WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE

Aligning for Health: Western Idaho Health Implementation Plan

2023-2026

WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE

November 16, 2023

Dear Communities and Partners,

Southwest Idaho is one of the most desirable places to live in the country. Through this Regional Health Implementation Plan, we aim to make it one of the healthiest places to live, as well.

Overall, our population has positive health outcomes. Yet we know that not all in our 10-county region have the same experience; Those of us who have been historically marginalized and underserved – such as our rural communities, communities of color, and lower-income households – have poorer health outcomes than their counterparts across the region.

Against this backdrop, partners across our health systems, public health organizations, public safety agencies, local governments, philanthropic foundations, community-based nonprofits and health experts came together to form the Western Idaho Community Health Collaborative – a partnership unlike anything ever seen in Idaho before. Our goal was ambitious: to work across our entire region to understand our health context more deeply, using well-grounded data; make informed, collaborative decisions that leverage all partners' expertise and resources; and to implement new, transformative strategies and solutions that improve the health and well-being of all southwestern Idahoans in tangible, measurable and new-found ways.

The resulting Regional Health Implementation Plan is Idaho's first ever community-driven plan to address complex health issues. The plan will serve as a north star as we work side by side with communities to listen, learn from each other, align resources, and implement substantive solutions.

We look forward to the work together, and to a healthier western Idaho for all!

In partnership,

Alexis Pickering, MHS

Western Idaho Community Health Collaborative Program Manager
Central Health District | Southwest District Health

Acknowledgements

This plan was developed through the expertise and experience of the partners listed below. Through the work of Western Idaho Community Health Collaborative member workshops and input from additional community partners, we have an actionable implementation plan for moving forward together as a region focused on improving health outcomes for our community.

Cas Adams, *Southwest District Health*
Daniel Adams, *Southwest District Health*
Mark Babson, *Ada County EMS*
Alicia Baptiste, *Idaho Dept. of Juvenile Corrections*
Kelli Badesheim, *At-Large Member*
Maureen Brewer, *City of Boise's Our Path Home*
Jonny Carkin, *Idaho Assoc. for the Education of Young Children*
Charlene Cariou, *Southwest District Health*
Kelsey Cooper, *Idaho Foodbank*
Tiffany Dobbs, *St. Luke's Health System*
Raul Enriquez, *Southwest Idaho Area Agency on Aging*
Ariel Foster, *Saint Alphonsus*
Courtney Frost, *Blue Cross of Idaho Foundation for Health*
Angie Gribble, *St. Luke's Health System*
Commissioner Elt Hasbrouck
Sara Hegerle, *St. Luke's Health System*
Tracy Humpherys, *PacificSource*
Courtney Kelly, *Western Idaho Community Health Collaborative*
Ashley Knight, *St. Luke's Health System*
Brian Knight, *Human Supports of Idaho*
Amanda Leader, *Boise County*
Rebecca Lemmons, *Saint Alphonsus*
Halle McDermott, *Southwest District Health*
Mary Mlot, *Molina Health Plans*
Jean Mutchie, *St. Luke's Health System*
Alexis Pickering, *Western Idaho Community Health Collaborative*
Yvette Primero, *Molina Health Plans*
Hayley Regan, *United Way of Treasure Valley*
Neva Resendez, *Valley Regional Transit*
Megan Remaley, *United Way of Treasure Valley*
Dr. Kevin Rich, *Full Circle Health*
Florina Ruvio, *Idaho Assoc. for the Education of Young Children*
Becca Sprague, *Central District Health*
Emily Straubhar, *Southwest District Health*
Amy Stahl, *SelectHealth/Intermountain Health*
Hailee Tilton, *Southwest District Health*
Dr. Sarah Toevs, *Boise State University*
Kristen Tracey, *Blue Cross of Idaho*
Anne Wolverton, *United Way of Treasure Valley*
Tara Woodward, *Southwest District Health*
Jackie Yarborough, *Blue Cross of Idaho Foundation for Health*

Plan prepared by Agnew::Beck with financial support from St. Luke's Health System, Saltzer Health/Intermountain Health, Central District Health and Southwest District Health.

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Introduction

The Western Idaho Community Health Collaborative (WICHC) Regional Health Implementation Plan (RHIP) is a groundbreaking collaborative plan to comprehensively address factors that impact the health and well-being of residents in the 10 counties of southwest Idaho. The Implementation Plan was developed from the regional 2023 Community Health Needs Assessment's identified priority areas of housing, behavioral health, and access to care.

Key Priority Areas

Housing

Behavioral Health

Access to Care

About WICHC

The Western Idaho Community Health Collaborative (WICHC) aligns health care, public health, and community-based organizations to improve the social influencers of health.

As a community of stakeholders, WICHC aims to transform the health of our community by collaborating, prioritizing, and collectively supporting the community health needs and healthcare transformation efforts that will have the greatest impact on improving health outcomes and lowering the costs of healthcare for the ten-county region that includes: Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties. The work of the collaborative is to serve all those who live, work, learn or play in the ten-county region, focusing on all ages of residents in our urban and rural settings.

WICHC prioritizes these core concepts to achieve our goal to unite leaders in the common cause of improving health through upstream, strategic efforts.

Our Approach

WICHC identified core principles that drive our approach and our understanding of how to accomplish the important work ahead:

- *Leverage the power of collaborative impact.*
  Affecting real change in housing, behavioral health, and access to care is a multi-year effort requiring alignment of partners from across sectors; as an active, regional partnership WICHC has a key role in leading and contributing to this effort. We work in collaboration to be efficient and effective and achieve optimal health outcomes in all the contexts (urban, rural) within our region.
- *Build WICHC capacity to lead.*
  In order to successfully execute the Regional Health Implementation Plan, WICHC needs additional resources and staffing to advance the work, particularly in rural areas.
- *Stay in our lane.*
  The strategies and actions identified in this Regional Health Implementation Plan are the ones best suited for WICHC to lead. We recognize our work exists alongside that of many other partners and collaborators throughout Idaho.
- *Be transparent and accountable.*
  We use data and measures to identify priority areas, develop strategies, and measure change. Using data ensures accountability to the communities we serve and to each other and allows us to determine if identified strategies and investments are effective or need to be modified.

About This Plan

What is a Regional Health Implementation Plan?

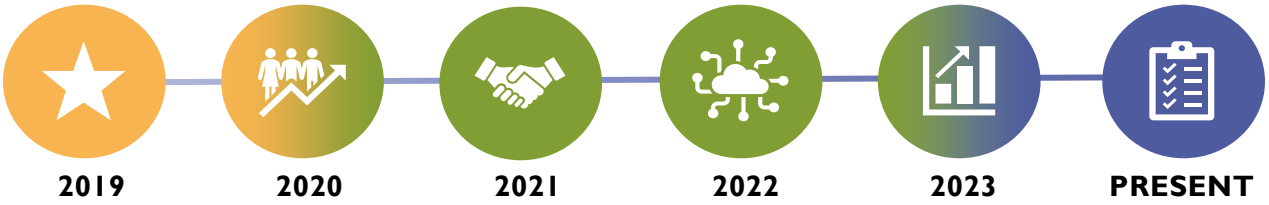
A regional health implementation plan expands on the community health improvement plan (CHIP) model to focus on a wider geography context. It provides strategies and actions that work toward WICHC's goal to promote and improve health access across our ten-county region in the next three years.

The benefit of creating an implementation plan lies in the strengthened collaborative that invests in their own communities through shared knowledge and resources to better serve the overall region's health needs. Further value is added by WICHC members who provide a necessary role in this work. Regional health implementation plans cannot be created in a vacuum, it requires deep collaboration and coordination from diverse sector experts. WICHC members will contribute to the plan in various ways, through programming alignment with the implementation plan, funding, or other in-kind supports. In leveraging each other's investments, the collaborative will take the plan's ideals and fortify them through the real-world applications and modifications.

Plan Development Process

After an initial landscape analysis, the implementation planning process started after the CHNA was published; it included two workshops with WICHC members and interviews with partners. The first workshop focused on collecting all possible solutions to improve regional efforts within the identified priority areas of housing, behavioral health, and access to care. All workshop input was organized into draft implementation tables which were reviewed at the second workshop; further refinement and suggested potential partnerships also occurred in the second workshop.

Organizations that expressed interest in supporting implementation plan work were asked to an interview where they provided further ideas of how their organization was able to lend a hand toward regional and local solutions. The implementation tables were further edited based on all interview input and have been approved by WICHC members.



2019

With matching funds from four private partners and the State Legislature, WICHC got to work.

2020

Set strategies, applied and received grants. Received small and large place-based grants like the Get Healthy Idaho grant (Elmore County).

2021

Kicked off CHNA process, partnered with other communities to address SDOH.

2022

Collected CHNA data and completed WICHC evaluation.

2023

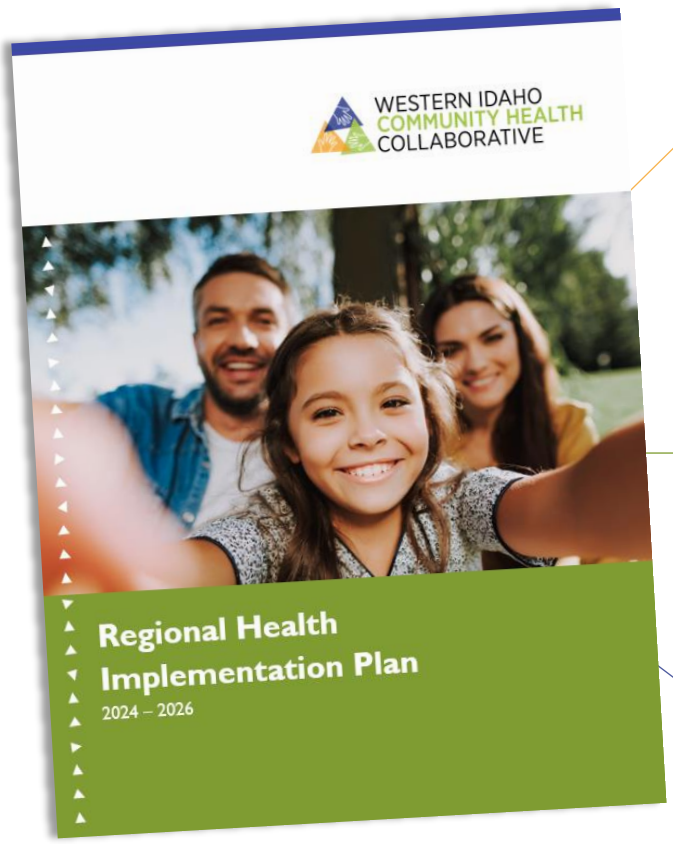
CHNA is published, began implementation planning process.

PRESENT

Create 3-year plan aligning WICHC members to address health priorities across the region.

How to Use this Plan

The plan contains three sections, described below.



Introduction

Details the plan process and development.

Highlights our priority action areas and principles of our approach.

Implementation Framework

Features information about the implementation direction and goals established through this process.

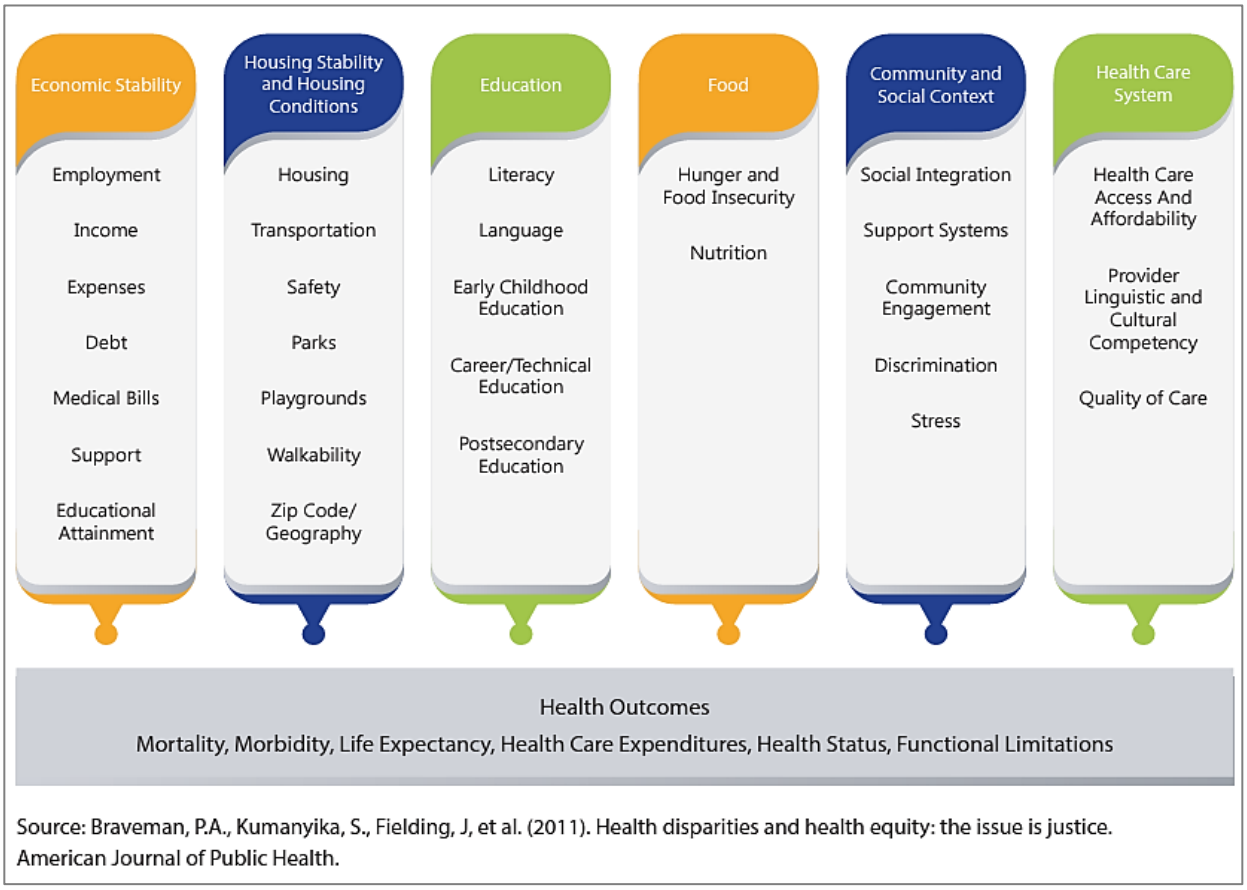
Implementation Plan Tables

Highlights the specific implementation strategy and actions WICHC will accomplish to achieve its vision and goals.

Key Priority Areas and Actions

Community Health Needs

The 2023 WICHC Community Health Needs Assessment (CHNA) analyzed existing social, educational, economic and health data to determine the health needs of the Greater Treasure Valley. The analysis evaluated data for the 10-county region in the areas shown below – areas that correlate to individual, family, community and regional health outcomes.



Source: Braveman, P.A., Kumanyika, S., Fielding, J, et al. (2011). Health disparities and health equity: the issue is justice. American Journal of Public Health.

Through the CHNA process, three clear priority areas were indicated for the WICHC region: **Housing, Behavioral Health, and Access to Care.** WICHC recognizes the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only the most pressing health needs within its ability to influence. Please review the 2023 CHNA and the Idaho Oregon Community Health Atlas for a comprehensive dive beyond these three priorities.

Priority Areas

Housing

Housing is a critical foundation to support healthy, thriving communities – it "helps catalyze the physical, economic, and social conditions a community needs to help its members thrive."[1] As communities have been living out varying degrees of the housing crisis, many communities have been evaluating what can be done to

[1] Robert Wood Johnson Foundation – Housing Policy and Practice

address housing unit shortages, affordability, increased cases of homelessness, and how solutions can be applied equitably.

To address the unique housing needs in the region, WICHC identified solutions that included piloting a housing learning collaborative and identifying ways to align existing funding whilst pursuing transformational sources of funding.

Behavioral Health

Workforce shortages, cost of services and stigma around using services have made it increasingly difficult for people to access needed behavioral health and substance misuse treatment services.

Recruitment and retention improvements to the behavioral health workforce are a priority to support healthier communities as are increased rural access to behavioral health services, and expansion and investment of the community school model.

Access to Care

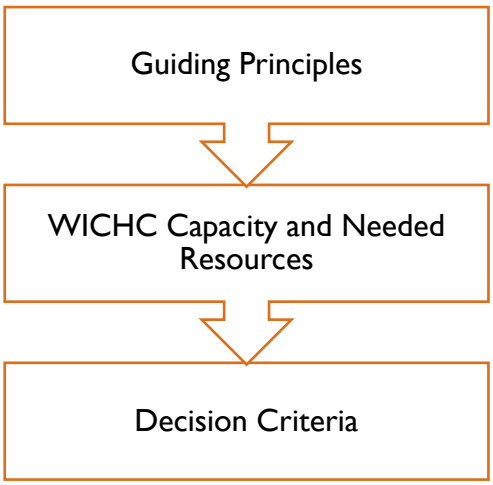
Idahoans in the region, especially those in rural areas, struggle to access health-related services. Whether it is because there are a lack of providers in their area, a lack of transportation options to attend appointments, affordability or lack of insurance, there are many barriers throughout the region that inhibit residents from seeking and accessing the care that they need.

Alleviating these barriers will need to include retaining the existing workforce, enhanced care coordination and resource navigation through shared provider platforms and strategically locating mobile and co-located services to best meet service area gaps.

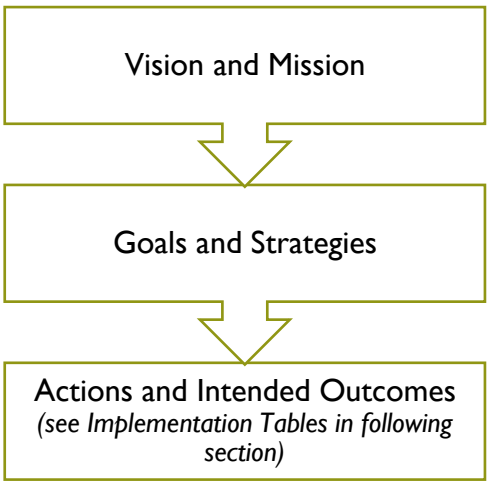
Regional Implementation Framework

This section has two components: "Inputs to the Plan," which helped shape the plan itself and "Implementation Framework," which frames and describes the work of implementation. The following section "Implementation Plan Tables" details specific actions, timing, partners, and intended outcomes of our collective efforts.

Inputs to the Plan



Implementation Framework



Guiding Principles

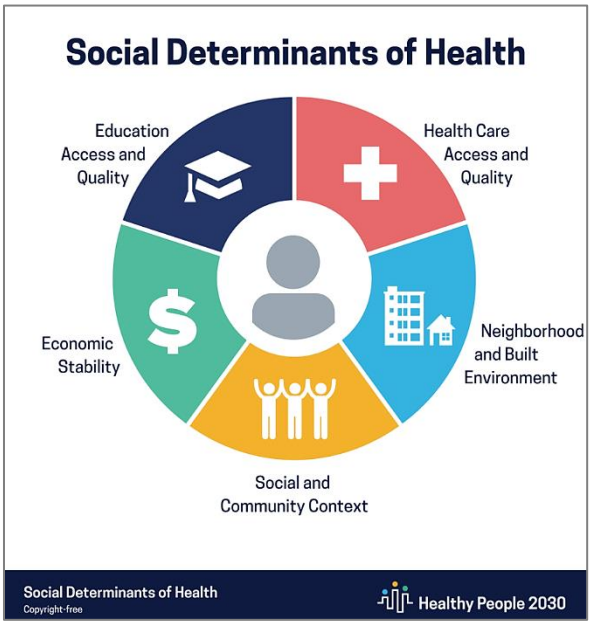
The development of the Regional Implementation Plan was informed by the following core principles.

We work to address the complexity of factors impacting health social determinants of health.

Social determinants of health are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies, racism and climate resilience and political systems.[2]

We strive to achieve health equity.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices,



[2] Social Determinants of Health at CDC

and social determinants of health — and to eliminate disparities in health and health care.[3]

We invest in both health interventions and universal prevention practices.

Prevention and working upstream is proven to be the best long-term strategy to improve individual and community health. It is important to simultaneously invest in health interventions which promote population health and well-being in efforts to increase life expectancy, improve quality of life and reduce health care costs.[4]

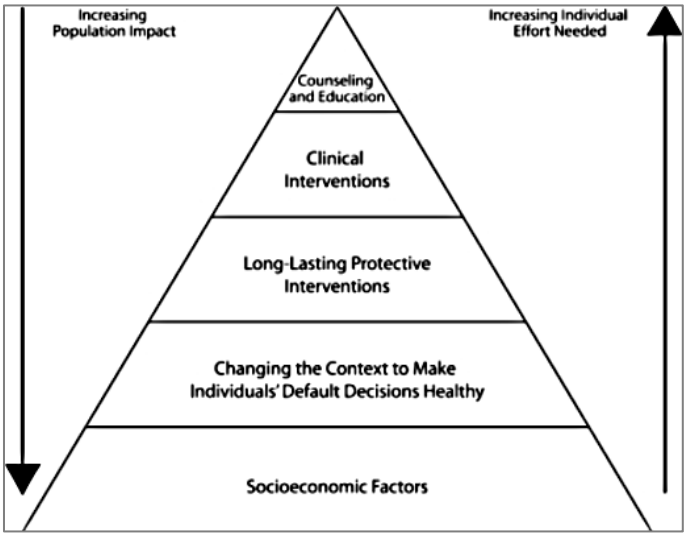
WICHC Capacity and Organization

The Regional Health Improvement Plan is a collaborative plan aligning multiple agencies, resources and partners. WICHC's role is to act as the centralized "implementation hub" to coordinate partnering organizations, disseminate relevant information, connect opportunities and funding, and "right-size" work with appropriate individuals, groups, and organizations.

WICHC should maintain a strong, sustainable collaborative with clear organization, operations, communications, and adequate capacity. To advance the work, WICHC itself would benefit from additional resources and targeted sub collaborations. Below are specific recommendations that will help ensure WICHC has right-sized capacity and organization in plan implementation.

Capacity for Implementation

1. Fund and hire a WICHC Implementation Plan Coordinator dedicated to overseeing and coordinating implementation of this plan.
2. Obtain funding and necessary resources to implement near-term and long-term priorities. Coordinate with partnering organizations to identify and obtain needed funding, such as through submitting grant applications, leveraging existing resources, and identifying new fundraising opportunities.



3. Conduct trainings and learning opportunities for WICHC members on all priority policy areas.

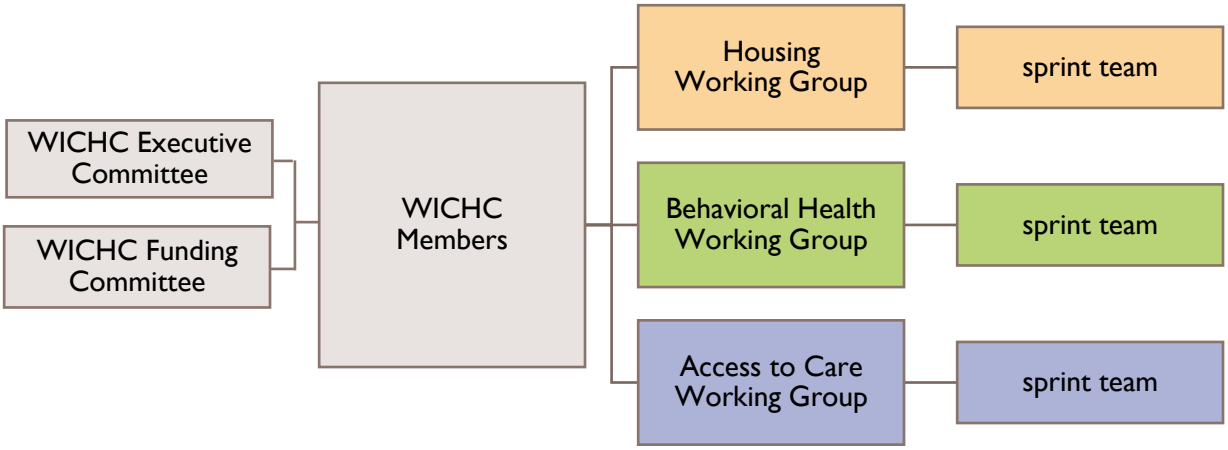
Collaborative Organization

4. Build on the existing WICHC structure by continuing/adding Working Groups focused on each priority area – housing, behavioral health and access to care.

[3] Health Equity People 2030

[4] CDC Places: Local Data for Better Health Programs and Interventions

5. Consider adding specific "sub collaborations" or "sprint teams" within Working Groups, as needed, as needed, for high priority and/or specialized tasks.



Outreach and Engagement

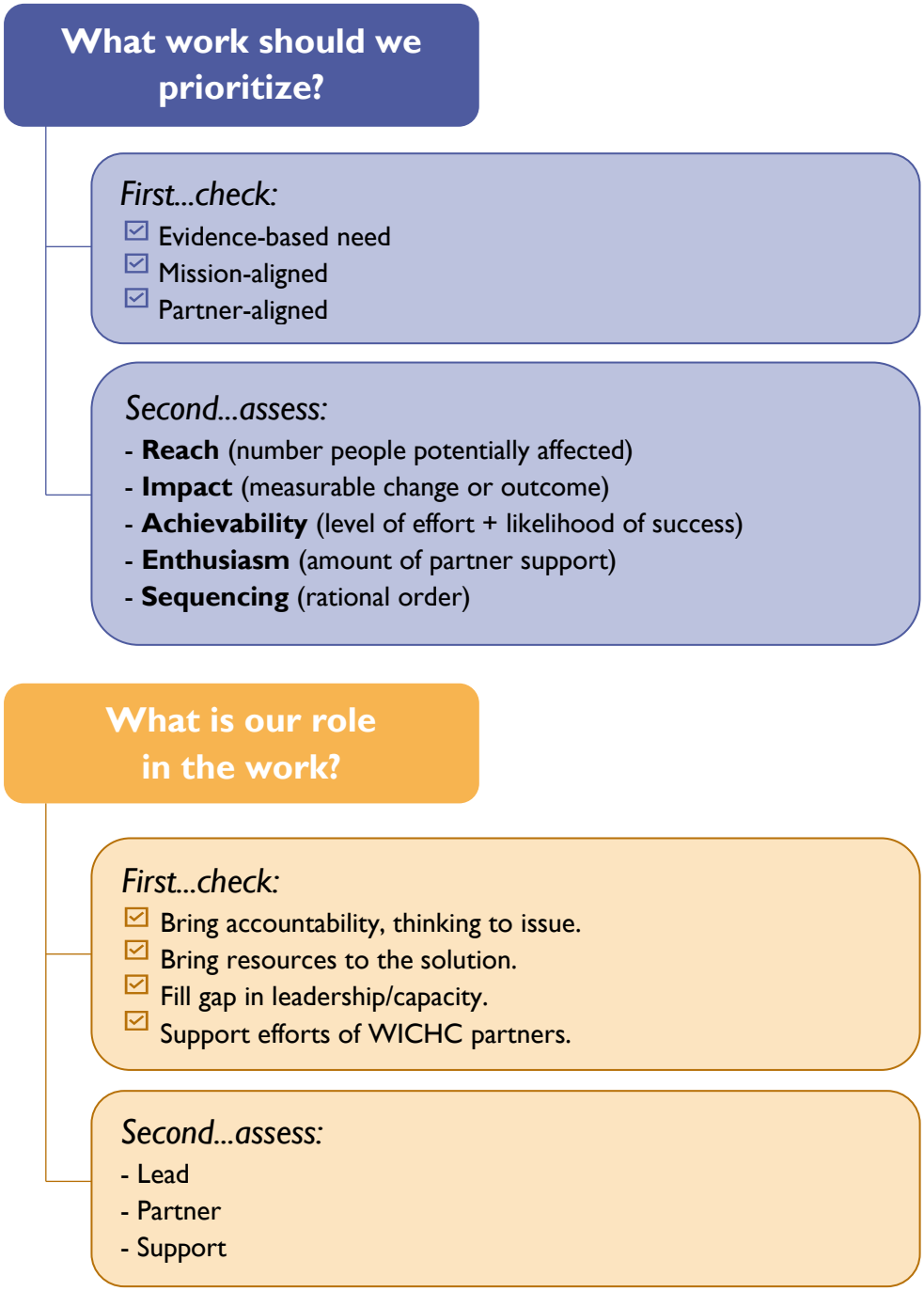
6. Regularly disseminate WICHC information to relevant organizations, decisionmakers, and the public.
7. Invite local governments, organizations and community members to help refine and ground WICHC's work by convening meetings, hosting listening/work sessions and conducting interviews to share information and identify solutions that work in specific subareas of the WICHC region.

Evaluation

8. Develop more detailed work plans for each of the priority areas to coordinate efforts and report on progress.
9. Develop evaluation structure to track key performance measures, outputs and outcomes and measure progress and impact.

Decision Criteria Framework

This decision criteria framework was developed as a means to evaluate and validate the strategies and actions identified in the Regional Health Implementation Plan. All strategies and actions were developed and then evaluated by WICHC members according to these criteria before being included in the plan. The ideation, winnowing, selection and refinement process occurred through a series of facilitated WICHC workshops and interviews with WICHC members, helping ensure the plan is supported, actionable and achievable.



WICHC Vision and Mission

Vision

Every person in the WICHC region has the opportunity to thrive.

Mission

We transform the health of our communities by collaborating, prioritizing, and collectively supporting the upstream community health needs of our region.

Priorities and Goals

Based on the processes and framework in previous sections, the following goals, focused work areas, and strategies were developed to meet WICHC and the region's health priorities. Actions for strategies are provided in the Implementation Plan Tables on page 13.

Housing

Goal: Support local decision makers and community efforts to increase available housing supply and overall housing stability.

Focused Work Area 1: Educate partners and collaborators to increase housing.

Strategy 1: Host Regional Health and Housing Learning Collaborative and develop supporting resources and strategies to deepen understanding of housing dynamics and increase action on housing solutions and investments.

Focused Work Area 2: Align and secure additional funding sources.

Strategy 2: Identify and advocate for new transformational funding sources for housing investments.
Strategy 3: Further leverage philanthropic supports for housing.

Behavioral Health

Goal: Improve access to behavioral health services and behavioral health outcomes.

Focused Work Area 1: Develop and support behavioral health workforce.

Strategy 1: Understand the behavioral health workforce pipeline and rural community access.

Focused Work Area 2: Invest in and scale proven prevention and early intervention programs.

Strategy 2: Support the Idaho Community School Initiative through partnerships to increase capacity.

Focused Work Area 3: Increase community awareness and education.

Strategy 3: Reduce behavioral health stigma.

Access to Care

Goal: Improve accessibility and availability of care, free from discrimination and bias.

Focused Work Area 1: Increase awareness and access to resources.

Strategy 1: Expand and improve partner and community use of resource and referral pathways.
Strategy 2: Develop and support partner programs focused on eliminating access barriers.

Focused Work Area 2: Create inclusive and culturally competent spaces and services.

Strategy 3: Identify and standardize resources for expansion of culturally appropriate communications.

Implementation Plan Tables

HOUSING IMPLEMENTATION PLAN KPIs in this area: Rental assistance priority index, increase of coordinated investments for supportive housing region-wide, participants completing Health and Housing Collaborative and implement Housing Strategy tools.																
GOAL: Support local organizations and community efforts to increase affordable housing supply and overall housing stability.	**Key Partners**	**Forecasted Timeline**														
		2024				2025				2026						
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
FOCUS AREA - EDUCATE PARTNERS and COLLABORATORS to Increase Housing																
Strategy 1: Host Regional Health and Housing Learning Collaborative and develop supporting resources and strategies to deepen understanding of housing dynamics and increase action on solutions and investments.																
POTENTIAL ACTION AREAS																
A. Identify aspirational outcomes, key audiences, and messages to include in a housing curriculum/seminar series.	City of Boise, BCIF, SWDH															
B. Host incentivized Health and Housing Learning Collaborative for cohort of regional decision-makers.	Municipalities, counties, relevant WICHC members															
C. Develop pro-housing implementation tools, e.g., renter protection policies, planning and zoning toolkits, etc.	Saint Alphonsus															
D. Design and implement curriculum for WICHC members to replicate experience of the Learning Collaborative.	BCIF, City of Boise, Saint Alphonsus, SWDH															
E. Develop regional health and housing action plan with rural strategies for Learning Collaborative participants.	City of Boise, BCIF, Saint Alphonsus, St. Luke's															
F. Develop template/toolkit of Local Public Health Department and Atlas Data that is shared with regional municipal leaders (or local CHATs) to inform them of health needs of their community.	CDH, SWDH, BSU															
G. Co-host community housing tour.	Municipalities, counties, BCIF															
FOCUS AREA - SECURE ADDITIONAL FUNDING SOURCES																
Strategy 2: Identify and advocate for new transformational funding sources for housing investments.																
POTENTIAL ACTIONS AREAS																
A. Create an inventory of existing and potential types of gap financing available in Idaho.	City of Boise, Saint Alphonsus															
B. Collaborate and assist in designing recommendations for programs to be included in a Medicaid 1115 waiver to address health needs of the region.	SWIA3, SWDH, BSU, CDH, Intermountain/Saltzer, Molina															
C. Secure dedicated source(s) of funding for housing in the WICHC region and/or statewide.	local municipalities, Saint Alphonsus															
Strategy 3: Further leverage philanthropic supports for housing.																
POTENTIAL ACTION AREAS																
A. Convene a funders forum to discuss potential alignmentments and opportunities to leverage WICHC member funds for housing-related projects and services.	Molina, BCIF, St. Alphonsus															
B. Develop a criteria and best-practices for investing in housing opportunities and programs (e.g. childcare).	St. Luke's, BCIF, Saltzer/Intermountain Health															

BEHAVIORAL HEALTH IMPLEMENTATION PLAN KPIs in this area: Child opportunity index increases regionally, increase number of community schools in the WICHC footprint, and suicide mortality decreases regionally to less than 15/100k residents.																
GOAL: Improve access to behavioral health services and behavioral health outcomes.	**Key Partners**	**Forecasted Timeline**														
		2024				2025				2026						
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
FOCUS AREA - DEVELOP and SUPPORT BEHAVIORAL HEALTH WORKFORCE																
Strategy 1: Understand the behavioral health workforce pipeline and rural community access.																
POTENTIAL ACTION AREAS																
A. Understand and examine rural behavioral health services and workforce needs.	IDJC, SWIA3, Full Circle Health, WICHC BH Provider Member, St. Luke's															
B. Develop and fund training on behavioral health rapid/crisis response such as QPR and Gatekeeper Training for community-based organizations and community members.	Saint Alphonsus, St. Luke's															
C. Advocate for and advise on training curriculum, certification, and licensing monitoring for paraprofessionals and peer-service providers.	UWTV, Full Circle Health, BSU, St. Luke's, Saint Alphonsus, Molina															
FOCUS AREA - INVEST IN AND SCALE PROVEN PREVENTION and EARLY INTERVENTION PROGRAMS																
Strategy 2: Support the Idaho Coalition for Community Schools through partnerships to increase capacity.	UWTV															
POTENTIAL ACTION AREAS																
A. Educate WICHC members on Community School Strategy and potential impacts and effectiveness.	BCIF															
B. Host two Community School site visits for WICHC members, with at least one being outside of Ada/Canyon County.	St. Luke's															
C. Partner with regional Community Schools to understand and bring resources to needed areas.	Idaho AEYC (ELCs)															
INCREASE COMMUNITY AWARENESS and EDUCATION																
Strategy 3: Reduce behavioral health stigma.	CDH, SWDH, hospitals, Boise County, Ada County EMS															
POTENTIAL ACTIONS																
A. Develop education campaign/materials focused on normalizing and increasing awareness for a targeted population around behavioral health issues.																
B. Audit marketing and messaging of current behavioral health services and resources to determine how to share information more effectively.																
C. Target stigma reduction materials at community gathering places, including schools, local markets, clinics, libraries, etc.																

ACCESS TO CARE IMPLEMENTATION PLAN KPIs in this area: Social vulnerability index decreases regionally to 20%, hardship index decreases regionally to 30%, minority health social vulnerability index decreases regionally to 25%.															
GOAL: Improve accessibility and availability of care that is delivered impartially, fairly, and properly to all.	**Key Partners**	**Forecasted Timeline**													
		2024				2025				2026					
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
FOCUS AREA - INCREASE AWARENESS AND ACCESS TO RESOURCES															
Strategy 1: Expand and improve partner and community use of resources and referral pathways.	UWTV														
POTENTIAL ACTION AREAS															
A. Support access to and host trainings for WICHC members and their agencies to learn more about findhelpidaho.org; receive annual data report outs on service area impact.	St. Luke's, PacificSource														
B. Offer certification/incentives for WICHC members who enroll in findhelpidaho.org and host at least one program on the site and/or promote the tool.	St. Luke's, PacificSource														
C. Support findhelpidaho.org by promoting community use and increased partner/provider engagement.	St. Luke's, Idaho Foodbank, SWIA3, CDH, SWDH, IAEYC, Boise County														
D. Educate WICHC members on connections between Find Help Idaho and 211 services to create effective, efficient resource navigation pathways.	Navigation														
Strategy 2: Develop and support partner programs focused on eliminating access barriers.															
POTENTIAL ACTION AREAS															
A. Create a mobile health map focused on primary care and prevention services for rural counties.	SWDH, St. Luke's, Boise County														
B. Develop a regional strategy for mobile health partners outside of Ada County to identify and address gaps and ease or eliminate access barriers.	Idaho Foodbank, SWDH, St. Alphonsus, St. Luke's, PacificSource, Boise County														
C. Offer opportunities to assist in assessing what kinds of services could be co-located within a community and provide connections to those partner services.	Idaho Foodbank, Boise County														
FOCUS AREA - CREATE INCLUSIVE and CULTURALLY COMPETENT SPACES and SERVICES															
Strategy 3: Identify resources for expansion of culturally appropriate communications.															
A. Incorporate feedback from diverse communities to address service delivery challenges, strength, and opportunities.	St. Luke's/SWIA3 grant, Valley Regional Transit, Ada County EMS, Idaho Foodbank														
B. Develop recommendations for standardization of communications in health and community-based organizations including simplifying readability to a 5th-grade level, translation services and translating public-facing material, and making materials ADA accessible/optimized.	Molina, Full Circle Health, CDH, Valley Regional Transit, Ada County EMS, St. Luke's														
C. Develop standardized cultural competency best practices and established training opportunities for WICHC members.	Molina, CDH, Valley Regional Transit														

Appendices

Acronyms

Acronym	Definition
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
PSE	Policy System and Environment
SDOH	Social Determinants of Health
WICHC	Western Idaho Community Health Collaborative

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