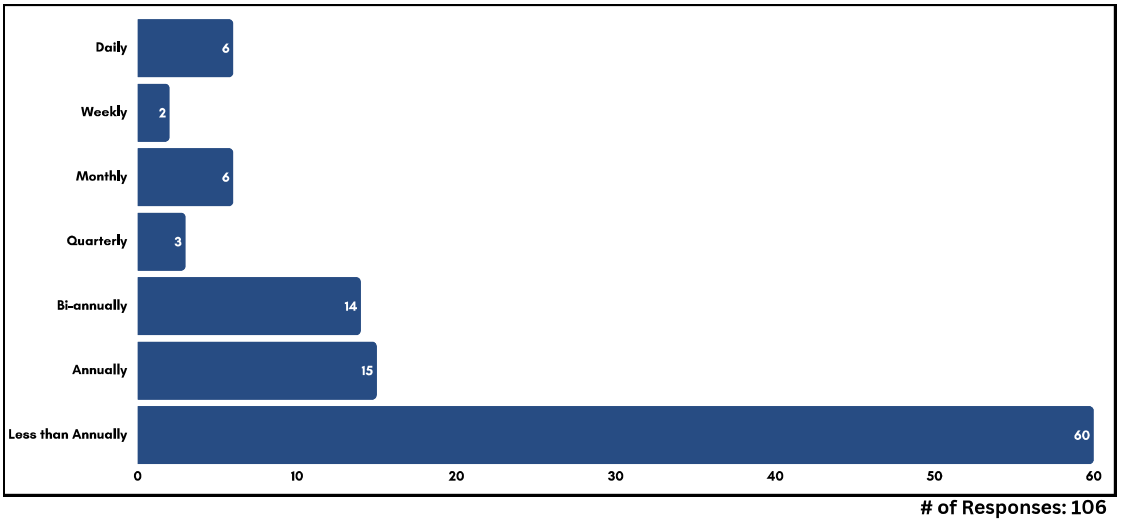
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 102

Approximately how often do you or members of your household visit this facility?



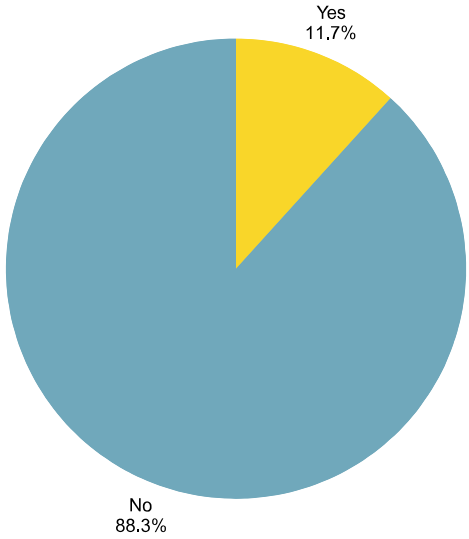
# of Responses: 106

Emmett Satellite Office

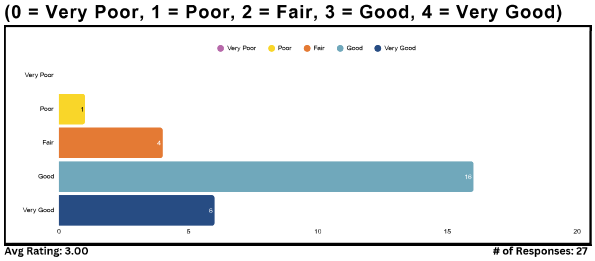
Have you visited the Emmett Office?

(1008 E Locust St. Emmett, ID 83617)

# of Responses: 239

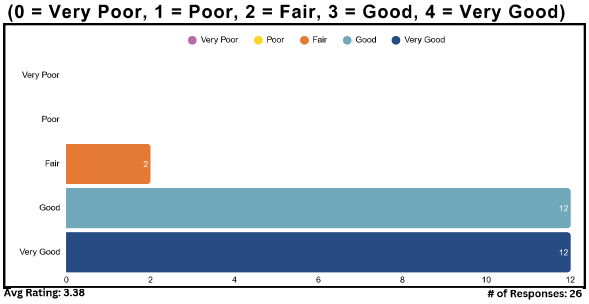


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



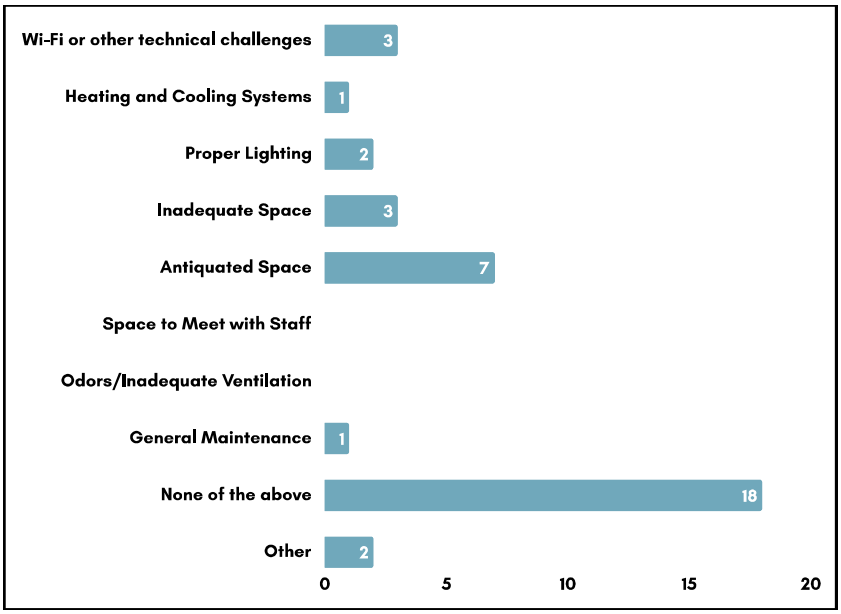
Avg Rating: 3.00 # of Responses: 27

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.38 # of Responses: 26

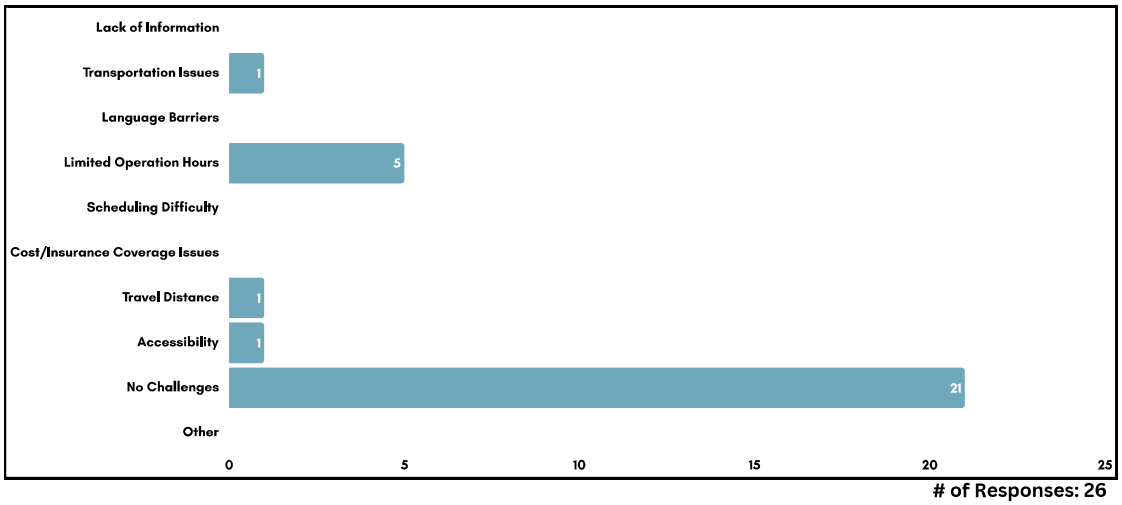
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 27

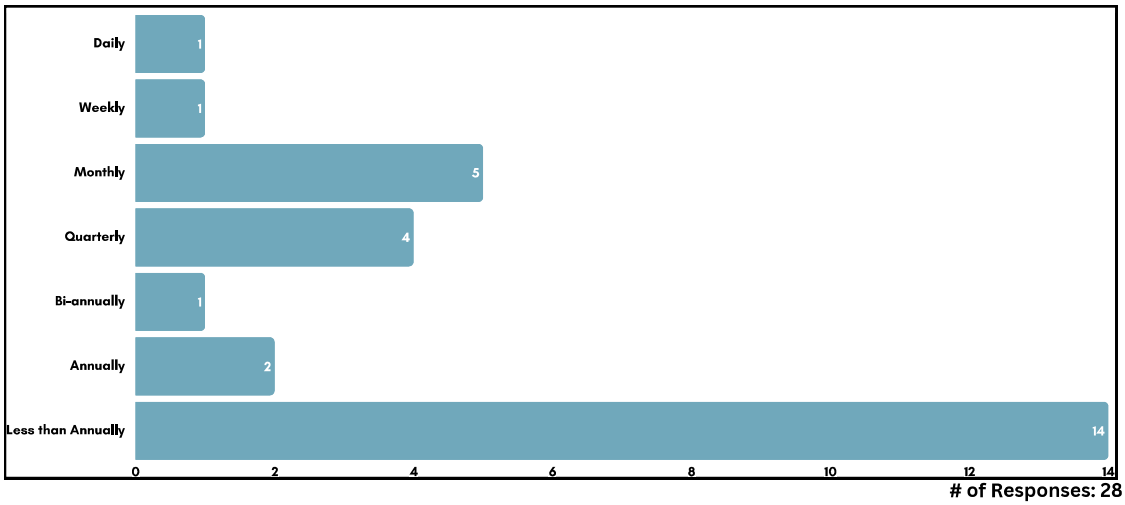
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 26

Approximately how often do you or members of your household visit this facility?



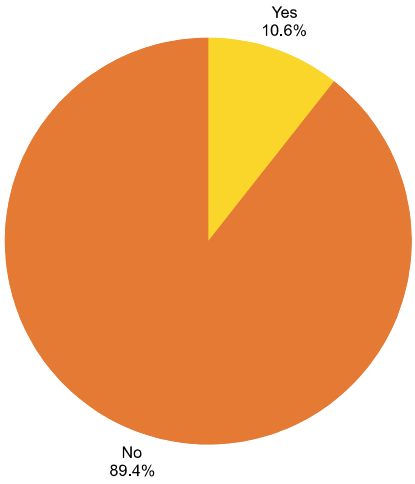
# of Responses: 28

Payette Satellite Office

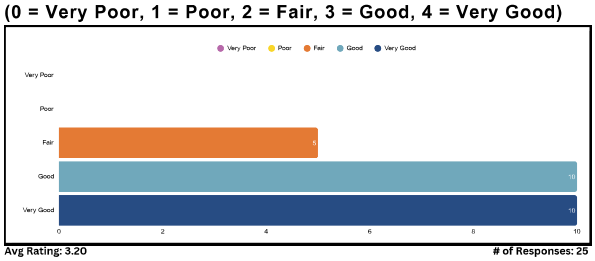
Have you visited the Payette Office?

(1155 3rd Ave N. Payette, ID 83661)

# of Responses: 237

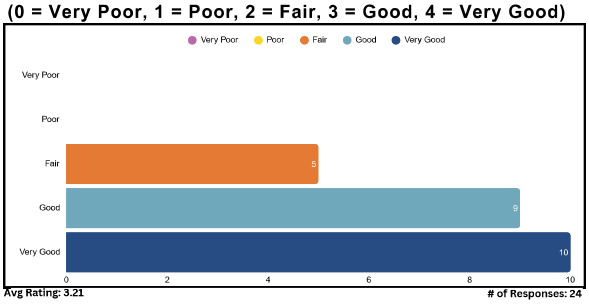


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



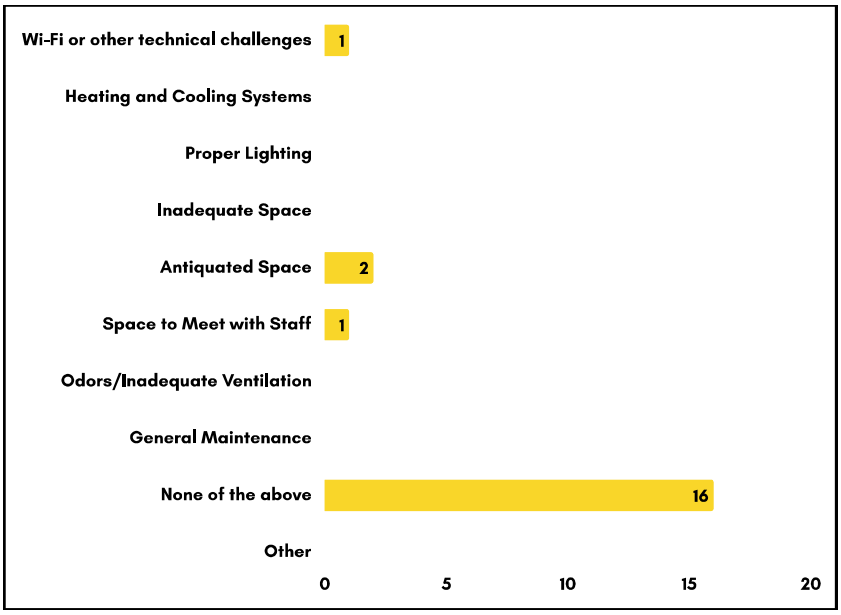
Avg Rating: 3.20 # of Responses: 25

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.21 # of Responses: 24

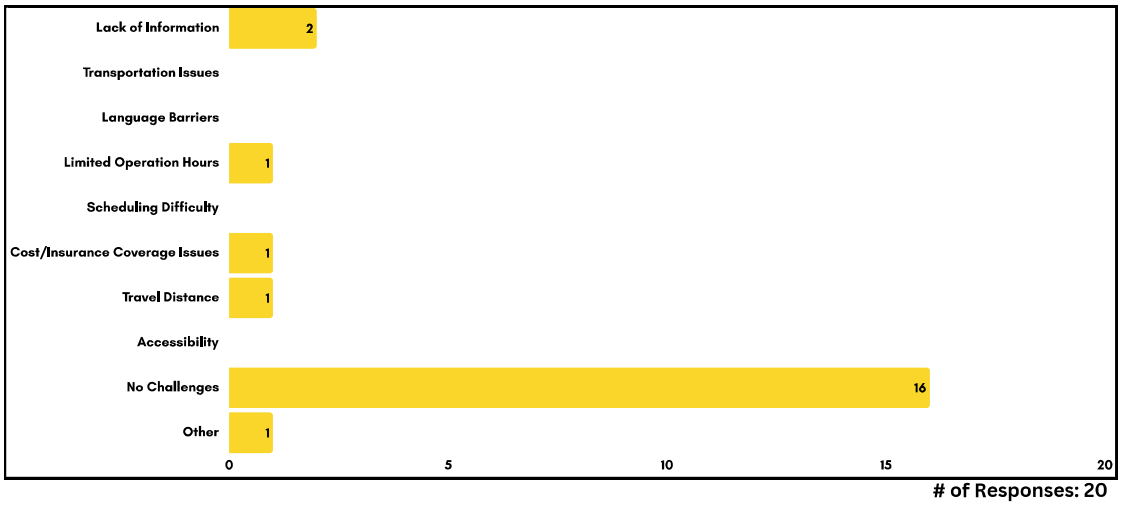
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 20

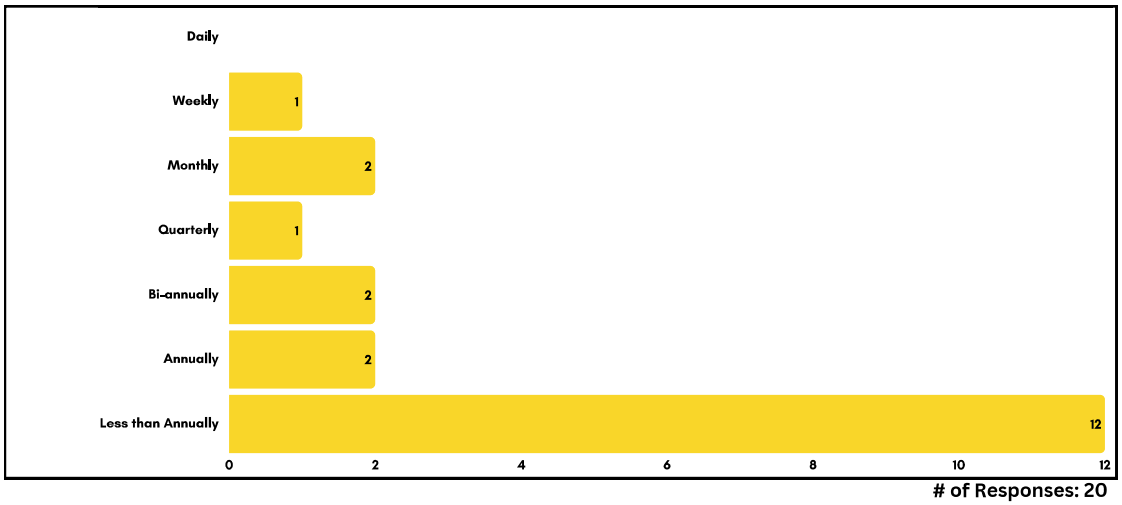
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 20

Approximately how often do you or members of your household visit this facility?



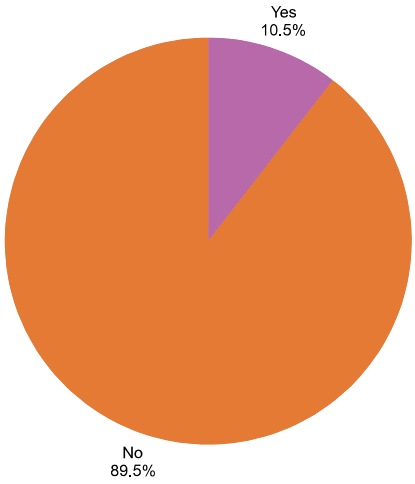
# of Responses: 20

Weiser Satellite Office

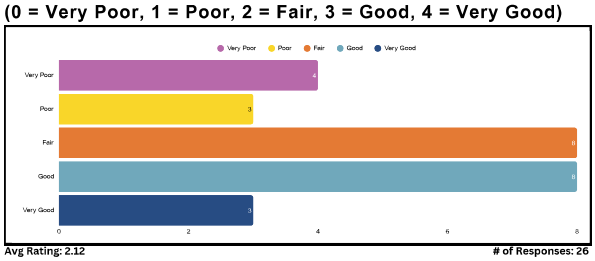
Have you visited the Weiser Office?

(46 W Court St. Weiser, ID 83672)

# of Responses: 248

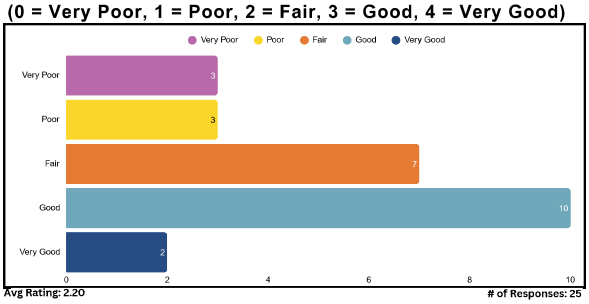


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



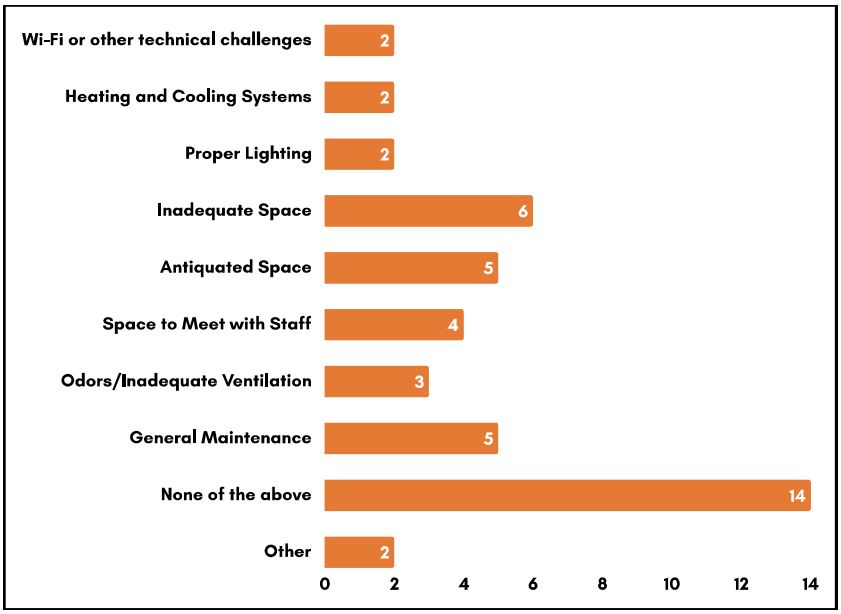
Avg Rating: 2.12 # of Responses: 26

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 2.20 # of Responses: 25

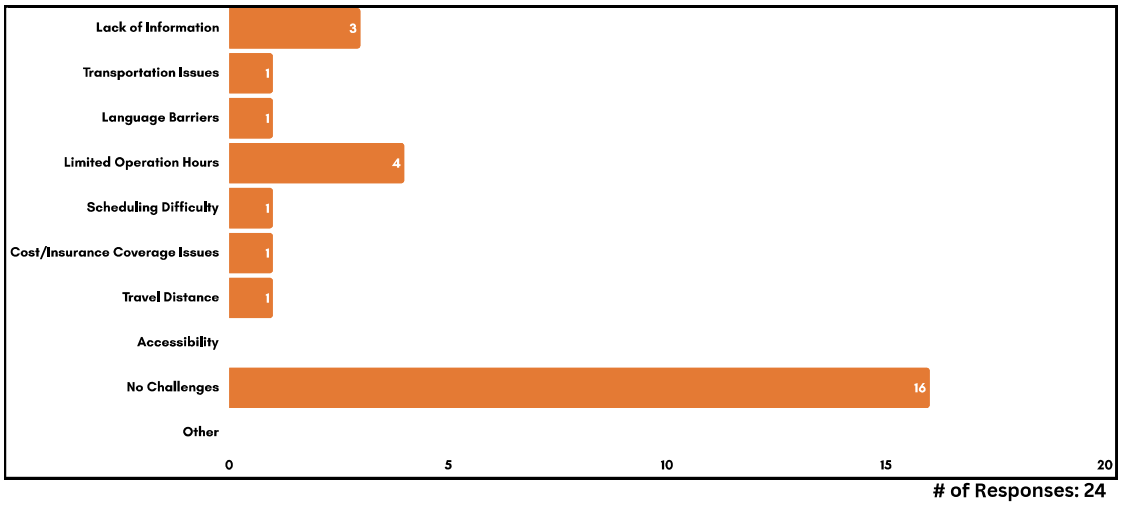
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 23

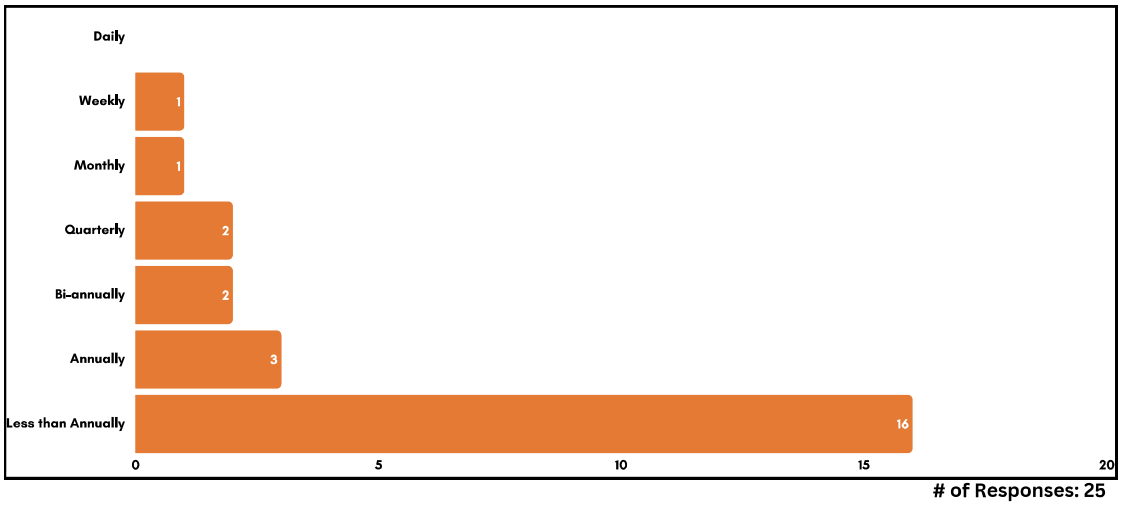
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 24

Approximately how often do you or members of your household visit this facility?



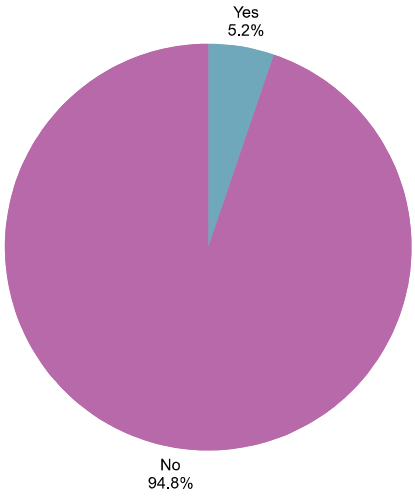
# of Responses: 25

The Hub

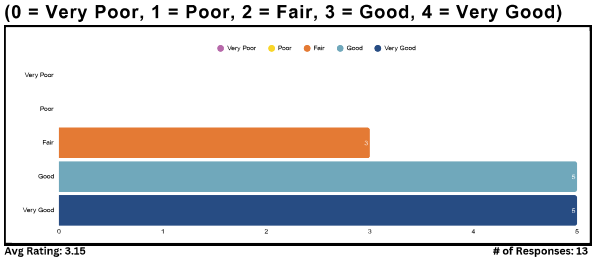
Have you visited the Hub at Marsing School District?

(205 8th Ave W. Marsing, ID 83639)

# of Responses: 248

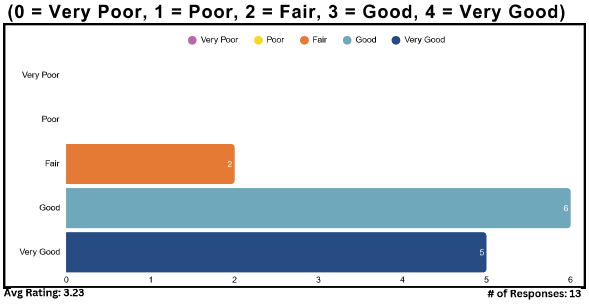


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



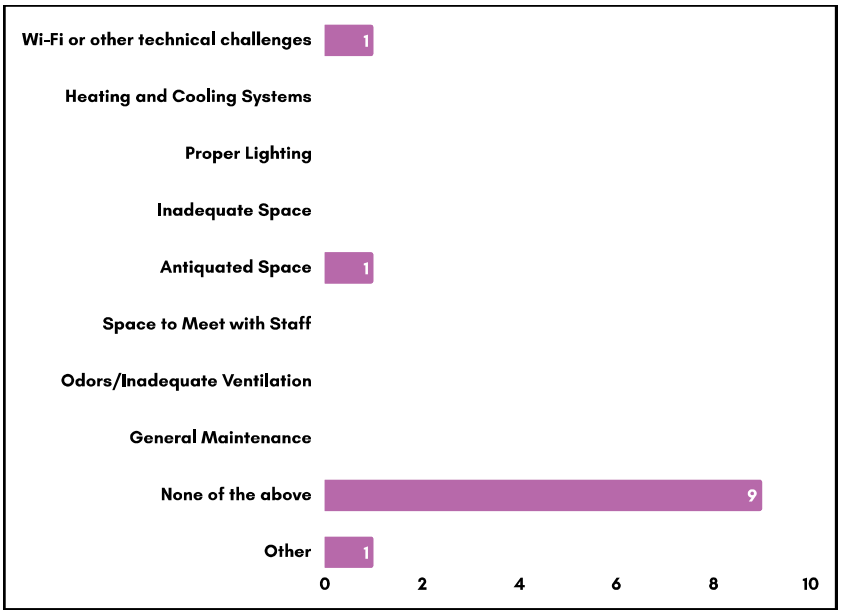
Avg Rating: 3.15 # of Responses: 13

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.23 # of Responses: 13

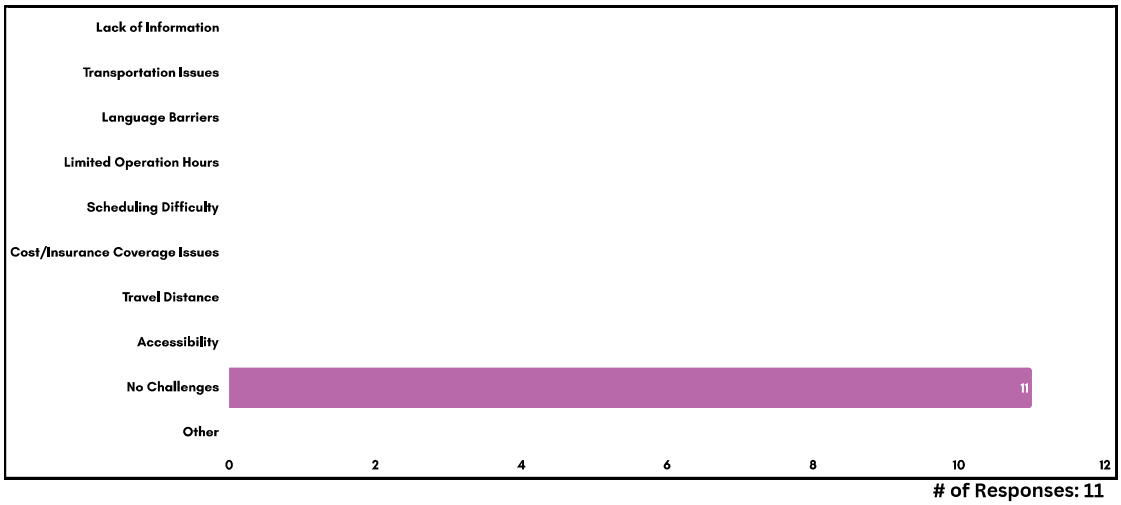
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 11

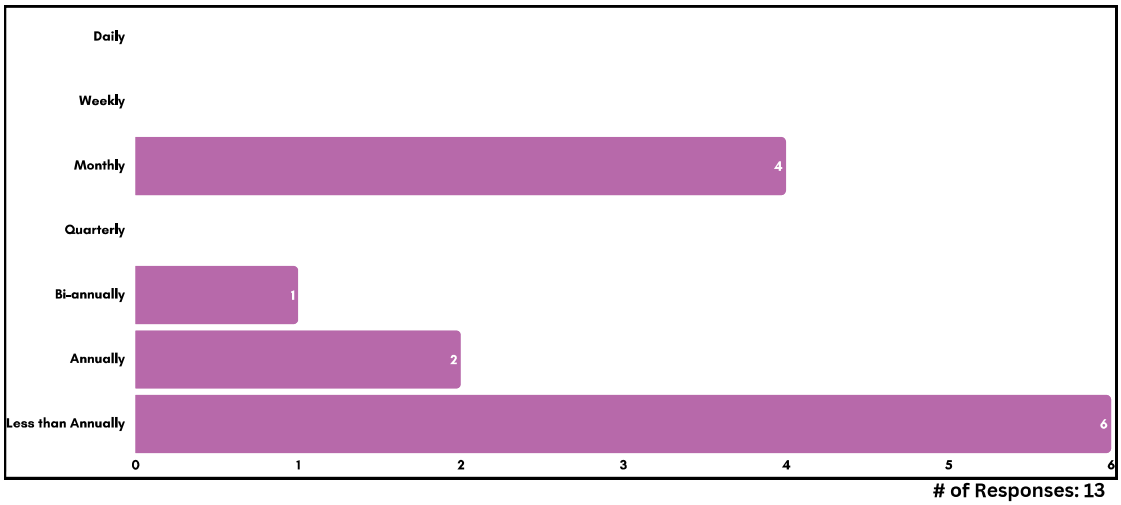
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 11

Approximately how often do you or members of your household visit this facility?



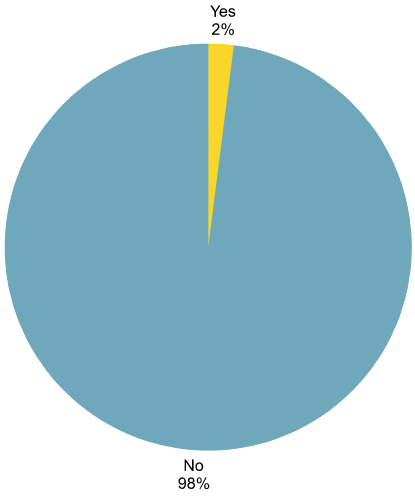
# of Responses: 13

Council WIC

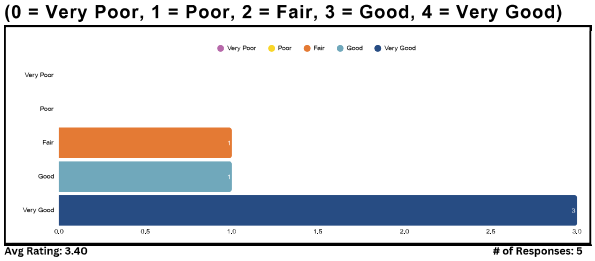
Have you visited the Council WIC location?

(205 N. Berkley St. Council, ID 83612)

# of Responses: 247

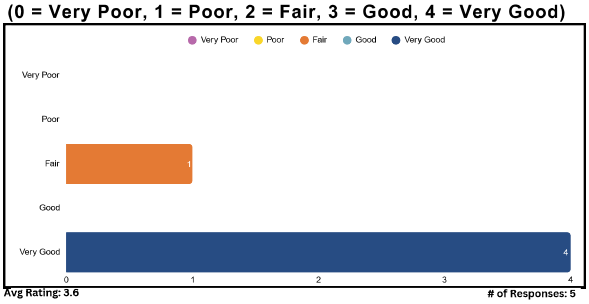


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



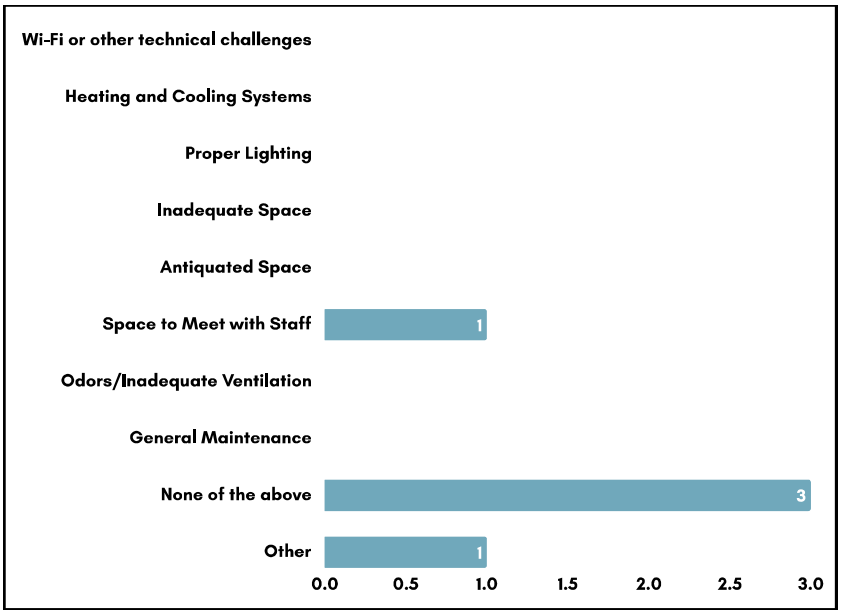
Avg Rating: 3.40 # of Responses: 5

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.6 # of Responses: 5

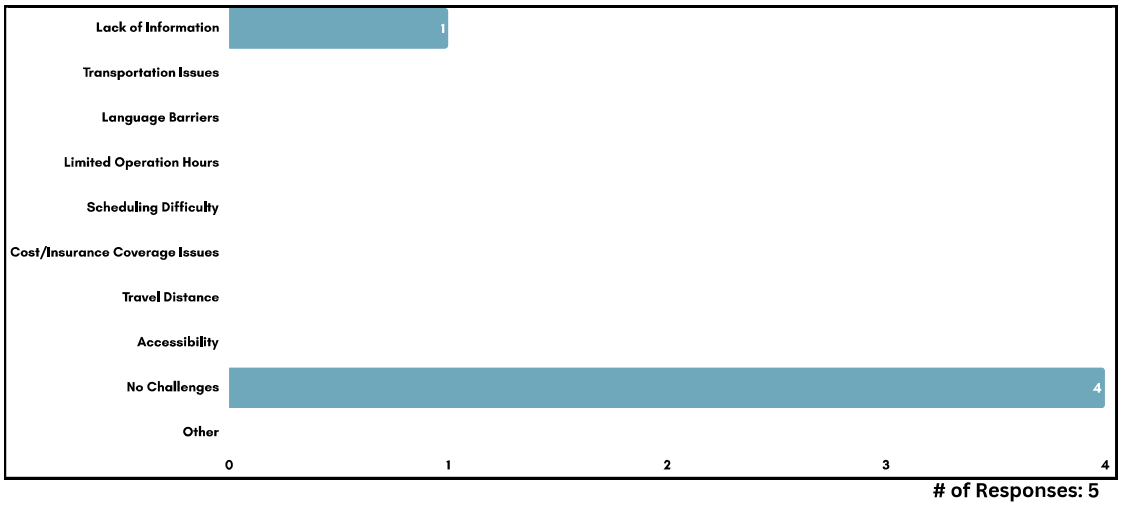
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 5

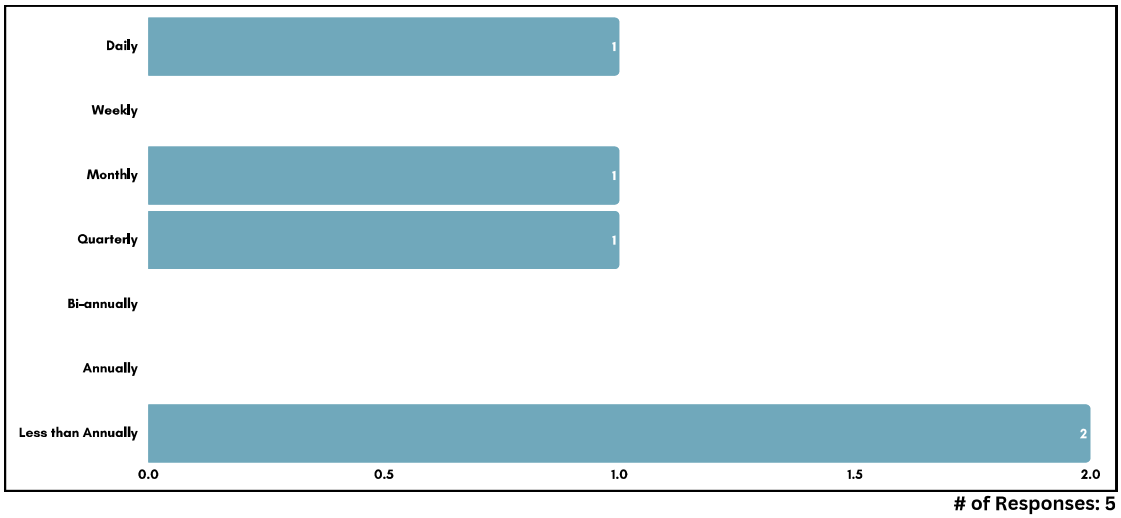
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 5

Approximately how often do you or members of your household visit this facility?



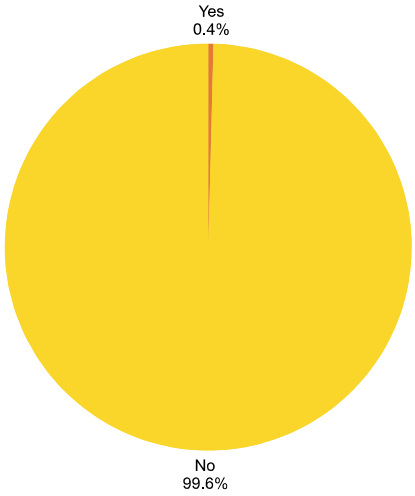
# of Responses: 5

Homedale WIC

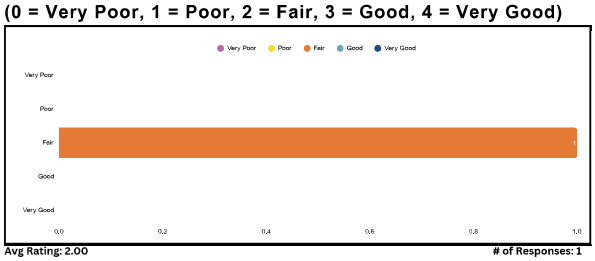
Have you visited the Homedale WIC location?

(125 W. Owyhee Ave. Homedale, ID 83628)

# of Responses: 241

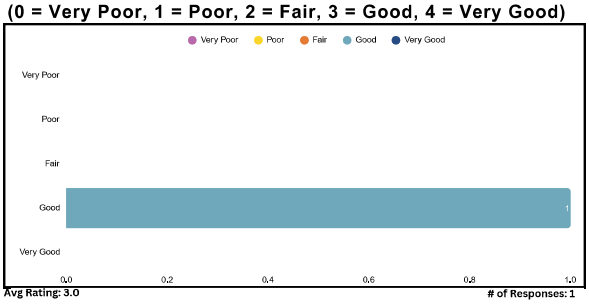


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



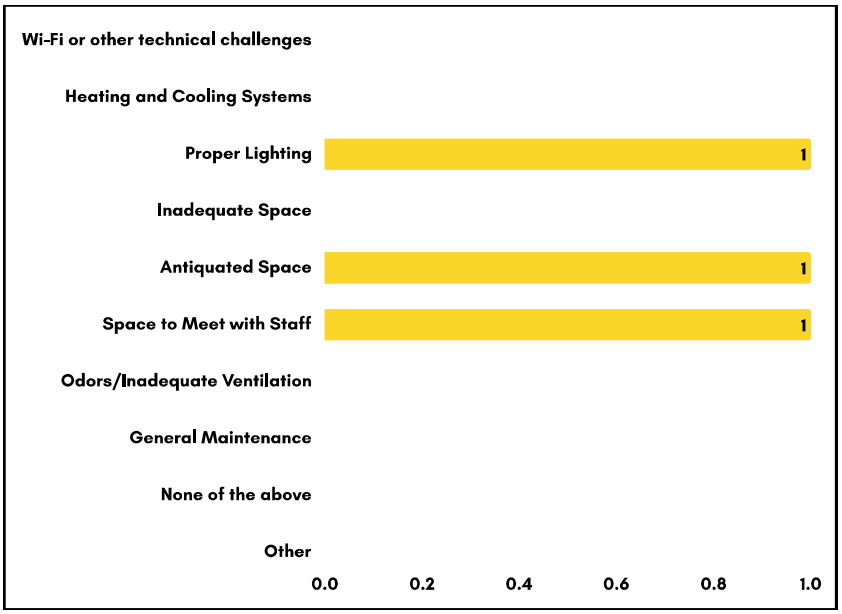
Avg Rating: 2.00 # of Responses: 1

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.0 # of Responses: 1

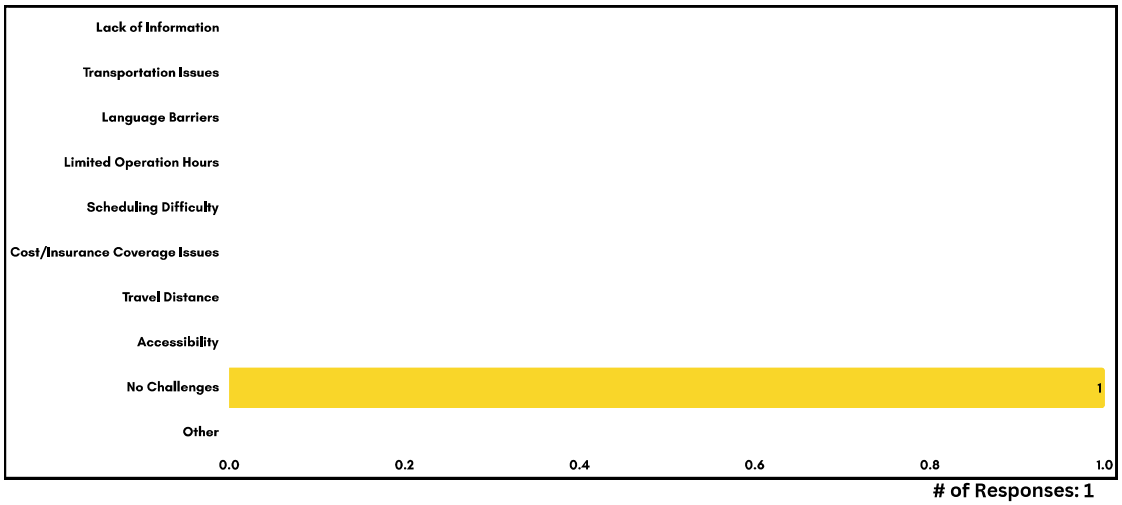
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 1

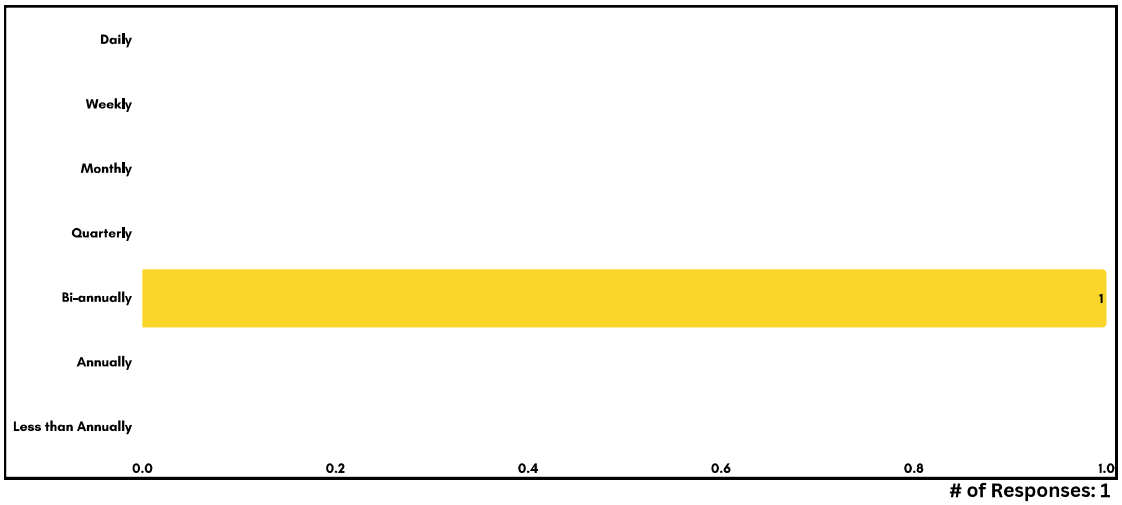
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 1

Approximately how often do you or members of your household visit this facility?



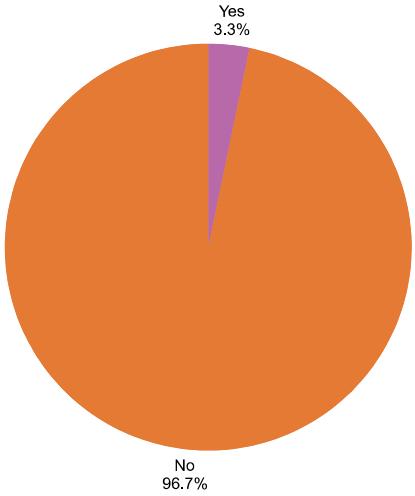
# of Responses: 1

Farmway WIC

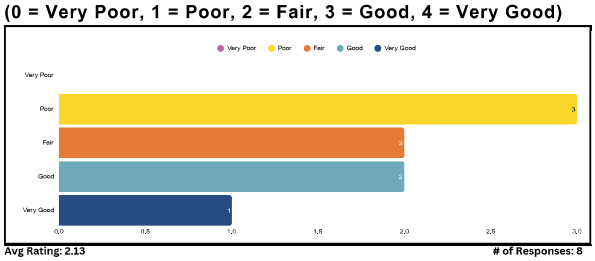
Have you visited the Farmway WIC location?

(22730 Farmway Rd. #114 Caldwell, ID 83607)

# of Responses: 245

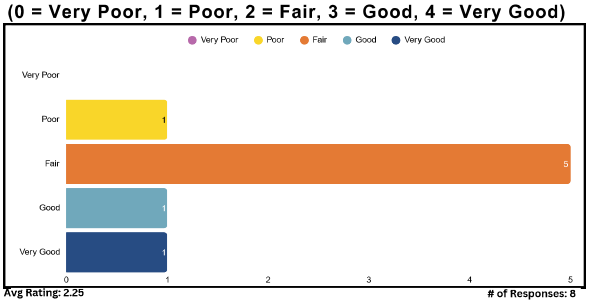


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



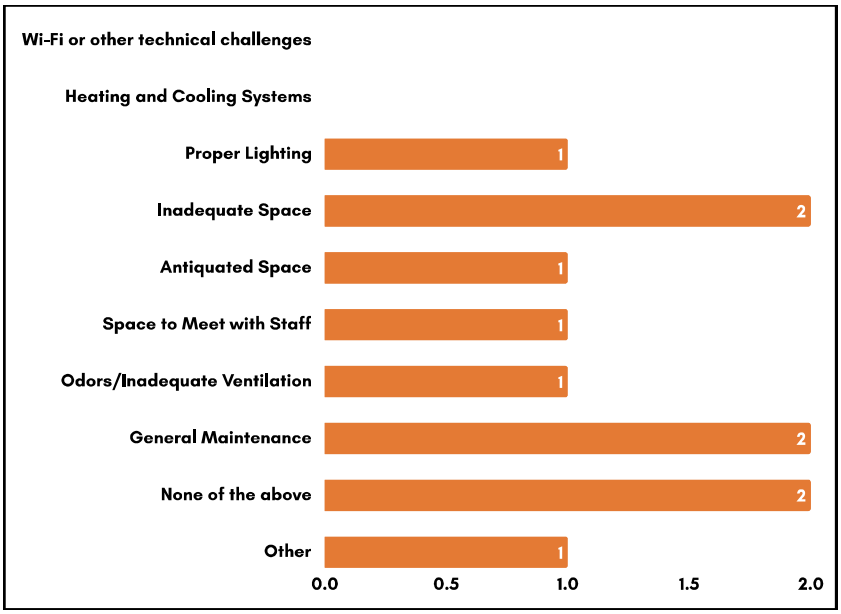
Avg Rating: 2.13 # of Responses: 8

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 2.25 # of Responses: 8

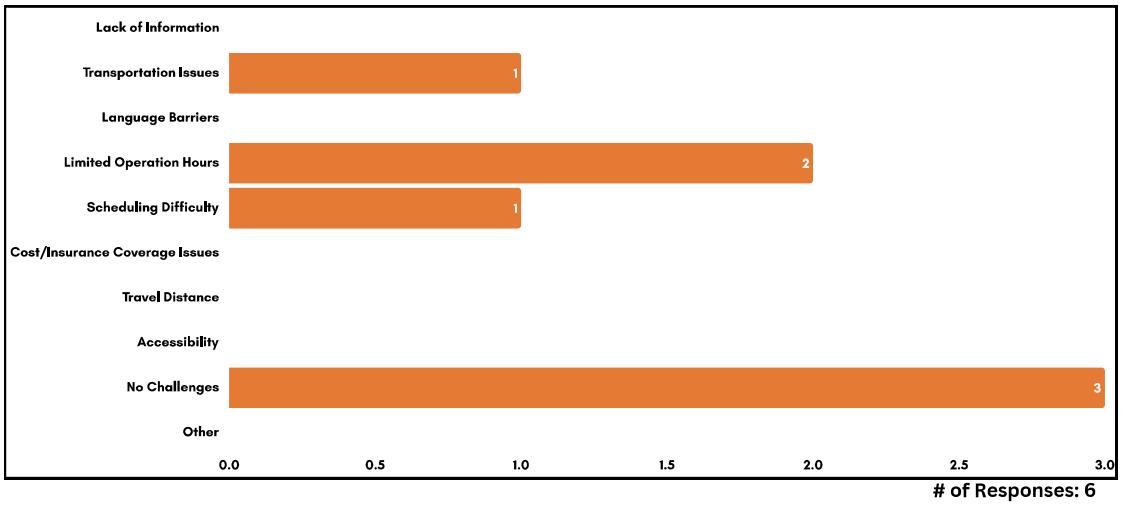
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 6

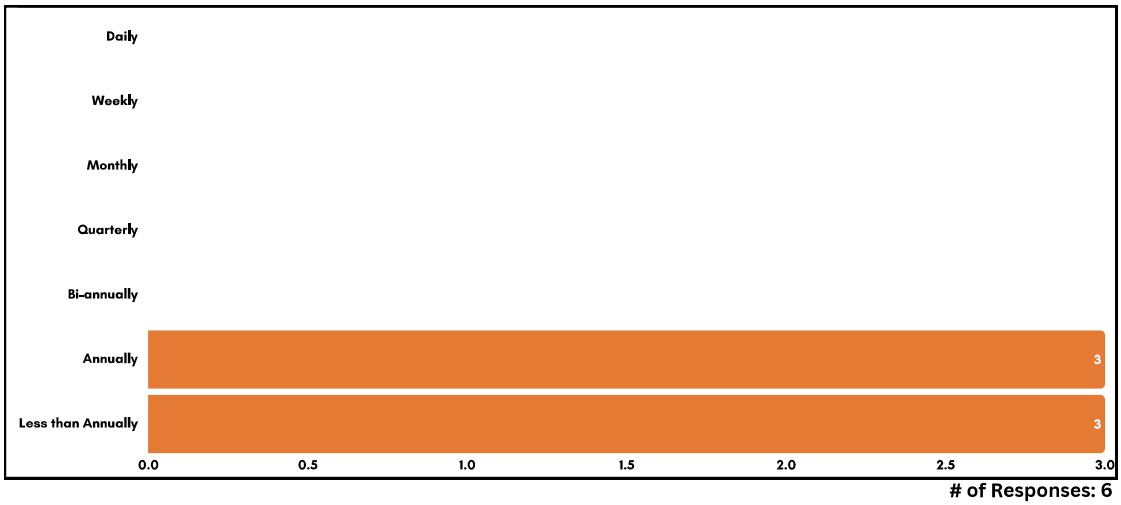
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 6

Approximately how often do you or members of your household visit this facility?



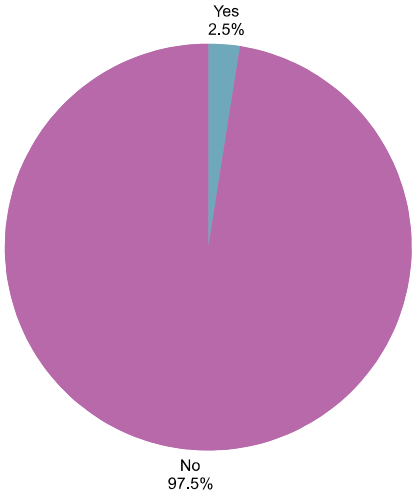
# of Responses: 6

Nampa WIC

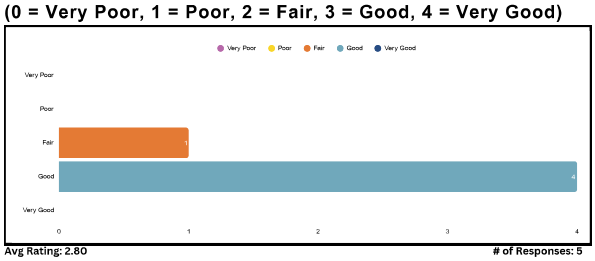
Have you visited the Nampa WIC location?

(315 Stampede Dr. Nampa, ID 83687)

# of Responses: 241

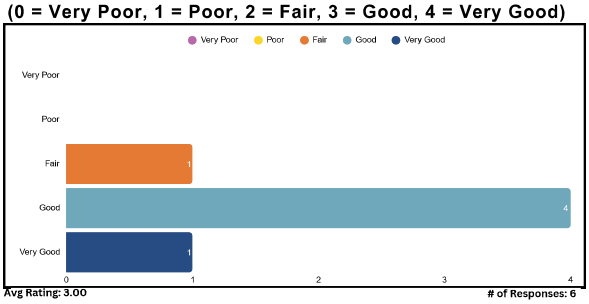


How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



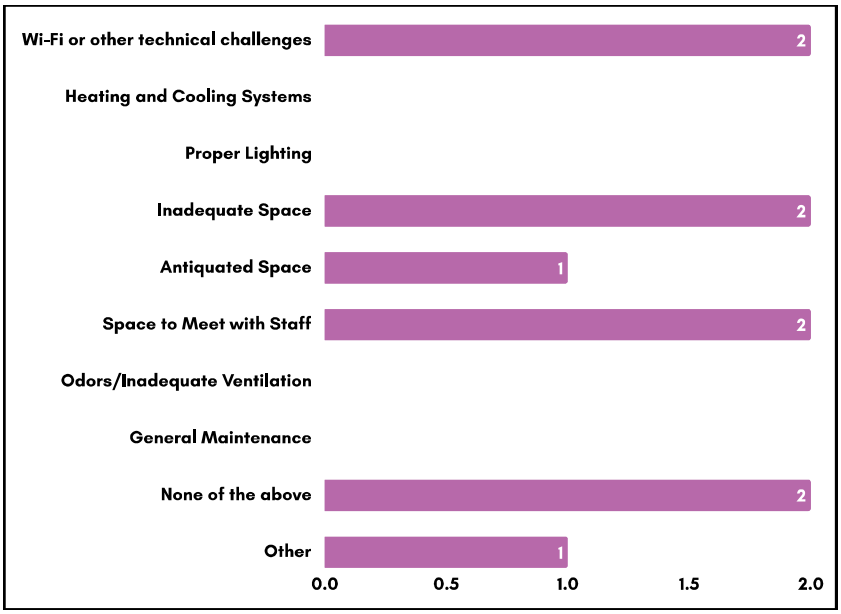
Avg Rating: 2.80 # of Responses: 5

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.00 # of Responses: 6

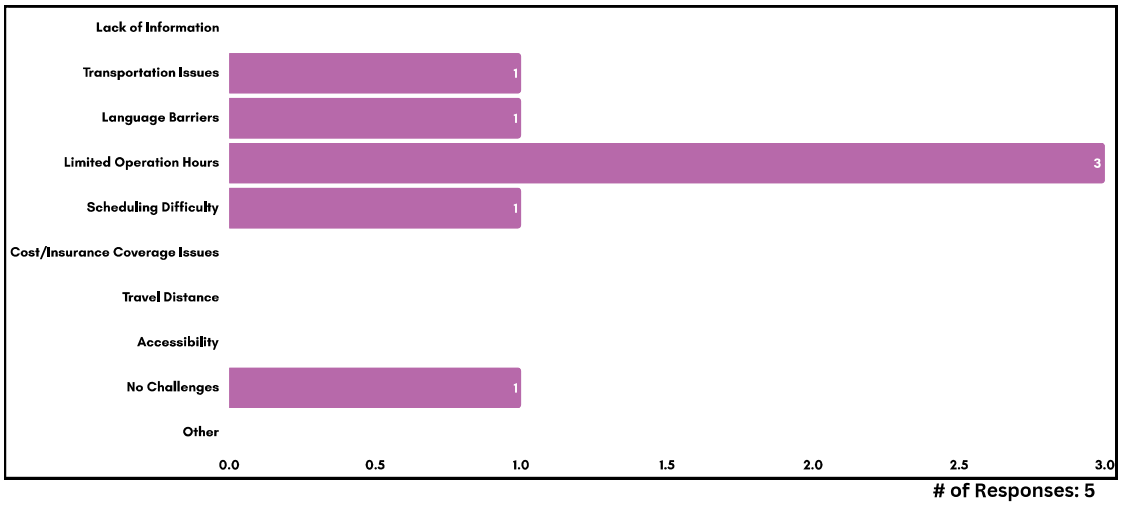
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 5

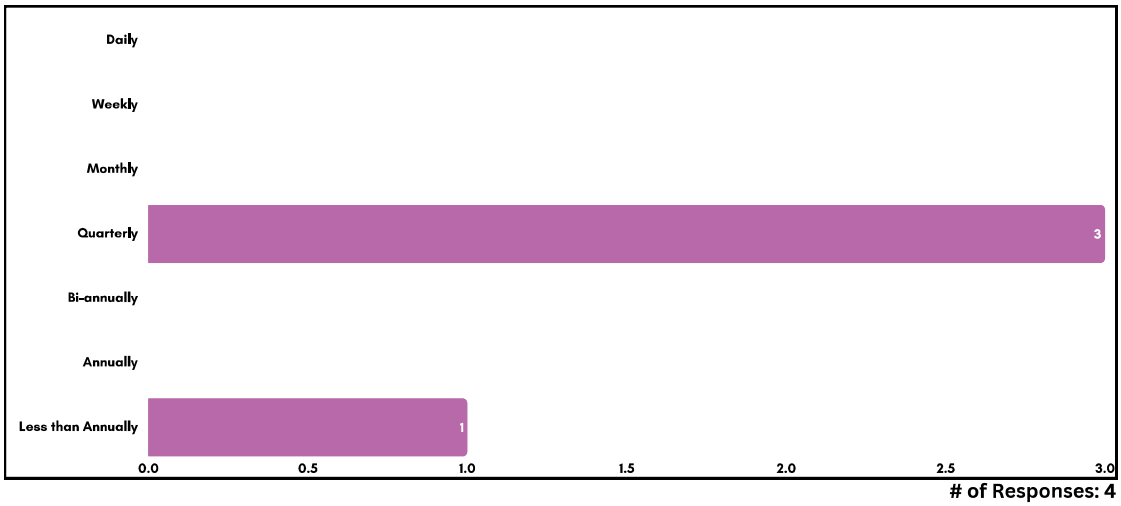
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 5

Approximately how often do you or members of your household visit this facility?

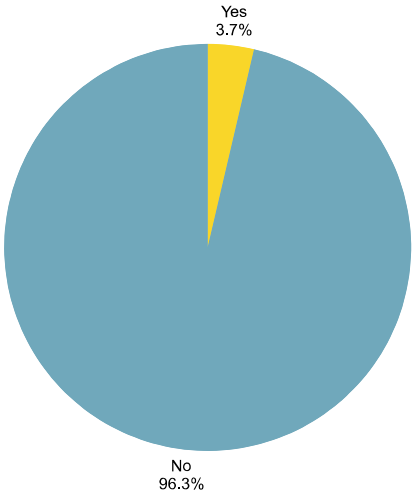


# of Responses: 4

Mobile Clinics

Have you visited one of our mobile clinics?

# of Responses: 246



A mobile clinic is a place where SWDH comes to provide a medical service outside of the District's regular locations, e.g. school-based oral health services, school-based immunizations services, long-term care facility immunization clinic, health fair, etc.

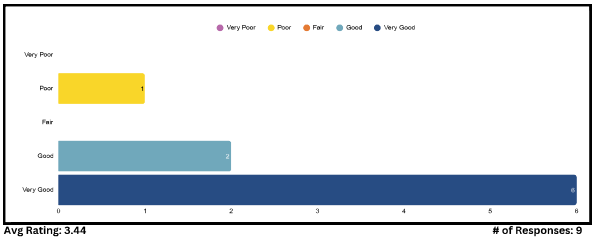
It does **NOT** include SWDH's WIC locations in Council, Farmway, Homedale, and Nampa. It also does NOT include The Hub at Marsing School District.

Which one(s) have you visited/ where was it located?

# of Responses: 6

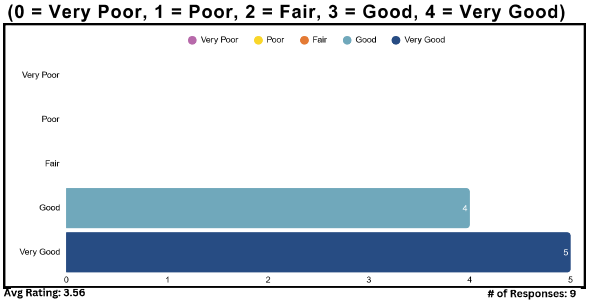
- Gem County
- Weiser Senior Center
- Vallivue High School
- School-based oral health services
- Health Fair - Nampa
- Nampa/Caldwell

How would you rate the physical space of this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



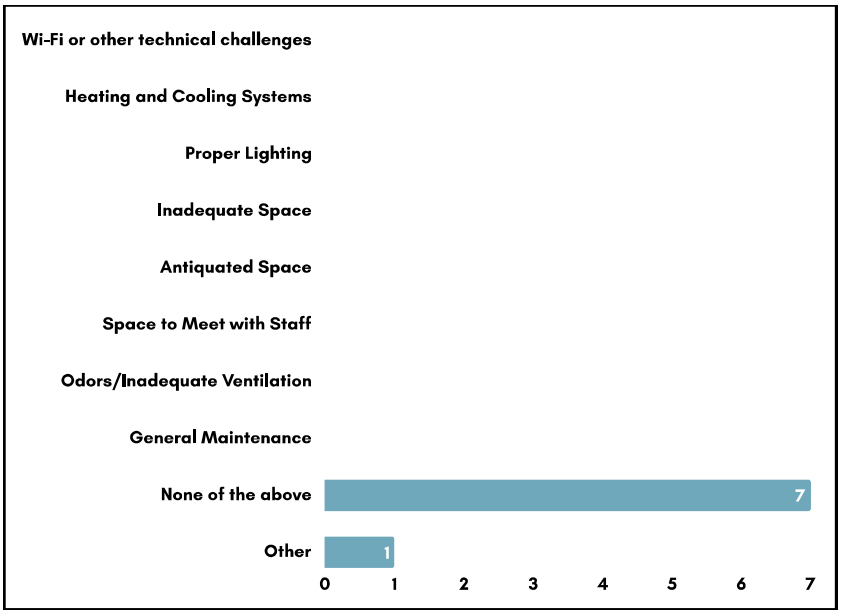
Avg Rating: 3.44 # of Responses: 9

What was your experience parking at this facility?
(0 = Very Poor, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good)



Avg Rating: 3.56 # of Responses: 9

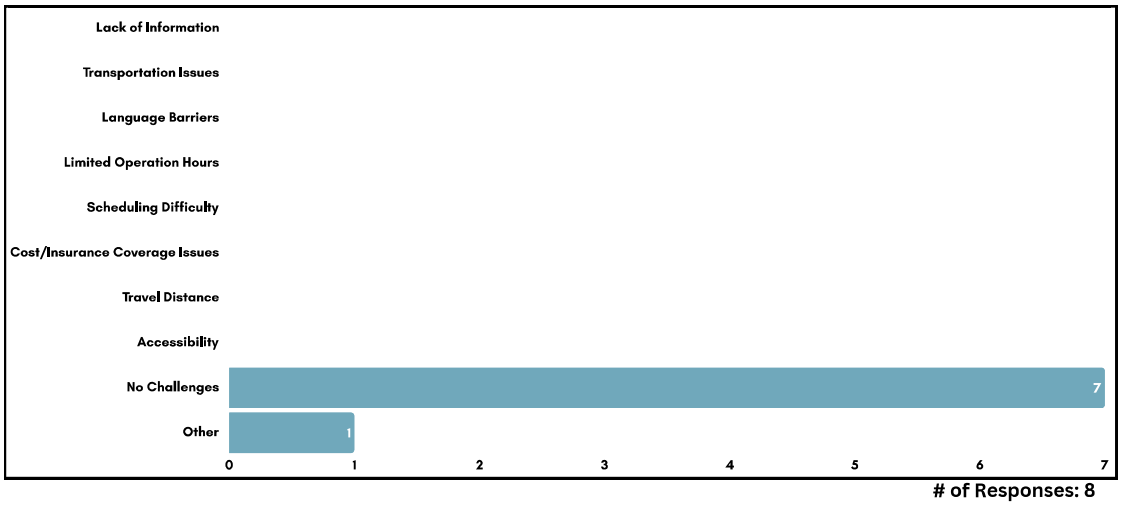
Did you observe/experience any other facility needs? (Check all that apply)



# of Responses: 8

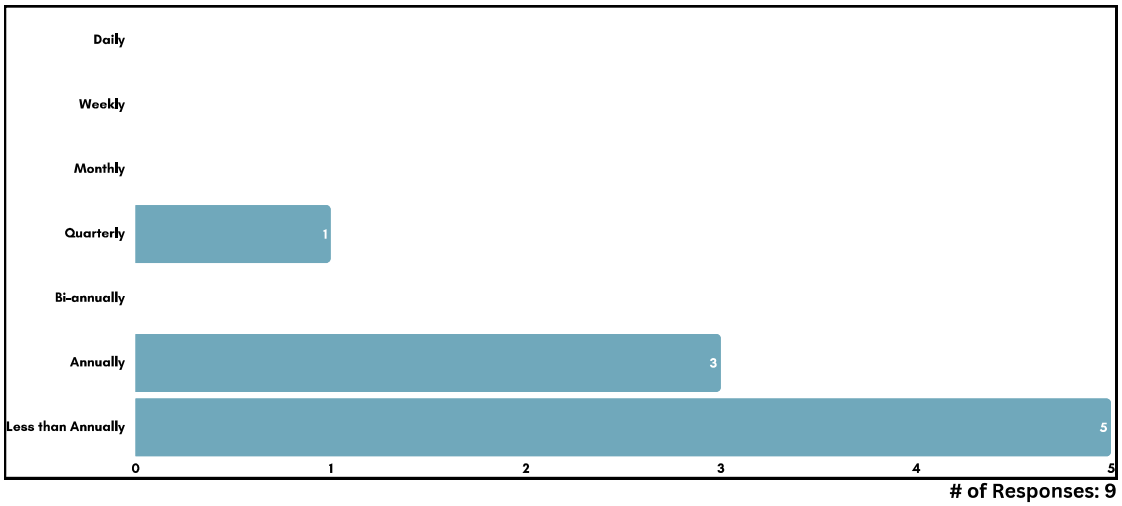
What challenges have you faced when trying to access SWDH services at this location?

(Select all that apply)



# of Responses: 8

Approximately how often do you or members of your household visit this facility?



# of Responses: 9

RESULTS OVERVIEW

- **Representation** from **all six counties** in the District.
- **Canyon County** dominated responses **(55%)**, followed by Gem, Washington, Owyhee, Payette, and Adams counties.
- **High satisfaction** with services **overall** — average rating of 3.05/4.
- **Facilities** and **parking** rated well overall, though **scores varied by location** (main office highest, Weiser lowest).
- **Preferred access methods**:
  - In-person (58%),
  - Online/telehealth (37%), and
  - Phone (35%)
- **Top services used**:
  - Well water testing,
  - Septic systems,
  - Immunizations,
  - WIC, and
  - Medical services
- **Top services needed most**:
  - Well water testing,
  - Immunizations,
  - Septic systems, and
  - Medical services
- **Barriers to access:**
  - 49% reported no challenges; others included:
  - Lack of information,
  - Distance to travel,
  - Limited hours, and
  - Scheduling difficulties

End of Survey Results



Appendix 11.6
Citizens' Committee Recommendation Letter

Southwest District Health Citizens Committee
Recommendation to the Board of Health

Dear Members of the Board of Health:

As members of the Southwest District Health Citizens Committee, we appreciate the opportunity to participate in the District's Master Facilities and Comprehensive Financial Plan process. Through facility tours, review of background materials, including facility assessments, and committee discussion, we developed a clearer understanding of the District's facilities, services, and the challenges associated with delivering public health services across the region.

The committee recognizes the complexity of these decisions and supports the District's continued use of long-term planning to guide facility and service improvements. We also acknowledge that District leadership and staff are best positioned to determine how these priorities are implemented.

Based on our discussions, the committee offers the following recommendations for the Board's consideration:

1. **Increase service availability before pursuing major facility expansion.** The Committee recommends prioritizing expanded hours of operation and improved service availability at existing locations before undertaking significant facility expansion. Evaluating service demand under more consistent operating schedules will help the District better understand long-term facility and service needs. The Committee also encourages maximizing the use of existing space through flexible room scheduling and shared clinical areas where possible, while focusing on addressing the growing demand for behavioral health services.

2. **Strengthen community awareness and outreach.** The Committee recommends strengthening public awareness of District services, hours of operation, and satellite locations. Increased communication may help ensure residents understand what services are available and how to access them. The Committee also encourages expanded outreach to Spanish-speaking and Hispanic communities across the District.

3. **Address ADA accessibility and facility access issues.** The Committee recommends prioritizing improvements related to accessibility and ADA compliance across District facilities, including reception areas, parking, restrooms, and building access. Examples identified during the process include parking and accessibility concerns at the Weiser office and ramp accessibility issues at the Emmett location.

4. **Continue exploring partnerships and co-location opportunities.** The Committee recommends the District continue evaluating opportunities to partner with schools, community centers, and other local organizations to expand service access while maintaining a visible presence in communities across the District. When exploring shared facilities, the District should ensure that appropriate client privacy, both visual and sound, is maintained for services such as WIC and other client interactions.

On behalf of the Citizens Committee, we appreciate the opportunity to contribute to this important effort and thank the District for its commitment to strengthening public health services throughout Southwest Idaho.

Thank you again for this opportunity.

Sincerely,
MFP/CFP Citizens Committee

Members:

Adam Gonzalez	Andy Rodriguez	Julie Yamamoto
Patrick Nauman	Surine Greenway	Thomas Butler



Appendix 11.7
Facility Action Items

Facility Action Items

based on the Preliminary Facility Scenarios

PREPARED BY AMANDA SWAILS DESIGN, LLC
MARCH 23, 2026

SWDH FACILITY ACTION ITEMS: LISTED BY FACILITY

CALDWELL

1. Convert Room 236 into an Infectious Disease Room.
2. Reallocate existing Clinic office space for Behavioral Health Offices.
3. Reconfigure and reduce workstation sizes with future staffing increases.
4. Optimize use of space in Administration area.

PAYETTE

1. Reorganize space allocation to include a behavioral health room in the existing Storage Room.
2. Reduce the height of the existing reception desk and add knee space to comply with ADA code.
3. Demo wall between existing File Room and Parents as Teachers Room to form a new Conference Room.
4. Subdivide the existing Conference Room into two Behavioral Health Rooms.
5. Demolish the three front offices and renovate to create a large Community Room.

WEISER

1. Create an ADA-compliant parking space at the rear of the building, including paving all or part of the existing parking area. Install a security camera with digital access at back entrance to facilitate ADA accessibility.
2. Relocate Immunization Storage and Lab to the current File Room.
3. Reduce the height of the existing reception desk and create appropriate knee clearance to ensure ADA compliance or consider relocating and constructing a new compliant reception desk in the proposed central area to avoid future redundancy.
4. Build partition walls to form Clinic Hall and new office space.
5. Build a partition wall to create a Nurse's Office at former Reception Desk location.
6. Repurpose the former Nurse's Office to serve as a Behavioral Health or WIC Office.
7. Build a partition wall as proposed to create a WIC and Behavioral Health hallway using additional space from the larger WIC room. The existing WIC room could also be further divided into two separate WIC Rooms if needed.
8. Remove the existing wall to the smaller WIC Room to expand and form a larger Waiting & Community Room space as proposed.
9. Increase the size of the existing Exam Room by relocating the door and removing the existing wall as proposed.

EMMETT

1. Repair or replace the exterior ramp railing to comply with IBC code requirements, as the railing presents a greater code issue than the ramp. Options include immediate railing-only replacement, a total ramp and railing replacement at the current location or building a new ramp and railing at the proposed Community Room addition.
2. Repair the 3 existing concrete steps and railings.
3. Install an ADA-compliant sink with adequate knee space in the existing ADA restroom.
4. Reduce the height of the existing reception desk and add knee space to comply with ADA code.
5. Build a partition wall to split the existing oversized Reception and Waiting area as proposed. This modification creates a separate Reception and an open Nurse's Office space.
6. Relocate the existing Nurse's Office to the new Nurse's Office Workstation. Repurpose former Nurse's Office to be an Exam or Behavioral Health Room.
7. Infill doorway between former Reception area and WIC Room.
8. Build a partition wall to divide the existing conference room into two Behavioral Health Offices.
9. Build the proposed Community Room addition with two ADA-compliant restrooms and adequate entry space and ramps. The addition is designed to also be available for after-hours use.

WIC NAMPA OFFICE

1. Improve sound privacy. Sound machines are currently used, but floor-to-ceiling, sound-insulated partitions walls are more effective.

WIC OFFICES (Farmway, Homedale, and Council)

1. Create visual privacy with partition walls or screens. Floor-to-ceiling, sound-insulated partition walls are ideal, but if not possible, opt for mobile screens or cubicle dividers.
2. Create sound privacy with sound-insulated partition walls or sound machines. Floor-to-ceiling, sound-insulated partition walls are ideal, but if not possible, opt for sound machines to mask conversations.

SWDH FACILITY ACTION ITEMS: LISTED WITH FACILITIES COMBINED

1. EMMETT: Repair or replace the exterior ramp railing to comply with IBC code requirements, as the railing presents a greater code issue than the ramp. Options include immediate railing-only replacement, a total ramp and railing replacement at the current location or building a new ramp and railing at the proposed Community Room addition.
2. WIC OFFICES (Farmway, Homedale, and Council): Create visual privacy with partition walls or screens. Floor-to-ceiling, sound-insulated partition walls are ideal, but if not possible, opt for mobile screens or cubicle dividers.
3. WIC OFFICES (Farmway, Homedale, and Council): Create sound privacy with sound-insulated partition walls or sound machines. Floor-to-ceiling, sound-insulated partition walls are ideal, but if not possible, opt for sound machines to mask conversations.
4. CALDWELL: Convert Room 236 into an Infectious Disease Room.
5. CALDWELL: Reallocate existing Clinic office space for Behavioral Health Offices.
6. PAYETTE: Reorganize space allocation to include a behavioral health room in the existing Storage Room.
7. WEISER: Create an ADA-compliant parking space at the rear of the building, including paving all or part of the existing parking area. Install a security camera with digital access at back entrance to facilitate ADA accessibility.
8. EMMETT: Reduce the height of the existing reception desk and add knee space to comply with ADA code.
9. WEISER: Reduce the height of the existing reception desk and create appropriate knee clearance to ensure ADA compliance or consider relocating and constructing a new compliant reception desk in the proposed central area to avoid future redundancy.
10. PAYETTE: Reduce the height of the existing reception desk and add knee space to comply with ADA code.
11. EMMETT: Install an ADA-compliant sink with adequate knee space in the existing ADA restroom.
12. EMMETT: Repair the 3 existing concrete steps and railings.
13. WEISER: Relocate Immunization Storage and Lab to the current File Room.
14. WEISER: Build partition walls to form Clinic Hall and new office space.
15. WEISER: Build a partition wall to create a Nurse's Office at former Reception Desk location.
16. WEISER: Repurpose the former Nurse's Office to serve as a Behavioral Health or WIC Office.
17. WEISER: Build a partition wall as proposed to create a WIC and Behavioral Health hallway using additional space from the larger WIC room. The existing WIC room could also be further divided into two separate WIC Rooms if needed.
18. WEISER: Remove the existing wall to the smaller WIC Room to expand and form a larger Waiting & Community Room space as proposed.
19. EMMETT: Build a partition wall to split the existing oversized Reception and Waiting area as proposed. This modification creates a separate Reception and an open Nurse's Office space.
20. EMMETT: Relocate the existing Nurse's Office to the new Nurse's Office Workstation. Repurpose former Nurse's Office to be an Exam or Behavioral Health Room.
21. EMMETT: Infill doorway between former Reception area and WIC Room.
22. EMMETT: Build a partition wall to divide the existing conference room into two Behavioral Health Offices.
23. WEISER: Increase the size of the existing Exam Room by relocating the door and removing the existing wall as proposed.
24. EMMETT: Build the proposed Community Room addition with two ADA-compliant restrooms and adequate entry space and ramps. The addition is designed to also be available for after-hours use.
25. WIC NAMPA OFFICE: Improve sound privacy. Sound machines are currently used, but floor-to-ceiling, sound-insulated partitions walls are more effective.
26. PAYETTE: Demo wall between existing File Room and Parents as Teachers Room to form a new Conference Room.
27. PAYETTE: Subdivide the existing Conference Room into two Behavioral Health Rooms.
28. CALDWELL: Reconfigure and reduce workstation sizes with future staffing increases.
29. CALDWELL: Optimize use of space in Administration area.
30. PAYETTE: Demolish the three front offices and renovate to create a large Community Room.



Appendix 11.8
Emerging Themes

Emerging Themes for Facility Scenarios

PREPARED BY AMANDA SWAILS DESIGN, LLC
OCTOBER 2025

Where is the demand high, low or just right?

In order to meet the demand, what is needed?

1. Facility Improvements
2. Changes to Hours of Operation
3. Increased Staffing

SWDH Locations and Hours of Operation - October 2025

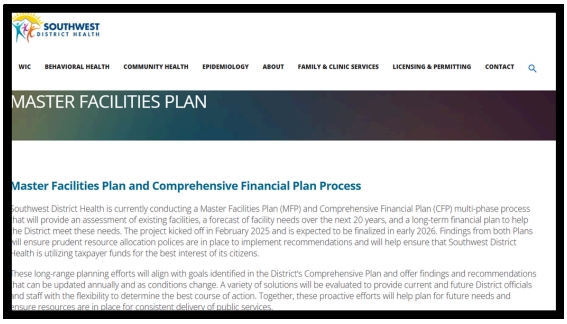
SWDH Location	Building Hours + Environmental Health Drop-off	Building Days per Month	Clinic Operational Hours	Clinic Days per Month	Behavioral Health Operational Hours	Behavioral Health Days per Month	WIC Operational Hours	WIC Days per Month	Needs
Caldwell Office	M-F 8:00am - 5:00pm	20 days/ month	M-W 7:30am - 6:30pm Th-F 8:00am - 5:00pm	12 days/ month	M-Th 8:30am -5:30pm	16 days/ month. 1 counselor	M-F 8:00am - 5:00pm	20 days/ month	#3
Payette Office	M-F 8:00am - 5:00pm	20 days/ month	Thursday 9:00am-5:00pm (3 week rotation)	1-2 days/ month	N/A	N/A	M/W/F 8:00am - 5:00pm	12 days/ month	#2, #3
Weiser Office	M-F 8:00am - 5:00pm	20 days/ month	Thursday 9:00am-5:00pm (3 week rotation)	1-2 days/ month	N/A	N/A	Thurs 8:00am - 5:00pm	4 days/ month	#1, #2, #3
Emmett Office	M-F 8:00am - 5:00pm	20 days/ month	Thursday 9:00am-5:00pm (3 week rotation)	1-2 days/ month	N/A	N/A	Tues 8:00am - 5:00pm	4 days/ month	#1, #2, #3
Nampa Office			N/A	N/A	N/A	N/A	M/T/Th/F 9:00am - 4:00pm	16 days/ month	#3
Homedale Office			N/A	N/A	N/A	N/A	T/Th 9:00am - 4:00pm	8 days/ month	#2, #3
Farmway Office			N/A	N/A	N/A	N/A	1st Monday of month 9am - 4pm, 3rd Thursday of month 9am - 4pm	2 days/ month	#1, #2, #3
Council Office			N/A	N/A	N/A	N/A	Call for day (previously 3rd Wednesday of even months)	.5 days/ month	#2, #3
Marsing Hub			M-F School Hours		N/A	N/A	N/A	N/A	#2, #3



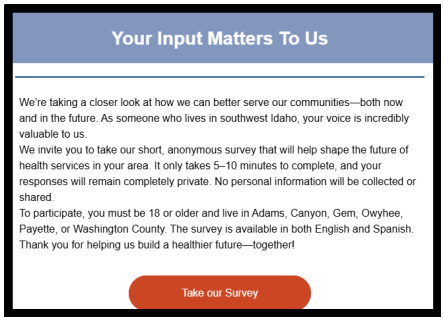
Appendix 11.9
Public Engagement & Outreach

PUBLIC ENGAGEMENT & OUTREACH

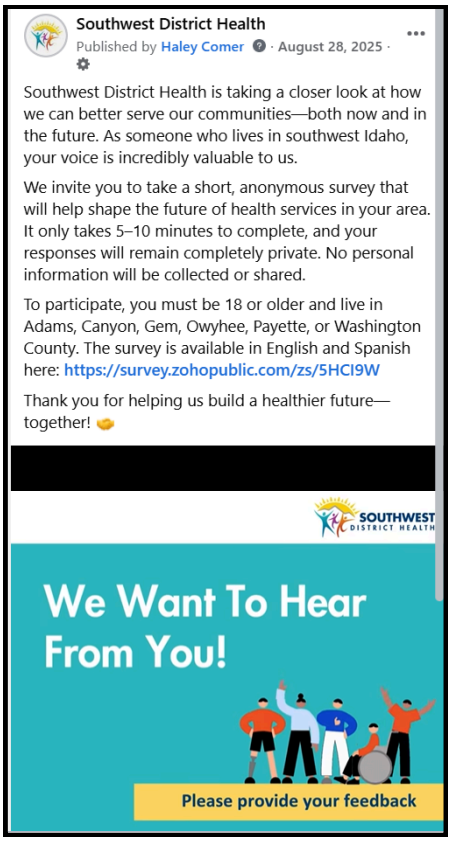
Webpage



Newsletter



Social Media Post



Lobby Monitor



Lobby Flyer



Community Survey



PUBLIC ENGAGEMENT & OUTREACH

Earned Media

Southwest District Health looks to the future, seeks community feedback



Government + Politics
Health

Gem State Roundup

Idaho is growing fast. Southwest District Health wants public input on future plans.



FOR IMMEDIATE RELEASE

March 10, 2025

Southwest District Health Kicks Off Master Facility & Financial Planning Process

Caldwell, Idaho – Southwest District Health (SWDH) has officially launched a comprehensive Master Facility and Comprehensive Financial Plan (MFP/CFP, Plan) to guide the future of its facilities and financial sustainability. The planning process, which kicked off on February 14, 2025, will help ensure SWDH's infrastructure and services align with the evolving needs of the communities it serves over the next 50 years.

To support this effort, SWDH has engaged Clearwater Financial as a key partner in facilitating the planning process. Clearwater will provide expertise in facility planning, financial analysis, and public engagement to develop a long-term, sustainable approach for SWDH's operations.

SWDH currently operates a main office in Caldwell, three satellite locations in Emmett, Payette, and Weiser, as well as additional service sites throughout its six-county region that includes Adams, Gem, Canyon, Payette, Washington, and Owyhee counties. With significant population growth and evolving healthcare needs, the District aims to ensure accessible, efficient, and community-centered services well into the future.

The Master Facility Plan will provide a comprehensive assessment of SWDH's current facilities, evaluate their utilization, and identify areas for improvement. As part of this process, SWDH will explore opportunities for co-locating services to enhance efficiency and better serve residents. Additionally, the Plan will examine potential facility relocations or expansions, ensuring that services remain accessible as the region grows. A key focus will be addressing barriers to service, such as transportation challenges and technological limitations, to improve overall accessibility for the community.

The Comprehensive Financial Plan will focus on ensuring the long-term financial sustainability of SWDH's facilities and services and the implementation of the Plan. This will include identifying funding strategies to support infrastructure needs and evaluating budgeting models that promote fiscal responsibility. Additionally, the Plan will explore potential funding opportunities, such as grants and voter-approved initiatives, to secure resources necessary for implementing the Plan.

As part of the early phases of this process, the consultancy team began their site tours and facility analysis at the Caldwell location on March 7th and will visit the District's other location in the following weeks.

"We want to ensure that our facilities and financial planning reflect the needs of our communities," said Nikki Zogg, Executive Director of SWDH. "This process is about making strategic decisions that are informed and supported by the communities we serve that will shape the future of public health services in Southwest Idaho."

The planning process will take place over the next year, with opportunities for public input at multiple stages. The final Plan is expected to be presented in early 2026. SWDH encourages residents, business leaders, and community partners to stay engaged and participate in upcoming discussions.

For updates on the planning process, please visit https://swdh.id.gov/about/master-facilities-plan/.

2026 Summary of Public Health Related Legislative Activities - Final

BILLS SIGNED BY THE GOVERNOR			
BILL NO	**DESCRIPTION**	**DATE SIGNED**	**DATE EFFECTIVE**
H491	Emergency mental health first aid	**MARCH 26**	**JULY 1**
H494	Background checks, health and welfare (childcare providers)	**MARCH 27**	**JULY 1**
H542	Harms of addictive social media	**APRIL 2**	**JULY 1**
H555	Solid waste facilities (moves authority back to DEQ)	**MARCH 2**	**JULY 1**
H749	Annexation by cities (septic systems)	**MARCH 20**	**JULY 1**
H860	Parental rights, medical decisions	**MARCH 31**	**MARCH 31**
S1239	Sex offenders, daycares (expands to any daycare, licensed or not)	**MARCH 17**	**JULY 1**
S1283	Direct-to-Consumer	**MARCH 20**	**MARCH 20**
S1297	Conversational AI safety act (clear disclosure)	**MARCH 31**	**JULY 1, 2027**
S1314	Department of Health and Welfare (eliminates State Board of Health and Regional Behavioral Health Boards)	**MARCH 16**	**MARCH 16**
S1326	Property rights protection	**MARCH 31**	**MARCH 31**
S1453	Approp, H&W, rural health, add'l (Rural health transformation)	**APRIL 13**	**JULY 1**

Other Bill Updates

BILLS THAT HAVE STALLED OR DIED	
BILL NO	**DESCRIPTION**
H526	Cottage food operations, TCS foods
H536	Agricultural pests (rats)
H614	Detention, involuntary admission
H554	Abatement districts (mosquito)
H743	State law, enforcement (replaced by H896)
H747	Abatement districts (mosquito)
H758	Daycare supervision requirements
H781	Agricultural pests (rats)
H808	Medical mandates
H830	Mitragyna speciosa alkaloids
H850	Medicaid expansion repeal
H860	Parental rights, medical decisions
H862	Rural health transformation
H864	Mitragynine, controlled substances
H884	Nicotine, taxes, permits
H896	State law, compliance
S1271	Rats, health and safety nuisance
S1282	Kratom consumer protection & safety

Southwest District Health

Originator	Parties
Propio, LS, LLC	Southwest District Health

Document Type

Agreement	☐	Amendment

Summary

Name/Title:	Propio Order Form and Business Associate Agreement
Description (long title):	Propio Translation Services Agreement
FAIN#:	NA
Funding Source:	Mix of Federal & State
SWDH Project Code:	Varies. 95331010 and 95333010 mainly.
Original Effective Date:	03/20/2026
Current Expiration Date:	
Total [Funding Amount or Cost of Service]:	$ 40,000.00
Allowable Indirect Rate:	0.00%
Match Required:	NO
Match Amount:	$ 0.00
FTE Supported:	0
District Funds Budgeted in Current FY:	$ 0.00
Restrictions:	NA
Target Population:	All SWDH clients speaking a language other than English
If this is an amendment, briefly describe the change. NA	

Contacts

Contact Name (Internal & External)	**Contact [Agency, Organization, Contractor, Vendor, Partner]**	**Contact Email or Phone Number**
Don Lee	Southwest District Health	don.lee@swdh.id.gov
Josie Thorpe	Propio	jthorpe@propio.com

Created July 17, 2025

Applicable Law and/or Agreement

Idaho Statutes or Rules (select up to 3)	39-409, IC	39-605, IC	74-106, IC
Agreement	N/A		

Public Impact

Scope of Work Summary (3-5 bullets)	• Interpretation services potentially including on-demand over the phone interpretation, scheduled over the phone interpretation, on-demand video interpretation, scheduled video interpretation, on-site and in-person interpretation, AI interpretation using Propio Agent, and third-party platform virtual interpretation. • Written translation services
Summary Public Impact (3-5 bullets)	• Bridging linguistic divides • Ensuring inclusivity in a multilingual society • Preventing disparities in access and quality
Summary of Evidence-based (3-5 bullets)	• "RSMI resulted in fewer medical errors and was faster than non-RSMI methods of interpreting." RSMI = Remote simultaneous medical interpreting F Gany, L Kapelusznik, K Prakash, J Gonzalez, LY Orta, CH Tseng, J Changrani, Journal of general internal medicine, 2007•Springer • "Among adult Spanish-speaking Latinos, interpreter use is independently associated with higher satisfaction with doctor communication, office staff helpfulness, and ambulatory care. Increased attention to the need for effective interpreter services is warranted in areas with rapidly growing Spanish-speaking populations." G Moreno, LS Morales, Journal of general internal medicine, 2010•Springer

Reviewer/Approve

	Program Manager	PM2	Division Administrator	Financial Officer	Legal*	Director
Date			03/23/2026	03/23/2026		03/23/2026
Initials			DL DL	MH		NZ

** The necessity of legal review will be determined by the Financial Officer, Division Administrator, or Director.*

Southwest District Health

Originator	Parties
Southwest District Health	Meadows Valley School District

Document Type

Contract	☐	Amendment

Summary

Name/Title:	CMB Program Implementation MVSD
Description (long title):	CATCH My Breath Program Implementation Meadows Valley School District
FAIN#:	N/A
Funding Source:	State
SWDH Project Code:	95341260
Original Effective Date:	04/01/2026
Current Expiration Date:	06/28/2026
Total [Funding Amount or Cost of Service]:	600.00
Allowable Indirect Rate:	0
Match Required:	NO
Match Amount:	0
FTE Supported:	n/a
District Funds Budgeted in Current FY:	0
Restrictions:	none
Target Population:	Youth in grades 5-12.
If this is an amendment, briefly describe the change. N/A	

Contacts

Contact Name (Internal & External)	**Contact [Agency, Organization, Contractor, Vendor, Partner]**	**Contact Email or Phone Number**
Hailee Ketchum	hailee.ketchum@swdh.id.gov	208.477.4162
Shannon McKnight	outreach@planetyouthwcm.org	208.315.0890

Applicable Law and/or Agreement

Idaho Statutes or Rules (select up to 3)	39-409, IC	N/A	N/A
Agreement	N/A		

Public Impact

Scope of Work Summary (3-5 bullets)	SWDH to provide funding for Meadows Valley School District to implement CATCH My Breath. Program implemented in four lessons 45-50 minutes each. There are 4 versions of the program, each catered to different grade levels (5th, 6th, 7th/8th, and 9-12th).
Summary Public Impact (3-5 bullets)	To prevent youth e-cigarette use and vaping through education, advocacy, and skill-building. Reductions in nicotine vaping use and overall tobacco use. Increases in nicotine vaping knowledge and positive perceptions of a vape-free lifestyle.
Summary of Evidence-based (3-5 bullets)	The CMB Program is a peer-reviewed, evidence-based youth vaping prevention program developed by The University of Texas Health Science Center at Houston (UTHealth) School of Public Health. The program provides up-to-date information to equip students with the knowledge and skills they need to make informed decisions about the use of e-cigarettes.

Reviewer/Approve

	Program Manager	PM2	Division Administrator	Financial Officer	Legal*	Director
Date	03/23/2026	03/23/2026	03/24/2026	03/24/2026		03/24/2026
Initials	HA	Charlene Cariou	BS	MH		NZ

** The necessity of legal review will be determined by the Financial Officer, Division Administrator, or Director.*

Southwest District Health

Originator	Parties
SWDH	Wilder School District, Communities for Youth

Document Type

Agreement	☐	Amendment

Summary

Name/Title:	Communities for Youth Wilder Initiative MOU
Description (long title):	Communities for Youth Wilder Initiative MOU
FAIN#:	H79SP083777
Funding Source:	Federal
SWDH Project Code:	95341127
Original Effective Date:	09/30/2025
Current Expiration Date:	09/29/2026
Total [Funding Amount or Cost of Service]:	0.00
Allowable Indirect Rate:	0.00
Match Required:	NO
Match Amount:	0
FTE Supported:	0
District Funds Budgeted in Current FY:	-9753
Restrictions:	N/A
Target Population:	Youth 10-19 and their families
If this is an amendment, briefly describe the change.	

Contacts

Contact Name (Internal & External)	**Contact [Agency, Organization, Contractor, Vendor, Partner]**	**Contact Email or Phone Number**
Kaydin Griffin/Tara Woodward	SWDH Contact/ SWDH, subgrant monitor	Kaydin.griffin@swdh.id.gov
Alejandro Zamora ~~Megan Smith~~	Superintendent, Wilder School ~~Director, Communities for Youth~~	azamora@wilderschoools.org/ ~~mlsmith@boisestate.e~~

Created July 17, 2025

Applicable Law and/or Agreement

Idaho Statutes or Rules (select up to 3)	39-409, IC	N/A	N/A
Agreement	N/A		

Public Impact

Scope of Work Summary (3-5 bullets)	Maintain a community-led coalition in Marsing focused on youth well-being and substance use prevention, meeting monthly (8-10 times a year) using an action plan informed by youth well-being survey. • Educate school staff and annually administer a youth well being survey with parental consent. • Share survey results through a community event and ongoing
Summary Public Impact (3-5 bullets)	Coalition developed action plan will result in strategies implemented in the Wilder community to support data findings, and prevent youth substance use/support youth mental well being • Anticipated reach of 150+ youth, 50+ parents/caregivers • Anticipated increase of protective factors/decrease of risk factors over the 2 year partnership period
Summary of Evidence-based (3-5 bullets)	The Icelandic Prevention Model is an evidence-informed approach focused on addressing community-based risk and protective factors. • The approach is based on the annual administration of a youth well-being survey that allows understanding of current conditions positively or negatively contributing to youth's health and well being/substance use. • Strategies are built off of data, community developed and implemented. Progress is checked every year through the youth well-being survey. • Article: https://pmc.ncbi.nlm.nih.gov/articles/PMC6918020/

Reviewer/Approve

	Program Manager	PM2	Division Administrator	Financial Officer	Legal*	Director
Date	04/01/2026	04/01/2026	04/01/2026	04/01/2026		04/01/2026
Initials	KJ	Charlene Cariou	BS	MH		WZ

** The necessity of legal review will be determined by the Financial Officer, Division Administrator, or Director.*

Southwest District Health

Originator	Parties
IDHW	SWDH

Document Type

Subgrant	☑ Amendment

Summary

Name/Title:	Southwest District Health - PHD 3 -PHEP
Description (long title):	Viral Hepatititis Case Monitoring, Investigation, and Reporting
FAIN#:	By reference
Funding Source:	Federal
SWDH Project Code:	95345031
Original Effective Date:	05/05/2025
Current Expiration Date:	04/30/2027
Total [Funding Amount or Cost of Service]:	17866.00
Allowable Indirect Rate:	33.84
Match Required:	NO
Match Amount:	0
FTE Supported:	3 partial FTEs
District Funds Budgeted in Current FY:	0.00
Restrictions:	None
Target Population:	All those with reportable viral hepatitis infections
If this is an amendment, briefly describe the change. Extending subgrant expiration date and adding $8,951.	

Contacts

Contact Name (Internal & External)	**Contact [Agency, Organization, Contractor, Vendor, Partner]**	**Contact Email or Phone Number**
Jared Bartschi	DHW	jared.bartschi@dhw.idaho.gov
Ricky Bowman	SWDH	ricky.bowman@swdh.id.gov

Created July 17, 2025

Applicable Law and/or Agreement

Idaho Statutes or Rules (select up to 3)	IDAPA 16.02.10	N/A	N/A
Agreement	N/A		

Public Impact

Scope of Work Summary (3-5 bullets)	- Timely surveillance and investigation of all viral hepatitis infections. - Complete and accurate documentation of reportable cases within statewide reporting database. - Coordination and capacity building for an effective public health response to hepatitis outbreaks.
Summary Public Impact (3-5 bullets)	- Timely review of laboratory reports and rapid case and contact investigations enable public health to identify infections sooner and interrupt hepatitis transmission before it spreads further in the community. - Complete and accurate documentation in the surveillance system ensures reliable data for monitoring trends, identifying outbreaks, and guiding prevention and resource allocation efforts. - Coordinated contact follow-up, outbreak notification, and referral to local testing and treatment.
Summary of Evidence-based (3-5 bullets)	- Timely electronic laboratory reporting and surveillance improve outbreak response and prevention outcomes:Moore, K. M., Reddy, V., Kapell, D., & Balter, S. (2008). Impact of electronic laboratory reporting on hepatitis A surveillance in New York City. Journal of Public Health Management & Practice, 14(5), 437–441. https://doi.org/10.1097/01.PHH.0000333877.78443.f0 - Case investigation and contact tracing are effective tools for reducing infectious disease transmission, including viral hepatitis:Hossain, A. D., Jarolimova, J., Elnaiem, A., Huang, C. X., Richterman, A., & Ivers, L. C. (2022). Effectiveness of contact tracing in the control of infectious diseases: A systematic review. The Lancet Public Health, 7(3), e259–e273. https://doi.org/10.1016/S2468-2667(22)00001-9 - High-quality surveillance data are essential for informed public health decision-making and viral hepatitis elimination efforts:Casillas, S. M., Hoots, B. E., & Gupta, N. (2025). Data to monitor viral hepatitis elimination in the United States. Public Health Reports, 1–5. https://doi.org/10.1177/00333549251372034

Reviewer/Approve

	Program Manager	PM2	Division Administrator	Financial Officer	Legal*	Director
Date	04/07/2026		04/07/2026	04/07/2026		04/07/2026
Initials	RB Ricky Bowman		BS	MH		WZ

** The necessity of legal review will be determined by the Financial Officer, Division Administrator, or Director.*

Southwest District Health

Originator	Parties
IDHW	SWDH

Document Type

Subgrant	☑ Amendment

Summary

Name/Title:	Southwest District Health - PHD 3 -PHEP
Description (long title):	Sexually Transmitted Disease (STD) and Human Immunodeficiency Virus (HIV) Case and Outbreak Investigation and Response
FAIN#:	By reference
Funding Source:	Federal
SWDH Project Code:	95345015
Original Effective Date:	06/01/2025
Current Expiration Date:	05/31/2027
Total [Funding Amount or Cost of Service]:	60997.00
Allowable Indirect Rate:	33.84%
Match Required:	NO
Match Amount:	0
FTE Supported:	1 partial FTE
District Funds Budgeted in Current FY:	0.00
Restrictions:	None
Target Population:	Those with HIV and sexually transmitted infections
If this is an amendment, briefly describe the change. Extending subgrant expiration date and adding $23,456.00.	

Contacts

Contact Name (Internal & External)	**Contact [Agency, Organization, Contractor, Vendor, Partner]**	**Contact Email or Phone Number**
Jared Bartschi	DHW	jared.bartschi@dhw.idaho.gov
Ricky Bowman	SWDH	ricky.bowman@swdh.id.gov

Created July 17, 2025

Applicable Law and/or Agreement

Idaho Statutes or Rules (select up to 3)	IDAPA 16.02.10	N/A	N/A
Agreement	N/A		

Public Impact

Scope of Work Summary (3-5 bullets)	- Investigate HIV and sexually transmitted infections per Idaho law and CDC standards with priority to congenital syphilis - Complete and document case investigations into the National Electronic Disease Surveillance System. - Provide partners services and other treatment recommendations to patients.
Summary Public Impact (3-5 bullets)	- Faster detection and reduced spread of HIV and sexually transmitted infections. - Improved health outcomes for individuals and families. - Stronger trust and protection through data security and preparedness.
Summary of Evidence-based (3-5 bullets)	- Hall, H. I., et al. (2012). HIV transmission rates from persons living with HIV who are aware and unaware of their infection. AIDS, 26(7), 893–896. https://doi.org/10.1097/QAD.0b013e328351f73f - Golden, M. R., et al. (2005). Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydial infection. New England Journal of Medicine, 352(7), 676–685. https://doi.org/10.1056/NEJMoa041681 - Kass, N. E. (2001). An ethics framework for public health. American Journal of Public Health, 91 (11), 1776–1782. https://doi.org/10.2105/AJPH.91.11.1776

Reviewer/Approve

	Program Manager	PM2	Division Administrator	Financial Officer	Legal*	Director
Date	04/07/2026		04/07/2026	04/07/2026		04/08/2026
Initials	RB Ricky Bowman		BS	MH		WJ

** The necessity of legal review will be determined by the Financial Officer, Division Administrator, or Director.*

Southwest District Health

Originator	Parties
IDHW	SWDH

Document Type

Subgrant	☐	Amendment

Summary

Name/Title:	PUBLIC HEALTH DISTRICT NO 3: FTT
Description (long title):	Families Talking Together Programming
FAIN#:	1602IDTANF
Funding Source:	Federal
SWDH Project Code:	95341215
Original Effective Date:	04/01/2026
Current Expiration Date:	06/30/2027
Total [Funding Amount or Cost of Service]:	38152
Allowable Indirect Rate:	33.84%
Match Required:	NO
Match Amount:	0
FTE Supported:	.19
District Funds Budgeted in Current FY:	0
Restrictions:	n/a
Target Population:	
If this is an amendment, briefly describe the change:	Families & caregivers of youth 10-14

Contacts

Contact Name (Internal & External)	**Contact [Agency, Organization, Contractor, Vendor, Partner]**	**Contact Email or Phone Number**
Hailee Ketchum	Southwest District Health	hailee.ketchum@swdh.id.gov
ANA VIDALES	SUBGRANT MONITOR	ANA.VIDALES@DHW.IDAHO.GOV

Created July 17, 2025

Applicable Law and/or Agreement

Idaho Statutes or Rules (select up to 3)	39-409, IC	N/A	N/A
Agreement	N/A		

Public Impact

Scope of Work Summary (3-5 bullets)	SWDH will implement the FTT parent-engagement curriculum with 20-25 Idaho parents and caregivers. SWDH must ensure all new staff responsible for FTT implementation complete training. SWDH may provide additional parent resources during program implementation including but not limited to, internet safety with prior approval from DHW. SWDH must participate in quarterly calls with DHW and develop work plans for activities planned for completion in the next fiscal year.
Summary Public Impact (3-5 bullets)	Help caregivers reduce/prevent youth risk behaviors Help caregivers develop positive parenting techniques Help promote effective parent-adolescent communication skills Help caregivers teach adolescent assertiveness to avoid risky behaviors Help caregivers promote delayed sexual debut
Summary of Evidence-based (3-5 bullets)	Families Talking Together (FTT) is an evidence-based, parent-focused intervention proven by randomized controlled trials (RCTs) to reduce adolescent sexual risk behaviors. Recognized by the U.S. Dept of Health and Human Services (HHS) and other agencies, it targets parents/ caregivers of youth aged 10-14.

Reviewer/Approve

	Program Manager	PM2	Division Administrator	Financial Officer	Legal*	Director
Date	04/02/2026	04/02/2026	04/07/2026	04/07/2026		04/07/2026
Initials	HA	Charlene Cariou	BS	MH		WJ

** The necessity of legal review will be determined by the Financial Officer, Division Administrator, or Director.*