WESTERN IDAHO
COMMUNITY HEALTH
COLLABORATIVE

Community Health Needs Assessment

GREATER TREASURE VALLEY 2026

Saint Alphonsus
A Member of Trinity Health

St Luke's

SOUTHWEST DISTRICT HEALTH

UNITED WAY
Treasure Valley

CENTRAL DISTRICT HEALTH

Acknowledgements

CHNA LEAD TEAM

- Angie Gribble, St. Luke's Health System
- Anne Wolverton, United Way of Treasure Valley
- Ariel Foster, Saint Alphonsus
- Berenice Medina, Public Health District 3 (Southwest District Health)
- Charlene Cariou, Public Health District 3 (Southwest District Health)
- Corey Surber, Saint Alphonsus
- Kara Mastalski, Saint Alphonsus
- Rebecca Jenkins, Public Health District 4 (Central District Health)

WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE ADVISORY BOARD

- Ariel Foster, Saint Alphonsus
- Kathy Holland, The Idaho Foodbank
- Kelli Badesheim, Retired, Former CEO of Valley Regional Transit
- Kevin Rich, Full Circle Health
- Marnie Packard, Molina Healthcare of Idaho
- Megan Remaley, United Way of Treasure Valley
- Nikki Zogg, Public Health District 3 (Southwest District Health)
- Rebecca Lemmons, Saint Alphonsus
- Russ Duke, Public Health District 4 (Central District Health)
- Theresa McLeod, St. Luke's Health System

WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE MEMBERS

- Blue Cross of Idaho
- Boise State University
- Central District Health
- Full Circle Health
- Idaho Crisis & Suicide Hotline
- Idaho Department of Juvenile Corrections
- Idaho Association for the Education of Young Children
- Molina Healthcare of Idaho
- Saint Alphonsus
- Southwest District Health
- St. Luke's Health System
- The Idaho Foodbank
- United Way of Treasure Valley
- United HealthCare Services, Inc.
- Valley Regional Transit
- Weiser Memorial Hospital

COMMUNITY LEADER INTERVIEW PARTICIPANTS

- Adams County Health Center
- Advocates Against Family Violence
- Boys & Girls Club of Ada County
- Caldwell Housing Authority
- Cascade Medical Center
- City of Marsing
- City of New Meadows
- Desert Sage Health Centers
- El Ada Community Action Partnership
- Emmett Valley Friendship Coalition
- Gem County Recreation District
- Horseshoe Bend School District
- Idaho Department of Education
- Idaho National Guard
- Idaho Organization of Resource Councils
- Jesse Tree
- Mountain Home School District
- Meadows Valley Public Library District
- St. Luke’s Health System
- TANTA and Safe Connections, LLC
- Terry Reilly Health Services
- The Idaho Foodbank
- United Way of Treasure Valley
- Valley Family Health Care
- Valley Regional Transit
- Weiser Memorial Hospital
- WICAP Community Collaborative

FOCUS GROUP HOSTS

- Adams County Health Center
- Elmore County Health Coalition
- City of Marsing
- Garden Valley Senior Center
- Gem County Recreation Center
- Idaho Hispanic Foundation
- Ignite Idaho Family Resource Center
- LEAP Housing
- Lewis and Clark Elementary School
- Marsing Chamber of Commerce
- Marsing School District - The HUB
- McCall Community Center
- Sacagawea Elementary
- The Eddy
- Treasure Valley Housing Coalition
- United Way of Treasure Valley
- Valley Family Health Care
- WICAP Community Collaborative

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Executive Summary

The Community Health Needs Assessment (CHNA) for the Greater Treasure Valley Region, conducted by the Western Idaho Community Health Collaborative (WICHC) and its health partners, aims to identify and address the health needs of our community. Established in 2019, WICHC is a regional collaborative that combines two health districts into a 10-county region.

WICHC's mission is to transform the health of our communities by collaborating, prioritizing, and collectively supporting the upstream community health needs of our region. WICHC's vision is that every person in the WICHC region has the opportunity to thrive.

WICHC encompasses the counties served by Central District Health (Public Health District 4: Service Area includes Ada, Elmore, Boise, and Valley Counties) and Southwest District Health (Public Health District 3: Service Area includes Adams, Canyon, Gem, Owyhee, Payette, and Washington Counties). Through a Collective Impact approach, WICHC works closely with community partners to improve the health and well-being of all residents.

The CHNA process included a comprehensive assessment of the health needs across the 10-county region. Community surveys, focus groups, interviews and existing health and community data were utilized to identify key health themes and needs. **The assessment highlighted several critical areas that require attention and intervention. Identified health needs include:**

- ✓ **Access to Care**
- ✓ **Behavioral Health**
- ✓ **Childcare**
- ✓ **Chronic Disease**
- ✓ **Food Access**
- ✓ **Housing**
- ✓ **Maternal and Child Health**
- ✓ **Tobacco and Nicotine Use**

These needs were presented to community partners and leaders, who were then asked to vote to determine the upcoming priorities. Based on input from these partners, the following health needs were prioritized (see pages 47-48 for full voting results):

- ✓ **Behavioral Health**
- ✓ **Housing**
- ✓ **Access to Care**

Background

Community Health Needs Assessments (CHNAs) are conducted to help nonprofit health systems, public health districts, and community organizations identify and better understand the most significant community and health challenges facing individuals and families in the communities they serve.

In Idaho, organizational CHNAs were traditionally produced independently. However, in 2023, the Greater Treasure Valley CHNA represented an unprecedented partnership to align several independent regional assessments. This collaboration was anchored by Central District Health, Intermountain Health System (Saltzer Health), Saint Alphonsus Health System (Saint Alphonsus), Southwest District Health, St. Luke's Health System (St. Luke's), United Way of Treasure Valley (United Way), Weiser Memorial Hospital, and the Western Idaho Community Health Collaborative (WICHC).

WICHC, established in 2019, combines two health districts into a 10-county regional collaborative aligning healthcare, social services, and public health to work together and invest in communities towards a common goal of improving health outcomes and saving costs. WICHC's region includes the counties served by Central District Health (Public Health District 4: Service area includes Ada, Elmore, Boise, and Valley Counties) and Southwest District Health (Public Health District 3: Service area includes Adams, Canyon, Gem, Owyhee, Payette, and Washington Counties).

> ***The mission of Central District Health is partnering to promote and protect health in our communities. The values include excellence, positive impact, partnership, innovation, credibility, and humanity.***
>
> ***The mission of Southwest District Health is to promote the health and wellness of those who live, work and play in Southwest Idaho. Core values include accountability, customer-focused, and teamwork.***

Saint Alphonsus is a mission-driven, innovative health organization that strives to become the national leader in improving the health of communities and each person served. This CHNA report is inclusive of Saint Alphonsus Medical Center (Boise), Saint Alphonsus Medical Center- Nampa, and the Saint Alphonsus Regional Rehabilitation Hospital. See Appendix 1 for additional hospital information.

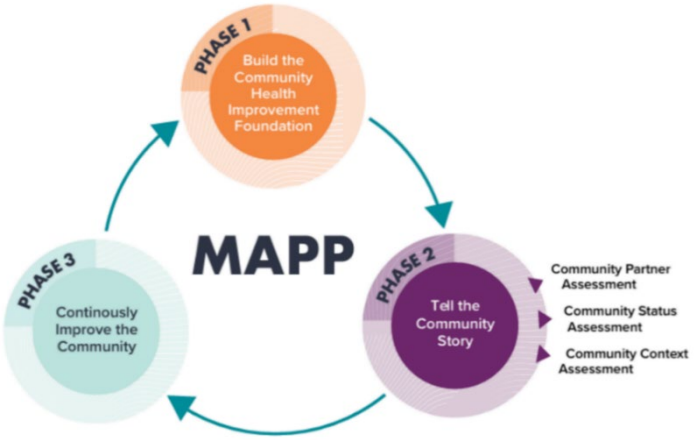
St. Luke's is an Idaho-based nonprofit health system with a mission to improve the health of people in the communities it serves. As a nonprofit health system, St. Luke's conducts a CHNA every three years and develops subsequent plans of action to address the top needs in their communities. This CHNA report is inclusive of St. Luke's Regional Medical Center (Boise and Meridian hospitals), St. Luke's Elmore, St. Luke's Nampa and St. Luke's McCall. See Appendix 2 for additional hospital information.

United Way of Treasure Valley responds to the evolving needs of the community - bringing people and resources together to create lasting solutions. From strengthening local resilience to advancing health, youth opportunity, and financial security, United Way mobilizes communities to action so all can thrive.

The 2026 CHNA continued the collaborative approach established in 2023. The partnership gathered input during data collection from community organizations including small- and medium-sized businesses, major corporations, and financial institutions; hospitals and healthcare organizations; and faith-based organizations, civic groups, governments, nonprofits, and volunteers to confront the socioeconomic challenges within the Greater Treasure Valley (see Acknowledgments). The information gathered through this assessment will guide the alignment of resources and implementation of needs-driven, evidence-based solutions.

Methodology

The Greater Treasure Valley CHNA process was conducted using the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. This framework emphasizes a community-based approach to identify, prioritize, and address current public health issues. MAPP 2.0 engages the entire local public health system, which ensures a thorough evaluation of the community's health through the three-phase process:



Phase 1: Building the foundation.

Preparing for this cycle included forming a CHNA Committee, collaborating with WICHC members and local networks, identifying community members and partners to engage, and assessing both available and needed resources.

Phase 2: Telling the community story.

Using MAPP 2.0's three streamlined assessments, we combined quantitative data with community voice.

1. The Community Status Assessment utilized quantitative data and analyzed comparisons to state and national averages, trends over time, and inequities among populations. Sources included community surveys and publicly available data from local, state, and federal sources.
2. The Community Context Assessment, built on community partner interviews and community member focus groups, revealed root causes such as affordability and access challenges.
3. The Community Partners Assessment identified strengths and gaps in the local public health system, and revealed additional opportunities for collaboration.

Detailed descriptions of these data sources can be found in the next section.

Phase 3: Continuously improving the community.

With a shared evidence base, three strategic issues were prioritized which will be leveraged to write a Community Health Improvement Plan.

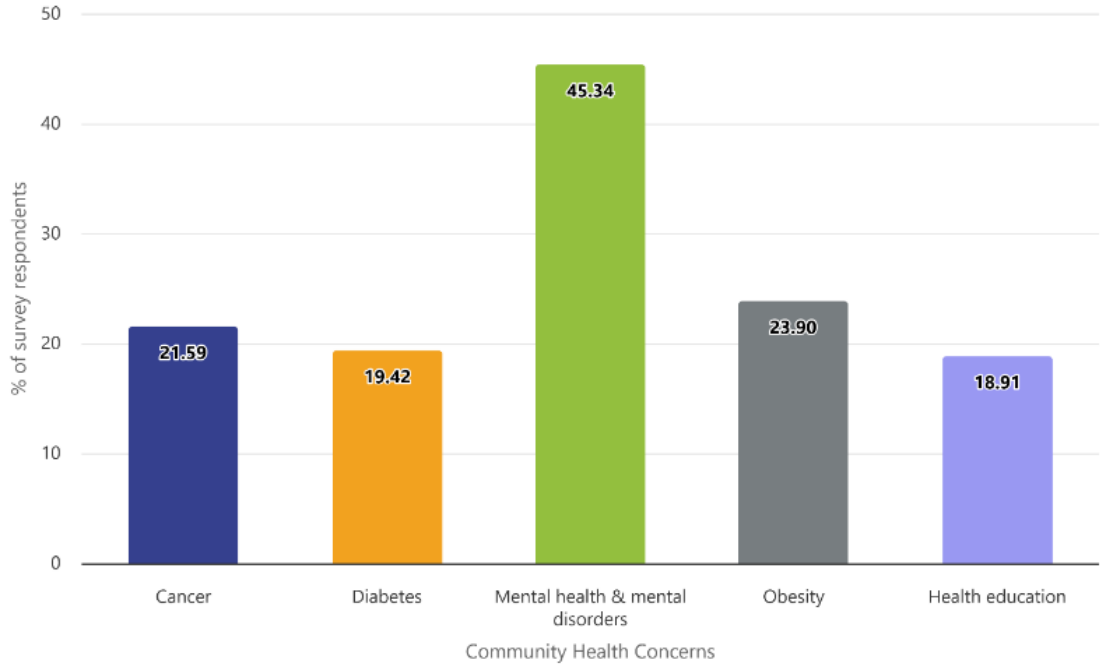
Data Sources

COMMUNITY SURVEY

- Surveys included questions about health behaviors, mental health, and aspects related to the Greater Treasure Valley community. The questions were developed to supplement publicly available data. Survey questions can be found in Appendix 3
- Conducted between March and June 2025
- Survey was available in both English and Spanish, with additional languages available upon request
- Promoted via community partner events, email, social media, newspaper, and included digital and in-person outreach
- Available online or on paper
- Nearly 8,000 Greater Treasure Valley survey responses were collected

Among survey respondents, the top health needs identified included mental health, obesity, cancer, diabetes, and health education.

Respondents perceived top health issues by Community Health Concerns, Districts 3 & 4 – 2025



Created on Metopio | metopio | **Data source:** Idaho Oregon Community Health Survey

Respondents' perceived top health issues: Percentage of survey respondents who selected each option in response to the question: "What health issues are having the biggest impact in your community? Please select your top three (3)."

FOCUS GROUPS

- Participants were community members and community partners
- Conducted between March and June of 2025
- Focus groups were held in a semi-structured format, and were conducted in person or virtually via Zoom
- 19 focus groups were conducted

INTERVIEWS

- Participants were community leaders serving the Greater Treasure Valley
- Respondents were asked to identify the health needs and community needs in the Greater Treasure Valley
- Conducted between March and June of 2025
- Interviews were conducted in a semi-structured format
- 30 interviews were completed

COMMUNITY PARTNER ASSESSMENT

- Participants were partners who have supported, or hope to support, community health improvement efforts
- Respondents were asked to describe their organizations' strengths, resources, and barriers
- Conducted between June and July of 2025
- 52 Community Partner Assessment surveys were completed

METOPIO

Metopio is a robust platform that offers curated data from public and proprietary sources, providing information on health behaviors, health risks, health outcomes, and community-level drivers of health. In this assessment, Metopio was used to gather secondary data to complement the primary data collected from surveys, focus groups, and interviews. This data helped to contextualize the findings and provide a broader understanding of the community's health needs.

Community Definition

For the purpose of this CHNA report, the geographic area served, and named as 'Greater Treasure Valley', includes the Western Idaho Community Health Collaborative (WICHC) footprint comprised of the 10 counties served by Southwest District Health (also referred to as District 3, shown below in orange) and Central District Health (also referred to as District 4, shown below in green). This area is home to 48% of Idaho's total population.

Community Demographics

Demographic characteristics are essential to understanding a community's health challenges. Factors such as race and ethnicity, gender, income, and education are closely linked to health outcomes and protective factors.

Race/Ethnicity

The chart below represents the population distribution across various racial and ethnic categories in Health Districts 3 and 4.

Population by Race/Ethnicity (2019-2023)

Race/Ethnicity	Health District 3	Health District 4
White *(Non-Hispanic)*	70.7%	81.8%
Hispanic or Latino *(Regardless of Race)*	23.6%	9.8%
Two or more races *(Non-Hispanic)*	4.0%	4.1%
Black *(Non-Hispanic)*	0.5%	1.3%
Native American *(Non-Hispanic)*	0.4%	0.3%
Pacific Islander/Native Hawaiian *(Non-Hispanic)*	0.1%	0.2%

Created on Metopio | metop.io/i/8zzqbhkz | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

Income and Employment

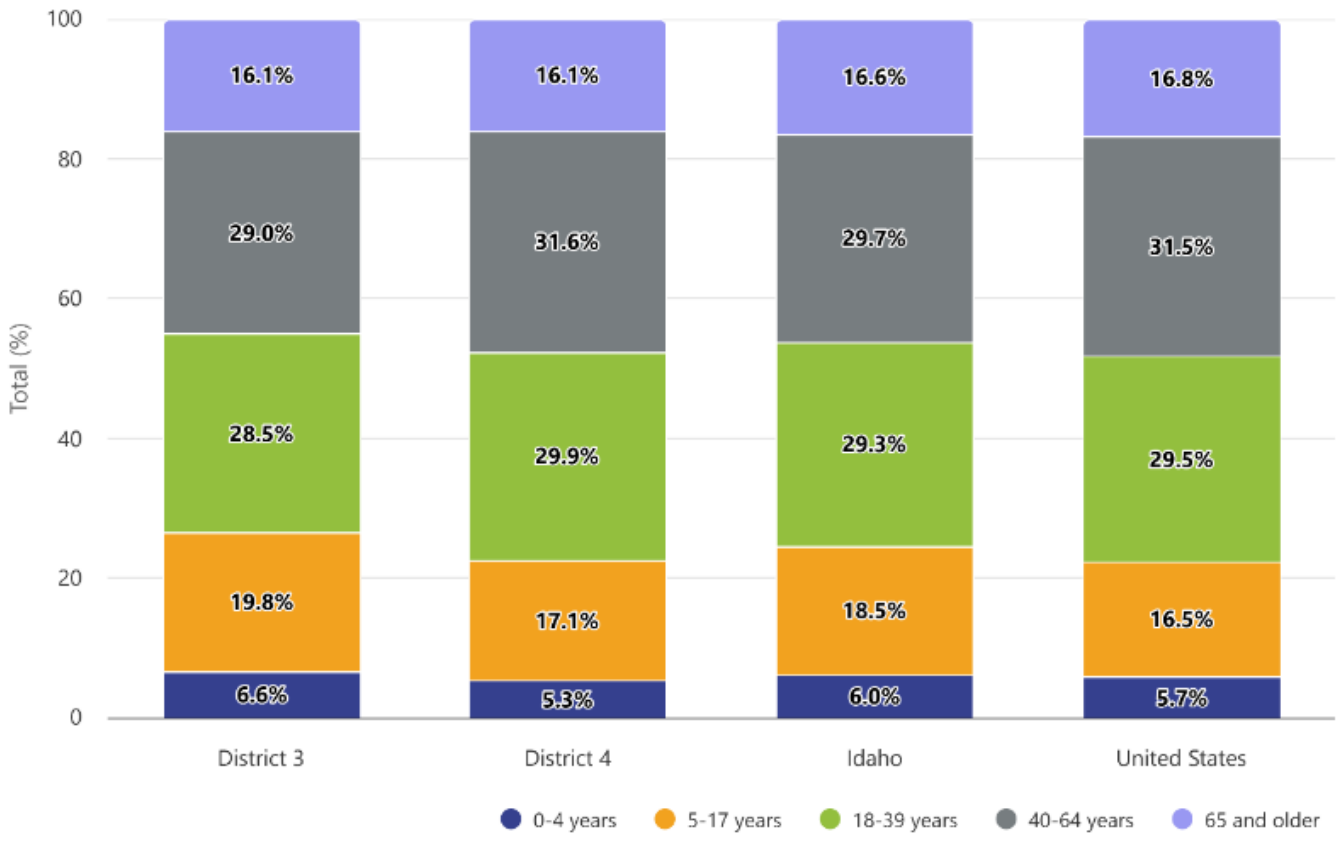
	Health District 3	Health District 4	Idaho	United States
Median Household Income	$70,076	$86,888	$74,636	$78,538
Poverty Rate*	10.45%	8.85%	10.64%	12.44%
Unemployment Rate	3.37%	3.29%	3.68%	5.20%

U.S. Census Bureau: American Community Survey (ACS), 2019-2023
** Percent of residents in families that are in poverty (below the Federal Poverty Level).*

Age Distribution

The data compares the population distribution across different age groups in Health District 3, Health District 4, Idaho, and the United States. Health District 3 has a higher percentage of individuals 0-17 compared to Idaho and the United States.

Population by Age (2019-2023)



Created on Metopio | metop.io/i/kyc2wau3 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

Population Groups

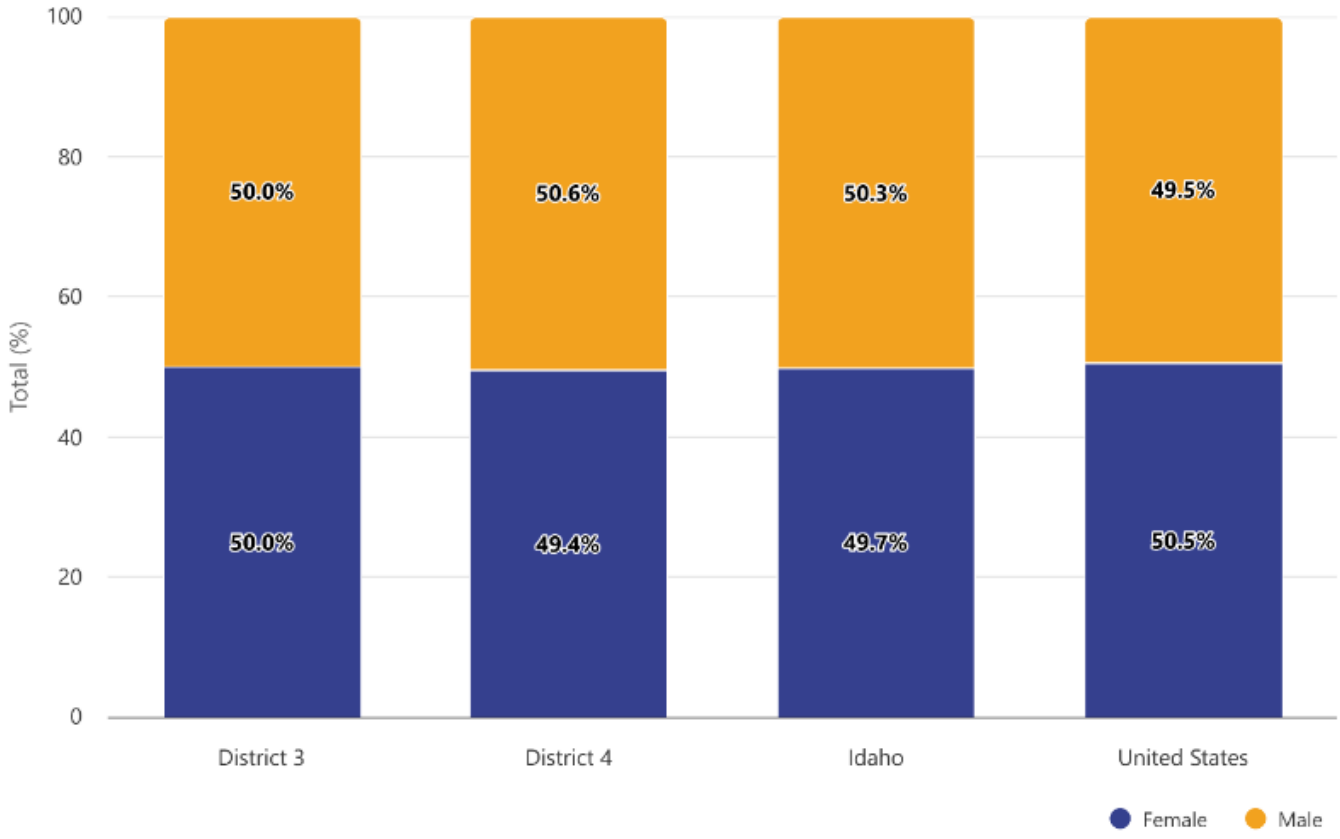
% of residents	Health District 3	Health District 4	Idaho	United States
Veterans	9.12%	8.84%	8.25%	6.44%
Disability	15.37%	11.57%	13.78%	13.04%
Limited English Proficiency	6.11%	2.95%	3.58%	8.39%

U.S. Census Bureau: American Community Survey (ACS), 2019-2023

Population by Sex

The data represents the population distribution by sex across the United States, with a slight female majority at the national level. In Health District 3, the sex distribution is nearly even, while in Idaho and Health District 4, males slightly outnumber females.

Population by Sex (2019-2023)



Created on Metopio | metop.io/i/yd9btuqk | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

Education

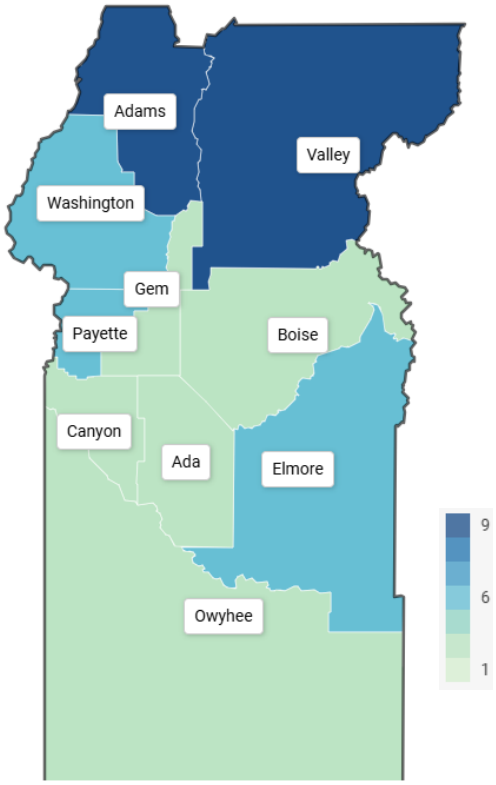
% of residents	Health District 3	Health District 4	Idaho	United States
High School Graduation Rate	87.43%	94.62%	91.68%	89.39%
College Graduation Rate	22.01%	42.32%	31.18%	35.00%

U.S. Census Bureau: American Community Survey (ACS), 2019-2023

Rural-Urban Continuum

Rural-Urban Continuum Codes form a classification scheme that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area or areas. The codes range from 1 (central counties of highly populated metro areas) to 9 (entirely rural areas, not adjacent to a metro area). The counties that comprise the Greater Treasure Valley range from 2 to 9, shown in the map to the right.

2: Gem, Boise, Canyon, Ada, and Owyhee Counties
6: Elmore, Washington, and Payette Counties
9: Adams and Valley Counties



US Department of Agriculture (USDA), 2023

The table below shows the population of each county within the Greater Treasure Valley region, their largest industry sector, and the percentage of households below the ALICE* Threshold. On average, 41 percent of Idaho households fall below the ALICE Threshold.

County	Population	Largest Industry Sector	Percentage of Households Below ALICE Threshold
Ada County	508,052	Healthcare and Social Assistance	34.11
Adams County	4,599	Retail Trade	47.66
Boise County	8,045	Healthcare and Social Assistance	38.42
Canyon County	242,405	Healthcare and Social Assistance	46.87
Elmore County	29,046	Healthcare and Social Assistance	47.35
Gem County	19,854	Healthcare and Social Assistance	42.53
Owyhee County	12,284	Agriculture, Forestry, and Hunting	55.20
Payette County	26,190	Retail Trade	46.99
Valley County	12,136	Accommodation and Food	40.13
Washington County	10,866	Manufacturing	60.50

*The % of households below the ALICE threshold are those that don't meet the minimum income level necessary to afford the Household Survival Budget for each county in the U.S. ALICE households earn above the Federal Poverty Level (FPL) but are unable to afford the basics of housing, child care, food, transportation, health care, and technology in the communities where they live.

Current Idaho ALICE data can be found here - https://www.unitedforalice.org/introducing-ALICE/Idaho

Health Needs Identified

For this health assessment report, primary and secondary data were gathered and analyzed to determine the top health needs in the Greater Treasure Valley. A closer look at the data for each of these themes will be provided in the report, listed in order of ranking by community partners. As shown in the list below, health and community needs were identified. For more information about Social Determinants of Health (SDoH), go here https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html

1. Behavioral Health
2. Housing
3. Access to Care
4. Maternal and Child Health
5. Food Access
6. Child Care
7. Chronic Disease
8. Tobacco and Nicotine Use

Behavioral Health

Includes the prevalence of mental health disorders and access to mental health services, addressing issues like depression and anxiety, and other disorders, as well as substance use.

COMMUNITY INPUT

Focus group and key informant participants described challenges accessing mental health services, particularly for children and adolescents. Long waiting lists for therapy and a shortage of pediatric mental health professionals leave many families without the support they need. Stigma surrounding mental health discourages individuals from seeking help, further compounding the problem. Residents also described substance use disorders in their communities, with limited resources for treatment and prevention. The COVID-19 pandemic has exacerbated these issues, leading to increased isolation, anxiety, and stress among community members. Many people also report difficulties accessing care due to transportation barriers, especially in rural areas.

One quote highlights the lack of providers: **"There's a big need for mental health services in the community, there are only a few providers in the county."** This underscores the critical shortage of mental health professionals, which limits access to care for those in need. Another community member pointed out the difficulty in obtaining timely services: **"The wait lists for behavioral health supports for young children are years long."** This reflects the need for more mental health providers and an intentional focus on prevention to reduce overall demand for mental health services, particularly for children and adolescents. Additionally, the stigma surrounding mental health remains a significant barrier: **"We live in a very conservative state and unfortunately people still look down upon those who might have a mental health condition."** Addressing these concerns requires not only increasing the number of providers but also implementing community-based programs that reduce stigma and promote mental health and well-being.

> *"There's a big need for mental health services in the community, there are only a few providers in the county."*
>
> **Washington County Resident**

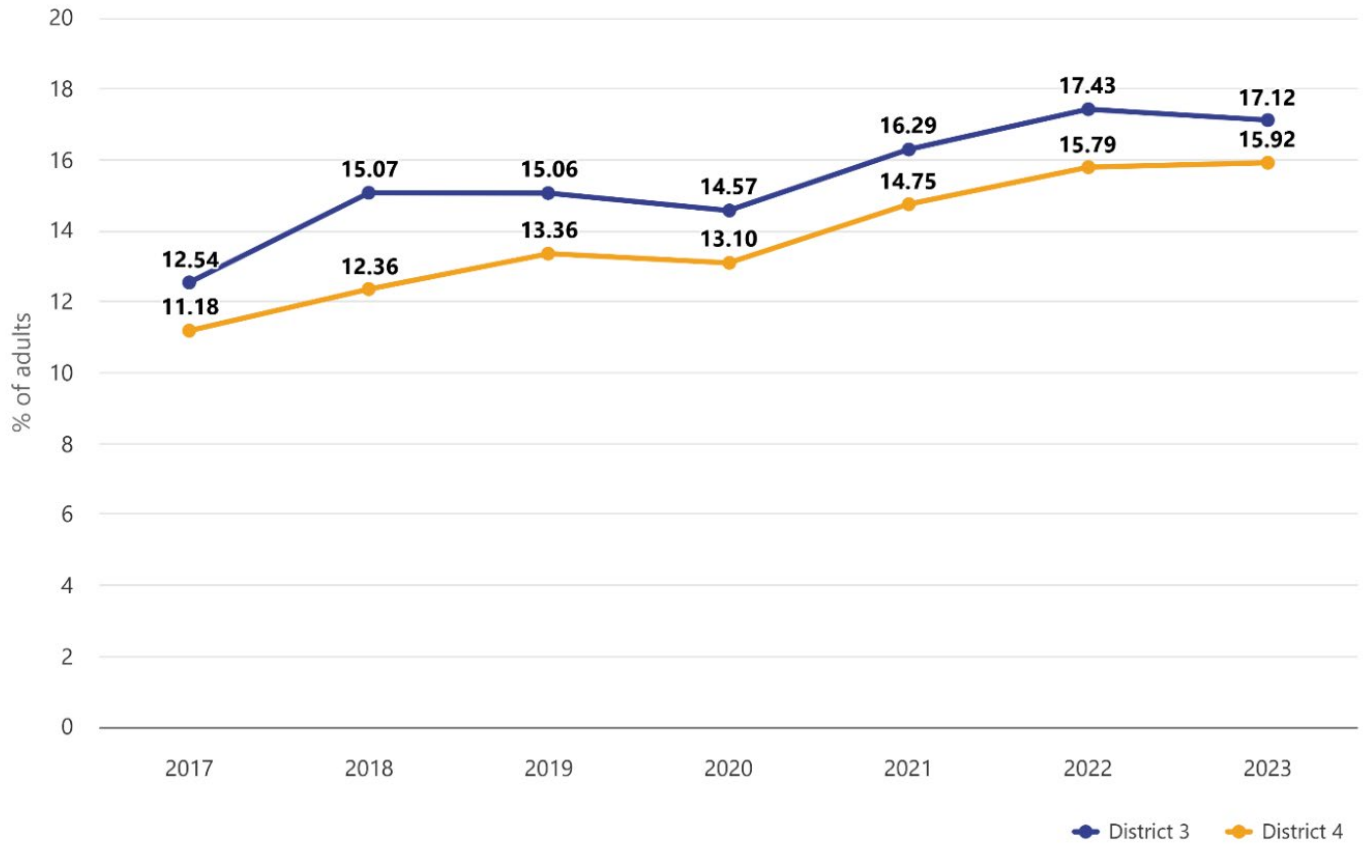
Mental health was ranked the #1 health issue by community survey respondents.

MENTAL HEALTH

Self-Reported Poor Mental Health

Since 2017, more people in our region struggle with their mental health. In Health District 3, the percentage of individuals reporting poor mental health has increased from 12.54% in 2017 to 17.12% in 2023. Similarly, in Health District 4, the rate has increased from 11.18% in 2017 to 15.92% in 2023. In 2023, the Idaho average was 16.86%, and the United States average was 17.24%.

Self-reported poor mental health



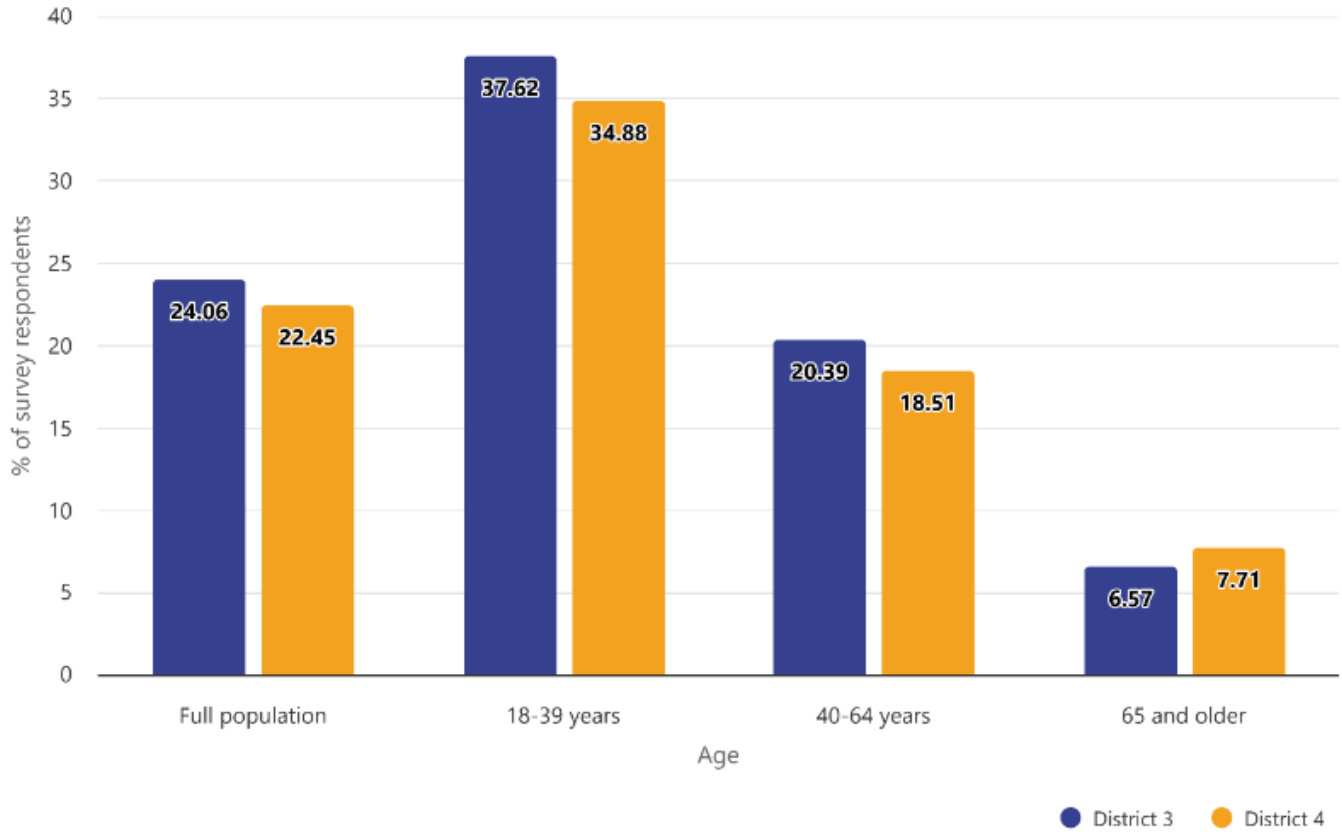
Created on Metopio | metop.io/i/k3awznt2 | **Data source:** Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)
Self-reported poor mental health: Percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Anxiety

The chart below shows the percentage of survey respondents who selected "More than half the days" or "Nearly every day" in response to the question: "Over the past two weeks, how often have you been bothered by the following problems: feeling anxious, nervous, or on edge?"

The highest reported anxiety levels among survey respondents were 18-39 year olds, with Health District 3 having the highest percentage at 37.62%.

Anxious respondents by Age, 2025



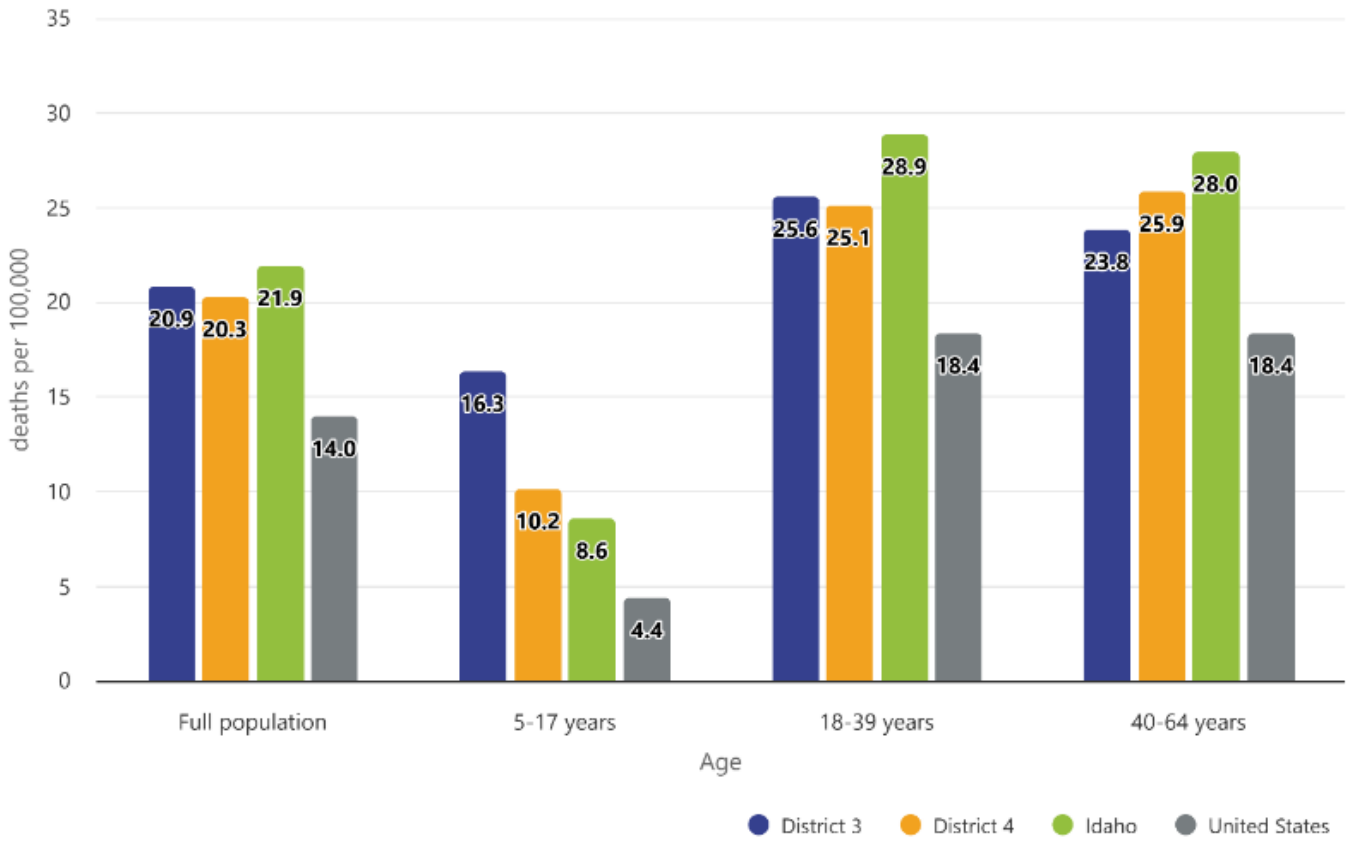
Created on Metopio | metop.io/i/g53u1qov | **Data source:** Idaho Oregon Community Health Survey

Anxious respondents: Percentage of survey respondents who selected "More than half the days" or "Nearly every day" in response to the question: "Over the past two weeks, how often have you been bothered by the following problems: feeling anxious, nervous, or on edge?"

Suicide Mortality

Suicide mortality rates in Health Districts 3 and 4 are higher than the United States averages in all age categories. In both Health Districts, rates for 18-39 year olds and 40-64 year olds are lower than the Idaho averages, but rates for 5-17 year olds are both higher than the Idaho averages.

Suicide mortality by Age (2019-2023)



Created on Metopio | metop.io/i/u9k6own1 | **Data source:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov)

Suicide mortality: Deaths per 100,000 residents due to suicide (ICD-10 codes *U03, X60-X84, Y87.0). In the United States, decisions about whether deaths are listed as suicides on death certificates are usually made by a coroner or medical examiner. The definition of suicide is "death arising from an act inflicted upon oneself with the intent to kill oneself."

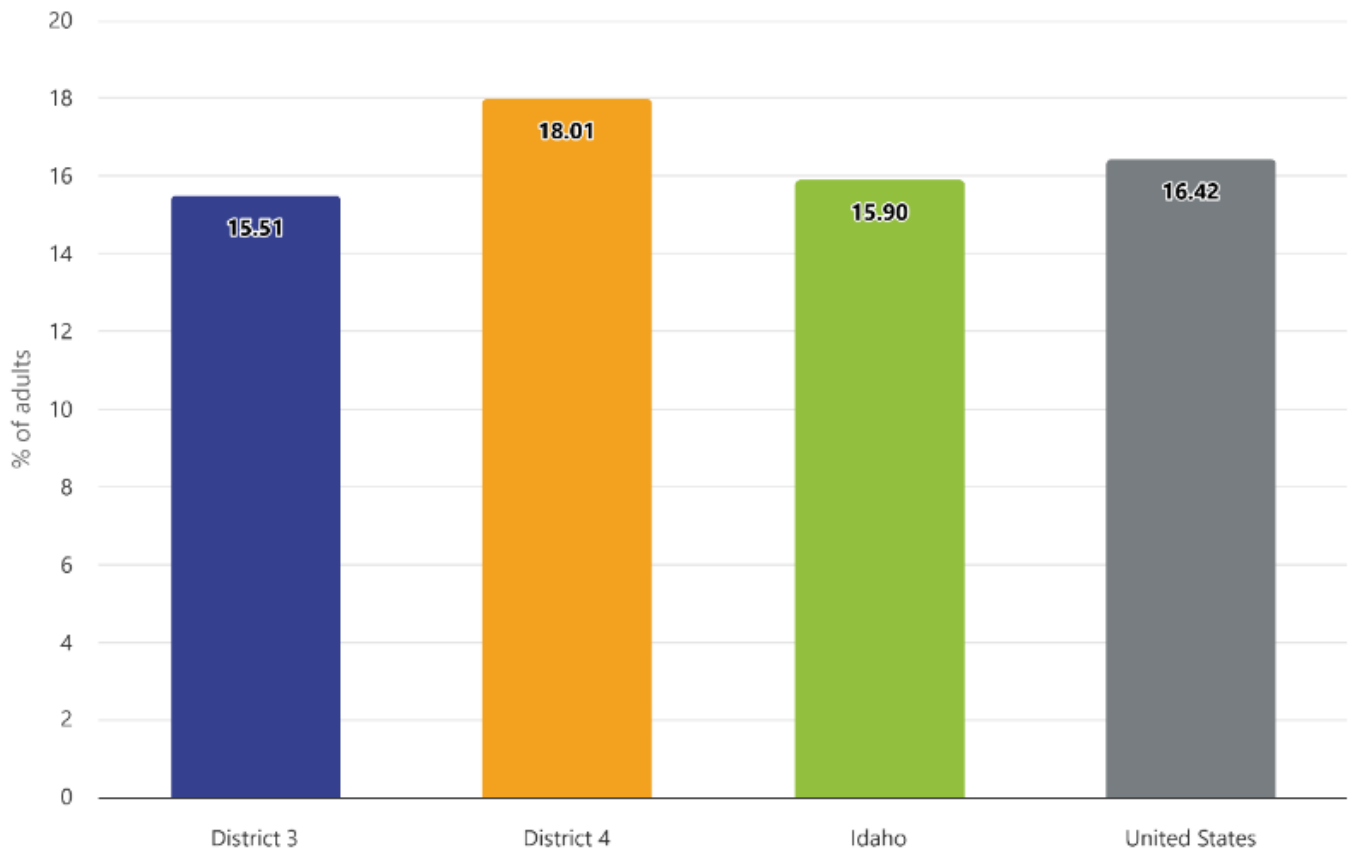
SUBSTANCE USE

Binge Drinking

Binge drinking is defined as the percentage of adults aged 18 and older who report that in the past 30 days, on at least one occasion had 5 or more drinks (men) or 4 or more drinks (women) in one day. Alcohol use is likely seriously underreported, so these estimates may not reflect actual instances of binge drinking.

The reported binge drinking rate in Health District 3 is 15.51% of adults, which is lower than state and national averages. The reported binge drinking rate in Health District 4 is 18.01% of adults, which is higher than state and national averages.

Binge drinking (2023)

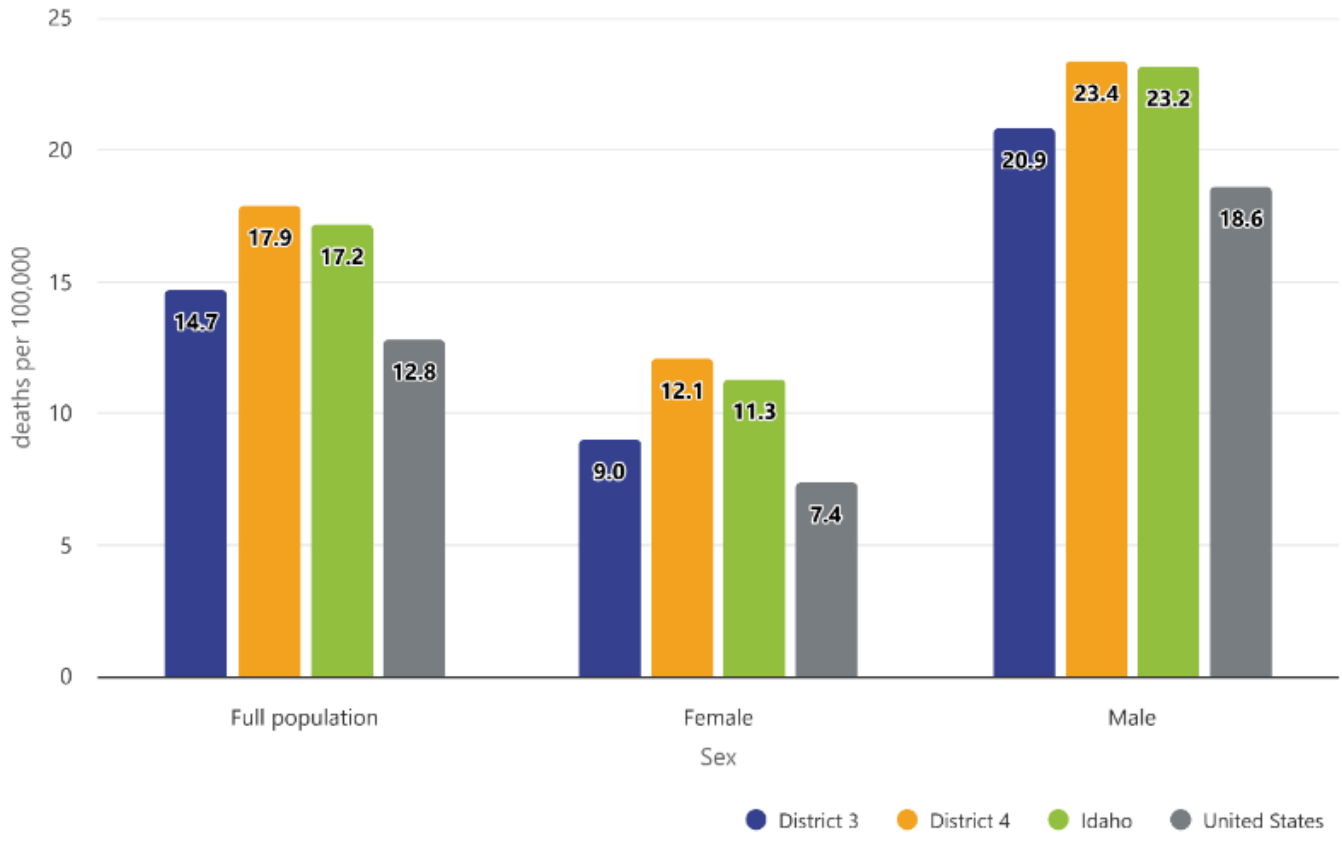


Created on Metopio | metop.io/i/v56rcfk5 | **Data sources:** Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)
Binge drinking: Percent of adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Alcohol use is likely seriously underreported, so these estimates are an extreme lower bound on actual binge drinking prevalence.

Alcohol-Related Mortality

Alcohol-related mortality varies widely across regions and demographic groups. In Health District 3, the rate among males is highest at 20.85 deaths per 100,000 and 9.0 among females, while in Health District 4 the rates rise to 23.35 per 100,000 for males and 12.09 for females.

Alcohol-related mortality by Sex (2019-2023)

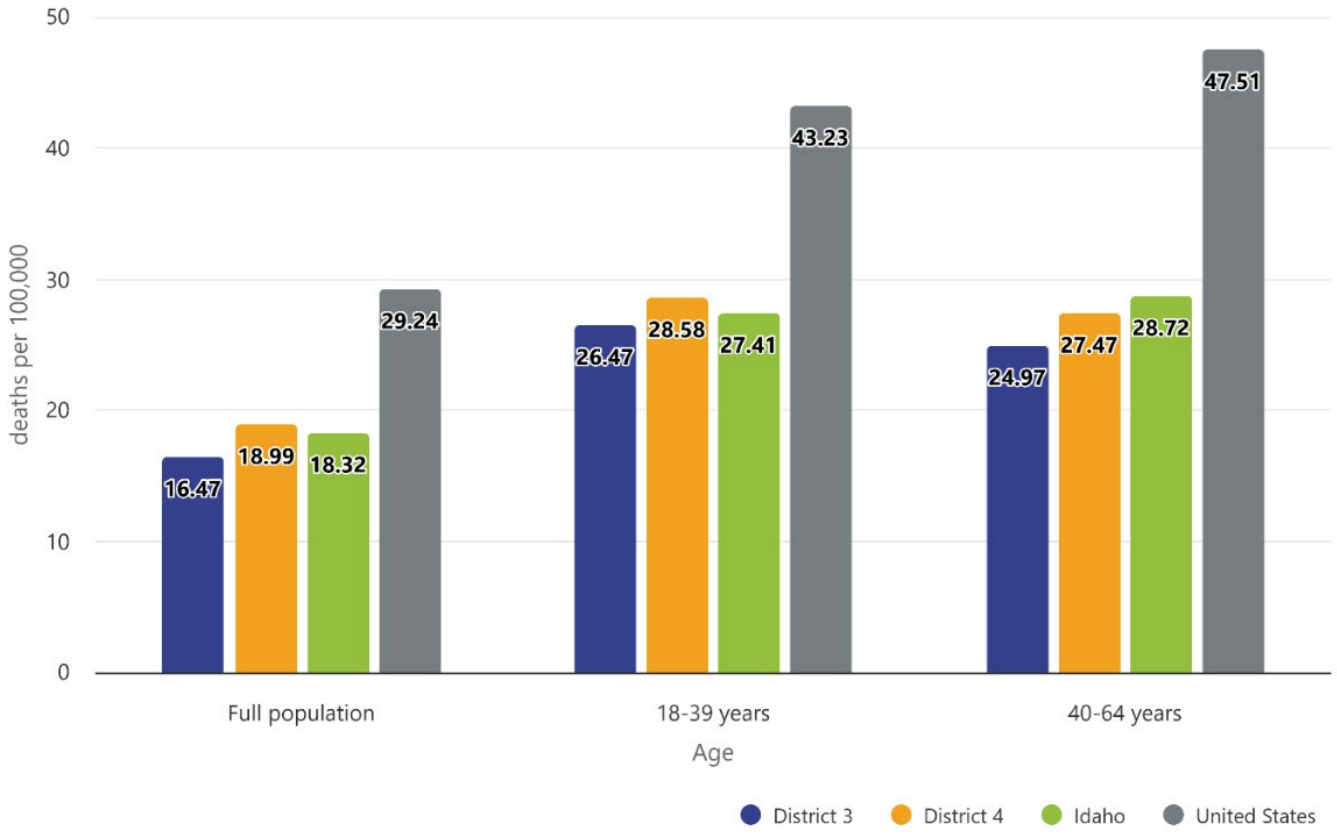


Created on Metopio | metop.io/vfZpbSkbu | **Data source:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System Mortality (NVSS-M) (via CDC Wonder)
Alcohol-related mortality: Deaths per 100,000 residents with an underlying cause related to excessive alcohol use. This includes deaths attributable to conditions such as alcohol abuse, alcohol poisoning, alcoholic liver disease (cirrhosis), alcohol-induced pancreatitis, and others. Because alcohol use is often a contributing factor in mortality from many other diseases, the CDC uses a complicated methodology to estimate total alcohol-related mortality, which is described in the technical notes.

Drug Overdose Mortality

Drug overdose mortality rates in Health Districts 3 and 4 are lower than the United States average. There are no significant differences in rates between adults ages 18-39 years and adults age 40-64.

Drug overdose mortality by Age (2019-2023)



Created on Metopio | metop.io/i/gyg2xtpq | **Data source:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder)
Drug overdose mortality: Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here. Age-adjusted.

Housing

Housing quality and affordability play a crucial role in shaping health outcomes as they directly influence various aspects of well-being. Rising housing costs and rent, as well as stagnant median household income, have contributed to escalating rates of housing insecurity and homelessness nationwide. High housing cost burdens, eviction rates, vacant (unused) housing, or crowded housing translate directly into poorer socioeconomic and health outcomes, including housing instability and homelessness.

COMMUNITY INPUT

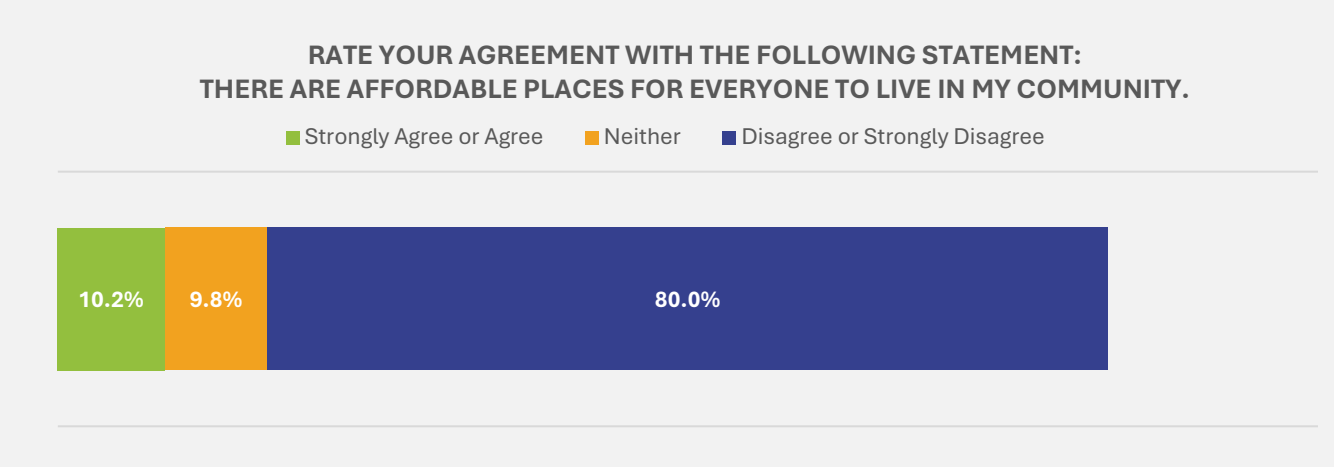
Focus group and key informant participants described housing as one of the most pressing challenges facing the area. Residents shared challenges in accessing and affording safe housing. Individuals spoke to the need for more permanent, supportive housing.

"There is not enough affordable housing and rentals. The waitlist can be up to 5 years."
Community Partner

Community members emphasized the lack of supportive resources, with one community member stating, **"There is not enough affordable housing and rentals. The waitlist can be up to 5 years."** Another community member spoke to a similar need stating, **"I would say that there needs to be a lot more affordable housing. There's not a whole lot of low-income housing that's available, and if there is low-income housing, then there's a long wait list."**

Affordable housing was a top community concern by community survey respondents.

Among community survey respondents, 80% disagreed or strongly disagreed with the statement "There are affordable places for everyone to live in my community."



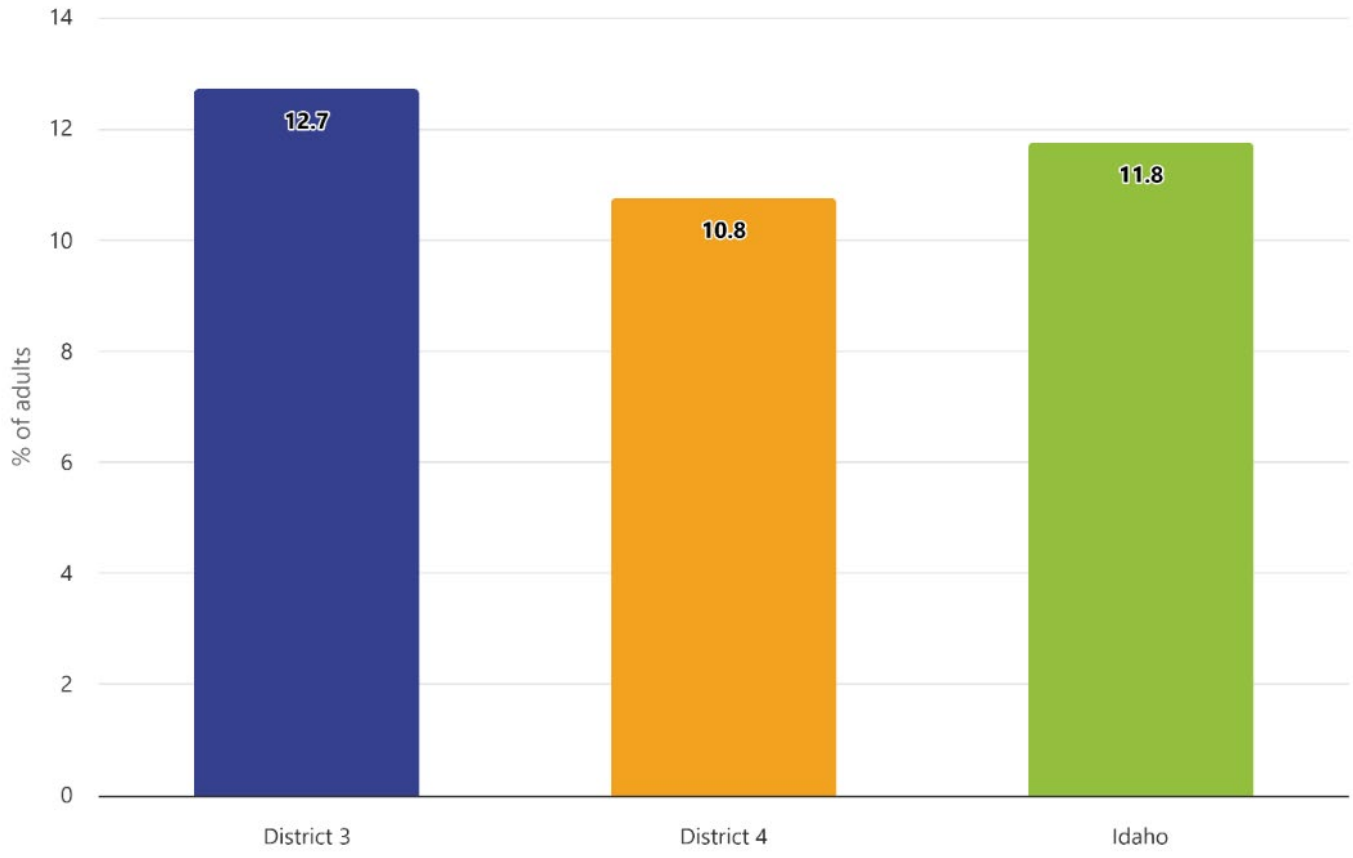
Source: 2025 Idaho Oregon Community Health Survey

HOUSING INSECURITY

Housing insecurity is defined as the percentage of adults who were not able to pay mortgage, rent, or their utility bill in the past 12 months.

Housing insecurity varies across Idaho, with Health District 3 experiencing a higher rate compared to the state average at 12.71%, while Health District 4 has a lower rate of 10.77%. Although Ada County has a housing insecurity rate of 9.1%, the lowest throughout the Greater Treasure Valley region, because of the county's population size, that still equates to over 46,000 individuals in households unable to pay mortgage, rent or their utility bill in the past 12 months.

Housing Insecurity (2022)



Created on Metopio | metop.io/i/4a7j3mv5 | **Data source:** Centers for Disease Control and Prevention (CDC): PLACES

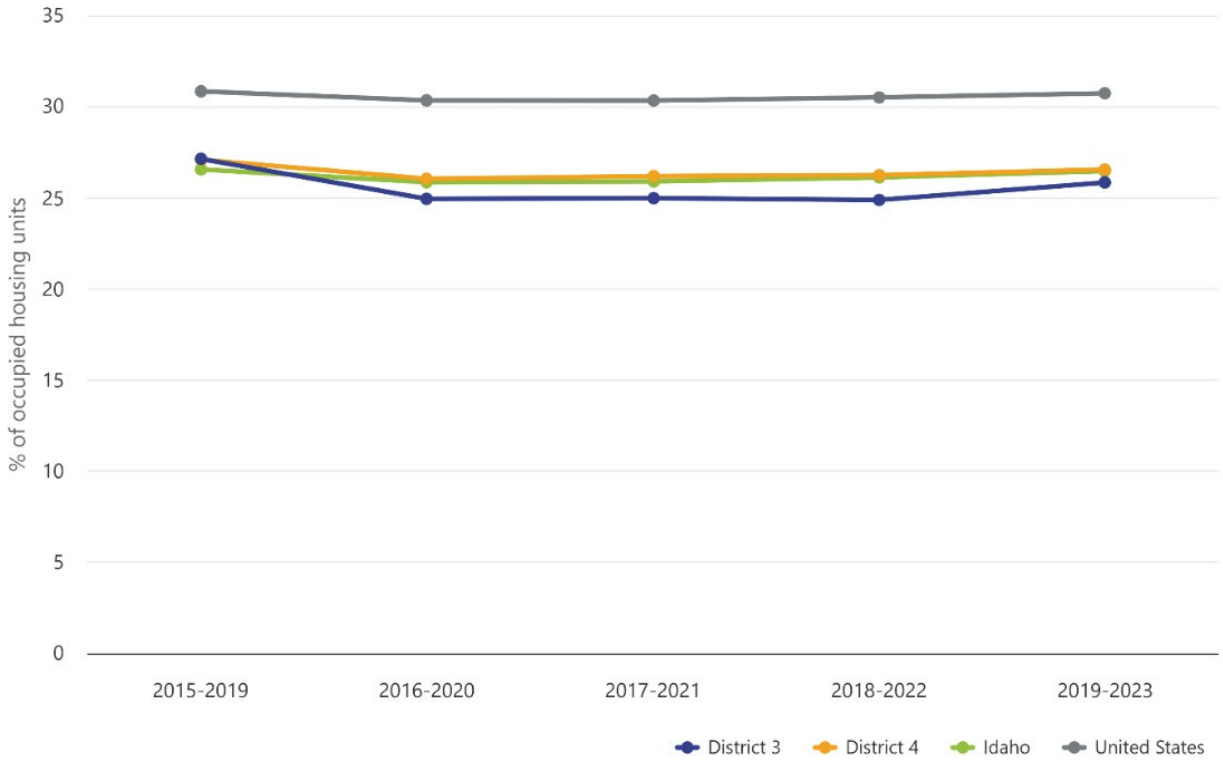
Housing Insecurity: The percent of adults who were not able to pay mortgage, rent, or utility bill in the past 12 months.

HOUSING COST BURDEN

Households spending more than 30% of their income on housing are considered cost burdened. This includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees.

Housing cost burden in the United States is significant, with 30.74% of households affected. Idaho has a lower burden at 26.47%, while Health District 4 and Health District 3 have burdens of 26.56% and 25.84%, respectively. Throughout the Greater Treasure Valley region, the rate of housing cost burden is highest in Valley County (27.21%), and lowest in Boise County (19.98%).

Housing cost burden



Created on Metopio | metop.io/i/2rubtvoy | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B25070/B25091)

Housing cost burden: Households spending more than 30% of income on housing are considered housing cost-burdened. Includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees.

Housing Cost Burden	Health District 3	Health District 4	Idaho	United States
2015-2019	27.14	27.09	26.56	30.85
2016-2020	24.94	26.05	25.86	30.35
2017-2021	24.98	26.19	25.90	30.34
2018-2022	24.89	26.24	26.12	30.51
2019-2023	25.84	26.56	26.47	30.74

U.S. Census Bureau: American Community Survey (ACS), 2019-2023

Access to Care

Limited access to healthcare providers can result in delayed or inadequate healthcare, affecting the overall health outcomes of community members. Access can be restricted by a lack of providers, poor geographic distribution of services, difficulty affording and signing up for health insurance, and the cost of services even after health insurance.

COMMUNITY INPUT

Focus group and key informant participants expressed frustration over the lack of accessible healthcare services, especially in rural areas. Limited transportation options make it difficult for individuals to reach medical facilities, leading to delays in care. Many residents are unable to afford necessary treatments, including dental and mental health services, and those without insurance are particularly vulnerable. Long waiting lists for specialty care further exacerbate the problem, leaving patients without timely access to critical medical attention, described by one resident noting, **"Long wait times for appointments pose a serious obstacle."** These barriers contribute to a cycle of unmet health needs, increased reliance on emergency services, and worsening health conditions.

One resident remarked, **"Transportation is a big issue,"** highlighting the difficulties faced by those without reliable means to travel to medical appointments. Another individual noted, **"I would say that, especially in our rural areas, that dental access is also a real struggle,"** emphasizing the specific challenges in accessing dental care. The lack of transportation not only affects routine medical visits but also limits access to specialists, forcing individuals to travel long distances for care. Additionally, the high cost of healthcare, especially for those without insurance, leads to many avoiding necessary treatments. Addressing these issues requires targeted interventions, such as expanding transportation services, increasing the availability of healthcare providers, and implementing policies to reduce the financial burden of care.

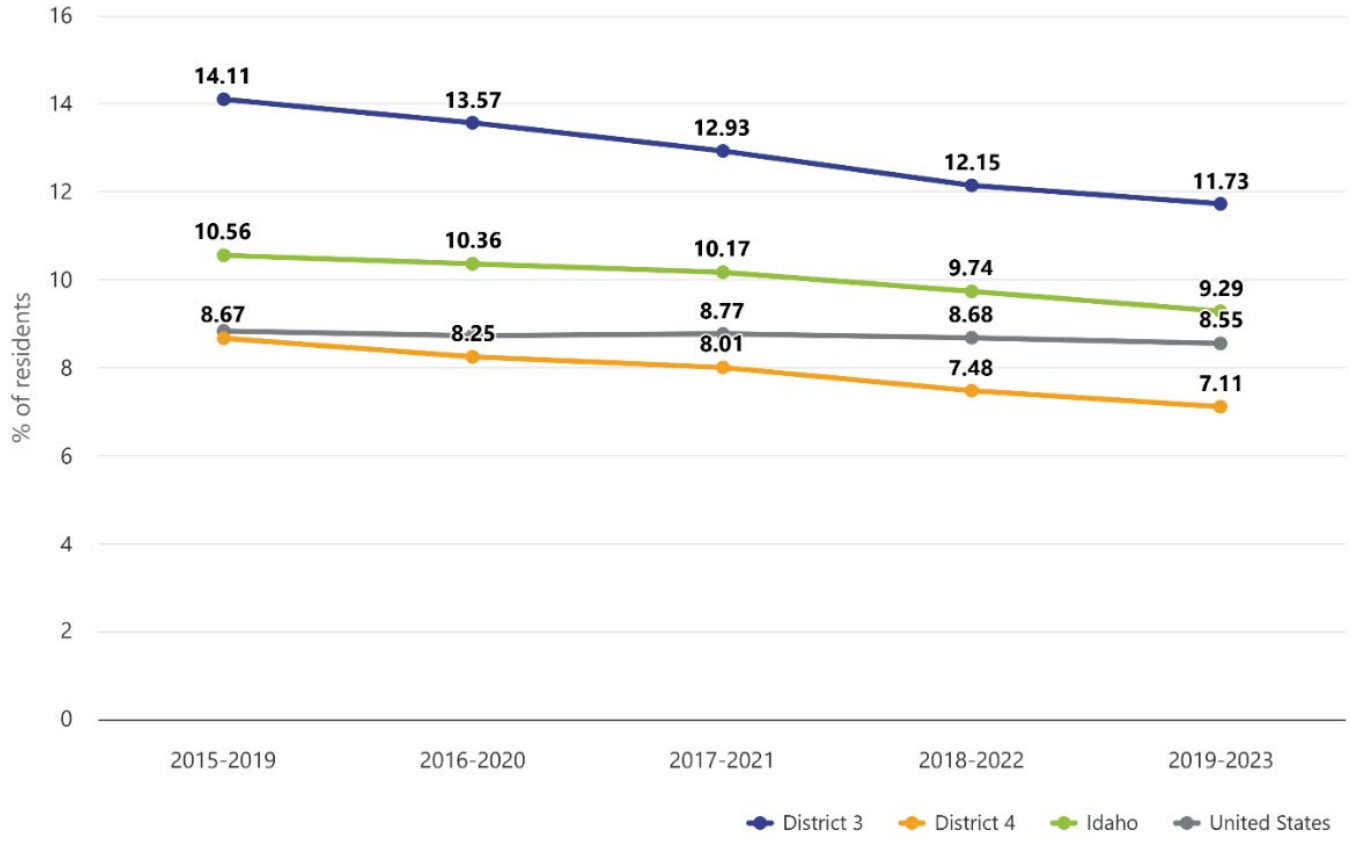
> *"Long wait times for appointments pose a serious obstacle."*
>
> **Canyon County Resident**

INSURANCE

Uninsured Rate

The rate of uninsured residents in Health Districts 3 and 4 have decreased since 2015. However, Health District 3 uninsured rates remain higher than state and national averages.

Uninsured rate



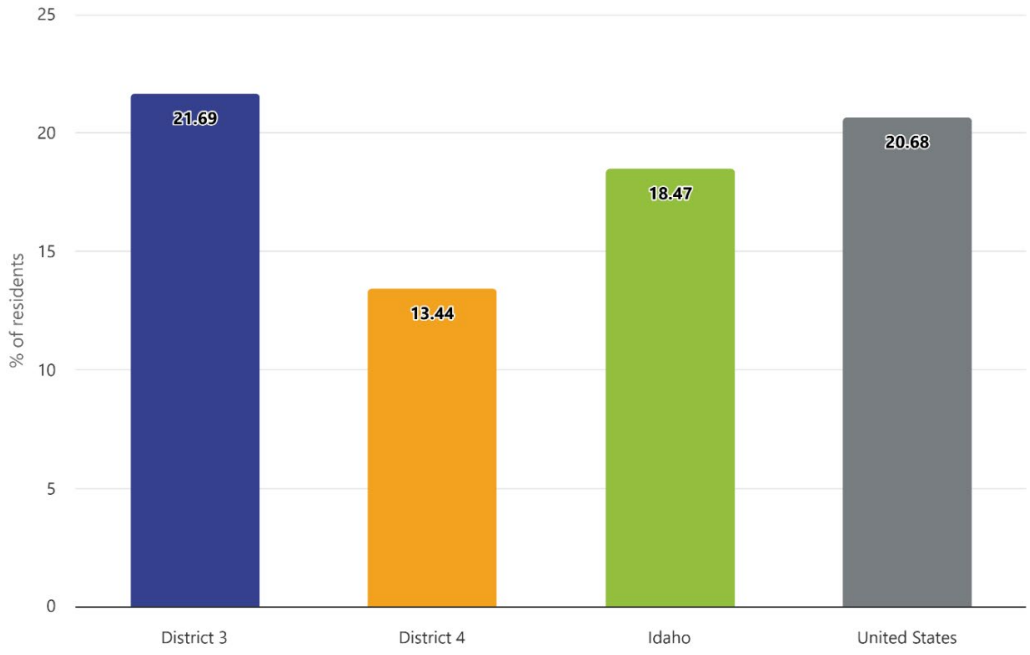
Created on Metopio | metop.io/i/ess6s1rv | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Uninsured rate: Percent of residents without health insurance (at the time of the survey).

Medicaid Coverage

Medicaid coverage in Health District 3 exceeds the national average, standing at 21.69% (roughly 70,000 residents), while Health District 4 has a lower overall percentage at 13.44% (roughly 76,000 residents). The United States overall has a coverage rate of 20.68%, and Idaho at 18.47%.

Medicaid coverage (2019-2023)

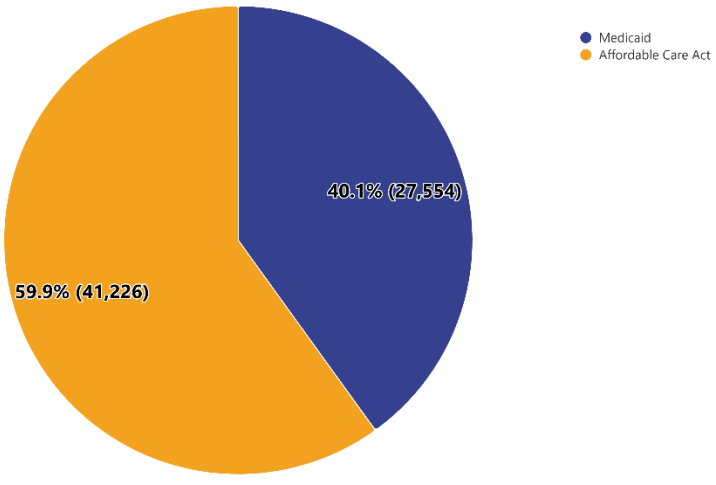


Created on Metopio | metop.io/i/qceejpuq | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables S2704, S2701, and B27010)

Medicaid coverage: Percent of residents covered by Medicaid, a state-administered health insurance program for residents meeting certain income limits and other eligibility standards that vary by state.

Additionally, an estimated 68,780 Idahoans will lose health insurance coverage by 2034 under H.R. 1, the One Big Beautiful Bill Act, as passed by the House of Representatives on May 22, 2025. An estimated 40.1% of those individuals are currently on Medicaid.

Projected loss of insurance coverage by Type of Coverage

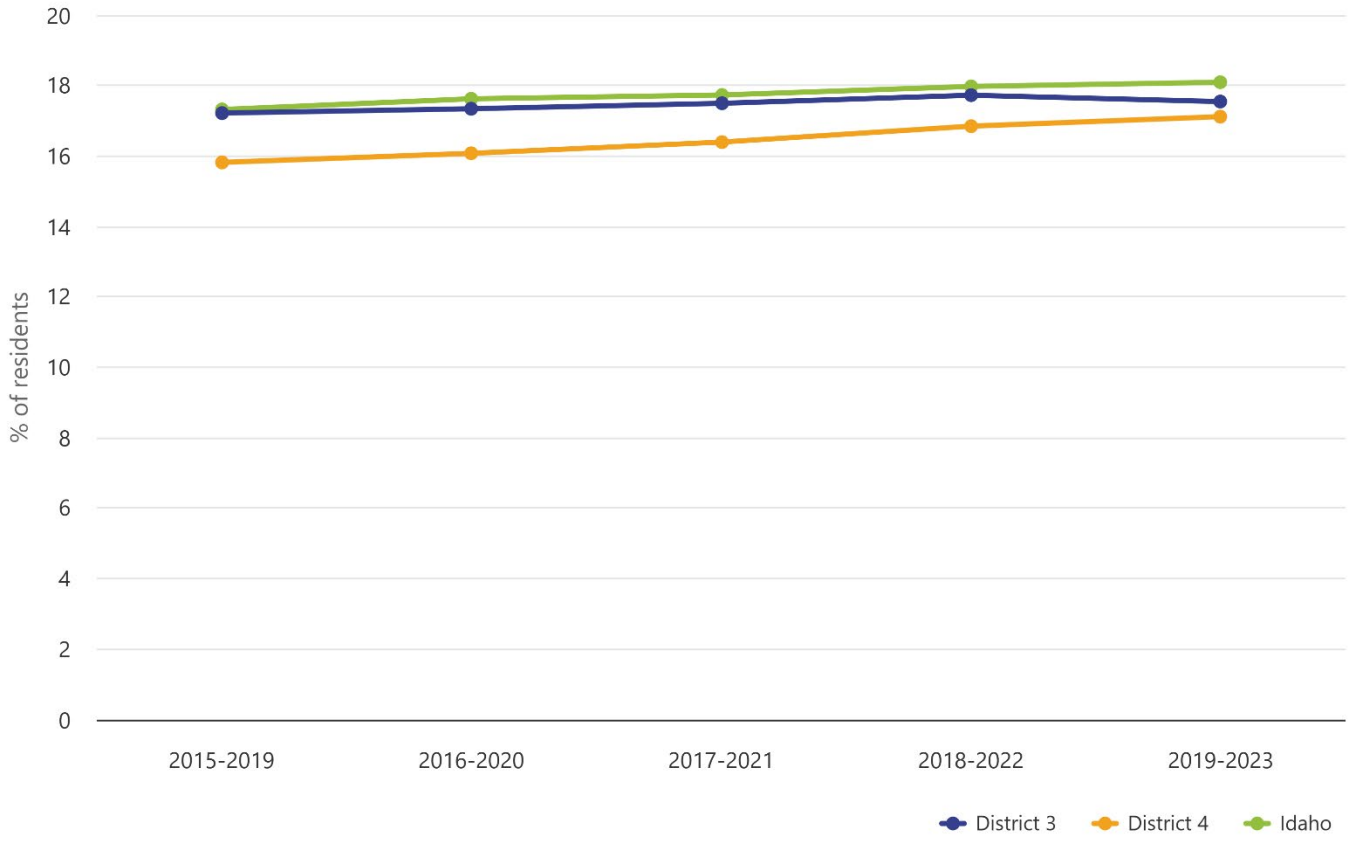


Created on Metopio | metop.io/i/q64sabwp | **Data source:** Joint Economic Committee
Projected loss of insurance coverage: Estimation of the number of people who would lose health insurance coverage by 2034 under H.R. 1, the One Big Beautiful Bill Act, as passed by the House of Representatives on May 22, 2025.

Medicare Coverage

Medicare coverage in Health District 3 has remained stable from 17.2% of residents in 2015-2019 to 17.5% in 2019-2023. Medicare coverage has increased in Health District 4 from 15.8% of residents in 2015-2019 to 17.1% in 2019-2023.

Medicare coverage



Created on Metopio | metop.io/i/izizrmrg | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables S2704, S2701, and B27010)
Medicare coverage: Percent of residents covered by Medicare, the federal health insurance system for seniors and some people with disabilities.

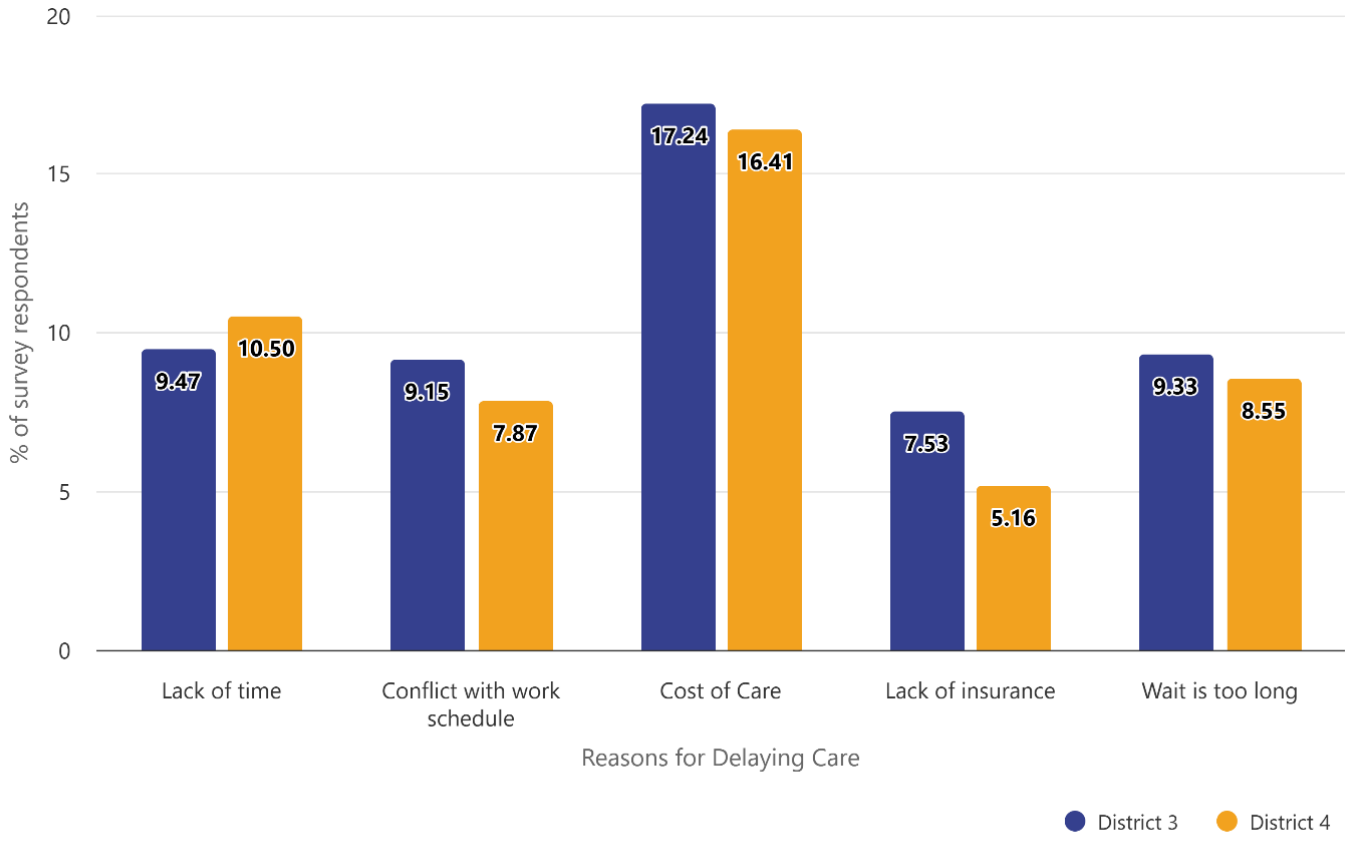
Medicare Coverage	Health District 3	Health District 4	Idaho	US
2015-2019	17.2	15.8	17.3	20.2
2016-2020	17.3	16.1	17.6	20.1
2017-2021	17.5	16.4	17.7	20.2
2018-2022	17.7	16.8	18.0	20.4
2019-2023	17.5	17.1	18.1	20.7

BARRIERS TO CARE

Reasons for Delaying Care

Among survey respondents in Health Districts 3 and 4, the most common reasons for delaying needed care were cost of care, lack of time, wait is too long, conflict with work schedule, and lack of insurance.

Reasons respondents did not receive care by Reasons for Delaying Care (2025)



Created on Metopio | metop.io/i/e41qn5b1 | **Data source:** Idaho Oregon Community Health Survey

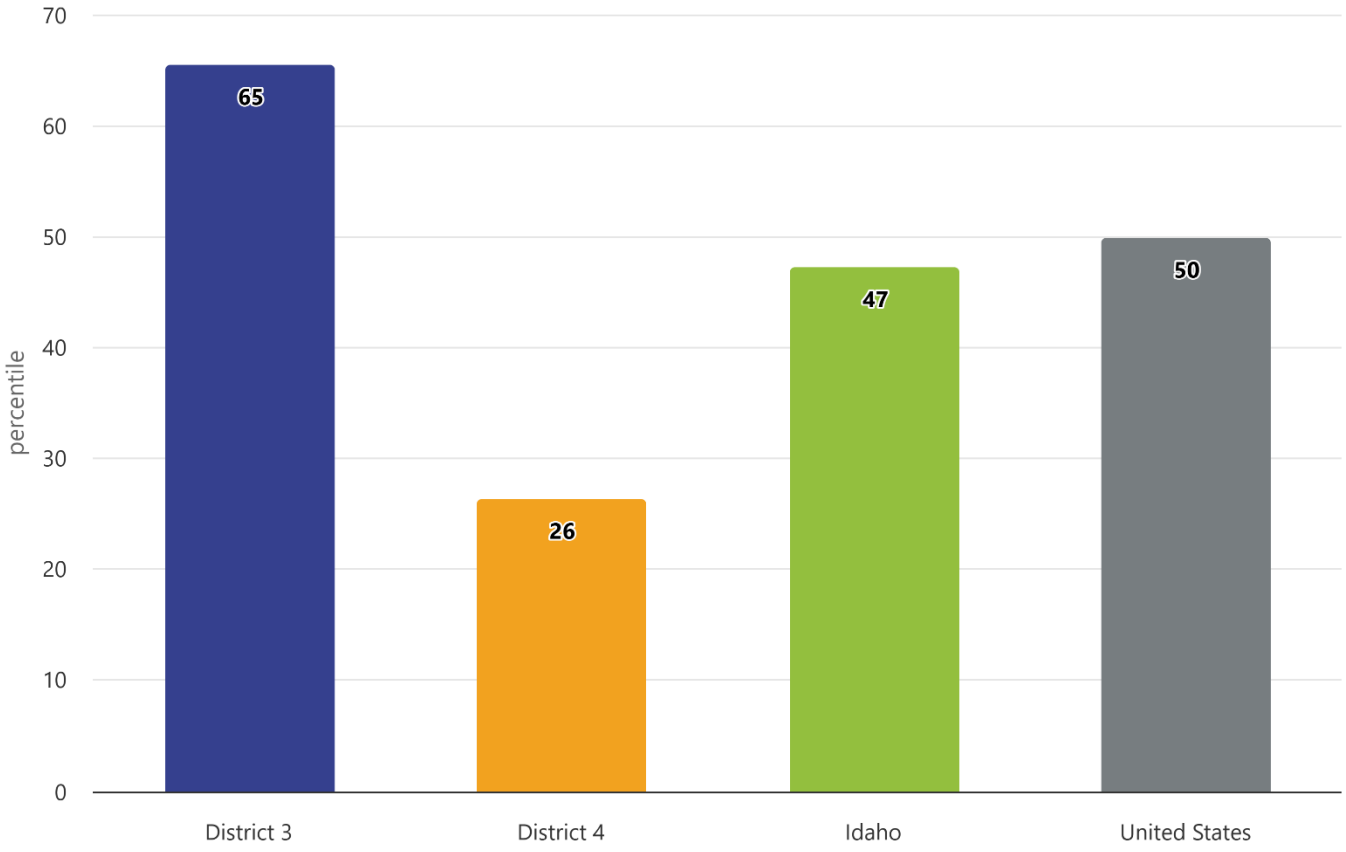
Reasons respondents did not receive care: Percentage of survey respondents who selected each option in response to the question: "If you did not receive any of the services listed above, why not? Check all that apply."

Transportation Burden

Transportation burden is a measure of transportation insecurity, ranging from 0 to 100, that takes into account average relative cost and time spent on transportation relative to all other expenses.

The data indicates a notable variation in transportation burden across different areas, with District 3 experiencing the highest burden at 65.0, significantly higher than the national average of 50.0. In contrast, District 4 has a much lower transportation burden at 26.0, suggesting more efficient or affordable transportation options in that area. Throughout the Greater Treasure Valley region, the transportation burden is highest in Boise County at 92.0, and lowest in Ada County at 24.0.

Transportation burden (2022)



Created on Metopio | metop.io/i/5zvfw9mq | **Data source:** White House Council on Environmental Quality (CEQ): Climate & Economic Justice Screening Tool (CEJST) (Data calculated from the U.S. Department of Transportation's (DOT) mapping tool of Transportation Disadvantaged
Transportation burden: A measure of transportation insecurity that takes into account average relative cost and time spent on transportation relative to all other tracts.

PROVIDER ACCESS

The United States has an average of 90.83 primary care providers (PCP) per capita, with Health District 4 having a higher rate at 105.9. Idaho has a significantly lower rate of 74.06, while Health District 3 has the lowest at 43.65. The rates of dentists per capita in Health District 3 and Health District 4 are significantly lower than both the state and national averages. These disparities indicate a need for increased healthcare resources.

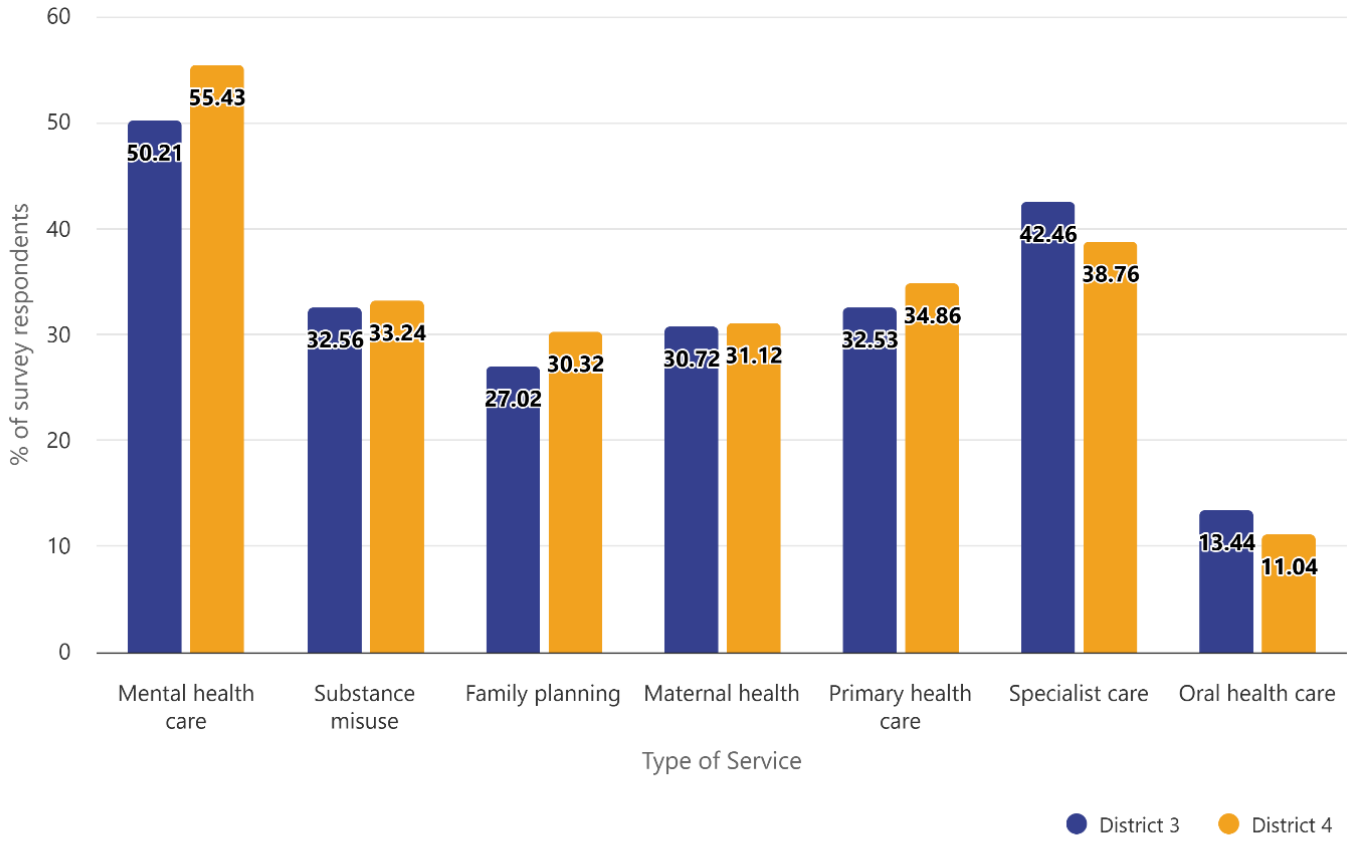
Providers per 100,000 residents, 2022	Health District 3	Health District 4	Idaho	United States
Primary Care Providers (PCP) per capita	**43.6**	105.9	74.1	90.8
Mental Health Providers per capita	**307.3**	602.3	395.1	500.8
Dentists per capita	**39.0**	**67.4**	114.8	106.4
Pediatrics Physicians per capita	**10.12**	34.49	22.05	43.13
Specialist Physicians per capita	**15.54**	84.72	45.40	107.95
Obstetrics & Gynecology Physicians per capita	**10.51**	25.99	17.37	23.81

Centers for Medicare and Medicaid Services (CMS) National Provider Identifier Files (NPI), 2022

At least 20% lower than state average

Among community survey respondents, when asked, “Which of the following health services are currently insufficient in your community? Check all that apply” community members were most likely to select mental healthcare and specialty care.

Respondents perceived health service gaps by Type of Service (2025)



Created on Metopio | metop.io/i/5fd4cy3t | **Data source:** Idaho Oregon Community Health Survey

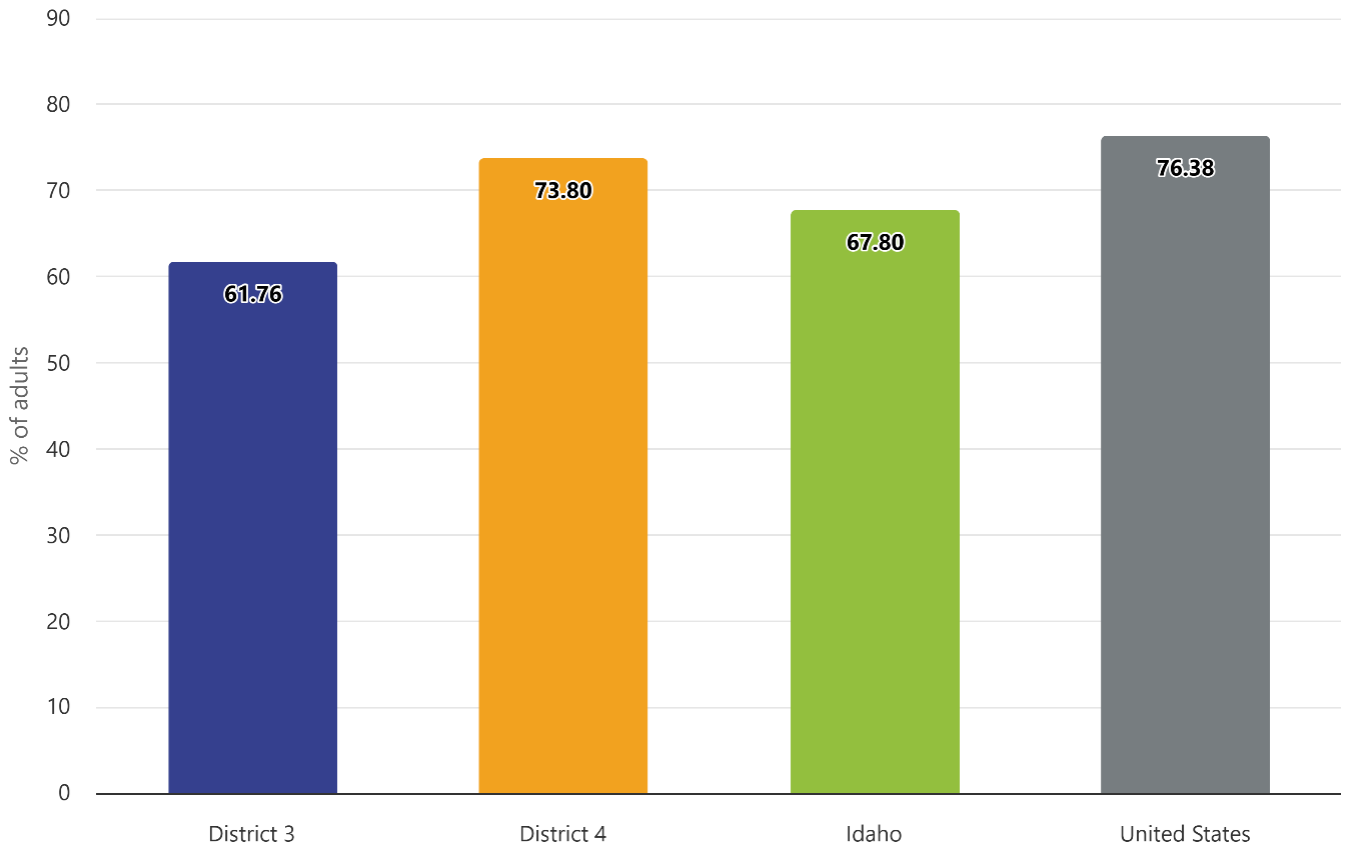
Respondents' perceived health service gaps: Percentage of survey respondents who selected each option in response to the question: "Which of the following health services are currently insufficient in your community? Check all that apply."

SCREENINGS AND IMMUNIZATIONS

Mammography

Mammography use in the United States is relatively high at 76.38% of females 50-74 years old, with Health District 4 slightly lower at 73.8%. Idaho has a significantly lower rate of 67.8%, and Health District 3 has a lower rate at 61.76%.

Mammography use (Female), 2022

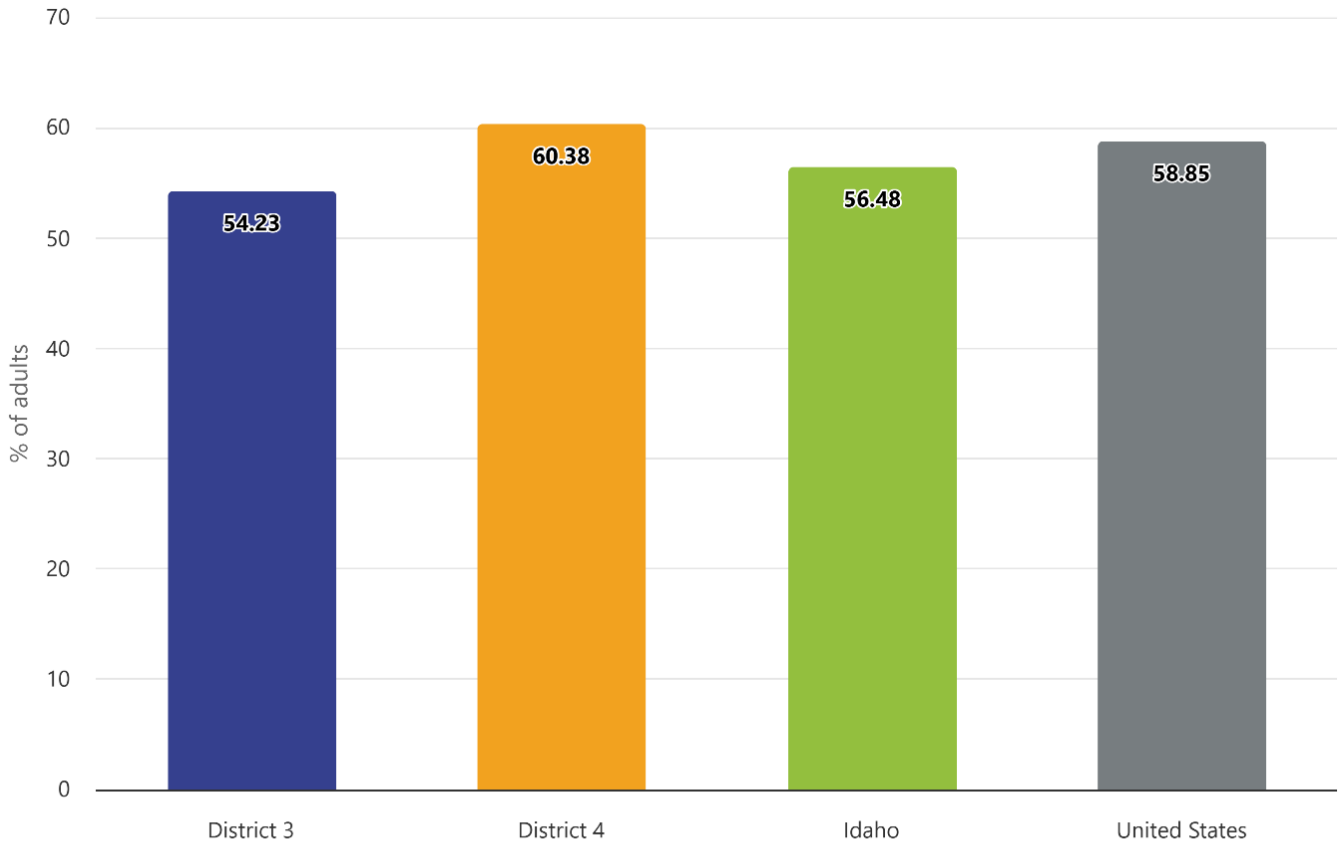


Created on Metopio | metop.io/i/dy5cawz1 | **Data sources:** Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)
Mammography use: Percent of resident female adults aged 50-74 years who report having had a mammogram within the previous 2 years.

Colorectal Cancer Screening

The highest rate is observed in Health District 4 at 60.38% of adults 50-75 years old meeting colorectal cancer screening recommendations, while the United States overall has a rate of 58.85%. Idaho has a lower screening rate of 56.48%, and Health District 3 has the lowest rate at 54.23%.

Colorectal cancer screening (2022)



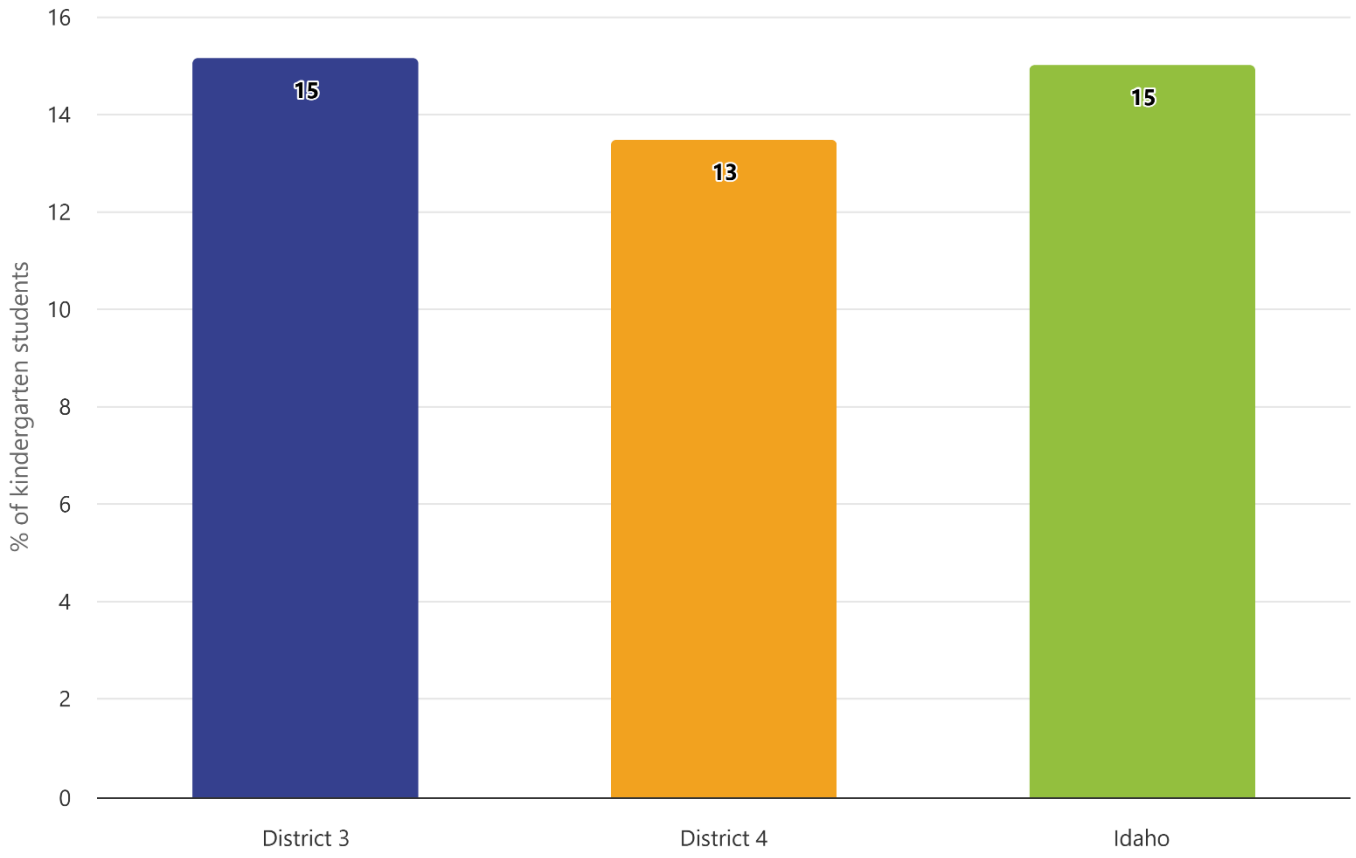
Created on Metopio | metop.io/i/e554hbmz | **Data sources:** Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract), Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA)
Colorectal cancer screening: Percent of resident adults aged 50-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Vaccine Exemptions

The vaccine exemption rate, or percentage of children who are unable to receive one or more vaccinations due to medical, religious, or personal reasons, in Health District 3 is notably high at 15.16%. Health District 4 also shows a significant exemption rate, though slightly lower at 13.49%. These high exemption rates could increase risk of outbreaks in the future.

In the 2024-2025 school year, Idaho had the highest vaccine exemption rate nationally (Kindergarten Routine Vaccination Rates Continue to Decline | KFF).

Vaccine exemption (ID), 2024-2025



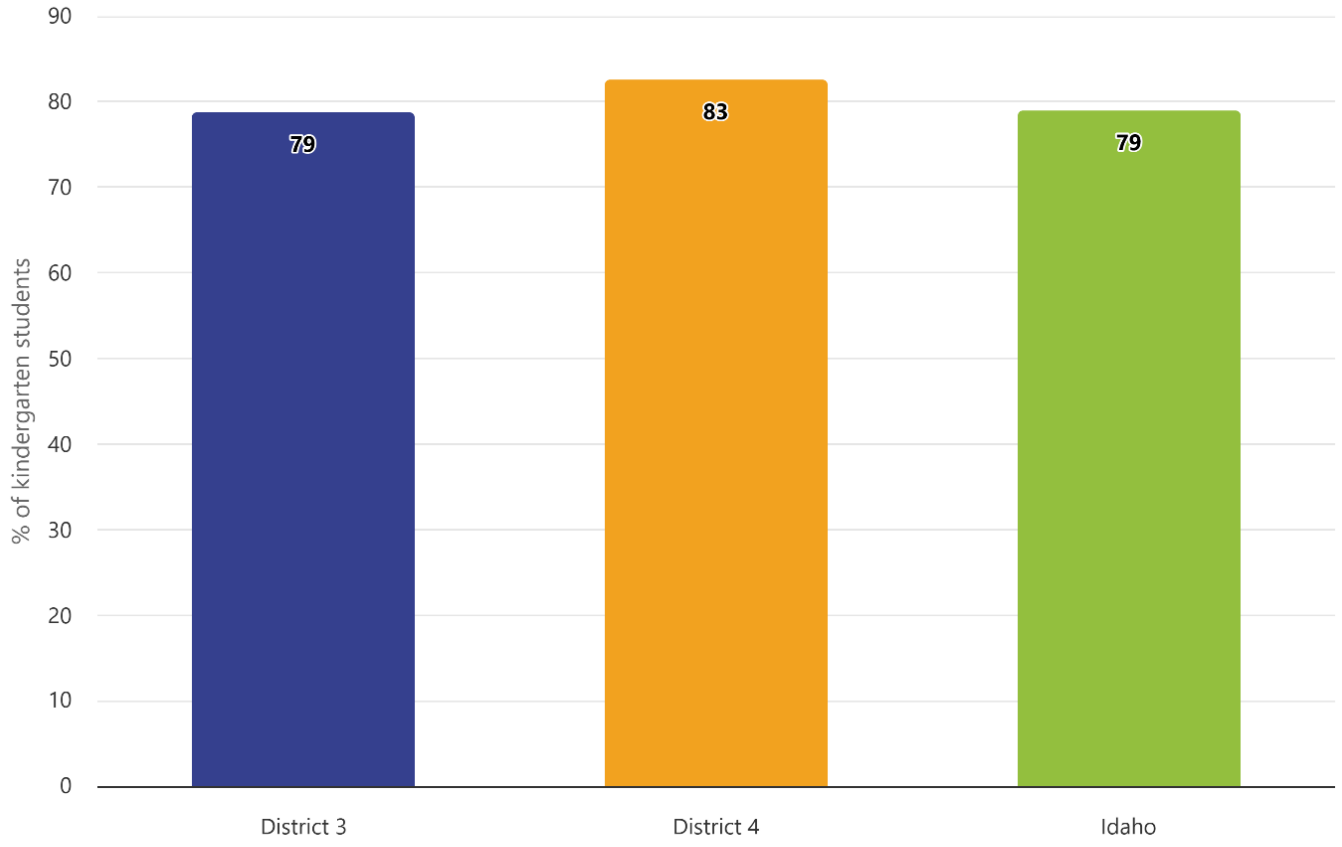
Created on Metopio | metop.io/i/avotsxt1 | **Data source:** Idaho Department of Health and Welfare: Idaho Division of Public Health
Vaccine exemption (ID): Percent of kindergarten students who were vaccine exempt.

Measles, Mumps, Rubella (MMR) Vaccination

In Health Districts 3 and 4, only 79% and 83% respectively of kindergarten students have at least two doses of the MMR vaccine on file.

MMR vaccination coverage among kindergartners in the U.S. was 92.5% during the same time period (CDCSchoolVaxView).

MMR vaccine (ID), 2024-2025



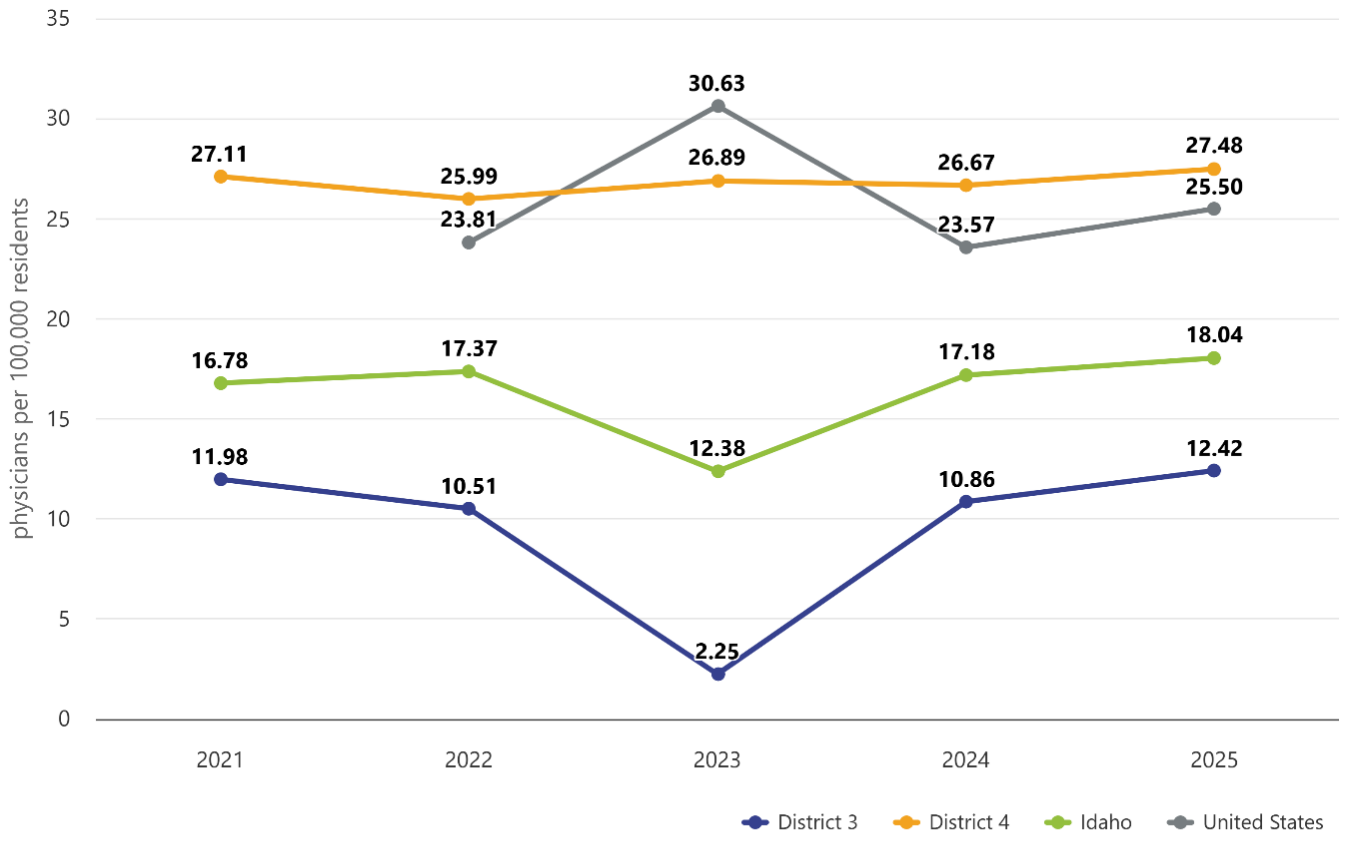
Created on Metopio | metop.io/i/pavn1yan | **Data source:** Idaho Department of Health and Welfare: Idaho Division of Public Health
MMR vaccine (ID): Percent of kindergarten students who have at least two doses of MMR on file.

Maternal and Child Health

OBSTETRICS AND GYNECOLOGY PHYSICIANS

In 2023, the number of obstetrics and gynecology physicians per capita in Health District 3 is significantly lower than state and national averages. This article, discusses how the Dobbs decision in 2022 impacted the number of obstetrics and gynecology physicians in Idaho. Following the ruling, physicians retired, changed to gynecology only, left rural practice for urban areas, and moved out of state. In the chart below, you may notice that Health District 4, which contains Boise, does not show the same decrease as Health District 3 and Idaho, likely because fewer physicians left urban areas and the movement of obstetrics and gynecology physicians from rural to urban areas offset some of the movement out of state.

Obstetrics & gynecology physicians per capita



Created on Metopio | metop.io/i/v5h6eqrf | **Data source:** Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

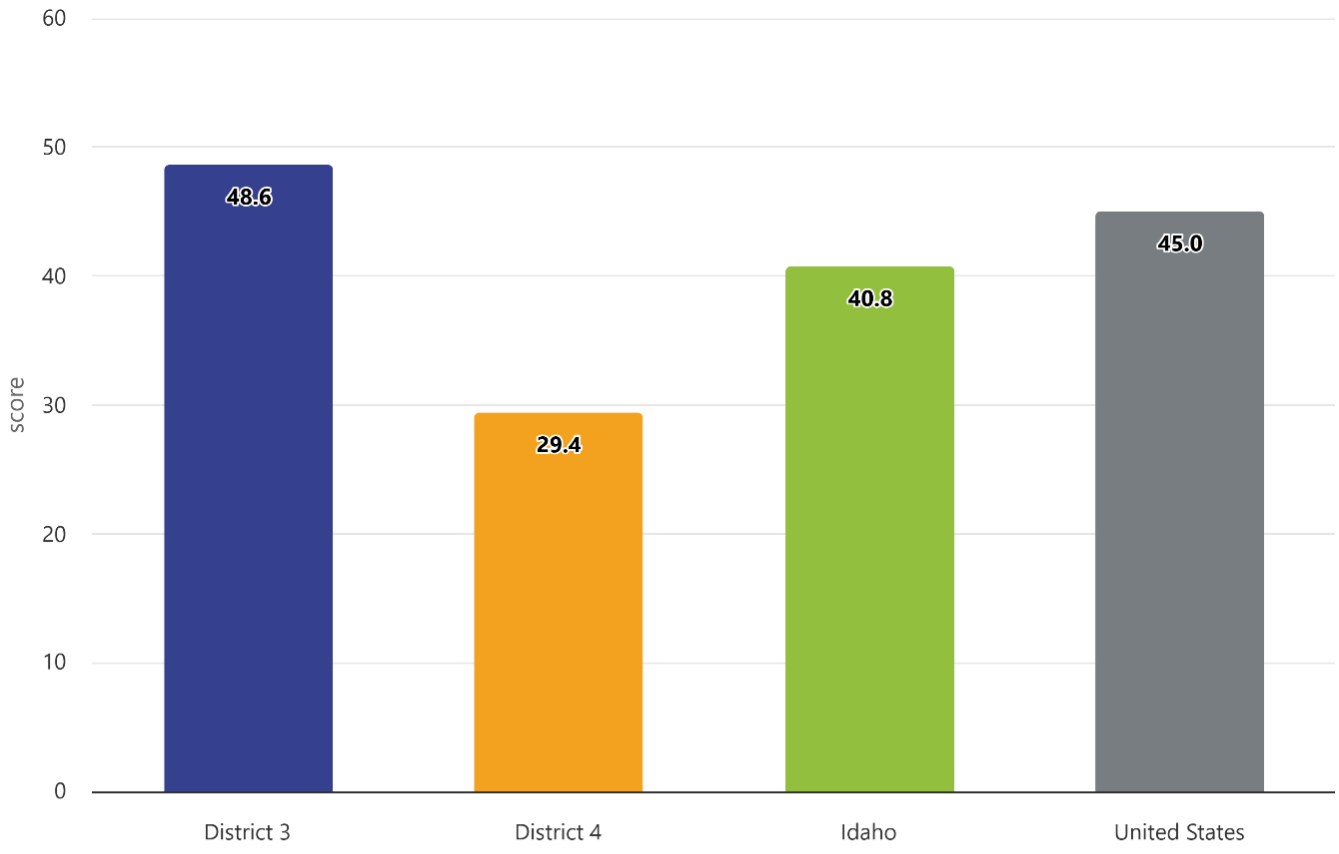
Obstetrics & gynecology physicians per capita: An obstetrician/gynecologist possesses special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders.

MATERNAL HARDSHIP INDEX

The Maternal Hardship Index is a comprehensive scale ranging from 0 to 100, designed to quantify the level of hardship faced by women during pregnancy, childbirth, and postpartum periods. This index incorporates a wide range of factors that influence maternal health outcomes, including healthcare access, physical and mental health outcomes, socioeconomic determinants, and built environment. Higher values represent greater maternal hardship.

The Maternal Hardship Index in Health District 3 is higher than state and national averages.

Maternal Hardship Index (2016-2023)



Created on Metopio | metop.io/i/twmy36da | **Data source:** Metopio

Maternal Hardship Index: The Maternal Hardship Index is a comprehensive scale ranging from 0 to 100, designed to quantify the level of hardship faced by women during pregnancy, childbirth, and postpartum periods. This index incorporates a wide range of factors that influence maternal health outcomes, including health care access, physical and mental health outcomes, socioeconomic determinants, and built environment. Higher values represent greater maternal hardship.

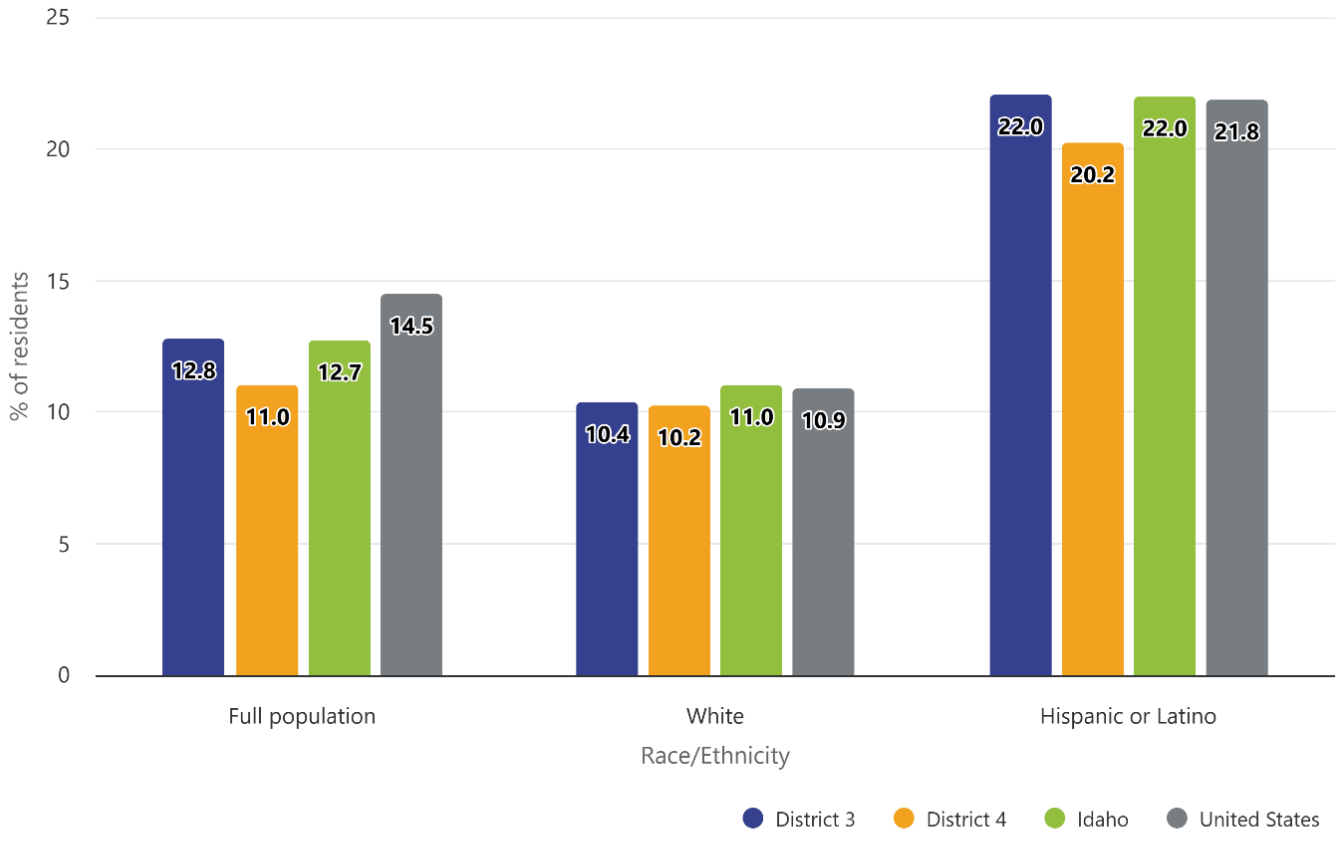
Food Access

Access to fresh, healthy, and/or affordable food. This can be related to grocery store proximity, school lunches, and availability of fruits, vegetables, and other healthy foods.

FOOD INSECURITY

Food insecurity rates vary significantly across different demographics and regions. In Health Districts 3 and 4, Hispanic or Latino populations experience higher food insecurity rates compared to the full population and non-Hispanic White populations.

Food insecurity by Race/Ethnicity (2023)



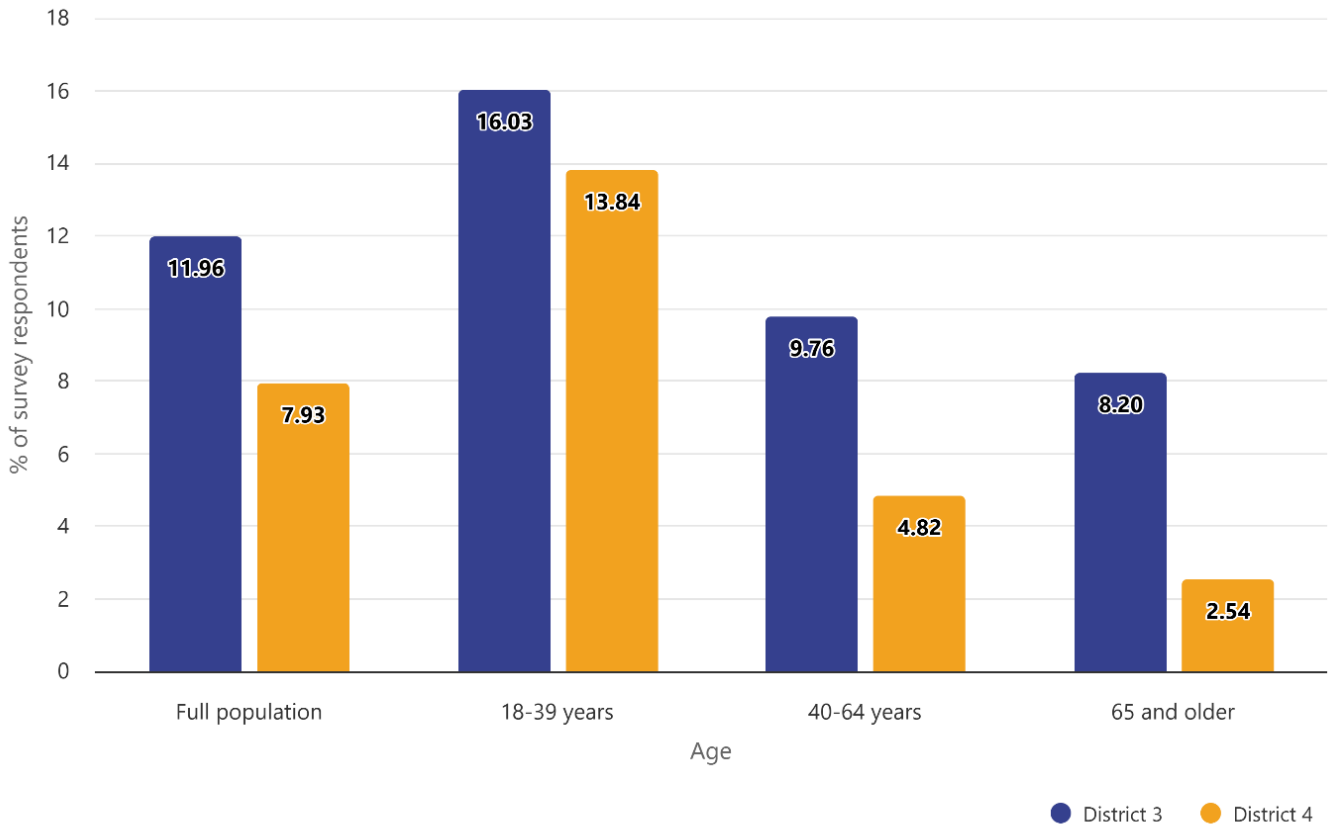
Created on Metopio | metop.io/i/95qj4cf9 | **Data source:** Feeding America: Map the Meal Gap

Food insecurity: Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.

FOOD PANTRY ACCESS

In Health Districts 3 and 4, survey respondents 18-39 years old were most likely to report accessing a food pantry, at 16.03% of survey respondents in Health District 3 and 13.84% of survey respondents in Health District 4.

Respondents who accessed a food pantry by Age (2025)



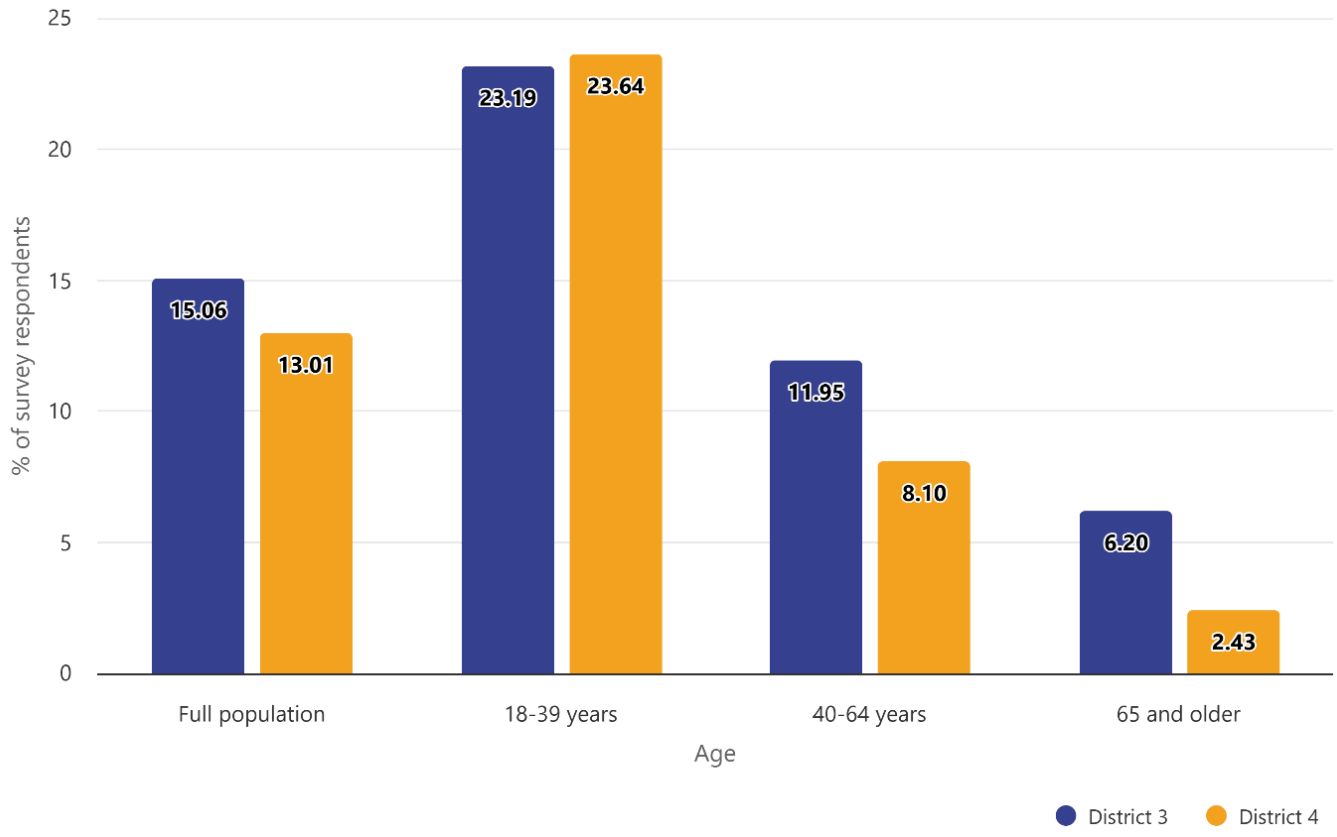
Created on Metopio | metop.io/i/vrsdapuf | **Data source:** Idaho Oregon Community Health Survey

Respondents who accessed a food pantry: Percentage of survey respondents who selected "Yes" in response to the question: "In the past 12 months, have you ever accessed free or emergency food at a local food pantry or meal site?"

FOOD ACCESS

In Health Districts 3 and 4, survey respondents 18-39 years old were most likely to report not having enough money to afford food, with 23.19% of survey respondents in Health District 3, and 23.64% of survey respondents in Health District 4.

Respondents without enough money for food by Age (2025)



Created on Metopio | metop.io/i/x6y5w8c6 | **Data source:** Idaho Oregon Community Health Survey

Respondents without enough money for food: Percentage of survey respondents who selected "Yes" in response to the question: "In the past 12 months, have you ever eaten less than you felt you should because there was not enough money for food?"

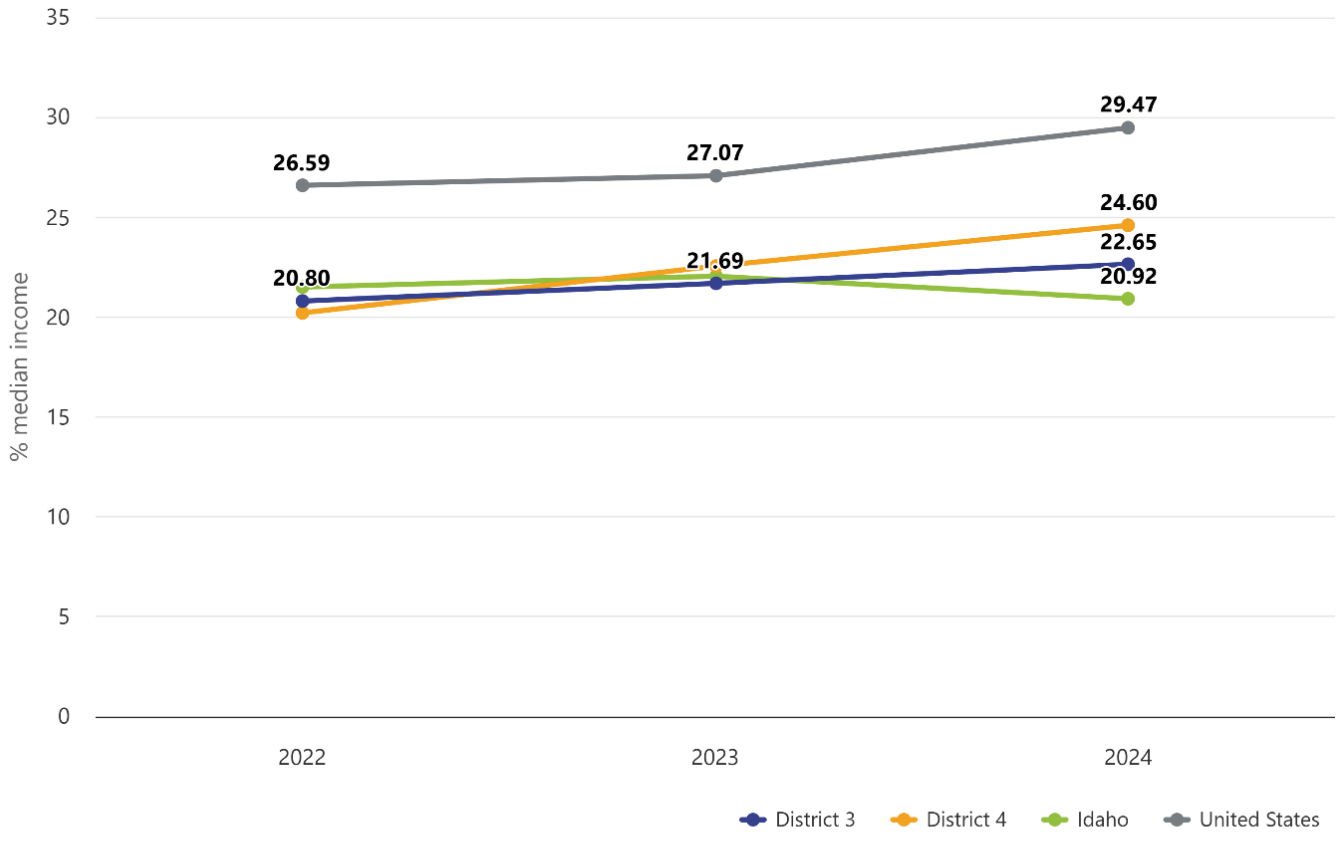
Childcare

CHILDCARE COST BURDEN

Childcare cost burden is calculated by the average childcare costs for a household with two children as a percent of median household income. The United States Department of Health and Human Services (HHS) considers childcare costs affordable when they stay below 7% of gross household income. Many households exceed this threshold substantially, especially if low-income.

Childcare cost burden for Health Districts 3 and 4 are lower than the United States averages, but higher than the Idaho averages. These rates have increased since 2022.

Childcare cost burden

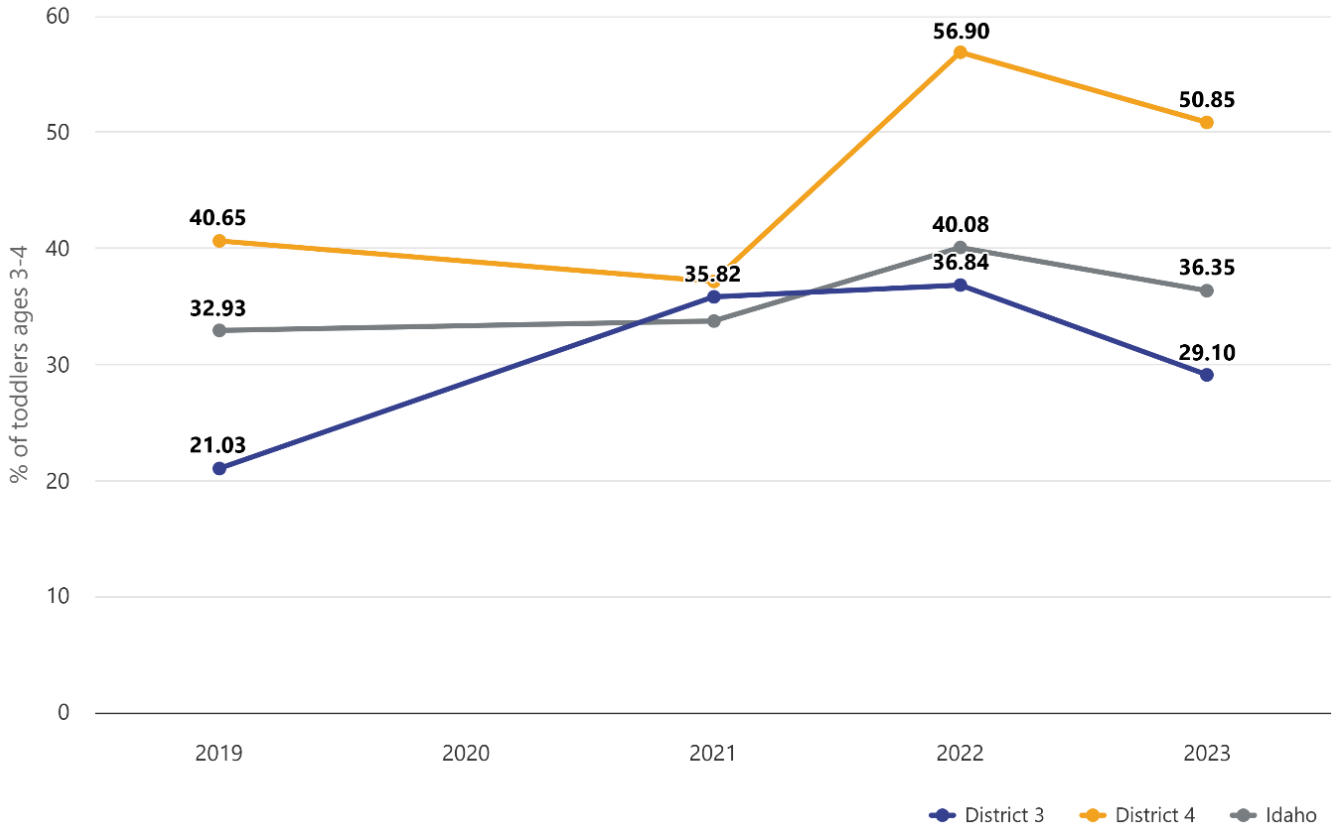


Created on Metopio | metop.io/i/ihfwwixj | **Data source:** University of Wisconsin Population Health Institute: County Health Rankings (Calculated using data from the Living Wage Institute and Small Area Income and Poverty Estimates)
Childcare cost burden: Child care costs for a household with two children as a percent of median household income.

PRESCHOOL ENROLLMENT

Preschool enrollment rates have fluctuated across Health Districts 3 and 4, and Idaho from 2019 to 2023. In 2023, Health District 4 had enrollment rates higher than the state average at 50.85%, while Health District 3 saw the lowest enrollment at 29.10%.

Preschool enrollment (3-4 years)



Created on Metopio | metop.io/i/t5bshku5 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B14003)

Preschool enrollment: Percentage of 3- and 4-year-olds enrolled in school.

Chronic Disease

Chronic disease, such as diabetes, heart disease, asthma, obesity, tend to comprise the greatest burden on health in a community and can significantly affect lifespan and quality of life.

CHRONIC DISEASE PREVALENCE

The table below shows the chronic disease prevalence for Health District 3 and Health District 4, compared to Idaho and United States averages.

	Health District 3	Health District 4	Idaho	United States
Have ever had cancer *% of adults*	7.07	7.19	7.30	6.64
Diagnosed stroke *% of adults*	3.05	2.55	2.60	2.91
Coronary heart disease *% of adults*	**5.52**	**4.88**	2.70	3.40
Current asthma *% of adults*	10.86	10.34	10.50	9.88
Diagnosed diabetes *% of adults*	**10.9**	7.6	8.7	8.6
High blood pressure *% of adults*	29.60	28.94	28.20	31.14

Centers for Disease Control and Prevention PLACES, 2023

At least 20% higher than state average

CHRONIC DISEASE MORTALITY

The table below shows the chronic disease mortality for Health District 3 and Health District 4, compared to Idaho and United States averages.

	Health District 3	Health District 4	Idaho	United States
Alzheimer's disease mortality *deaths per 100,000, 2019-2023*	40.7	**47.2**	37.2	30.0
Cancer mortality *deaths per 100,000, 2019-2023*	**168.4**	152.6	137.5	144.1
Breast cancer mortality *deaths per 100,000, 2019-2023*	12.1	11.6	10.1	10.5
Heart disease mortality *deaths per 100,000, 2019-2023*	**191.4**	148.6	154.1	166.5
Diabetes mortality *deaths per 100,000, 2019-2023*	22.0	18.5	21.3	23.6

Centers for Disease Control and Prevention National Vital Statistics Systems-Mortality (NVSS-M), 2019-2023

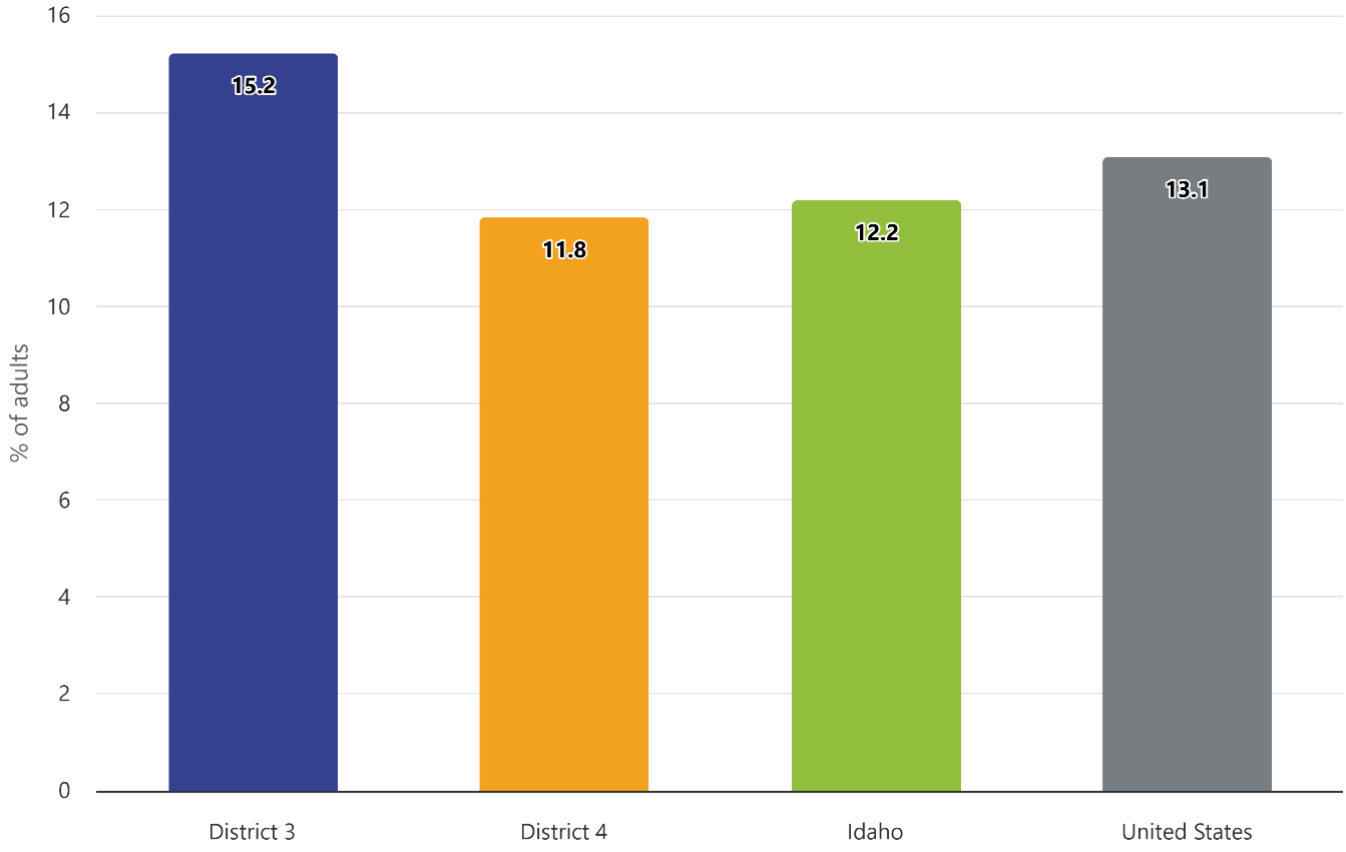
At least 20% higher than state average

Tobacco and Nicotine Use

CIGARETTE SMOKING

Cigarette smoking rates vary across Idaho and the nation. In Health District 3, 15% of the population reported having smoked, which is about 25% higher than Idaho.

Cigarette smoking rate (2022)

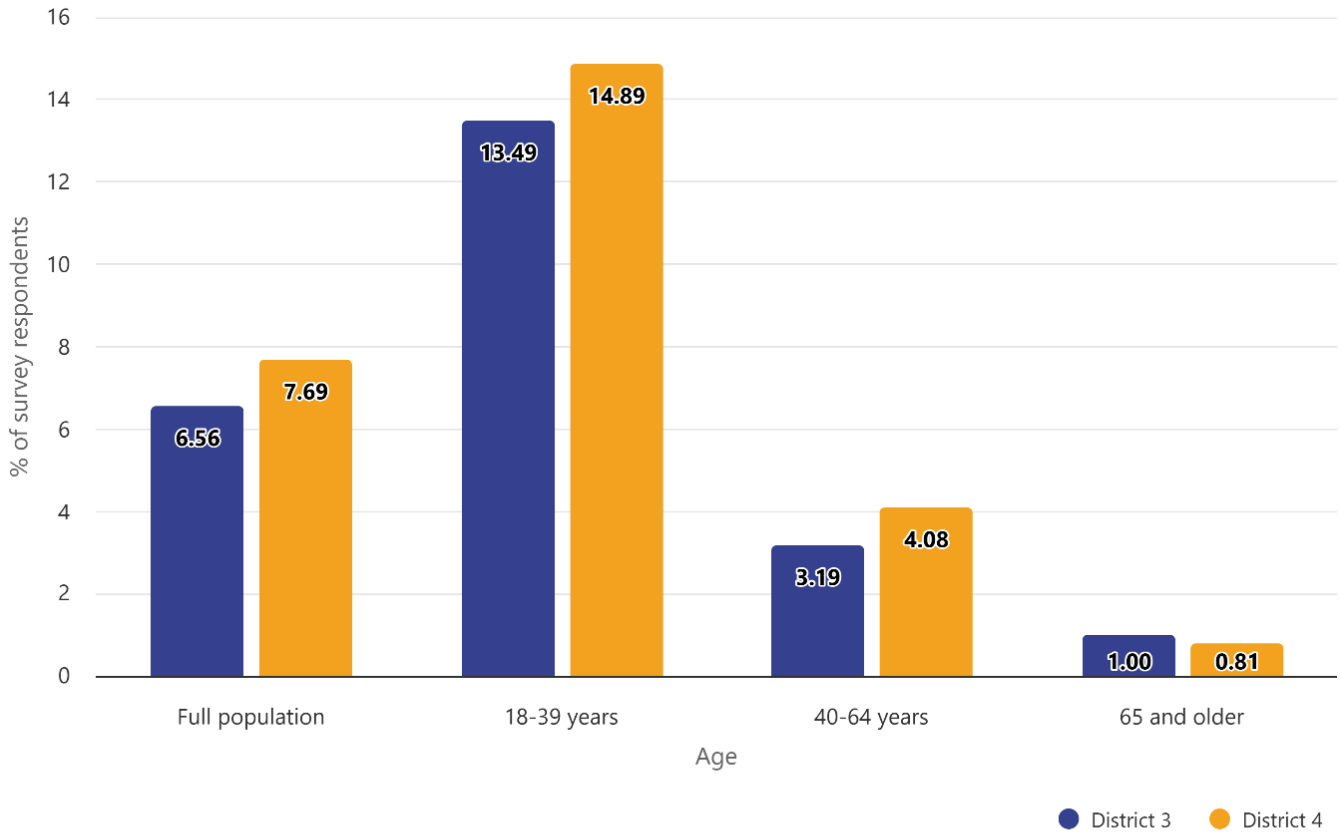


Created on Metopio | metop.io/i/6jm2j147 | **Data sources:** Dwyer-Lindgren, Mokdad, et al. (Population Health Metrics, 2014) (Data modeled from BRFSS for years 1996-2012), Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): **Cigarette smoking rate:** Percent of resident adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

VAPING

Respondents who have vaped are most prevalent in the 18-39 age group, at rates approximately double the Health District Averages.

Respondents who have vaped by Age (2025)



Created on Metopio | metop.io/i/var3rr7u | **Data source:** Idaho Oregon Community Health Survey

Respondents who have vaped: Percentage of survey respondents who selected "Yes" in response to the question: "In the past 30 days, have you used electronic cigarettes or vape?"

Prioritization

On October 7, 2025, community partners and leaders reviewed the Community Health Needs Assessment results and collaboratively determined the priority health issues for the implementation strategy.

The session began with a presentation outlining the top health needs identified through both quantitative and qualitative data collection. These themes included access to care, behavioral health (mental health and substance use), childcare, chronic disease, food access, housing, maternal and child health, and tobacco and nicotine use.

Following the presentation, participants engaged in discussion regarding the presented data, and were asked to rank the top health needs using an online survey. The following factors were considered during ranking:

- **Seriousness and Impact:** How does the identified need impact health and quality of life?
- **Consequences of Inaction:** What impact would inaction have on individuals and the community?
- **Magnitude and Inequity:** How many people in the community are or will be impacted? Who is most impacted?
- **Feasibility of Influencing:** What assets or capacity currently exist to address the need?
- **Trend:** How has the need changed over time?

After ranking, each health need was assigned a score from 1-100, with higher scores indicating a higher need.

The results are shown below:

Health Need	Score
Behavioral Health	74
Housing	70
Access to Care	66
Maternal and Child Health	46
Food Access	46
Child Care	42
Chronic Disease	39
Health Behaviors: Tobacco and Nicotine Use	17

Community Resources and Assets

Hospital systems and the Western Idaho Community Health Collaborative (WICHC) will develop and publish implementation strategies upon publication of the report. Access free and reduced-cost resources to address these and other SDoH needs can be accessed by calling 211 or visiting findhelpidaho.org.

The Community Partner Assessment (see Page 9 for description) identified strengths, assets, resources, and gaps among local partners. Key findings include:

STRENGTHS OF COMMUNITY PARTNERS:

- Over 80% of respondents reported addressing the Social Determinants of Health (ex. housing, food, workforce) in their organization
- More than half of respondents are currently addressing Access to Healthcare, Education, and Youth Development, and Behavioral Health
- More than half of respondents reported willingness to share staff time, meeting space, and partnership to help drive Community Health Improvement Plan (CHIP) work
- Most respondents reported using community partnerships and education to drive their work
- The most common communication method among respondents was social media

OPPORTUNITIES:

- Respondents were least likely to report working with environmental justice (e.g., conservation, advocacy, pollution control), racial justice, restaurants, and immigration organizations
- Respondents were least likely to report legal expertise and voter engagement as drivers of their work

2023-2026 Evaluation of Impact

Summary of Previous CHNA

The 2023 Community Health Needs Assessment utilized a Greater Treasure Valley Steering Committee, as convened by the Western Idaho Community Health Collaborative (WICHC), inclusive of Boise State University's Idaho Policy Institute, Central District Health, Regence BlueShield of Idaho, Saint Alphonsus Health System, Saltzer (Intermountain) Health, Southwest District Health, St. Luke's Health System, United Way of Treasure Valley, and Weiser Memorial Hospital.

As the first-ever regional initiative, partners included Blue Cross of Idaho Foundation for Health, Boise State University, Community Council of Idaho, Inc., the Idaho Anti-Trafficking Coalition, The Idaho Area Agency on Aging, the Idaho Association for the Education of Young Children, The Idaho Foodbank, the Idaho Housing and Finance Association, Idaho Primary Care Associates, Jesse Tree, Micron, Terry Reilly Health System, Valley Regional Transit, the Western Idaho Community Action Partnership, and the Women and Children's Alliance.

In partnership with the partners listed above, the June 2023 CHNA identified significant health needs within the WICHC region including:

- Safe, Affordable Housing and Homelessness.
- Behavioral Health, Including Mental Health and Well-Being and Substance Misuse.
- Access to Affordable Health Care, Including Oral and Vision Health.

2023-2026 Evaluation of Impact

The Western Idaho Community Health Collaborative (WICHC) acknowledged the wide range of priority health issues impacting the Greater Treasure Valley and agreed to focus on the most pressing, severe, and unresolved priorities. Together, WICHC and its CHNA Lead Committee focused on the initiatives they could support and leverage within housing, behavioral health, and access to care.

2023 Priority Area 1: Safe, Affordable Housing, and Homelessness

To address this priority area, WICHC established a housing workgroup led by St. Luke's Health System to support local decision-makers and community efforts to increase available housing supply and overall housing stability. Once formed, WICHC helped bring these partners together to focus on its goal and to reinforce the connection between housing and health. Partners included CATCH Idaho, the City of Boise, NeighborWorksBoise, Saint Alphonsus, and Southwest District Health. Beyond these partnerships, relationships with local officials have been made such as Senator Ali Rabe, who now leads the Gem State Housing Alliance.

Since its development in 2023, partners of the housing workgroup have invested and educated the broader community about the connection between housing and health. Organizations include the Idaho Housing and Finance Association 2026 Conference on Housing and Economic Development, Region 3 Housing Coalition Conference, and Urban Land Institute Housing Week.

From a funding perspective, these priorities have contributed to local organizations contributing to and championing community investments. For example, United Way of Treasure Valley has invested in solutions that create affordable, attainable housing, along with programs that keep people housed. The momentum behind this priority resonates with a community that has experienced tremendous growth in the past few years. In response to this growth, the housing workgroup created a Community Planning Association of Southwest Idaho one-pager to help inform future housing investments in Idaho. For WICHC and the community, not only is it necessary to make the connection between housing and health for our community, but to also be a thought partner in the development of new housing initiatives in Idaho.

Search data from findhelpidaho.org shows that housing-related needs remain the most frequently searched category across all regions in Idaho. Over the three-year period from January 1, 2023 through December 31, 2025, housing accounted for 42% of all searches in Region 3 and 40% of searches in Region 4, highlighting the continued demand for housing-related resources.

Strategy: Identify and advocate for new transformational funding sources for housing investments.	
Key Partners	**Blue Cross of Idaho Foundation, CATCH Idaho, City of Boise, Gem State Housing Alliance, NeighborWorks Boise, Saint Alphonsus, Southwest District Health**
2023-2026 Outcomes	• Presented at the Region 3 Housing Coalition Conference • Presented at the 2026 Conference on Housing and Economic Development
Systems-level Outcome (Structural Change):	Illustrated the importance and link between housing and health, across the Greater Treasure Valley

2023 Priority Area 2: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse

The Idaho Crisis & Suicide Hotline and Southwest District Health, the behavioral health workgroup set a goal to improve access to behavioral health services and behavioral health outcomes. Partners co-leading the efforts of this workgroup included ECHO Idaho, Idaho Department of Juvenile Corrections, Idaho State University, Ignite Idaho, Magellan, Southwest District Health, St. Luke's Health System, and Veterans Affairs, to name a few.

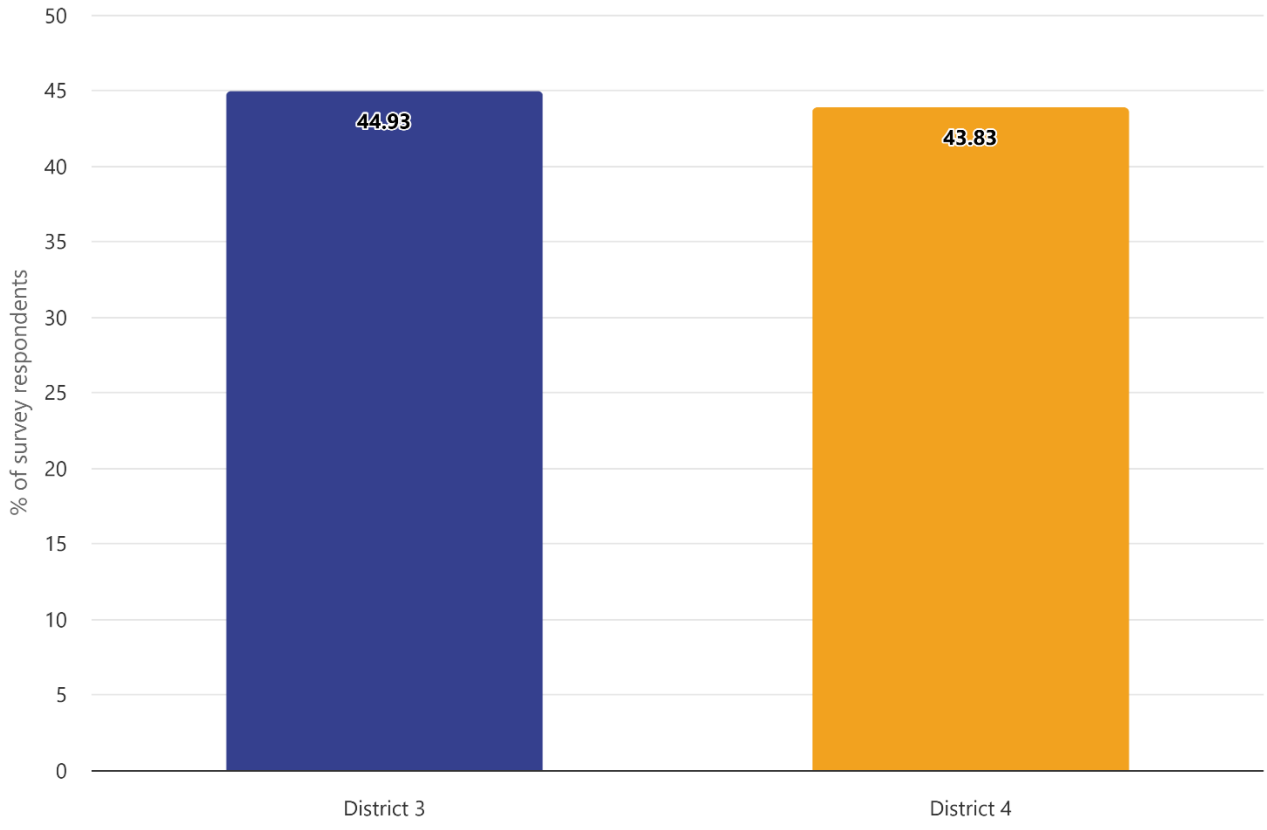
In the spring of 2025, the stigma reduction project team created a mental health and wellbeing training flyer showcasing behavioral health trainings offered by WICHC partners in the region. Trainings included Adult Mental Health First Aid & Youth Mental Health First Aid; Question, Persuade, Refer (QPR); Adolescent Mental

Health 101; Applied Suicide Intervention Skills Training (ASIST); Counseling on Access to Lethal means (CALM); Naloxone Training; Strengthening Families; and Veteran-specific Trainings.

As part of their efforts, the stigma reduction project team is also working on creating a best practice toolkit designed for organizations. The purpose of this toolkit is to help local organizations effectively speak to behavioral health stigma while equipping them with additional resources designed with the community in mind. To inform the toolkit, the stigma reduction project team reviewed and analyzed existing nationwide resources to inform the development of this toolkit.

Simultaneously, the behavioral health workforce project team is in the process of conducting a behavioral health assessment survey collecting information on the existing needs of the workforce and the pipeline of the workforce to better understand and respond to their needs. Upon completion, the survey data will be distributed to WICHC and its community partners for analysis. Additionally, the data from this workforce survey will be used for advocacy purposes during the 2027 Idaho State Legislature.

Respondents who know how to use Narcan, 2025



Created on Metopio | metop.io/i/z32o3nri | **Data source:** Idaho Oregon Community Health Survey
Respondents who know how to use Narcan: Percentage of survey respondents who selected "Yes" in response to the question: "Do you know how to use Narcan?"

Survey respondents had slightly higher rates of individuals who know how to use Narcan compared to the national averages of 40% (https://pubmed.ncbi.nlm.nih.gov/40131292/).

Strategy: Understand the behavioral health workforce pipeline and rural community access	
Key Partners	**Blue Cross of Idaho Foundation, Idaho Crisis & Suicide Hotline, Idaho Department of Juvenile Corrections, Idaho State University, Ignite Idaho, Southwest District Health, Veterans Affairs**
2023-2026 Outcomes	Partnered with Idaho State University and current workgroup partners (listed below) to develop a Behavioral Health Workforce Survey, statewide
Systems-level Outcome (Structural Change):	Fostering connections to better understand the statewide behavioral health workforce

Strategy: Reduce behavioral health stigma	
Key Partners	**The College of Idaho, Idaho Department of Juvenile Corrections, St. Luke's Health System, Southwest District Health, Veterans Affair**
2023-2026 Outcomes	• Developed a Mental Health & Well-being Flyer promoting **free** behavioral health trainings across the 10-county region • Developed a stigma reduction organizational toolkit for organizations to advance mental health and well-being
Systems-level Outcome (Structural Change):	Developing tools to enhance and support mental health in Southwest Idaho

Priority Area 3: Access to Affordable Health Care, Including Oral and Vision Health

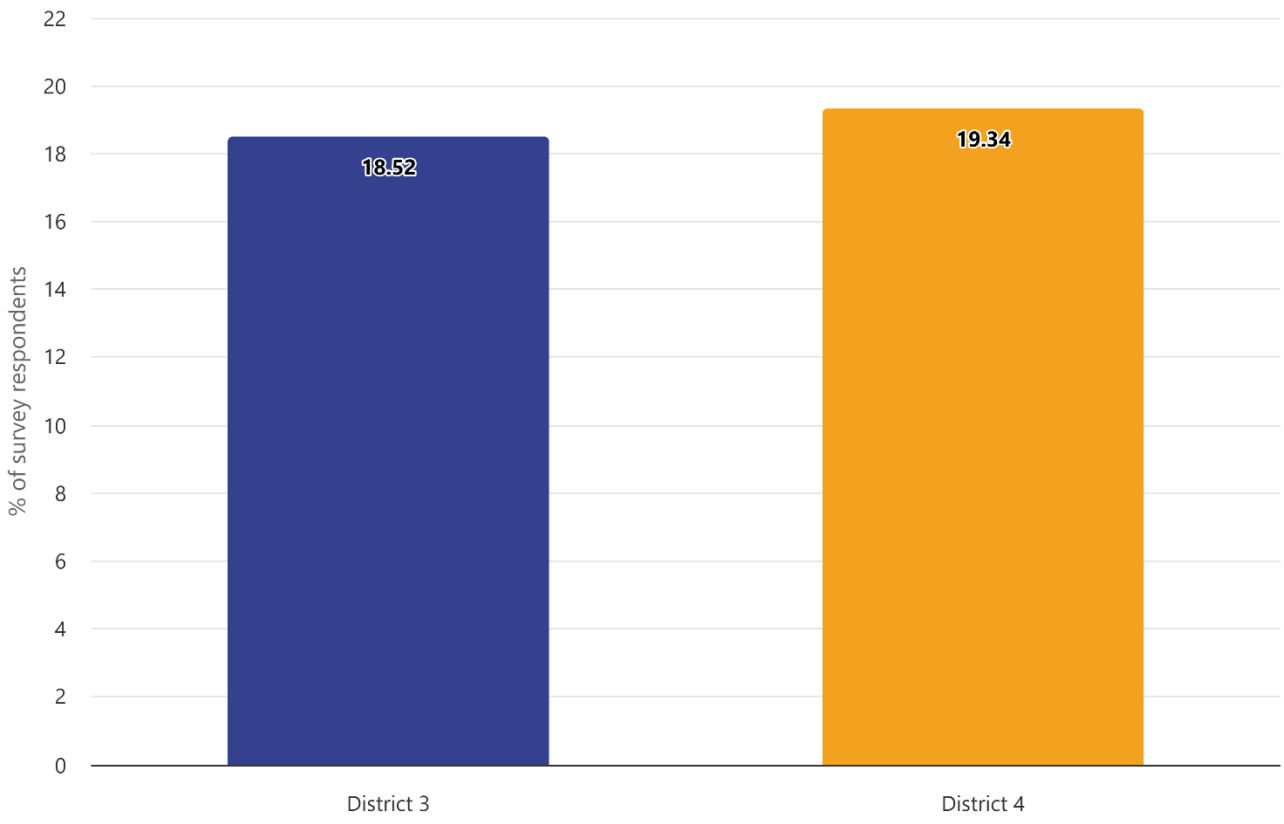
The access to care workgroup has enhanced the use of community resources and referral pathways through two platforms findhelpidaho.org and Mobile Health Map. Composed of many health partners in the Greater Treasure Valley, including but not limited to Southwest District Health, St. Alphonsus, Terry Reilly, UnitedHealthcare, United Way of Treasure Valley, etc., this workgroup has focused on promoting findhelpidaho.org in both urban and rural counties to increase utilization of the resource platform. Since 2023, United Way of Treasure Valley has seen strong community utilization of findhelpidaho.org. From January 1, 2023, through December 31, 2025, the platform experienced an 11% increase in network size, with 1,104 programs added to the site during that period. This growth contributes to a statewide network that now includes 4,491 national, statewide, regional, and local programs serving Idaho. Search traffic on the platform also increased by nearly 5%, with a total of 327,180 searches conducted within Idaho over the three-year period.

To support continued utilization, United Way hosted more than 189 virtual and in-person 101 training courses and technical assistance sessions across the state, including in every county within the Western Idaho Community Health Collaborative footprint. These trainings were delivered in partnership with local organizations to build trust and strengthen community buy-in. United Way also developed an Idaho-specific certification program as part of the 101 training, along with a virtual certification option designed for a train-the-trainer model that supports deeper platform utilization and expands the network of trained users. In addition, United Way has presented on the platform at more than a dozen regional, statewide, and national conferences. In 2024, the findhelpidaho.org platform was recognized by KLAS as a Point of Light finalist for work addressing Social Determinants of Health and reducing barriers to access to care.

These outreach and training efforts have helped strengthen community engagement with the platform. Between 2023 and 2025, 639 programs were claimed by organizations managing their listings directly on the platform, helping ensure that resource information is accurate and up to date for community members seeking help. During the same period, 424 programs activated the intake or referral tool, enabling organizations to move beyond a traditional resource directory and support closed-loop referrals. These tools allow partners to track referrals, coordinate services, and generate real-time insights about community needs and whether individuals are successfully connected to care.

With the demand for healthcare services and primary care, the access to care workgroup has also promoted and shared Mobile Health Map's free platform for local mobile health clinics in the Greater Treasure Valley. This free nationwide platform offered by Harvard Medical School helps mobile health clinics by offering a centralized location to promote their service in their state or region. In Idaho, four health centers host their clinic on the platform. As a result, mobile clinics can track and monitor number of patients served, types of services utilized, and capture demographic information.

Respondents who believe people know where to access resources, 2025



Created on Metopio | metop.io/i/bwmndc48 | **Data source:** Idaho Oregon Community Health Survey
Respondents who believe people know where to access resources: Percentage of survey respondents who selected "Agree" or "Strongly Agree" in response to the statement: "Individuals in my community know where to go to access resources."

According to the 2026 Community Health Survey, 18.52-19.34 percent of survey respondents believe people know where to go to access resources.

Strategy: Expand and improve partner and community use of resources and referral pathways	
Key Partners	**Saint Alphonsus, United HealthCare Services, Inc., United Way of Treasure Valley**
2023-2026 Outcomes	• Hosted 10 findhelpidaho.org training courses specific to the WICHC region, offered online or in-person • Created a virtual certification course and module available statewide
Systems-level Outcome (Structural Change):	Promoted and expanded the integration and use of findhelpidaho.org, in the Greater Treasure Valley and Statewide

Summary

As the first-ever regional community health needs assessment done in partnership with local partners, WICHC has laid the foundation for continued cross-sector collaboration across its footprint. Ultimately, creating the groundwork for continued long-term systems-level collaboration.

Appendix 1: Saint Alphonsus Health System

As a Catholic health system, Saint Alphonsus is committed to advocacy for and service to individuals who are underserved and underrepresented in our communities. We are called to minister to those who are vulnerable and to ensure the dignity of all people.

Our Mission calls us to serve together with Trinity Health, in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. The Community Health Needs Assessments (CHNA) allow Saint Alphonsus to be responsible stewards of our resources and target our efforts and financial investments to where there is the greatest need and increased potential for effectiveness.

A Community Health Needs Assessment provides the opportunity to:

- Gain insights into the needs and assets of the communities served,
- Identify and address the needs of vulnerable populations and those experiencing health disparities and inequities within the community,
- Enhance relationships and opportunities for collaborative community action, and
- Provide information for community outreach planning, evaluation, and assessment.

Hospital Overview

Saint Alphonsus Regional Medical Center (SARMC) in Boise, Idaho is dedicated to delivering advanced medical services in a spiritual, healing environment throughout southwest Idaho, eastern Oregon and northern Nevada. Through innovative technologies, compassionate staff, and warm, healing environments, Saint Alphonsus strives to provide care that is focused on patients. Founded in 1894 by the Sisters of the Holy Cross, SARMC was the first hospital established in Boise, bringing health care to the poor and

underserved. Now referred to as Saint Alphonsus Regional Medical Center, our licensed medical-surgical/acute care 381-bed facility serves as the center for advanced medicine and is poised to support the community well into the future. Saint Alphonsus also has an intricate system of health and wellness services that extend into the communities around our region.

The Saint Alphonsus Regional Rehabilitation Hospital (SARRH), an affiliate of Encompass Health, is committed to helping patients regain independence after a life-changing illness or injury. SARRH is a 40-bed rehabilitation hospital that opened in July 2019 across the street from the SARMC campus. It serves the Boise area as a leading provider of inpatient rehabilitation for stroke, spinal cord injury, brain injury, and other complex neurological and orthopedic conditions. SARRH uses an interdisciplinary team approach that includes physical, speech and occupational therapists, rehabilitation physicians, rehabilitation nurses, case managers, dietitians and more, combined with our advanced technology and expertise, to help patients achieve their goals. Patients receive at least three hours of therapy five days per week while under the constant care of registered nurses, many of whom specialize in rehabilitation, and frequent independent private practice physician visits.

The Saint Alphonsus Medical Center (SAMC-N) in Nampa, located at the corner of I-84 and Garrity Boulevard, offers state-of-the-art, best-in-class health care to residents of Canyon County. This 100-bed hospital that spans more than 240,000 square feet, features a complete diagnostic center, six-suite surgical operating theatre, pre/post-operative holding and recovery rooms, 10-bed short stay observation unit, spacious and private patient rooms, and an 18-bed intensive care unit. Built with preventive and ambulatory health in mind, the facility accommodates the latest information technology, updated diagnostic and treatment technology, and an environment proved to reduce patient stress and recovery times.

Saint Alphonsus is a proud affiliate of Trinity Health, one of the largest not-for-profit, faith-based health care systems in the nation. It is a family of 133,000 colleagues and more than 38,900 physicians and clinicians caring for diverse communities across 25 states. Nationally recognized for care and experience, the Trinity Health system includes 92 hospitals, 101 continuing care locations, the second largest PACE program in the country as well as many other health and well-being services.

Mission Statement

We, Saint Alphonsus and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Core Values

- **Reverence:** We honor the sacredness and dignity of every person.
- **Commitment to Those Experiencing Poverty:** We stand with and serve those who are poor, especially those most vulnerable.
- **Safety:** We embrace a culture that prevents harm and nurtures a healing, safe environment for all.
- **Justice:** We foster right relationships to promote the common good, including sustainability of Earth.
- **Stewardship:** We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
- **Integrity:** We are faithful to who we say we are.

Services Provided

Services offered by SARMC, SARRH, and SAMC-N include, but are not limited to: brain injury program, breast care, cardiology and vascular care, cancer care, diabetes care and education, emergency and trauma, endoscopy, hospitalists, infusion clinic, laboratory, Mako Robotic-Arm® Assisted Joint Replacement, maternity services, neuroscience, nutrition, orthopedics, pain management, palliative care, pharmacy, physical therapy and rehabilitation, pulmonary diagnostics, radiology and medical imaging, research, sleep disorders, spine care, stroke center, surgical services, including Treasure Valley Surgery Center, telestroke, women's and children's services, and wound and hyperbaric.

Conducting the 2026 Community Needs Assessment

Saint Alphonsus Regional Medical Center (SARMC) and the Saint Alphonsus Regional Rehabilitation Hospital (SARRH) in Boise, Idaho, and Saint Alphonsus Medical Center (SAMC-N) in Nampa, Idaho, participated a coordinated comprehensive Community Health Needs Assessment that was reviewed by the Boise, SARRH, and Nampa Community Hospital Advisory Boards. SARMC, SARRH, and SAMC-N performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment considered input from representatives of the community, community members, and various community organizations. It is available publicly online at https://www.saintalphonsus.org/about-us/community-benefit/community-needs-assessment , or by request from the Saint Alphonsus Health System Community Health and Well-Being Department.

The collaborative 2026 Community Health Needs Assessment was led by Central District Health Department (CDH), Saint Alphonsus Health System, Southwest District Health Department (SWDH), St. Lukes Health System, United Way of Treasure Valley, and the Western Idaho Community Health Collaborative (WICHC) with Metopio as research partners using the same tools and protocols used in the 2026 Malheur and Baker County CHNAs. Ten counties: Ada, Canyon, Boise, Valley, Canyon, Adams, Owyhee, Payette, Washington, and Gem were the primary service areas studied, with analysis and comparison of county/health district, state, and national data wherever available. These communities were selected for review as they comprise the WICHC, CDH, and SWDH services areas, which is also where the majority of SARMC, SARRH, and SAMC-N patients draw from. The Idaho Oregon Community Health Data Atlas was utilized as the primary sources for secondary data, in addition to localized data sources provided by the Treasure Valley Steering Committee members. Additional duties of the Steering Committee, whose members are listed in the Acknowledgements, included selecting secondary data indicators, developing the community survey and focus group/interview instruments, disseminating community surveys, conducting and participating in focus groups and key informant interviews, selecting significant health needs, providing review and revision to the draft assessment report, and drafting the plan for communications and dissemination of the completed assessment. The detail processes for conducting community surveys, focus groups, and key informant interviews is listed in the 2026 Community Health Needs Assessment document, as are the methods for prioritizing the key health needs for 2026.

The 2026 Community Health Needs Assessment processes and drafts were presented to the local Community Hospital Advisory Boards. Their input was reviewed and approved by the Saint Alphonsus Health System Board on February 18, 2026, with delegation of approval for any subsequent edits to board chair Adam Richins.

Summary of Previous CHNA

The 2023 Community Health Needs Assessment utilized a Treasure Valley Steering Committee, as convened by the Western Idaho Community Collaborative (WICHC), inclusive of Saint Alphonsus, as the primary method of gathering public input on the draft reports between January and May 2023. The community organizations that made up the 2023 Steering Committee were provided with drafts of the assessment report and provided comments back to WICHC for inclusion in the final document. Additionally, the SARMC, SARRH, and SAMC-N Community Hospital Boards were provided with drafts of the Community Assessment and provided input the 2023 CHNA priorities.

The 2023 SARMC, SARRH, and SAMC-N Community Health Needs Assessments can be found online at: https://www.saintalphonsus.org/about-us/community-benefit/community-needsassessment/ and at https://encompasshealth.com/locations/boiserehab .

The prior CHNA, completed in June 2023, identified significant health needs within the SARMC, SARRH, and SAMC-N community:

- Safe, Affordable Housing and Homelessness
- Behavioral Health, Including Mental Health and Well-Being and Substance Misuse
- Access to Affordable Health Care, Including Oral and Vision Health

The 2023 Community Health Needs Assessment was reviewed in detail within the Saint Alphonsus Health System Community Health and Well-Being Department in partnership with CDH, St. Luke's Health System, SWDH, United Way, and WICHC prior to the development of the 2026 Community Health Needs Assessment processes and tools.

Saint Alphonsus did not receive any comments from the public on the 2023 CHNA beyond the contributions of the Treasure Valley Steering Committee, hospital boards, and qualitative data collection methods between January and June 2023.

Evaluation of Impact

SARMC, SARRH, and SAMC-N acknowledged the wide range of priority health issues that emerged from the 2023 CHNA process and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. SARMC, SARRH, and SAMC-N developed and/or supported initiatives to improve the health needs of affordable, safe housing and homelessness, mental health and well-being and substance use, and access to affordable health care, including behavioral and dental health care.

SAFE, AFFORDABLE HOUSING AND HOMELESSNESS:

SARMC and SAMC-N were committed to addressing the increasing costs of housing and the decreasing availability of affordable housing units by striving to increase the amount of affordable housing stock in Ada and Canyon Counties.

In response to the 2023 CHNA findings, SARMC sought to invest in expanding the stock of affordable housing units available in Ada County. SARMC was the preliminary investor alongside the City of Boise in the Ada County Supportive Housing Investment Fund (SHIF), a shared impact investment fund held by the Idaho Community Foundation to create a pipeline of supportive housing units across Ada County. In addition to the SHIF, SARMC contributed to Roundhouse Development's Finch Housing, supporting their application for Low Income Housing Tax Credits toward 30 units of affordable and permanent supportive housing units in Boise.

SAMC-Nampa also supported the preservation of 60 deeply affordable apartment units for older adults in Nampa via Golden Glow Towers in partnership with LEAP Housing. SAMC-Nampa assisted in the capital campaign for LEAP to purchase Golden Glow Towers and provided funds to revitalize the building to make it more ADA and modern city code compliant for more than 65 residents.

Additionally, SARMC and SAMC-Nampa have made significant community contributions to community partners engaged in housing and homelessness work including Jesse Tree, CATCH, Home Partnership Foundation, Good Samaritan Home, Idaho Youth Ranch, Salvation Army, and the Boise Rescue Mission.

Saint Alphonsus began assessing the housing needs of patients in FY21 with the establishment of the Community Health Worker (CHW) Hub. CHWs follow up with patients with housing needs by helping patients navigate to community partners through the Saint Alphonsus Community Resource Directory. Additionally, CHWs helped patients with qualifying health needs to access patient assistance funds to help keep them housed while improving their health outcomes.

BEHAVIORAL HEALTH, INCLUDING MENTAL HEALTH AND WELL-BEING AND SUBSTANCE MISUSE:

SARMC and SAMC-Nampa aimed to increase behavioral health support and programmatic provision across Ada and Canyon counties.

Specifically, the Community Health & Well-Being (CHWB) department conducted Question, Persuade, Refer (QPR) suicide prevention curriculum for colleagues across the Saint Alphonsus Health System.

- FY23: 19 classes, 106 attendees
- FY24: 12 classes, 23 attendees
- FY25: 9 classes, 18 attendees

The CHWB Department also provided no-cost Mental Health and Youth Mental Health First Aid classes to community members starting in FY24.

- FY24: 13 classes, 148 attendees
- FY25: 3 classes, 30 attendees

Additionally, the Saint Alphonsus Faith Community Nursing program sponsored Signs of Suicide (S.O.S.) training for the seven local Catholic schools between Ada and Canyon Counties.

SARMC and SAMC-Nampa colleagues participated in the Idaho Suicide Prevention Action Collective monthly meetings, Suicide Prevention Resource Center Community of Practice, and the Veterans Suicide Group between FY23-25.

SARMC continued to provide financial contributions annually to Allumbaugh House and the Idaho Crisis and Suicide Hotline. Between FY23-25, SARMC contributed $675,000 to community partners and programs to address mental health and substance use.

Saint Alphonsus Health System (SAHS) employed a Tobacco Treatment Specialists (TTS), who provided tobacco cessation counseling to patients admitted to the hospitals and a Tobacco Health Educator continued to offer no-cost tobacco and vape cessation classes for patients and community members through the SAHS Tobacco Free Living (TFL) Program. Patients reported were from across the health system service area in Idaho and Oregon.

- FY23: 303 average TTS patients, 575 referrals
- FY24: 434 average TTS patients, 411 referrals, 23 TFL classes, 73 attendees
- FY25: 348 average TTS patients, 296 referrals, 22 TFL classes, 85 attendees

ACCESS TO AFFORDABLE HEALTH CARE, INCLUDING ORAL AND VISION HEALTH:

SARMC and SAMC-Nampa sought to improve access to health care, including mental and oral health, by identifying and removing access barriers, and providing equitable services to those who are underserved. SARMC plays an active role in community groups such as the Boise Public Library Board of Trustees, findhelpidaho.org Steering Committee, Idaho Suicide Prevention Coalition, Our Path Home Community Resource Committee, Treasure Valley YMCA Board of Directors, and the Western Idaho Community Health Collaborative. SAMC-Nampa plays an active role in community groups such as 2C Kids Succeed, Caldwell Health Coalition, Healthy Impact Nampa, Invest Health Food Access Coalition, Owyhee County Community Health Action Team, and Region III Suicide Prevention Coalition.

Specifically, SARMC and SAMC-Nampa provided patient transportation to and from health care appointments for those experiencing financial barriers to transport by contracting with Valley Regional Transit to provide Rides to Wellness for patients.

- FY23: 533 Ada County rides, 668 Canyon County Rides= 2,181 total rides.
- FY24: 2,681 Ada County rides, 1,550 Canyon County Rides= 4,231 total rides. Also supported 644 transportation vouchers via Salvation Army in Boise, Nampa and Caldwell.
- FY25: 914 Ada County Rides, 594 Canyon County Rides= 2,731 total rides (Oct 2024-Aug 2025 to date).

Saint Alphonsus has a longstanding relationship with Genesis Community Health to provide low and no-cost medical services to patients with financial need. Specifically, Saint Alphonsus provided no-cost laboratory testing and specialty care services to Genesis Community Health patients in Ada and Canyon County. Saint Alphonsus was also a significant contributor to Genesis' Caldwell Health Center opening in 2024.

- FY23: 233 patients provided no-cost laboratory and/or specialty care services
- FY24: 232 patients provided no-cost laboratory and/or specialty care services
- FY25: 194 patients provided no-cost laboratory and/or specialty care services

SARRH addressed health care access by providing patients with access to a monthly stroke support group in partnership with American Heart Association and American Stroke Association local chapters.
SARRH case managers accessed SARRH patient social care needs prior to discharge/transfer from the hospital.

- FY23: 1038 discharges
- FY24: 1036 discharges
- FY25: 1110 discharges

SARMC and SAMC-Nampa Community Health Worker (CHW) Supports in Ada and Canyon Counties

- FY23: 5100 CHW encounters, 1312 CHW referrals, 488 CHW hotline calls
- FY24: 7847 CHW encounters, 1559 CHW referrals, 853 CHW hotline calls
- FY25: 7675 CHW encounters, 1835 CHW referrals, 619 CHW hotline calls

SAMC-Nampa Mobile Clinics provide no-cost primary, basic urgent care, and women's health services throughout Canyon County, meeting patients where they are.

- FY23: 11 clinics, 46 patients
- FY24: 18 clinics, 84 patients
- FY25: 18 clinics, 107 patients

Comments

Any comments on this report may be submitted to Corey Surber Saint Alphonsus Health System Regional Director of Community Health and Well-Being at Corey.Surber@saintalphonsus.org.

Date Adopted by Board

The 2026 Community Health Needs Assessment was reviewed by local Community Hospital Advisory Boards and approved by the Saint Alphonsus Health System Board on May 13, 2026.

Appendix 2: St. Luke's Health System

Each St. Luke's medical center is responsive to the people it serves, providing a scope of services appropriate to community needs. Our volunteer boards include representatives from each St. Luke's service area, helping to ensure local needs and interests are addressed. This governance structure supports the mission, vision, strategy, and overarching goal for improving community health.

St. Luke's Mission: To improve the health of people in the communities we serve.

Hospital Overview

St. Luke's Health System is an Idaho-based, not-for-profit, integrated health system. We are guided by our vision to be the community's most trusted partner in health. By delivering care to patients, connecting care through our health network and funding care through St. Luke's Health Plan, we work every day to fulfill our mission to improve the health of the people in the communities we serve. We are an integrative network of seven separately licensed full-service medical centers and more than 100 outpatient centers and clinics serving people throughout Southern Idaho, Eastern Oregon, and Northern Nevada.

This section describes the St. Luke's hospitals associated with the Greater Treasure Valley CHNA and defines each hospital's service area. The criteria we use in selecting the service area is the identification of what counties our hospitalized patients reside in. Those counties that make up 70% or greater of the inpatient hospitalizations are identified as our service area.

ST. LUKE'S REGIONAL MEDICAL CENTER -BOISE AND MERIDIAN HOSPITALS

St. Luke's Regional Medical Center - Boise and Meridian Hospitals has been committed to serving the needs of a growing region for over 100 years. Founded in 1902 as a six-bed frontier hospital in downtown Boise, St. Luke's Regional Medical Center is recognized today as the region's leader in heart, cancer, and women's and children's health care. Other major services include inpatient and outpatient surgery, 24-hour emergency services, diagnostic imaging, epilepsy care, and minimally invasive surgery. Our Boise campus is also home to St. Luke's oncology services and St. Luke's Children's Hospital, Idaho's only children's hospital. Our Meridian campus is home to Idaho's busiest emergency department and the state's most advanced cardiac and pulmonary rehabilitation center.

Known for our clinical excellence, St. Luke's Regional Medical Center is nationally recognized for patient safety and quality patient care, and we are proud to be designated a Magnet hospital, the gold standard for nursing care.

Ada and Canyon counties represent the geographic area used to define the community we serve, also referred to here as our primary service area or service area. The residents of Ada and Canyon counties comprise about 79% of our inpatients with approximately 60% of our inpatients living in Ada County and 19% in Canyon County. Ada and Canyon counties are part of Idaho Public Health Districts 3 and 4.

ST. LUKE'S ELMORE

St. Luke's Elmore was founded in 1955 and has a long tradition of providing expert care to the people of the Mountain Home community, Elmore County and northern Owyhee County. Elmore Hospital is the local 25-bed critical access hospital featuring a 24-hour emergency department, lab and imaging services, family birthing suites, and a long-term care unit. St. Luke's Clinic – Trinity Mountain Medical offers primary care and specializes in family medicine & OB/GYN care. If a patient needs additional specialty care beyond Elmore's local facilities, clinicians will coordinate access to services and collaborate with a broader team of providers to assure the appropriate level of expert care is provided.

St. Luke's Elmore Medical Center Hospital Services		
Inpatient	Emergency Services 24/7	Urgent Care
Adult & Pediatric	Ambulance Services	Rural Health Clinic
Swing Beds	Long Term Care	Foot Clinic
Mother/Baby	Outpatient Infusion Services	Wound Clinic
Surgical Services	Rehabilitation Services	Telehealth
Podiatry	Physical Therapy	Behavioral Health
General	Speech Therapy	Visiting Specialties
OB/GYN	Occupational Therapy	Cardiology
Anesthesia	Cardiopulmonary Care	Orthotics
Endoscopy	Cardiac Monitoring	Peripheral Vascular Lab
Diagnostic Radiology	Cardiac Stress Testing	Urology
General Radiology	Pulmonary Function Testing	Nephrology
CT	Sleep Lab	Audiology
Mammography Screening	Clinical Laboratory	Dietician Services
MRI	Social Work Services	Nutrition Counseling
Ultrasound	Spiritual Care (Chaplains)	Pain Management
X-Ray		
Dexa Scan		
Interventional procedures		

We care about our patients, their health, and what's best for individuals and families. St. Luke's Elmore is fortunate to have caring and committed volunteers, dedicated medical staff, and an engaged Community and Hospital Board comprised of independent civic leaders who volunteer their time to serve.

Elmore County represents the geographic area used to define the service area we serve also referred to here as our primary service area or service area. The residents of Elmore County comprise over 90% of our inpatient visits. Elmore County is part of Idaho Public Health District 4.

ST. LUKE'S MCCALL

The hospital in McCall was founded in 1956 as a community hospital called McCall City Hospital. The hospital evolved administratively from a city hospital to a county hospital to a district hospital and as of 2010 is a member of St. Luke's Health System (SLHS)

St. Luke's McCall is a 15-bed Critical Access Hospital with orthopedic surgery and urgent care. The medical staff is comprised of 26 local physicians, 14 local advanced practice providers and 14 visiting specialist physicians providing local services in adult and pediatric cardiology, oncology, behavioral health, urology, pain management, dermatology and other medical specialties.

Hospital services include laboratory, medical imaging, cardiopulmonary, emergency department, maternal and childbirth services, pharmacy, rehabilitation therapy, sleep laboratory, social services, and surgery.

St. Luke's McCall has 370 full- and part-time employees, 32 hospital volunteers, and a 14-member community board. On average, St. Luke's McCall sees nearly 6,500 emergency room patients annually, and more than 30,000 patients for all other outpatient services. Our average daily in-patient census is 4.6.

Valley and Adams Counties represent the geographic area used to define the service area we serve, also referred to here as our primary service area or service area. The residents of Adams and Valley counties comprise about 80% of our inpatients with a little over 55% of our inpatients living in Valley County and a little over 20% living in Adams County. Valley County is part of Idaho Public Health District 4, and Adams County is part of Idaho Public Health District 3.

ST. LUKE'S NAMPA

St. Luke's Nampa was designed to meet the needs of Canyon County families by providing more health care services closer to home. Opened in October 2017, St. Luke's Nampa includes a fully equipped emergency department, level 4 trauma services, lab and imaging, and a $114 million, 87-bed full-service community hospital.

Accredited by The Joint Commission, St. Luke's Nampa Medical Center is known for clinical excellence, patient safety, and quality patient care. Hospital services include obstetrics and women's services, surgical services, family suites for new mothers and their babies, Newborn Intensive Care Unit, Intensive Care Unit, orthopedic services, screening and 3-D mammography, interventional radiology and urgent care. Our governing board and employees actively support non-profit partners who work to address Canyon County's high rates of child poverty, youth experiencing homelessness, domestic violence, and other social indicators that impact the health and well-being of the community.

Canyon County represents the geographic area used to define the service area we serve also referred to here as our primary service area or service area. The residents of Canyon County comprise over 70% of our inpatient visits. Canyon County is part of Idaho Public Health District 3.

OUR NEIGHBORING COMMUNITIES

Our patients in the surrounding counties of Southwestern Idaho and Eastern Oregon are important to us as well. To help us serve our patients, we have built positive, collaborative relationships with regional providers where appropriate. A philosophy of shared responsibility for the patient has been instrumental in past successes and remains critical to the future of St. Luke's. Partnerships allow us to meet patients' medical needs close to home and family.

ST. LUKE'S HEALTH SYSTEM REGIONAL MAP

Approach for Improving Community Health

St. Luke's Health System regularly undertakes a rigorous process to improve overall health and quality of life in the communities we serve. This process begins by conducting a comprehensive Community Health Needs Assessment (CHNA) to identify the priority health needs in each St. Luke's Health System service region.

St. Luke's will use the information, conclusions, and health needs identified in our assessment to efficiently deploy our resources and engage with partners to achieve the following long-term community health objectives:

- Address high priority health needs with a focus on prevention.
- Expand access to appropriate St. Luke's and community-based services.
- Coordinate and integrate population and community health strategies.
- Advance health equity through addressing social drivers of health and reducing health disparities.

IMPLEMENTATION PLAN OVERVIEW

St. Luke's will continue to collaborate with the people, leaders, and organizations in our community to carry out an implementation plan designed to address many of the most pressing community health needs identified in this assessment. Utilizing effective, evidence-based programs, activities, services and policies, we will work together with trusted partners to improve community health outcomes.

Future Community Health Needs Assessments

We intend to reassess the health needs of our community on an ongoing basis and conduct a full community health needs assessment once every three years. St. Luke's next Community Health Needs Assessment is scheduled to be completed in 2029.

History of Community Health Needs Assessments and Impact of Actions

In our 2023 Community Health Needs Assessment (CHNA), the following health needs were prioritized and named as the most significant health needs for our service areas:

- Safe, Affordable Housing and Homelessness
- Behavioral Health including Mental Health and Wellbeing and Substance Misuse
- Access to Affordable Healthcare, including Oral and Vision Health

ST. LUKE'S REGIONAL MEDICAL CENTER – BOISE AND MERIDIAN HOSPITALS

Priority Area Need 1: Safe Affordable Housing and Homelessness

Strategy 1: Support Households that are cost-burdened (greater than 30% of income spent on housing costs)	
Activities	**Our Path Home (OPH) Executive Committee**
Key Community Partner	**Our Path Home**
St. Luke's Resource	**Participation in OPH Executive Committee and Public Health Subcommittee and financial contributions to OPH strategic priorities**
FY2024 Outcomes	Participated in Our Path Home Executive Committee, which allocated funding to Jesse Tree to prevent homelessness and assist those that are cost-burdened from being evicted. Funding came to Jesse Tree through the Campaign to End Family Homelessness. Participated in grant review committees for both the City of Boise and City of Meridian, which awarded monies to agencies, such as Jesse Tree and NeighborWorks Boise to assist those that are cost burdened to remain safely and stably housed.
FY2025 Outcomes	Campaign to End Family Homelessness: • 1,083 families have received homelessness prevention assistance since the start of the campaign. • 668 families exited the coordinated entry system into housing during the campaign. • 153 families exited into Supportive Housing (rapid rehousing and permanent supportive housing) • 135 used Rapid Resolution • 381 families self-resolved their housing crisis without formal assistance
FY2026 Outcomes	Will contribute to the development of the new OPH Strategic Plan, to be completed in Spring 2026 that will identify priority areas for the Continuum of Care based on system

	gaps and needs. St. Luke's Sr. Director of Community Health & Engagement continues to sit on the OPH Executive Committee. Participated in discussions with OPH Managers and St. Luke's Boise, Meridian, Nampa Emergency Departments to determine capacity to participate in 2026 Annual Point-in-Time Count.
Strategy 2: Support for families and individuals experiencing homelessness	
Activities	**Interfaith Sanctuary shelter**
Key Community Partner	**Interfaith Sanctuary**
St. Luke's Resource	**Financial contribution to new shelter facility**
FY2024 Outcomes	Continued large funding support ($50,000) of Interfaith Sanctuary for build of new shelter facility in Boise.
FY2025 Outcomes	Final disbursement ($50,000) of large funding support of Interfaith Sanctuary for build of new shelter facility in Boise. Funding support of medical/respite wing also to include virtual/on-demand care technology provided by St. Luke's
FY2026 Outcomes	St. Luke's Behavioral Health leaders provided in-kind consultation on new Interfaith Sanctuary space, informing safe rooms and other behavioral services that will happen onsite at the shelter. St. Luke's donated Tyto-care virtual on-demand equipment to be placed onsite at the new Interfaith Sanctuary shelter.
Strategy 3: Increasing affordable housing options	
Activities	**Our Path Home (OPH) Fund Committee**
Key Community Partner	**Our Path Home**
St. Luke's Resource	**Participation in OPH Fund Committee**
FY2024 Outcomes	OPH Fund committee is developing tools for conversations with funders that have been identified to be able to support at either a one-time large gift level or an ongoing operational support level. Tools will be deployed in following years. Included OPH language in FY 2025 CHIF grant application for organizations noting they are working on housing and homelessness in Ada County, in an effort to align organizational funding streams with the strategy and partnership of Our Path Home.
FY2025 Outcomes	OPH Fund committee continued to develop tools for conversations with funders that have been identified to be able to support at either a one-time large gift level or an ongoing operational support level. Tools will be deployed in following years.
FY2026 Outcomes	OPH Fund Committee planned quarterly conversations to be held in 2026 with funders to support either one-time large gifts or ongoing operational support for housing solutions. St. Luke's Sr. Director of Community Health & Engagement is the chair of the OPH Fund Committee.
Activities	**Participate in WICHC Housing and Homelessness workgroup to identify and provide tools to unlock transformational funding for affordable housing**
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Participation in WICHC and WICHC Housing Subcommittee**

FY2024 Outcomes	WICHC workgroup has met with several regional housing partners such as the Blue Cross of Idaho Foundation for Health, House Idaho Collaborative, Jesse Tree, and Our Path Home. Goals and activities are being redefined as a result of these meetings, to clarify role and deliverables WICHC can contribute to increase education to decision-makers about housing and health, and influence funding streams towards evidence-based and community-relevant housing solutions.
FY2025 Outcomes	WICHC Workgroup created educational materials, explored data, and identified key stakeholders to increase awareness around housing as a top priority health need.
FY2026 Outcomes	WICHC Housing Workgroup provided educational sessions on the connection between housing and health at the Region 3 Housing Coalition's Housing Provider Forum in October 2025. WICHC Housing Workgroup developed policy tools to be used for advocacy efforts with housing legislation in the 2026 Idaho Legislative Session.
St. Luke's Resource	**Financial contributions for WICHC ($10,000 annually)**
FY2024-FY2026 Outcomes	Supported WICHC with $10,000 in funding, and St. Luke's Sr. Director of CH&E is the chair of WICHC's Housing and Homelessness workgroup.
Activities	**Fund housing projects in alignment with partners to maximize investment and impact**
Key Community Partner	**Local affordable housing development support**
St. Luke's Resource	**Letters of Support**
FY2024 Outcomes	Provided letter of support to Roundhouse for affordable housing development in west downtown Boise, which would have dedicated units for CATCH-assisted households.
FY2025 Outcomes	Letter of support to Finch Roundhouse Development of affordable housing in west Downtown Boise – received tax credit funding for Phase 1.
FY2026 Outcomes	Will continue to provide letters of support as appropriate and requested for affordable housing developments in Ada County and Canyon County.
Strategy 4: Support services that assist people in remaining successfully housed	
Activities	**Support the onsite services for Permanent Supportive Housing Models**
Key Community Partner	**Idaho Community Foundation, Our Path Home, Terry Reilly, Western Idaho Community Health Collaborative**
St. Luke's Resource	**Financial contribution to OPH Supportive Housing Investment Fund**
FY2024 Outcomes	Consideration of large funding request to support the Supportive Housing Investment Fund (SHIF). Decision on contribution to be made in Fiscal FY2025.
FY2025 Outcomes	$1.2M five year funding commitment to SHIF
FY2026 Outcomes	Ongoing $1.2M five year funding commitment to SHIF
Strategy 5: Community Health Improvement Fund Grant Program	
Key Community Partner	**CATCH, Inc.; Corpus Christi House; Intermountain Fair Housing Council, Inc.; Jannus, Inc.-Agency for New Americans; Jesse Tree; Jesse Tree of Idaho, Inc.; LEAP Charities (dba LEAP Housing); Ronald McDonald House Charities of Idaho; Treasure Valley Habitat for Humanity (formerly Boise Valley Habitat for Humanity); Women's and Children's Alliance**

FY2024 Outcomes	St. Luke's invested $60,000.00 in Boise/Meridian for the priority of Housing / Homelessness.
FY2025 Outcomes	St. Luke's invested $105,000.00 in Boise/Meridian for the priority of Housing / Homelessness.
FY2026 Outcomes	St. Luke's invested $121,500.00 in Boise/Meridian for the priority of Housing / Homelessness.

Priority Area Need 2: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse

Strategy 1: Awareness, Education and Skill-building	
Activities	**Promote existing gatekeeper trainings**
Key Community Partner	**Central District Health, Empower Idaho, Mexican Consulate, Mujeres Unidas, WICHC**
St. Luke's Resource	**Promotion and connection to existing gatekeeper trainings**
FY2024 Outcomes	Planned for Fiscal 25 delivery of Gatekeeper trainings and promoted partner trainings where appropriate.
FY2025 Outcomes	Coordinated four in-person Spanish language QPR trainings in the Ada county. A total of 64 community participants attended the trainings in collaboration with community partners including Empower Idaho, Mujeres Unidas, and the Mexican Consulate. Facility support was also provided by St. Luke's Lifestyle Medicine. WICHC Workgroup created an educational toolkit to be distributed in 2026, identified key regional stakeholders offering suicide prevention classes and created a flyer which is updated quarterly to promote gatekeeper training classes to increase awareness and education, promote resources, and reduce stigma for seeking help around mental health and suicide prevention as a top priority health need.
FY2026 Outcomes	Contract established with Maricela Rios, LLC in 2026 to deliver English and Spanish, in-person and virtual QPR Gatekeeper Trainings in Ada and Canyon County in 2026.
Activities	**Health Talks**
St. Luke's Resources	**Administration of pre-recorded health talks on mental and behavioral health talks offered to community members**
FY2024 Outcomes	Health Talk: Helping Youth Improve Mental Health and Prevent Suicide was held on September 19, featuring Gretchen Gudmundsen, with 50 registrations and 30 attendees. Additional 39 views on YouTube.
FY2025 Outcomes	Health Talks: Discontinued live, virtual health talks. Past sessions remain available on St. Luke's YouTube page.
FY2026 Outcomes	Health Talks: Past sessions remain available on St. Luke's YouTube page.

Strategy 2: Increase Access to Mental and Behavioral Health Services	
Activities	**Increase school-based mental and behavioral health services**
Key Community Partner	**Boise School District, Central District Health, Communities for Youth, ECHO Idaho, and Giraffe Laugh**
St. Luke's Resource	**St. Luke's Children's Behavioral Health service line school-based providers**
FY2024 Outcomes	Provided $2,000 to Giraffe Laugh to incorporate social, emotional learning components in their preschool classroom serving under-resourced kids and families. 37 families were assessed, 10 connected to resources. In addition, three (3) Ready for Kindergarten sessions were offered. SLHS provided financial support and subject matter expertise to the ECHO Idaho K12 Education Series that provided training opportunities for clinicians and school-based professionals to equip them with additional skills and knowledge to improve the quality of life and well-being of students. The series included topics of behavioral health, substance use prevention and treatment, school nursing, and youth suicide prevention. There were 417 unique attendees, 2,2027 CE hours earned, and 22 professions represented.
FY2025 Outcomes	St. Luke's provided subject matter expertise to the ECHO Idaho K12 Education Series that provided training opportunities for clinicians and school-based professionals to equip them with additional skills and knowledge to improve the quality of life and well-being of students. St. Luke's invested $1033.81 to host the Communities for Youth Boise Initiative Data Walk 1/15/25 at the Idaho State Museum and brought together 54 community members and partners for a highly engaging and collaborative session reviewing the results of the fall 2024 mental health survey taken by teens in Boise. The event successfully facilitated meaningful data-driven conversations and strengthened cross-sector relationships. St. Luke's extended the work in food insecurity by donating eight trays of remaining food to organizations supporting teens including First Presbyterian teen events, open to all teens, Boise Parks and Rec drop-in teen programs, and the resident women and children at City of Light Women's Shelter.
FY2026 Outcomes	St. Luke's team member participating in ECHO K-12 Youth Wellbeing and Upstream Prevention series, focused on teams of educator cohorts in K-12 schools statewide. Courses focus on strengthening school-based prevention efforts that directly target areas of need identified through local data, such as the Youth Wellbeing Assessment. Includes 8 live, virtual sessions. School cohorts also attend 7 asynchronous learning activities. The courses explore risk and protective factors, data collection and use, community and parent engagement, and sustainability.
Activities	**Participate in WICHC Access to Care workgroup to assess for mobile, co-location and telehealth strategies that may expand mental and behavioral health services**
Key Community Partner	**Boise School District, West Ada School District, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resources	**Participation in WICHC**
FY2024 Outcomes	Participating in workgroup meetings and provided recommendations to member list to add those who should be but not currently involved. Continuing to meet to discuss goals, define scope of work, assess priority areas, identify gaps, and develop action plans to improve mobile access
FY2025 Outcomes	Anticipate using findhelpidaho.org more robustly in FY26

FY2026 Outcomes	St. Luke's will continue participation in the workgroup meetings and contribute to activities in FY2026.
Activities	**Update and Distribute Treasure Valley Mental Health Guide**
Key Community Partner	**School districts**
St. Luke's Resources	**Publication of mental health guide – hard copy and online**
FY2024 Outcomes	TV Get Help guide has been updated and will be printed and distributed to communities by end of 2024. All versions are available in both Spanish and English, and are available as a printed booklet or digitally on our St. Luke's public website. On 8/21/24, St. Luke's sent an email to over 480,000 patients with Suicide Prevention with this educational message: "If you or someone you love needs immediate mental health support, call or text 988, the Idaho Suicide & Crisis Lifeline" and included links to St. Luke's Behavioral Health Services and 988"
FY2025 Outcomes	Over 10,000 copies printed for distribution. more than 1,100 distributed in the Treasure Valley Region. Distribution included: All St. Luke's Health System Community Boards and Foundations. Internal services lines, such as: Behavioral Health clinics, Social Work Community of Practice, Nursing Care Council, Home Health and Hospice, Emergency Departments, Care Management. An article on the Health System's Internal Source page, which generated requests from additional internal partners. Poster with QR code developed, distributed across SLHS sites and with community partners, faith-based organizations Wide-spread distribution in communities, including: schools, Chambers of Commerce, State, County and City social service organizations, community events, public health district offices, Fire Departments, community based mental health providers.
FY2026 Outcomes	Efforts planned for continued distribution of Treasure Valley mental health guides in FY26
Activities	**Grow Behavioral Health Workforce**
Key Community Partner	**Western Idaho Community Health Collaborative**
St. Luke's Resources	**Behavioral Health service line – workforce recruitment and retention strategies, including training and residency programs**
FY2024 Outcomes	Participated in WICHC Behavioral Health workforce subcommittee. Actions to be taken in FY2025.
FY2025 Outcomes	WICHC workgroup met bi-monthly in 2025 with a focus to learn more and promote peer support services as a means to increase/expand access to mental and behavioral health supports. The focus has shifted to focus on peer supports for substance misuse as policies have changed regarding peer supports focusing on mental and behavioral health. Additionally, exploring how to increase access to supervisors who can oversee those offering peer support service.
FY2026 Outcomes	Anticipate ongoing engagement and support of WICHC's Behavioral Health Workforce subcommittee and actions in 2026.

Strategy 3: Population-level Identification, Intervention and Measurement	
Activities	**Icelandic Prevention Model - Communities for Youth (C4Y)**
Key Community Partner	**Boise State University Communities for Youth**
St. Luke's Resource	**Financial support of Boise State University Communities for Youth program**
FY2024 Outcomes	The Communities for Youth (C4Y) Boise Initiative has continued building relationships, supporting activities and engaging partners around the key theme areas of building meaningful connections and reducing stress for Boise youth. Most notable accomplishments include a partnership with JUMP Boise for delivering Teen Takeover events, and the development of consistent messaging materials emphasizing the importance of connection. In addition Communities for Youth have attended the following events: Kid for A Night, FitOne, the Idaho Health Priorities Conference, and the Idaho Out of School Network conference. West Ada School District communities, including Eagle, Star and Meridian, have continued engaging community champions around youth mental health and Communities for Youth conversations. Community listening sessions occurred in Meridian in September 2024 and were planned through October 2024
FY2025 Outcomes	Transitioned lead Communities for Youth Boise initiative role to Central District Health.
FY2026 Outcomes	Boise State University Communities for Youth team completed Youth Well-being survey collection in Boise School District in November 2025. The team presented the new data during a public forum in January 2026, including improvements in youth mental and behavioral health indicators and what Boise's youth are currently most challenged with. The data will help inform the development of a strategic work plan to address challenges and opportunities through upstream interventions and programming in FY2026.
Key Community Partner	**City of Boise Mayor's Office**
St. Luke's Resources	**Facilitation of local community conversations, coalitions and action teams**
FY2025 Outcomes	St. Luke's CH team supported and facilitated collaborative conversations between the City of Boise and Communities for Youth to ensure alignment of initiative goals and utilization of local data to help inform the City of Boise's development of the Youth Roadmap.
FY2026 Outcomes	During FY2026, continue to support City of Boise's Youth Roadmap planning and implementation through collaboration, coordination, and engagement of partners. Will partner with and support both City of Boise and Communities for Youth, who will be a lead partner in the City's Youth Roadmap efforts, ensuring continuity and alignment across all efforts supporting youth in Boise.
Key Community Partner	**Boise School District**
St. Luke's Resources	
FY2024 Outcomes	The Idaho Department of Education, with funding from the Blue Cross of Idaho Foundation for Health, has endorsed the Youth Well-being Assessment as a survey option available to all schools in the 2024-2025 school year. List of schools that have adopted this survey will be available by Spring 2025.
FY2025 Outcomes	2025 Youth Wellbeing Survey results collected indicate positive trends in youth wellbeing and connection in Boise School District. The following outcomes demonstrate positive progress among key mental health indicators/protective factors:

	1. Youth feelings of connection and support have increased since 2023, with 43% of youth feeling connected to a trusted adult (up 9%), 65% stating strong family social support (up 10%), 56% stating positive friend support (up 8%), and 45% stating students are ""nice to each other"" (up 11%). 2. More students feel safe at school in 2025 (71%) compared to 2023 (60%). 3. Moderate to severe depression decreased significantly from 27% (2023) to 17% (2025). - Moderate to severe anxiety also declined slightly from 26% (2023) to 24% (2024). 4. Students reporting they had ever been drunk dropped from 14% (2024) to 11% (2025). - Nicotine vaping decreased from 11% (2024) to 8% (2025). Concerning trends were identified among the following indicators: 1. Only 50% of youth feel they matter (no prior data to compare. 2. Social isolation: Improved but still present - 17% (2023) to 8% (2025). 3. Marijuana use increased from 3% (2023) to 8% (2025). 4. Help seeking: About 21% (2025) still report they would not seek help for mental/emotional challenges. 5. Suicide deaths increasing among youth: Idaho reports 32 deaths among youth ages 3-17 in 2023, the latest data year reported.
FY2026 Outcomes	Boise School District completed the annual Youth Well-being Assessment in November 2025.
Key Community Partner	**Riverstone Charter School**
Key Community Partner	**Anser Charter School**
FY2025 Outcomes	Provided leadership from Anser Charter School with consultation on opportunities to support school health efforts, connecting them to potential funders in the community.
Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**Assistance League of Boise; BabySteps; Because Kids Grieve, Inc.; Big Brothers Big Sisters of Idaho; Boise Bicycle Project; Boise Rescue Mission; Boys & Girls Clubs of Ada County; Children's Home Society of Idaho; City of Boise - Parks and Recreation; Community Health Clinics, Inc. dba Terry Reilly Health Services; Family Advocates; Giraffe Laugh, Inc.; Girl Scouts of Silver Sage Council; Girls on the Run – Idaho, Inc. (dba Girls on the Run Treasure Valley); Hodia/Idaho Diabetes Youth Programs; Idaho Youth Ranch, Inc.; Idaho2Fly, Inc.; Jannus Inc.; Learning Lab; Life's Kitchen; River Discovery; St. Michael's Episcopal Cathedral; The Education Foundation for Joint School District No. 2, Inc. (West Ada Education Foundation); The Fund to Support Ada County; Valley Regional Transit; Victim Services Center, Inc.; Women's and Children's Alliance, Inc.; Wyakin Warrior Foundation; Young Men's Christian Association of Boise Inc (Treasure Valley Family YMCA)**
FY2024 Outcomes	St. Luke's invested $147,700.00 in Boise/Meridian for the priority of Behavioral Health/Wellbeing.
FY2025 Outcomes	St. Luke's invested $189,350.00 in Boise/Meridian for the priority of Behavioral Health / Mental Wellbeing.
FY2026 Outcomes	St. Luke's invested $233,500.00 in Boise/Meridian for the priority of Behavioral Health / Mental Wellbeing.

Priority Area Need 3: Access to Affordable Health Care, Including Oral and Vision Health

Strategy 1: Addressing transportation barriers to care	
Activities	**Rides2Wellness**
Key Community Partner	**Valley Regional Transit, Western Idaho Community Health Collaborative**
St. Luke's Resource	**Financial contribution to Rides2Wellness program**
FY2024 Outcomes	$50,000 in funding provided. Approximately 15,000 rides given in Ada and Canyon Counties.
FY2025 Outcomes	$104,500 in funding provided. • Quarter 1 ridership 3,383 (2,791 Ada County, 592 Canyon County) • Quarter 2 ridership 4,135 (3,204 Ada County, 931 Canyon County) • Quarter 3 ridership 4,832 (3,812 Ada County, 1,020 Canyon County) • Quarter 4 ridership 4,481 (3,860 Ada County, 981 Canyon County) • Fiscal year total ridership 17,191 • Fiscal year ridership increased 12% from 2024 • November 1, 2024, program changed to allow riders access to any Saint Alphonsus and St. Luke's clinic within the service areas • In August, VRT partnered with Central District Health to become a partner for the Rides2Wellness service. It is a pilot program running to one clinic in Boise. • Overall average cost per trip $38.91
FY2026 Outcomes	$130,000 in funding provided for FY2026 with the expected outcome to deliver over 18,000 rides in Ada and Canyon County.

Strategy 2: Support mobile, telehealth and onsite health services	
Activities	**St. Luke's Mobile Mammography**
Key Community Partner	**Idaho Caregiver Alliance, Mexican Consulate, and other Community Partners**
St. Luke's Resource	**Vehicle and operations of a mobile unit that is heavily subsidized are not reimbursed through billable services**
FY2024 Outcomes	St. Luke's Breast Care Services mobile mammography services included nine (9) mammography screenings at the Mexican Consulate in Boise, serving uninsured, low-income Latina women.
FY2025 Outcomes	Partnered with Idaho Caregiver Alliance to coordinate and schedule mammography mobile services during the Hispanic Caregiver Conference. A total of 13 women received screenings. Three out of thirteen patients were referred to additional imaging. Remaining 3 were recommended additional imaging to rule out breast cancer.
FY2026 Outcomes	St. Luke's will use community and patient data and insights to inform scheduling of the mobile mammography unit to communities of most need, and lowest access to existing breast cancer screening services.
Activities	**St. Luke's Mobile Care Pediatric Services**
Key Community Partner	**Nampa and Caldwell School Districts**
St. Luke's Resource	**Vehicle and operations of a mobile unit that is heavily subsidized are not reimbursed through billable services**

FY2024 Outcomes	Partnered with Children's Mobile Team and Nampa School District to provide site-based services to schools with the highest needs and lowest resources. Provided 223 clinic visits,331 flu vaccines and 190 behavioral health visits in one semester in two schools. Expansion planning in process with Caldwell School District.
FY2025 Outcomes	Partnered with Children's Mobile Team in Nampa and Caldwell school Districts to provide site-based services to schools with the highest need. Provided the following services - Nampa School District: • Provider Visits: 93 • Flu Vaccines: 91 • Sports Physicals: 25 • Therapy visits: 1,425 Caldwell School District • Provider Visits: 20 • Flu Vaccines: 104
FY2026 Outcomes	Partnership with Children's Mobile team will continue for Nampa, Caldwell, and Boise School Districts in FY2026. CH team members helped to identify locations for mobile services in FY26.
Key Community Partner	**Boise School District**
St. Luke's Resource	**Vehicle and operations of a mobile unit that are not reimbursed through billable services**
FY2024 Outcomes	Partnered with Boise School District and Children's Mobile Team to provide site-based services to schools with highest needs and lowest resources. Provided 198 clinic visits and 1,588 behavioral health visits in four schools.
FY2025 Outcomes	Partnered with Children's Mobile Team in Boise School District to provide site-based services to schools with the highest need. Provided the following services: • Provider Visits: 99 • Flu Vaccines: 24 • Sports Physicals: 25 • Therapy visits: 2,128 SL Children's provided support and subject matter expertise to West Ada school nurses to train how to reinsert GI tubes for high-need students.
Activities	**Map, align and leverage mobile health strategies**
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**St. Luke's mobile services**
FY2024 Outcomes	St. Luke's participated in initial WICHC Access to Care workgroup meetings. Discussion and planning will continue as the workgroup is tasked with defining scope of work and developing action plans related to mobile, telehealth and co-located health services.
FY2025 Outcomes	Telehealth pods and Tytocare donations to Hailey Library, Elmore Library, Ada County Library and South Meridian YMCA
FY2026 Outcomes	St. Luke's will use community and patient data and insights to inform scheduling of the mobile mammography unit to communities of most need, and lowest access to existing breast cancer screening services.

Activities	Health Talks
St. Luke's Resource	**Administration of pre-recorded health talks on access to care offered to community members**
FY2024 Outcomes	Health Talk: Helping Youth Improve Mental Health and Prevent Suicide was held on September 19, featuring Gretchen Gudmundsen, with 50 registrations and 30 attendees. Additional 39 views on YouTube.
FY2025 Outcomes	Health Talks: Discontinued live, virtual health talks. Past sessions remain available on St. Luke's YouTube page.
FY2026 Outcomes	Health Talks: Past sessions remain available on St. Luke's YouTube page.
Activities	**Ventanilla de Salud (Health Window) Onsite Health Services**
Key Community Partner	**Central District Health, FQHCs, Idaho Immunization Coalition, Idaho State University, Mexican Consulate**
St. Luke's Resource	**Coordinate, promote and staff onsite health care services at the Mexican Consulate and other locations serving Hispanic/Latino community members**
FY2024 Outcomes	Worked with over 30 community partners supporting outreach and prevention services at the Consulate • Screenings included: glucose, blood pressure, dental, vision, STD, cholesterol, and BMI • Vaccines included: influenza, COVID, Tdap, shingles, pneumococcal, hepatitis A & B, HPV, MMR • Education topics: access to low-cost care in the U.S., mental health, cancer, vape, infectious illnesses, STD's, sun safety/heat-related illnesses, screening guidelines, physical activity, nutrition/diet, diabetes, heart disease, etc. • All vaccine/screening participants receive list of medical home in their area for follow-up • Administered 1,010 total screenings, delivered 937 total vaccines and provided education to 5,023 people. • Made 84 total referrals on the following topics: Medical Home, Financial Assistance for Medical Services, Primary/Secondary Prevention Services, Resources for Mental/Emotional Health.
FY2025 Outcomes	Worked with over 30 community partners supporting outreach and prevention services at the Consulate • Screenings included: glucose, A1C, blood pressure, dental, vision, HIV, Hep C, Syphilis, cholesterol, and BMI • Vaccines included: influenza, COVID, Tdap, shingles, hepatitis A & B, HPV, MMR • Education topics: access to low-cost care in the U.S., health insurance in the U.S. and open enrollment season, mental health, cancer, vape, infectious illnesses, STD's, sun safety/heat-related illnesses, screening guidelines, physical activity, nutrition/diet, diabetes, heart disease, dementia etc. • All vaccine/screening participants receive list of medical home in their area for follow-up • Administered 1,883 total screenings, delivered 1,111 total vaccines and provided education to 7,329 people. • Made 123 total referrals on the following topics: Medical Home, Financial Assistance for Medical Services, Primary/Secondary Prevention Services, Resources for Mental/Emotional Health.

	• Made 123 total referrals on the following topics: Medical Home, Financial Assistance for Medical Services, Primary/Secondary Prevention Services, Resources for Mental/Emotional Health.
FY2026 Outcomes	Continuation of collaboration with community partners to increase access to prevention services to community served by the Ventanilla de Salud in FY26. Services will include prevention screenings, vaccines, education and referrals.

Strategy 3: Support Community Health Worker models, resource navigation services and engagement with vulnerable populations	
Activities	**Support and expansion of community school model**
Key Community Partner	**Blue Cross of Idaho Foundation for Health, Local School Districts, State Department of Education, United Way of Treasure Valley, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contribution to statewide Idaho Coalition of Community Schools**
FY2024 Outcomes	United Way was awarded a five-year, $46 million-dollar full-service community schools grant from the United States Department of Education focused on expansion of rural designation community schools. Currently 41 community schools in 25 districts. Five new schools in regions 3 and 4 indicated interest in new cohort. St. Luke's Community Health team members have connected with community school partners as appropriate to better support school needs.
FY2025 Outcomes	This catalytic funding is applied to grow schools' capacity to engage with local communities and meet the needs of their kids and families. In addition to these federal funds, St. Luke's contributed $5,000 directly to four community school districts to address social drivers of health identified by their community school coordinators. Several new schools in regions across the state indicated interest in new cohort. Additionally, there were: • 93 new opportunities for expanded learning • 70 Mental Health Programs • 179 Family Engagement Events
FY2026 Outcomes	United Way received a notice of continuation for the USDE Full-Service Community Schools grant for FY26. St. Luke's CH&E continues to be a partner and funder of the Idaho Coalition for Community Schools. In 2026, St. Luke's will identify opportunities to support the needs of students in Boise and West Ada School District community schools, as these districts do not receive scaling grant funds to support their community school initiatives.

Activities	**findhelpidaho.org**
Key Community Partner	**Idaho Health Data Exchange, United Way of Treasure Valley, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contract with findhelpidaho.org for internal patient community resource directory, Participation in findhelpidaho.org statewide collaborative, Participation in WICHC**

FY2024 Outcomes	Participated in monthly statewide steering committee meetings with United Way, findhelpidaho.org and Idaho Health Data Exchange to support the growth and engagement of the findhelpidaho.org platform. From Oct. 2023-Sept 2024 84,520 searches were conducted by Idahoans seeking local community resources, 630 new programs were added, and 198 programs were claimed by partner organizations. As of now, 4,371 programs are actively serving Idaho through the platform. This collaboration has strengthened the platform's capacity to connect residents with vital services and resources across the state. Community Health & Engagement continue to work with Care Management to ensure findhelpidaho.org program cards have the information required to feed our internal community resource directory which allows providers to refer patients to local resources.
FY2025 Outcomes	St. Luke's continued to participate in monthly statewide steering committee meetings to support platform growth and engagement. St. Luke's also hosted findhelpidaho.org community partner 101 trainings at the Twin Falls and McCall hospital locations. St. Luke's Community Health & Engagement (CH&E) partnered with internal stakeholders in Marketing, Communications, and PR to develop a statewide strategy promoting findhelpidaho.org across paid, shared, and owned channels. CH&E also collaborated with Care Management to ensure findhelpidaho.org program cards feed into our internal community resource directory and to remain aligned with the most current integrations that will enable closed-loop referrals in the future. In addition, CH&E updated its MOU with United Way of Treasure Valley to include expanded data-sharing agreements.
FY2026 Outcomes	In 2026, St. Luke's continued to support awareness and use of findhelpidaho.org, a statewide online resource connecting Idahoans to free and reduced-cost services. As of December 2025, findhelpidaho.org lists 4,437 programs and has facilitated 325,233 searches, helping 38,667 individuals connect with community resources across the state. St. Luke's continues to collaborate with Care Management to ensure our internal community resource directory reflects findhelpidaho.org listings, and the CH&E team developed a content map to provide consistent messaging as the system promotes the platform. St. Luke's plans to participate in the new Idaho Community Resource Network committees through the Idaho Department of Health & Welfare, helping guide outreach, resource validation, and integration with findhelpidaho.org, and aligning efforts with statewide initiatives to strengthen access to social services. These efforts help community members access services such as food assistance, housing support, health care, and transportation, supporting a coordinated, statewide social safety net.
Activities	**Downtown YMCA**
Key Community Partner	**Treasure Valley Family YMCA**
St. Luke's Resource	**St. Luke's staffed and operated Community Outreach Center**
FY2024-FY2026 Outcomes	Plans still in development for Downtown YMCA facility, with pending opening for 2027. Space is designed to provide a Center for Community Health service in the facility.
Activities	**Genesis Community Health Clinic**
Key Community Partner	**Genesis Community Health Clinic**
St. Luke's Resource	**Charity care for labs and imaging**

FY2024 Outcomes	Continue to provide lab and imaging services for Genesis patients at St. Luke's Clinics.
FY2025 Outcomes	A Memorandum of Understanding between St. Luke's Regional Medical Center and Genesis Community Health was developed in FY2025 to establish a cooperative partnership to provide coordinated healthcare services to uninsured patients below 200% of the federal poverty level.
FY2026 Outcomes	The MOU was executed in FY2026. Both parties agreed to share resources and expertise to assist patients at or below 200% Federal Poverty Level in accessing necessary lab, imaging, and behavioral health services.
St. Luke's Resource	**Large Financial Commitment**
FY2024 Outcomes	Provided large funding support for the build of new Genesis Clinic in Canyon County.
FY2025 Outcomes	St. Luke's provided $150K, paid over 3 years, to acquire a former VA facility to establish their Canyon County Clinic (Caldwell). Final payment made in 2025.
FY2026 Outcomes	Genesis applied for and received a 2026 CHIF grant in the amount of $5,000 to support establishing a medical home for low income, uninsured adults.

Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**Boise State University Foundation for Idaho Care Giver Alliance; Children's Home Society of Idaho; Faces of Hope; Family Advocates; Genesis Community Health; Idaho Voices for Children Foundation; Idaho Youth Ranch; Jannus, Inc-Aging Strong; Special Olympics Idaho**
FY2024 Outcomes	St. Luke's invested $25,000.00 in Boise/Meridian for the priority of Access to Care.
FY2025 Outcomes	St. Luke's invested $104,500.00 in Boise/Meridian for the priority of Access to Care.
FY2026 Outcomes	St. Luke's invested $39,500.00 in Boise/Meridian for the priority of Access to Care.

ST. LUKE'S ELMORE

Priority Area Need 1: Safe Affordable Housing and Homelessness

Strategy 1: Support Households that are cost-burdened (spending greater than 30% of income on housing costs)	
Activities	**Collaborate with Elmore County Health Coalition (ECHC) and other local stakeholders to educate, inform and address housing**
Key Community Partner	**ECHC, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Participation in ECHC & WICHC**
FY2024 Outcomes	Shared WICHC CHNA and Get Healthy Idaho plans with Elmore County Health Coalition to establish baseline understanding and alignment with activities. Initial discussions as part of EC Roundtable monthly meetings and introduction to key partners

FY2025 Outcomes	Continued involvement with ECHC & WICHC to assess gaps and needs for education and outreach opportunities Continued collaboration with key stakeholders, incl. Falcon's Landing, ECHC, ECDVC to educate, inform re: housing needs. This included attending ECHC roundtable presentations and networking with members involved in housing initiatives.
FY2026 Outcomes	Community partner collaboration continues through ECHC & WICHC meetings. ECDVC, ECHC and SLE joined the Region III Housing collaborative to gain insight, network and plan for future education and outreach opportunities.

Strategy 2: Support for families and individuals experiencing homelessness	
Activities	**Fund education and outreach efforts to support**
Key Community Partner	**Faith-based partners, libraries**
St. Luke's Resource	**Participation in coalitions and funding support**
FY2024 Outcomes	Met new University of Idaho resource at Mountain Home (MH) public library providing referral services and outreach support
FY2025 Outcomes	In conjunction with ECHC, continued support of library initiative to develop and publish an online padlet to highlight local services and support, including resources to assist with housing needs, utility expenses and healthcare services.
FY2026 Outcomes	Continued collaboration with the ECHC and public libraries to support education and outreach efforts. Worked with Virtual Care, library and community partners to raise awareness about the MH library privacy pod as a resource to assist people experiencing homelessness who frequent the library to support their need to access information and online services for housing, job seeking, healthcare and related services.

Strategy 3: Increasing affordable housing options	
Activities	**Fund housing projects in alignment with partners to maximize investment and impact**
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Participation in WICHC**
FY2024 Outcomes	Continued collaboration with County & City partners, the Elmore County Health Coalition and WICHC to learn areas of need and how best to support. Letter of support written on behalf of St. Luke's Elmore in Fall 2024 for the Elmore County Domestic Violence Council (ECDVC) services, which provides important services in the Mountain Home community, such as emergency shelter assistance, transitional housing and rapid rehousing support.
FY2025 Outcomes	Collaboration continued with SLHS, public and private sector partners, and key stakeholders such as Falcon's Landing, to address housing initiatives.

	Continued ongoing discussions and informed of opportunities to support local partners such as ECDVC and Falcon's Landing. This included touring facilities, receiving regular communications about programs, fundraisers and events.
FY2026 Outcomes	Will continue partner engagement and St. Luke's asset contributions to affordable housing projects and developments as appropriate in FY 2026.
Activities	**LEAP Housing/Falcon's Landing support**
Key Community Partner	**LEAP Housing/Falcon's Landing**
St. Luke's Resource	**Community Engagement participation in LEAP Housing/Falcon's Landing planning**
FY2024 Outcomes	Had initial introduction to Falcons Landing manager and Leap Housing liaison. Will work with these contacts to meet and assess needs and opportunities.
FY2026 Outcomes	Will continue partner engagement and St. Luke's asset contributions to Falcon's Landing as appropriate in FY 2026.

Strategy 4: Support services that assist people in remaining successfully housed	
Activities	**Support onsite services at affordable housing developments**
Key Community Partner	**Central District Health, Charlie's Produce, ECHC, LEAP Housing/Falcon's Landing, Rolling Tomato**
St. Luke's Resource	**Participation in coalition support**
FY2024 Outcomes	Had initial introduction to Falcons Landing manager and Leap Housing liaison. Will work with these contacts to meet and assess needs and opportunities. Attended LEAP Housing/Falcon's Landing presentation as part of ECHC meetings to learn about building schedule, location, services and priority needs.
FY2025 Outcomes	Continued collaboration with Falcon's Landing contacts in addition to CDH/ECHC for programming opportunities such as food rescue program and Cooking Matters classes.
FY2026 Outcomes	Finalizing food rescue program for Falcon's Landing residents in conjunction with Falcon's Landing staff and CDH/ECHC, Rolling Tomato and Charlie's Produce. CH&E is funding $1,000 with CDH pursuing grants to fund the food rescue program in Mountain Home, similar to others supported by CH&E in Ada and Canyon County. As part of ECHC, CDH is finalizing plans to bring Cooking Matters program to Falcon's Landing.

Priority Area Need 2: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse

Strategy 1: Awareness, Education and Skill-building	
Activities	**Promote existing gatekeeper trainings**
Key Community Partner	**Central District Health (CDH), WICHC**
St. Luke's Resource	**Promotion and connection to existing gatekeeper trainings**
FY2024 Outcomes	Supported CDH promotion of Question, Persuade, Refer (QPR) training
FY2025 Outcomes	Continued to promote trainings provided by CDH
FY2026 Outcomes	Promoted QPR training offered by CDH and hosted by MH School District
Key Community Partner	**Empower Idaho, Mountain Home and Glenns Ferry School Districts, Mountain Home and Glenns Ferry Libraries**
St. Luke's Resources	**Promotion and connection to existing gatekeeper trainings**
FY2024 Outcomes	Established contact with newly identified CDH bilingual coordinator and Empower Idaho bilingual trainer to plan future QPR and other mental health training for the Hispanic community In partnership with ECHC, shared information about mental health training, incl. QPR and Sources of Strength, as part of professional development day for Glenns Ferry School District staff.
FY2025 Outcomes	Coordinated one in-person Spanish language QPR training in Elmore county. A total of 16 community participants attended the training in collaboration with community partners including Empower Idaho, Mujeres Unidas, the Mexican Consulate, Hacker Elementary and Migrant and Seasonal Head Start. WICHC Workgroup created an educational toolkit to be distributed in 2026, identified key regional stakeholders offering suicide prevention classes and creating a flyer which is updated quarterly to promote gatekeeper training classes to increase awareness and education, promote resources, and reduce stigma for seeking help around mental health and suicide prevention as a top priority health need. Local SLM participation in workgroup.
FY2026 Outcomes	Contract established with Maricela Rios, LLC in 2026 to deliver English and Spanish, in-person and virtual QPR Gatekeeper Trainings in Elmore county in 2026.
Activities	**Health Talks**
Key Community Partner	**Internal St. Luke's staff**
St. Luke's Resource	**Administration of pre-recorded health talks on mental and behavioral health talks offered to community members**
FY2024 Outcomes	Health Talk: Helping Youth Improve Mental Health and Prevent Suicide was held on September 19, featuring Gretchen Gudmundsen, with 50 registrations and 30 attendees. Additional 39 views on YouTube.
FY2025 Outcomes	Health Talks: Discontinued live, virtual health talks. Past sessions remain available on St. Luke's YouTube page.
FY2026 Outcomes	Health Talks: Past sessions remain available on St. Luke's YouTube page.

Strategy 2: Increase Access to Mental and Behavioral Health Services	
Activities	**Assess and Increase school-based mental and behavioral health services**
Key Community Partner	**Glenns Ferry School District, Mountain Home School District, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Participation in WICHC**
FY2024 Outcomes	Established connection with Glenns Ferry and Mountain Home School district staff re: existing programs (e.g. Sources of Strength, School Pulse), in addition to MH Library and St. Luke's Virtual Care re: future opportunity via telehealth services and library-based pod.
FY2025 Outcomes	Continued to collaborate with school district staff to assess needs for behavioral health services. Shared information with school staff and community about virtual care services available and privacy pod resource at the MH library.
FY2026 Outcomes	Continued collaboration to identify needs and opportunities.
Activities	**Update and Distribute Elmore Mental Health Guide**
Key Community Partner	**Elmore County Health Coalition (ECHC), Mountain Home School District**
St. Luke's Resources	**Publication of mental health guide – hard copy and online**
FY2024 Outcomes	Updated St. Luke's Help is Here! mental health guide to include You Are More program in the introduction alongside the yellow Buddy Bench story; reprint is completed and poster used for outreach events Distributed printed copies of the SLE MH Guide to SLE clinics, local community partners (e.g. WIC, ECDVC, libraries, schools, etc.) and events (MH AFAD, GF SD professional development day, ECHC meetings)
FY2025 Outcomes	Collaborated with You Are More program organizers to support additional education and awareness activities and resources, including participation in local community events that featured a yellow Buddy Bench and distribution of St. Luke's Help is Here! mental health guide and 988 suicide prevention materials. The You Are More program was also awarded a $5,000 CHIF grant to support its mental health education and outreach program. Continued to distribute printed copies of the SLE mental health guide
FY2026 Outcomes	Installed a yellow Buddy Bench at the St. Luke's Elmore Campus. Event included a ribbon cutting ceremony that included remarks by local Mountain Home City, Chamber and school district representatives. Media attended with interviews that included St. Luke's leadership and Mountain Home High School students and faculty who were involved in the original campaign to raise awareness about suicide prevention and funds to purchase and install 9 Buddy Benches in 2019, the story of which is highlighted in the St. Luke's Help is Here! mental health guide. In addition, continued collaboration with You Are More program organizers to support mental health awareness activities and resources, including custom t-shirts with an illustration featuring a yellow Buddy Bench and Be Kind to Your Mind slogan. The #YouAreMore youth mental health awareness campaign established at Mountain Home School District impacts more than 4,000 students across the district every year. Through You Are More spirit days, students are encouraged to be aware of and talk

	about mental health. Exercise and education classes and field days hosted by the City of Mountain Home Parks and Recreation
Activities	**Grow Behavioral Health Workforce**
Key Community Partner	**Desert Sage Health Center, ECHC, ECHO Idaho, Get Healthy Idaho, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Behavioral Health service line – workforce recruitment and retention strategies, including training and residency programs**
FY2024 Outcomes	Meeting with Desert Sage Health Center leaders to collaborate & coordinate approach re: needs assessment and action plans. Shared information with ECHC and school district staff re: ECHO Idaho K12 Education Series. SLHS provided financial support and subject matter expertise to the ECHO Idaho K12 Education Series that provided training opportunities for clinicians and school-based professionals to equip them with additional skills and knowledge to improve the quality of life and well-being of students. The series included topics of behavioral health, substance use prevention and treatment, school nursing, and youth suicide prevention. There were 417 unique attendees, 2,2027 CE hours earned, and 22 professions represented
FY2025 Outcomes	Continue to share information with ECHC and school district staff re: ECHO Idaho K12 Education series.
FY2026 Outcomes	Continue to share information and connect with programs and key contacts. Recent conferences and meeting discussions with Idaho Community Health Worker Association (ICHWA) leadership and members may also provide additional opportunities for workforce development and recruitment opportunities.

Strategy 3: Population-level Identification, Intervention and Measurement	
Activities	**Icelandic Prevention Model**
Key Community Partner	**Bennett Mountain Community School, Boise State University Communities for Youth (C4Y), ECHC, Hacker Middle School, West Elementary School**
St. Luke's Resource	**Financial support of Boise State University Communities for Youth program**
FY2024 Outcomes	Coordinated presentation of Icelandic Prevention Model (IPM) presentation to the ECHC to provide a foundation of understanding for future strategy & action plan development. Met with SLE CE & CNO/COO to learn of their plans to gather data re: suicide attempts and related data to assess trends and other considerations.
FY2025 Outcomes	Continue to collaborate with school districts and C4Y team for opportunities for supporting youth engagement, school based assessment work and possible C4Y for Elmore County. ECHC collaboration with their mental health sub-committee for support of C4Y and related mental health education and outreach initiatives
FY2026 Outcomes	Community School assessment and strategic plan includes mental health priority. Will continue to attend Community School committee meetings to identify common goals and opportunities

	Continued collaboration with ECHC, Community Schools and You Are More program to coordinate mental health priority goals. Provided support for Bronco Bold application for Mountain Home and Glenns Ferry high schools. Both schools were accepted and began Bronco Bold's 3 year-program in Fall 2025.

Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**City of Mountain Home Parks and Recreation; Mountain Home Arts Council, Inc.; Mountain Home School District #193 Bennett Mountain High School YOU ARE MORE; The Watering Hole Community Center Inc.**
FY2024 Outcomes	St. Luke's invested $23,000.00 in Elmore for the priority of Behavioral Health/Wellbeing.
FY2025 Outcomes	St. Luke's invested $19,670.00 in Elmore for the priority of Behavioral Health / Mental Wellbeing.
FY2026 Outcomes	St. Luke's invested $23,000.00 in Elmore for the priority of Behavioral Health / Mental Wellbeing.

Priority Area Need 3: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse

Strategy 1: Access to Affordable Health Care, Including Oral and Vision Health	
Activities	**Continued assessment of service opportunities through community partners**
Key Community Partner	**Desert Sage and Valley Regional Transit**
St. Luke's Resource	**SLHS community-based transportation work**
FY2024 Outcomes	Working with Desert Sage to assess outcomes, key takeaways, and future opportunities stemming from their CHIF award that supported patient transportation to specialty care services in Boise.
FY2025 Outcomes	Continue to connect with Desert Sage contacts to coordinate expansion of transportation services to Elmore County. Assessments of existing resources, grant opportunities are among the discussions.
FY2026 Outcomes	Continue to connect with Desert Sage contacts to coordinate expansion of transportation services to Elmore County.
Key Community Partner	**Desert Sage**

Strategy 2: Support mobile, telehealth and onsite health services	
Activities	**St. Luke's Mobile Mammography**
Key Community Partner	**Various community partners**
St. Luke's Resource	**Vehicle and operations of a mobile unit that are heavily subsidized**
FY2024 Outcomes	Continued support of existing mobile mammography vehicle schedule and enhancing resources by providing Breast Care Services (BCS) with culturally relevant breast cancer information (e.g., American Indian materials for visits to Duck Valley) and St.

	Luke's Cancer Institute Breast Care support group information. Provided community with breast cancer awareness information at related events (e.g. MH Air Force Appreciation Day event that had the mobile in parade)
FY2025 Outcomes	Elmore and Magic Valley Foundation teams continued to support fundraising efforts towards the purchase of a new 3D mobile unit to address critical gaps of mammogram service needs in the area. The new mobile will provide consistent access to local mobile mammogram screening care.
FY2026 Outcomes	Official launch of a mobile unit to serve SL Elmore and Magic Valley needs. This new mobile unit will travel to both communities, with the new unit scheduled to remain at the St. Luke's Elmore campus for a specific time before traveling to Magic Valley. This unit supplements a Boise-based mobile unit that will continue to serve outlying areas of Elmore County region.
Activities	**Continued assessment of St. Luke's Mobile Care Pediatric Services to rural areas**
Key Community Partner	**Mountain Home School District**
St. Luke's Resource	**Vehicle and operations of a mobile unit that are heavily subsidized**
FY2024 Outcomes	Responded to request for Pediatric mobile service opportunity for MH Schools (not a current option but will revisit, as appropriate). Established connection with St. Luke's Virtual Care for assessing future opportunity via virtual options (either onsite or other location, e.g. library telehealth pod).
FY2025 Outcomes	Continued discussions with Children's and Mountain Home school district to plan for expansion of the Children's mobile unit to serve Mountain Home.
FY2026 Outcomes	The Children's mobile was successfully launched in Fall 2025 to the three Community Schools in Mountain Home. The mobile services have been established to visit West Elementary, Hacker Middle School and Bennett Mountain High School throughout the school year. The mobile was also featured in advance of the Fall launch to raise awareness and promote children's health at the West Elementary Kid's Fair where hundreds of parents, students and school staff attended and learned more about the mobile services, along with other community partners who participated as vendors. School staff were also presented an overview of the mobile services by Children's mobile staff prior to the start of the 2025-26 school year.
Key Community Partner	**Glenns Ferry School District**
St. Luke's Resource	**Vehicle and operations of a mobile unit that are heavily subsidized**
FY2025 Outcomes	Discussions to bring the Children's mobile unit to Glenns Ferry will be assessed based upon the launch of the mobile in Mountain Home
FY2026 Outcomes	Expansion of the Children's mobile services to Glenn's Ferry is pending and will be assessed following the review of the Mountain Home service launch.
Activities	**Map, align and leverage mobile health strategies**
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**St. Luke's mobile services** **Participation in WICHC**
FY2024 Outcomes	Met new Breast Care Services director and continuing discussions with internal stakeholders and community partners (e.g. Desert Sage, MH AFB, Rural Development director) realignment of mobile coverage for gap areas and high risk populations.

FY2025 Outcomes	Joined WICHC mobile access workgroup to work collaboratively with internal and community partners to address mobile health strategies. Initial work included identifying scope of work, clarifying definitions, etc.
FY2026 Outcomes	Continue to support WICHC mobile access workgroup activities.

Strategy 3: Support Community Health Worker models, resource navigation services and engagement with vulnerable populations

Activities	Support and expansion of community school model
Key Community Partner	**Blue Cross of Idaho Foundation for Health, Local School Districts, State Department of Education, United Way of Treasure Valley, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contribution to statewide Idaho Coalition of Community Schools, Local support of community school programming and services, Participation in WICHC**
FY2024 Outcomes	Established connection with community school coordinators in one of the 26 districts implementing the strategy.
FY2025 Outcomes	Continued to participate in the regularly scheduled Community School committee meetings. The schools activated programs to support needs identified in the assessment. This included expanding before and after school activities; creating a community closet for clothing needs; initiating WIC mobile clinics; and offering adult education classes such as financial literacy, healthy cooking and English for Spanish speakers.
FY2026 Outcomes	Continue to collaborate with Community School coordinators, and supporting needs for mobile services, mental health and well-being and training.
Activities	**findhelpidaho.org**
Key Community Partner	**Idaho Health Data Exchange, United Way, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contract with findhelpidaho.org for internal patient community resource directory, Participation in findhelpidaho.org statewide collaborative, Participation in WICHC**
FY2024 Outcomes	Continue to share information to the community about the findhelpidaho.org resource and communicate to community partners to update their information. Participated in monthly statewide steering committee meetings with United Way, findhelpidaho.org and Idaho Health Data Exchange to support the growth and engagement of the findhelpidaho.org platform. From Oct. 2023-Sept 2024 84,520 searches were conducted by Idahoans seeking local community resources, 630 new programs were added, and 198 programs were claimed by partner organizations. As of now, 4,371 programs are actively serving Idaho through the platform. This collaboration has strengthened the platform's capacity to connect residents with vital services and resources across the state. Community Health & Engagement continue to work with Care Management to ensure findhelpidaho.org program cards have the information required to feed our internal community resource directory which allows providers to refer patients to local resources.

FY2025 Outcomes	St. Luke's continued to participate in monthly statewide steering committee meetings to support platform growth and engagement. St. Luke's also hosted findhelpidaho.org community partner 101 trainings at the Twin Falls and McCall hospital locations. St. Luke's Community Health & Engagement (CH&E) partnered with internal stakeholders in Marketing, Communications, and PR to develop a statewide strategy promoting findhelpidaho.org across paid, shared, and owned channels. CH&E also collaborated with Care Management to ensure findhelpidaho.org program cards feed into our internal community resource directory and to remain aligned with the most current integrations that will enable closed-loop referrals in the future. In addition, updated MOU with United Way of Treasure Valley to include expanded data-sharing agreements.
FY2026 Outcomes	In conjunction with ECHC, continue to promote and advance communications regarding local findhelpidaho.org resources. A bilingual flyer was produced and distributed to local community contacts, including the library, chambers and partners to raise awareness. In 2026, St. Luke's continued to support awareness and use of findhelpidaho.org, a statewide online resource connecting Idahoans to free and reduced-cost services. As of December 2025, findhelpidaho.org lists 4,437 programs and has facilitated 325,233 searches, helping 38,667 individuals connect with community resources across the state. St. Luke's continues to collaborate with Care Management to ensure our internal community resource directory reflects findhelpidaho.org listings, and the CH&E team developed a content map to provide consistent messaging as the system promotes the platform. St. Luke's plans to participate in the new Idaho Community Resource Network committees through the Idaho Department of Health & Welfare, helping guide outreach, resource validation, and integration with findhelpidaho.org, and aligning efforts with statewide initiatives to strengthen access to social services. These efforts help community members access services such as food assistance, housing support, health care, and transportation, supporting a coordinated, statewide social safety net.

Activities	**Continued support of Get Healthy Idaho CHW initiative**
Key Community Partner	**Central District Health/Get Healthy Idaho (GHI) Community Health Worker (CHW) committee, Libraries, WICHC**
St. Luke's Resource	**Participation in GHI CHW committee, Collaboration and coordination with clinical staff (St. Luke's Elmore & Care Management and Desert Sage)**
FY2024 Outcomes	Held initial discussions with MH Library, GHI and ECHC to explore opportunity for CHW resource based at the library. Planning future meetings with Glenns Ferry Library and with Desert Sage to learn about their CHW staff as a part of the GHI CHW initiative and leverage best practices for future community-based CHWs (e.g. at the library).
FY2025 Outcomes	Get Healthy Idaho program completed it's 3-year Elmore County Action plan. GHI plan included supporting Desert Sage CHW staff and establishing as Elmore County CHEMS resource to address service needs.
FY2026 Outcomes	Continued collaboration with Desert Sage and CHEMS resources. In first 6 months of CHEMS program, over 150 calls were taken, , with 20 identified as consistent users of the CHEMS resource. A webpage was created through the Elmore County website to support the program and a link was provided to the findhelpidaho.org page for staff to use.

Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**Elmore County Domestic Violence Council.**
FY2026 Outcomes	St. Luke's invested $1,500.00 in Elmore for the priority of Housing / Homelessness.

ST. LUKE'S MCCALL

Priority Area Need 1: Safe Affordable Housing and Homelessness

Strategy 1: Support Households that are cost-burdened (spending greater than 30% of income on housing costs)	
Activities	**Woodstock**
Key Community Partner	**Community volunteers, Local churches, Heartland Hunger**
St. Luke's Resource	**Financial support for event**
FY2024 Outcomes	$500 financial support for food for volunteers splitting firewood for seniors and families in need of heating support. 70 families were provided wood the day of the event. More will be served throughout the year as needs arise.
FY2025 Outcomes	$500 financial support for food for 200 volunteers splitting and delivering firewood for seniors and families in need of heating support. 90 families were provided wood the day of the event. More will be served throughout the year as needs arise.
FY2026 Outcomes	Continued support planned for the 2026 FY budget
Activities	**Participate in local housing collaboratives and conversations**
Key Community Partner	**City of McCall, WCM Economic Development Council**
St. Luke's Resource	**Participation in local collaboratives**
FY2024 Outcomes	City of McCall Housing workgroup has been on pause waiting for a new hire of a Housing Coordinator by the City
FY2025 Outcomes	City of McCall Housing workgroup has continued to be on pause, however a new Housing Program Manager has been hired by the City and hopes to resume local collaborative meetings in 2026
FY2026 Outcomes	Participation TBD as opportunities arise locally

Strategy 2: Support for families and individuals experiencing homelessness	
Activities	**Support community housing efforts and other organizations working with families needing emergency housing supports**
Key Community Partner	**Rise Up 2 Thrive**
St. Luke's Resource	**Financial support**
FY2024 Outcomes	Rise Up 2 Thrive $15,000 CHIF 2024 grant recipient to support their work in the community.

FY2025 Outcomes	2025 $15,000 CHIF grant support to Rise Up 2 Thrive, our only local domestic violence advocacy group, to support their work in the community. These dollars support more than housing, but can be used for emergency needs such as housing, household goods, clothing, care.
FY2026 Outcomes	Continued support planned for the 2026 FY budget
Key Community Partner	**Ignite Idaho**
St. Luke's Resource	**Financial contributions where appropriate**
FY2024 Outcomes	$1000 to Ignite Idaho to support Emergency housing/utilities fund
FY2025 Outcomes	$2500 to Ignite Idaho to support Emergency Housing/utilities fund. These dollars provided families with money for prescriptions, food, housing deposit, and short term emergency housing assistance.
FY2026 Outcomes	Continued support planned for the 2026 FY budget

Strategy 3: Increasing affordable housing options	
Activities	**Fund housing projects in alignment with partners to maximize investment and impact**
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Participation in WICHC**
FY2024 Outcomes	WICHC workgroup has met with several regional housing partners such as the House Idaho Collaborative, Caldwell Housing Authority, Jesse Tree, Our Path Home, and Blue Cross of Idaho Foundation for Health. Goals and activities are being redefined as a result of these meetings, to clarify role and deliverables WICHC can contribute to increase education to decision-makers about housing and health, and influence funding streams towards evidence-based and community-relevant housing solutions.
FY2025 Outcomes	WICHC Workgroup created educational materials, explored data, and identified key stakeholders to increase awareness around housing as a top priority health need.
FY2026 Outcomes	WICHC Housing Workgroup provided educational sessions on the connection between housing and health at the Region 3 Housing Coalition's Housing Provider Forum in October 2025. WICHC Housing Workgroup developed policy tools to be used for advocacy efforts with housing legislation in the 2026 Idaho Legislative Session.
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contributions**
FY2024-FY2026 Outcomes	Supported WICHC with $10,000 in funding, and St. Luke's Sr. Director of CH&E is the chair of WICHC's Housing and Homelessness workgroup. Local SLM participation in the workgroup as well.
Activities	**Support SL workforce housing opportunities**
Key Community Partner	**SLM Foundation**
St. Luke's Resource	**SLHS funding where appropriate**

FY2024 Outcomes	SLM Foundation/District Board land purchase for employee housing development
FY2025 Outcomes	The St. Luke's McCall Foundation and the McCall Memorial Hospital District continued to make significant progress in 2025 on their public–private partnership aimed at addressing one of St. Luke's McCall's most urgent challenges: affordable housing for health care professionals. Phase one infrastructure of the development was completed, and construction of the first four plex is now underway. The building is expected to be finished and ready for occupancy in early April 2026.
FY2026 Outcomes	In 2026 a second four plex has been approved and is projected to begin construction in summer or fall 2026, bringing the total to eight townhomes available for St. Luke's McCall employees to rent. The full development, approved for 38 units, will include a mix of two- and three-bedroom townhomes built in phases as funding becomes available. Rent will be set at 30% of an employee's household income or at market rate—whichever is lower—ensuring affordability. St. Luke's will be responsible for management of the units.

Strategy 4: Support services that assist people in remaining successfully housed	
Activities	**Helping Hands**
Key Community Partner	**SLM Foundation**
St. Luke's Resource	
FY2024 Outcomes	Support SL staff in financial need to decrease the burden of health care on household expenses like housing. SLM Foundation provided $17,500 to help staff in 2024. Other funds providing support include the Compassionate Care fund, Hope and Healing, and the Community and Children's Medical Funds which SL staff participate on the board.
FY2025 Outcomes	Support SL staff in financial need to decrease the burden of health care on household expenses like housing. SLM Foundation provide $13,110 to help staff in 2025. Other funds providing support include the Compassionate Care fund, Hope and Healing, and the Community and Children's Medical Funds which SL staff participate on the board.
FY2026 Outcomes	Support SL staff in financial need to decrease the burden of health care on household expenses like housing. SLM Foundation provide to help staff in 2025. Other funds providing support include the Compassionate Care fund, Hope and Healing, and the Community and Children's Medical Funds which SL staff participate on the boards.
Activities	**Explore local opportunities to aid in assistance**
Key Community Partner	**CDH, Heartland Hunger**
St. Luke's Resource	**SLM Care Coordination team**
FY2024 Outcomes	Our SL Care Coordination team embedded in PLMC assisted over 2000 patients per year in a variety of way.
FY2025 Outcomes	Our SL Care Coordination team embedded in PLMC has over 2000 patients per year

	touches in a variety of ways annually finding transportation, food security assistance, assistance with filling out paperwork for financial support, educating and assisting on different assistance programs.
FY2026 Outcomes	Continued patient support through Care Coordination continues in 2026.
Key Community Partner	**Ignite Idaho**
St. Luke's Resource	**Financial support**
FY2024 Outcomes	$1000 to Ignite Idaho to support Emergency housing/utilities fund
FY2025 Outcomes	$2500 to Ignite Idaho to support Emergency Housing/utilities fund. These dollars provided families with money for prescriptions, food, housing deposit, and short term emergency housing assistance.
FY2026 Outcomes	FY2026 annual support to Ignite Idaho Family Resource Center to support their Emergency Housing/Utilities fund to use as needs arise for local families in need.
Key Community Partner	**American Legion**
St. Luke's Resource	**Financial and event support**
FY2025 Outcomes	Veteran's Stand Down Event hosted by the Valley County American Legion and partnered with many community partners. Held 2 events, approximately 150 veterans served. Food, household items, cold weather clothing. SL support through in-kind support of bags ($300) for food distribution, Get Help Mental Health Resource guides, and volunteer support.
FY2026 Outcomes	Continued support planned for the 2026 FY budget

Strategy 5: Community Health Improvement Fund Grant Program	
Key Community Partner	**Rise Up 2 Thrive, Inc; Shepherd's Home, Inc..**
FY2024 Outcomes	St. Luke's invested $5,000.00 in McCall for the priority of Housing / Homelessness.
FY2025 Outcomes	St. Luke's invested $20,000.00 in McCall for the priority of Housing / Homelessness.
FY2026 Outcomes	St. Luke's invested $6,000.00 in McCall for the priority of Housing / Homelessness.

Priority Area Need 2: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse

Strategy 1: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse	
Activities	**Health Talks**
Key Community Partner	
St. Luke's Resource	**Administration of pre-recorded health talks on mental and behavioral health talks offered to community members**
FY2024 Outcomes	Health Talk: Helping Youth Improve Mental Health and Prevent Suicide was held on September 19, featuring Gretchen Gudmundsen, with 50 registrations and 30 attendees. Additional 39 views on YouTube.

FY2025 Outcomes	Health Talks: Discontinued live, virtual health talks. Past sessions remain available on St. Luke's YouTube page.
FY2026 Outcomes	Health Talks: Past sessions remain available on St. Luke's YouTube page.
Activities	**Support community partners providing gatekeeper training**
Key Community Partner	**Adams County Health Action Team, Central District Health, Ignite Idaho, VCORP, Youth Advocacy Coalition**
St. Luke's Resource	**SL BH team, Promotion, connection, and financial support where appropriate to existing gatekeeper trainings**
FY2024 Outcomes	Girls' Wellness Series with Parks and Rec, Courtney Hill, Enliven Yoga Studio. Paid for yoga facility rental fee: $300 Promotion of CDH/SWDH and local community partners offering gatekeeper training opportunities to increase the number of community members with skills taught in gatekeeper trainings.
FY2025 Outcomes	WICHC Workgroup created an educational toolkit to be distributed in 2026, identified key regional stakeholders offering suicide prevention classes and creating a flyer which is updated quarterly to promote gatekeeper training classes to increase awareness and education, promote resources, and reduce stigma for seeking help around mental health and suicide prevention as a top priority health need. Continued promotion of local community partners offering gatekeeper training opportunities and community events for the education of suicide prevention awareness and stigma reduction.
FY2026 Outcomes	WICHC workgroup will continue to update of the toolkit and gatekeeper promotional flyers. Future plans in 2026 to create first responder/law enforcement mental/behavioral health/resource cards. Planned for FY 2026 delivery of Gatekeeper trainings.
Activities	**Participate in WICHC Behavioral Health workgroup to assess for stigma reduction messaging and activities**
Key Community Partner	**St. Luke's McCall Behavioral Health, WICHC**
St. Luke's Resource	**Participation in workgroup**
FY2024 Outcomes	WICHC workgroup has met several times. Goals and activities are being defined to clarify focus, role and deliverables. Local SLM participation in workgroup.
FY2025 Outcomes	WICHC Workgroup created an educational toolkit to be distributed in 2026, identified key regional stakeholders offering suicide prevention classes and creating a flyer which is updated quarterly to promote gatekeeper training classes to increase awareness and education, promote resources, and reduce stigma for seeking help around mental health and suicide prevention as a top priority health need. Local SLM participation in workgroup.
FY2026 Outcomes	WICHC workgroup to continue current efforts as appropriate and align with the new 2026 CHNA needs.
Activities	**Distribute "Help is Here!" guides as appropriate to system internal and external partners (budget is for printing. Anticipate some amount to be reimbursed by Health Window funds, McCall and WR Foundations**

Key Community Partner	St. Luke's McCall Foundation
FY2024 Outcomes	"Help is Here!" guides have been updated for all locations across our footprint and will be printed and distributed to communities by end of 2024. All versions are available in both Spanish and English, and are available as a printed booklet or digitally on our St. Luke's public website. On 8/21/24, St. Luke's sent an email to over 480,000 patients with Suicide Prevention with this educational message: If you or someone you love needs immediate mental health support, call or text 988, the Idaho Suicide & Crisis Lifeline" and included links to St. Luke's Behavioral Health Services and 988
FY2025 Outcomes	Provide St. Luke's "Help is Here!" Mental Health Resource Guides at the hospital and local St. Luke's clinics. Also provide to community partners for public facing events such as over 100 guides distributed to veterans at our local Stand Down event. Funds for printing provided by the SLM Foundation.
FY2026 Outcomes	Distribution at local events, clinics and hospital as needed.
Activities	**Support for continued Community Resiliency Model trainings in region**
Key Community Partner	**Brundage Mountain, Idaho Resilience Project, local Community Resilience Model (CRM) trainers, Resiliency Rising**
St. Luke's Resource	**Promotion and financial support where appropriate**
FY2024 Outcomes	Connected Brundage Mountain Resort with funding to provide CRM training to their winter staff. Conversations around pilot program with McCall Donnelly Elementary School staff
FY2025 Outcomes	Continued promotion between community partners, school districts and regional CRM instructors to provide possible trainings in the community and/or at schools
FY2026 Outcomes	Will continue to support as opportunities arise in 2026.
Activities	**Exploration of Suicide Prevention Awareness Alliance in the region**
Key Community Partner	**Adams County Health Action Team (ACHAT); Central District Health; Ignite Idaho; local providers; NAMI Idaho; Valley County Opioid Response Project (VCORP); Youth Advocacy Coalition (YAC)**
St. Luke's Resource	**Partner in local collaborative building**
FY2024 Outcomes	Continued conversations about Suicide Prevention. No coalition formally created due to community partner work capacity. VCORP efforts through the HRSA Behavioral Health grant continue suicide prevention efforts across the full West Central Mountains region.
FY2025 Outcomes	No conversations in 2025 regarding the creation of a Suicide Prevention Awareness Alliance. Work has focused on VCORP HRSA grant efforts with community partners focusing on crisis response, HOPE Squads in the schools, gatekeeper trainings, awareness messaging, Courage to Connect campaigns in different communities across the region. Courage to Connect campaigns led by VCORP partners in different communities across the region. Support and participation for the Adams County Mental Health Awareness walk with 45 participants for first event October 2025. Support and participation at the Ignite Idaho Resource Awareness event June 2025.

FY2026 Outcomes	Continue to participate and support organizations promoting suicide prevention efforts through events, classes, support groups, etc.
Activities	**Increase school-based mental and behavioral health services**
Key Community Partner	**McCall-Donnelly School District**
St. Luke's Resource	**St. Luke's Behavioral Health**
FY2024 Outcomes	School based SW position created. Should start fall 24.
FY2025 Outcomes	School based therapist hired and working within the MD schools started with the 2025 school year.
Key Community Partner	**Youth Advocacy Coalition (YAC)**
St. Luke's Resource	**Support programmatic work in school district supporting youth, teachers and parents**
FY2024 Outcomes	Hope Squad creation in MD, Cascade, and New Meadows School Districts through YAC: CHIF grant recipient. Council to start in Fall of 24
FY2025 Outcomes	Hope Squads expanded to all schools in the region through YAC grant funding. Summer Hope Squad retreat was scheduled for summer of 2025, but due to low enrollment was rescheduled as a Summit in February of 2026. SL support through board involvement, $2000 CH budget and $8,700 CHIF grant funds to support these efforts and events.
FY2026 Outcomes	Continued financial and board support planned for the 2026 FY budget. CHIF grant $4000 for Hope Squad activities and CH budget for programmatic work.
Activities	**Participation in Valley County Opioid Response Project Consortium (VCORP)**
Key Community Partner	**CDH; City of McCall; Ignite Idaho; The ROC; Valley County; YAC**
St. Luke's Resource	**Participation in collaboration and provide funding where appropriate**
FY2024 Outcomes	Participated in regular collaboration meetings; applied for HRSA IMPACT grant for community partners Participated in the anti-stigma workgroup and media campaign. Board of The Anchor: grant funded Youth Assessment Center HRSA Behavioral Health grant: participate in collaborative; work with SL data and analytics team to provide SL data for grant reporting.
FY2025 Outcomes	Participated in regular collaboration meetings; applied for HRSA IMPACT grant with community partners for substance misuse prevention but was not awarded. Participated in VCORP anti-stigma workgroup and media campaign. Participation on the advisory board of The Anchor Youth Assessment Center under Ignite Idaho: grant funded Youth Assessment Center HRSA Behavioral Health grant: participate in collaborative; work with SL data and analytics team to provide SL data for grant reporting.
FY2026 Outcomes	Will continue participation and contributions to VCORP as appropriate in FY 2026.

Strategy 2: Increase Access to Mental and Behavioral Health Services	
Activities	**Increase school-based mental and behavioral health services**
Key Community Partner	**McCall-Donnelly School District**
St. Luke's Resource	**St. Luke's Children's and St. Luke's Behavioral Health service lines school-based providers**
FY2024 Outcomes	School-Base Social Worker hired and will begin work in the school fall of 2024/early winter 2025
FY2025 Outcomes	School based therapist hired and working within the MD schools started with the 2025 school year.
FY2026 Outcomes	School-based therapist will continue to provide services in MD schools.
Activities	**Grow Current Behavioral Health Workforce/Participate in WICHC Behavioral Health workgroup to assess for behavioral health workforce development strategies that may expand mental and behavioral health services (Angie, Tiffany)**
Key Community Partner	**Western Idaho Community Health Collaborative**
St. Luke's Resource	**Behavioral Health service line – workforce recruitment and retention strategies, including training and residency programs**
FY2024 Outcomes	WICHC Increasing Access workgroup creation and participation. Local SLM participation in workgroup.
FY2025 Outcomes	WICHC workgroup met bi-monthly in 2025 with a focus to learn more and promote peer support services as a means to increase/expand access to mental and behavioral health supports. The focus has shifted to focus on peer supports for substance misuse as policies have changed regarding peer supports focusing on mental and behavioral health. Additionally, exploring how to increase access to supervisors who can oversee those offering peer support service. Local SLM participation in workgroup.
FY2026 Outcomes	WICHC workgroup to continue current efforts as appropriate and align with the new 2026 CHNA needs.
Activities	**Emergency Department Peer Recovery Coach program support**
Key Community Partner	**The Recovery Community Center (ROC)**
St. Luke's Resource	**St. Luke's Behavioral Health, St. Luke's McCall Emergency Department**
FY2024 Outcomes	ED Recovery Coach Warm Handoff program launched and monitored in partnership with ED staff, Behavioral Health, and Community Health in partnership with The ROC (Recovery Oriented Community Center). SLM is a pilot program to learn for expansion/duplication across the system. Provided $1700 funding to The ROC to support program participants with transportation to medical appointments, in-patient therapy in other locations, legal appointments, etc.
FY2025 Outcomes	ED Recovery Coach Warm Handoff program continues in partnership with The ROC (Recovery Oriented Community Center). Internal SL conversations started to expand the SLM pilot program to EDs across the Treasure Valley.

FY2026 Outcomes	Recovery Coach program planned expansion to St. Luke's ED facilities across the TV starting in 2026.

Strategy 3: Population-level Identification, Intervention and Measurement	
Activities	**Icelandic Prevention Model**
Key Community Partner	**Adams County Health Action Team (ACHAT), Boise State University Communities for Youth, Ignite Idaho, Planet Youth, Youth Advocacy Coalition (YAC)**
St. Luke's Resource	**Financial support of Boise State University Communities for Youth program, Facilitation of local community conversations, coalitions and action teams, Financial support to YAC**
FY2024 Outcomes	Participation in YAC as Vice Chair of the board $2000 to support programmatic work and Spring 24 Youth Summit YAC performs IPM surveys every 2 years through Planet Youth to track progress of work taking place in the community and in the schools.
FY2025 Outcomes	Participation in YAC as Vice Chair of the board $2000 to support programmatic work and Spring 25 Youth Summit YAC partnership with Planet Youth transitioning to partnership with Communities for Youth. Future surveys in the schools will be performed with C4Y. YAC surveys and programmatic efforts in all regional schools as of 2025 school year. Courage to Connect Mental Health Awareness walk in Adams County first year held in October 2025 with 45 participants in attendance. Regional community partners who provide a variety of services supporting mental health and well-being tabled for attendees. Provided staff time to plan and host the event, plus provided in-kind services for bags for event resources and swag. 45 participants with positive feedback to continue. ($75)
FY2026 Outcomes	Board support position transitioning from Vice Chair to Chair. Continue partnerships and efforts in 2026. Adams County Courage to Connect Walk planned for September 2026. Continued participation with ACHAT for 2026. Support as opportunities arise.

Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**Cascade Public Library; Cascade School District #422; Horizons Lifestyle and Education Team; Idaho West Central Mountain Youth Advocacy Coalition (YAC); Ignite Idaho Family Resource Center; McCall Arts and Humanities Council; Paradise Point Camp; Rise Up 2 Thrive, Inc; The Wellness Project; University of Idaho Foundation on behalf of McCall Outdoor Science School.**
FY2024 Outcomes	St. Luke's invested $39,800.00 in McCall for the priority of Behavioral Health/Wellbeing.
FY2025 Outcomes	St. Luke's invested $12,850.00 in McCall for the priority of Behavioral Health / Mental Wellbeing.

FY2026 Outcomes	St. Luke's invested $45,637.00 in McCall for the priority of Behavioral Health / Mental Wellbeing.

Priority Area Need 3: Access to Affordable Health Care, Including Oral and Vision Health

Strategy 1: Addressing transportation barriers to care	
Activities	**Connect U bus from Riggins**
Key Community Partner	**Riggins Community Center**
St. Luke's Resource	**Financial support**
FY2024 Outcomes	$12,500 in funding for 2024: 104 trips, 948 participants.
FY2025 Outcomes	$12,500 funding for 2025: 358 annual trips.
FY2026 Outcomes	$12,500 funding for 2026
Activities	**Gold Line Bus route support connecting New Meadows to McCall**
Key Community Partner	**Blue Cross of Idaho, City of New Meadows, Mountain Valley Transit, Perpetua**
St. Luke's Resource	**Participate in local conversations, Financial support**
FY2024 Outcomes	$12,000 in funding for 2024: ridership 1422 in 2024
FY2025 Outcomes	$12,000 funding for 2025: ridership 2,993 boardings in 2025
FY2026 Outcomes	$12,500 funding for 2026
Activities	**Explore opportunities for additional transportation options for homebound individuals**
Key Community Partner	**McCall Senior and Community Center**
St. Luke's Resource	**Participate in local conversations, financial support**
FY2024 Outcomes	Provided $1700 in funding to support transport of people utilizing the Peer Recovery Coach program to medical and legal appointments, in-patient therapy in other regions, etc.
FY2025 Outcomes	$1500 to McCall Senior and Community Center for community grant match for pilot program for non-emergent transportation for seniors and vulnerable populations unable to access public transportation. Representation on the Community Center board, assisting with grant writing, program development.
FY2026 Outcomes	McCall Senior and Community Center pilot transportation program to launch in 2026. This program will provide scheduled transportation for medical appointments, pharmacy visits, rides to the congregate meals for socialization. CHIF grant $10,000 to support the pilot program that will launch in 2026
Strategy 2: Support mobile, telehealth and onsite health services	
Activities	**St. Luke's Mobile Mammography**

Key Community Partner	**Adams County Health Center, Brundage Mountain, Cascade Medical**
St. Luke's Resource	**St. Luke's Mobile Services and Breast Care Team**
FY2024 Outcomes	Mobile Mammography bus traveled to Cascade and Council in 2024.
FY2025 Outcomes	Continued promotion and planning for the Mobile Mammography bus in the region in Cascade, Riggins and Council. Assisted with expansion of the mobile route in the Horseshoe Bend area.
FY2026 Outcomes	Support regional Mobile Mammography as bus is available. Mobile Mammography unit and members from the SL Breast Care Team attend Brundage Mountains Boarding for Breast Cancer event March 2026.
Activities	**Health Talks**
Key Community Partner	
St. Luke's Resource	**Administration of pre-recorded health talks on access to care offered to community members**
FY2024 Outcomes	Health Talk: Helping Youth Improve Mental Health and Prevent Suicide was held on September 19, featuring Gretchen Gudmundsen, with 50 registrations and 30 attendees. Additional 39 views on YouTube.
FY2025 Outcomes	Health Talks: Discontinued live, virtual health talks. Past sessions remain available on St. Luke's YouTube page.
FY2026 Outcomes	Health Talks: Past sessions remain available on St. Luke's YouTube page.
Activities	**Map, align and leverage mobile health strategies**
Key Community Partner	**Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Participation in WICHC**
FY2024 Outcomes	St. Luke's participated in initial WICHC Access to Care workgroup meetings. Discussion and planning will continue as the workgroup is tasked with defining scope of work and developing action plans related to mobile, telehealth and co-located health services.
FY2025 Outcomes	SL CH&E team participation in WICHC Access to Care mobile services workgroup. Continue meeting to discuss goals, define scope of work, assess priority areas, identify gaps, and develop action plans to improve mobile access.
FY2026 Outcomes	Continued CH&E Team participation and provided input to WICHC Access to Care mobile services workgroup. Anticipation of using findhelpidaho.org more robustly in FY26
Activities	**TeleSANE nursing program**
Key Community Partner	**Local law enforcement, local domestic violence advocates, local crisis response team, local legal support, Penn State University**
St. Luke's Resource	**St. Luke's Emergency Department staff, other St. Luke's supporting departments**
FY2025 Outcomes	SAFE-T TeleSANE program in partnership with Penn State launched across St. Luke's ED departments to be utilized when an ED does not have a SANE nurse on site to support sexual assault survivor exams. This program specifically benefits rural hospitals where staffing is especially challenging. This program went live in October

	2025 across the majority of the SL Health System with remaining sites onboarding in early 2026. Through the preparation of launching this program, community partners serving these patients, including law enforcement, legal, advocates, etc., came together to open discussions and plan processes for stream lined care.
FY2026 Outcomes	Program to continue and fine tune procedures and protocols across the SL health system during 2026.
Activities	**Drop-In Childcare for medical and wellness visits**
Key Community Partner	**Ignite Idaho Family Resource Center**
St. Luke's Resource	**Financial Support**
FY2024 Outcomes	2024 CHIF $16,000 grant 1799 hours of drop-in childcare provided, 51 families participating. 19% of participate were for treatment, 6% doctor visits/imaging, 39% counseling/medication management, 4% gym or workout classes, 32% other.
FY2025 Outcomes	SL provided $16,000 in 2025 to support the Ignite Idaho Drop-In Wellness program. This program is available for parents to drop their children for a few hours while they attend medical or behavioral health appointments without their children attending. Creating an opportunity for a more focused and open appointment which is better for both patient and provider. 1787 hours of care. Averaged 148 hours/month and 12 children served per month. 78 children total and 57 families were served.
FY2026 Outcomes	SL provided $16,000 in 2026 to support the Ignite Idaho Drop-In Wellness program. This program is available for parents to drop their children for a few hours while they attend medical or behavioral health appointments without their children attending. Creating an opportunity for a more focused and open appointment which is better for both patient and provider. $10,000 CHIF grant to support expansion of Ignite Idaho Family Resource Center services to Cascade. FY26 to date (Octo 25-Dec 25) in Cascade: 292 hours of service provided, averaging 97 hours of service per month and 7 children participating per month.
Activities	**Explore telehealth opportunities with local libraries**
Key Community Partner	**Local libraries**
St. Luke's Resource	**St. Luke's Health at Home telehealth team**
FY2024 Outcomes	Working with internal telehealth leads to connect with local libraries to support with education of services available and technical issues. McCall Library created a telehealth room in their new construction. New Meadows library has a telehealth pod
FY2025 Outcomes	Connections between the New Meadows Library and the SL Health at Home team about supporting services with their telehealth pod. Conversations still on hold as New Meadows determines the future of the pod in the library location.
FY2026 Outcomes	Support as local opportunities arise in 2026

Strategy 3: Support Community Health Worker models, resource navigation services and engagement with vulnerable populations	
Activities	**Support and expansion of community school model**
Key Community Partner	**Blue Cross of Idaho Foundation for Health; Local School Districts; State Department of Education; United Way of Treasure Valley; Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contribution to statewide Idaho Coalition of Community Schools, Local support of community school programming and services, Participation in WICHC**
FY2024 Outcomes	United Way was awarded a five-year, $46 million-dollar full-service community schools grant from the United States Dept of Ed focused on expansion of rural designation community schools. Currently 41 community schools in 25 districts. Five new schools in regions 3 and 4 indicated interest in new cohorts. Region 3 and 4 SL CH members connecting with rural districts and existing community school partners to better develop pathways to address SDOH drivers. SLM CH manager joined advisory board for the Cascade Community School. Role as YAC vice chair also supports the community school through the Icelandic Prevention Model surveys.
FY2025 Outcomes	Cascade Community School advisory board participation. Additional HRSA grant awarded to VCORP that will include programmatic efforts with the Cascade Community School. $3000 CHIF grant to support school programmatic work
FY2026 Outcomes	Support Community School efforts as appropriate in 2026. $2000 CHIF grant to support Parent Engagement classes/opportunities.
Activities	**findhelpidaho.org**
Key Community Partner	**Idaho Health Data Exchange, United Way, Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**Financial contract with findhelpidaho.org for internal patient community resource directory, Participation in findhelpidaho.org statewide collaborative, Participation in WICHC, SL Care Management**
FY2024 Outcomes	From Oct. 2023-Sept 2024 84,520 searches were conducted by Idahoans seeking local community resources, 630 new programs were added, and 198 programs were claimed by partner organizations. As of now, 4,371 programs are actively serving Idaho through the platform. This collaboration has strengthened the platform's capacity to connect residents with vital services and resources across the state.
FY2025 Outcomes	St. Luke's continued to participate in monthly statewide steering committee meetings to support platform growth and engagement. St. Luke's also hosted findhelpidaho.org community partner 101 trainings at the Twin Falls and McCall hospital locations.

	St. Luke's Community Health & Engagement (CH&E) partnered with internal stakeholders in Marketing, Communications, and PR to develop a statewide strategy promoting findhelpidaho.org across paid, shared, and owned channels. CH&E also collaborated with Care Management to ensure findhelpidaho.org program cards feed into our internal community resource directory and to remain aligned with the most current integrations that will enable closed-loop referrals in the future. In addition, CH&E updated its MOU with United Way of Treasure Valley to include expanded data-sharing agreements.
FY2026 Outcomes	In 2026, St. Luke's continued to support awareness and use of findhelpidaho.org, a statewide online resource connecting Idahoans to free and reduced-cost services. As of December 2025, findhelpidaho.org lists 4,437 programs and has facilitated 325,233 searches, helping 38,667 individuals connect with community resources across the state. St. Luke's continues to collaborate with Care Management to ensure our internal community resource directory reflects findhelpidaho.org listings, and the CH&E team developed a content map to provide consistent messaging as the system promotes the platform. St. Luke's plans to participate in the new Idaho Community Resource Network committees through the Idaho Department of Health & Welfare, helping guide outreach, resource validation, and integration with findhelpidaho.org, and aligning efforts with statewide initiatives to strengthen access to social services. These efforts help community members access services such as food assistance, housing support, health care, and transportation, supporting a coordinated, statewide social safety net.

Activities	**Senior supports identified through the Aging in Place Workgroup, Caregiver and chronic illness support groups, senior yoga, Farmers Market Senior Produce Program**
Key Community Partner	**Cascade Medical**
St. Luke's Resource	**Financial Supports, participation in workgroup as a St. Luke's resource**
FY2024 Outcomes	Participation in the Cascade Aging in Place workgroup.
FY2025 Outcomes	Cascade Aging in Place workgroup led by Cascade Medical Center continued meetings in 2025 to keep partner organizations informed of opportunities to support the aging population.
FY2026 Outcomes	Plans to continue workgroup in 2026
Key Community Partner	**Adams County Health Action Team (ACHAT), Southwest District Health**
St. Luke's Resource	**Participation in workgroup, financial support**
FY2024 Outcomes	Adams County Health Action Team (ACHAT) focus to include connection to address the health implications related to loneliness for seniors.
FY2025 Outcomes	Continued ACHAT discussions but no action specifically towards supporting seniors in Adams County in 2025.
Key Community Partner	**Local senior yoga and fitness instructors, Our Savior Lutheran Church**
St. Luke's Resource	**Financial Support, St. Luke's support group facilitators, local Farmers Markets**

FY2024 Outcomes	Monthly Support Groups (Caregiver Support Group and Chronic Illness Support Group) offered by SLM staff. Chronic Illness group 110/Caregiver group 151 Senior Yoga hosts approximately 575 participants per year ($2400/year).
	Participation on the board for the McCall Senior/Community Center. Organizing educational opportunities relating to health and housing.
	2024 Financial support of Donnelly ($5000) and New Meadows ($500) Farmers Markets senior nutrition programs. Aiding seniors receiving free fresh produce.
FY2025 Outcomes	Monthly Support Groups (Caregiver Support Group and Chronic Illness Support Group) offered by SLM staff. Chronic Illness group 92/Caregiver Group 146 participants. Senior Yoga hosts approximately 575 participants per year ($2400/year).
	Participation on the board for the McCall Senior/Community Center. Organizing educational opportunities relating to health and housing. Planning and fundraising to create a non-emergent transportation program to assist seniors with transportation to medical appointments, pharmacy visits, and rides to congregate meals for socialization and connection. $1500 provided from CH operational budget for a community match grant, plus $10,000 CHIF grant awarded to support. 2025 Financial support of Donnelly ($5000) and New Meadows ($1000) Farmers Markets senior nutrition programs. Aiding seniors receiving free fresh produce.
FY2026 Outcomes	Monthly Support Groups (Caregiver Support Group and Chronic Illness Support Group) offered by SLM staff. Average 5-10 people per month. Senior Yoga hosts approximately 575 participants per year ($2400/year). Launching of the transportation program and continued fundraising for the sustainability of the program and expansion of Meals on Wheels. Plans to continue workgroup in 2026

Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**Ignite Idaho Family Resource Center; McCall Nordic & Biathlon Ski Club; McCall Senior Center dba McCall Community Center; S.A.V.E.S.**
FY2024 Outcomes	St. Luke's invested $16,700.00 in McCall for the priority of Access to Care.
FY2025 Outcomes	St. Luke's invested $17,480.00 in McCall for the priority of Access to Care.
FY2026 Outcomes	St. Luke's invested $17,500.00 in McCall for the priority of Access to Care.

ST. LUKE'S NAMPA

Priority Area Need 1: Safe Affordable Housing and Homelessness

Strategy 1: Support Households that are cost-burdened (spending greater than 30% of income on housing costs)	
Activities	**Continue to serve on Region 3 Housing Coalition around ongoing housing initiatives for those experiencing housing insecurity.**
Key Community Partner	**Charitable Assistance to Community's Homeless (CATCH); Housing and Urban Development (HUD); Idaho Department of Health and Welfare (IDHW); Idaho Housing and Finance Association (IHFA); Jesse Tree; Nampa and Caldwell Cities; Nampa and Caldwell School Districts; Nampa Housing Authority; Saint Alphonsus; Salvation Army; Southwestern Idaho Cooperative Housing Authority (SICHA); Western Idaho Community Action Partnership (WICAP)**
St. Luke's Resource	**$2,000 annually**
FY2024 Outcomes	Provided funding support for Point-In-Time Count supplies to count those experiencing unsheltered homelessness in Region 3. This single night count provides data that determines funding support for homelessness services.
FY2025 Outcomes	Provided funding support for vouchers for January's Point-in-Time Count. • 857 individuals counted, 773 were unsheltered • This represents the highest region in the statewide count • Additional funds used to support Region 3 Housing Forum • About 200 cross-sector partners attended the Housing Conference with the goal to increase regional collaboration and focus on supporting coordinated entry and rapid rehousing Helped support Share the Day in November to serve at-risk community members needing wrap-around supports for food, health services, coats and others SDOH barriers. Partners provided services to: • 450 total attendees • 13 mammograms provided by St. Luke's Partners provided: • 24 blood pressure readings • 60 vaccines administered • 100 health ed encounters • 379 coats provided • 346 hot meals served • 100 additional sent to Salvation Army shelter • 191 food boxes provided • 43 free haircuts given
FY2026 Outcomes	Anticipate and have budgeted for continued support in 2026, especially as need increases and housing remains a CHNA high-priority health need. Will support the 2026 Point in Time Count as appropriate.

	Anticipate and have budgeted for continued support in 2026, especially as need increases and housing remains a CHNA high-priority health need. Share the Day will expand to Payette in March of 2026. We anticipate being a partner in that effort as well.

Strategy 2: Support for families and individuals experiencing homelessness	
Activities	**Continued financial and resource support of family shelter and other emergency shelters in West Treasure Valley.**
Key Community Partner	**CATCH, Jesse Tree, Nampa and Caldwell School Districts, Salvation Army**
St. Luke's Resource	**$5,000**
FY2024 Outcomes	Provided $2,500 to both Nampa and Caldwell School Districts McKinny Vento Program serving students and families experiencing homelessness. Each district purchased 25 hotel vouchers for $100 each for emergency shelter needs.
FY2025 Outcomes	Provided $2,000 to Nampa School District's McKenny-Vento Program to support emergency housing for unsheltered students/families. 1,291 students qualified as homeless under the McKinney-Vento Act. Funds supported families in need of emergency shelter to stay in a hotel to avoid them living in their car while they obtained permanent housing.
	Provided $5,000 to the Salvation Army Nampa Homeless Shelter to support extending shelter services for two additional months.
FY2026 Outcomes	Anticipate and have budgeted for continued support in 2026, especially as need increases and housing remains a CHNA high-priority health need.

Strategy 3: Increasing affordable housing options	
Activities	**Support Housing Forum with elected officials and stakeholders to review housing assessment and other data sources to address planning, zoning and code changes that could expand workforce and affordable housing.**
Key Community Partner	**CATCH; Healthy Impact Nampa; HUD; IDHW; IHFA; Jesse Tree; Nampa and Caldwell Cities; Nampa and Caldwell School Districts; Nampa Housing Authority; Saint Alphonsus; Salvation Army; SICHA; WICAP**
St. Luke's Resource	**$2,500**
FY2024 Outcomes	Held the first of three housing forums to engage community leaders and elected officials. Forum for 75 attendees featured author Greg Coburn, and included the Nampa mayor and two city council members.
FY2025 Outcomes	Nampa mayor convened a community and elected leaders dinner discussion. More than 60 leaders attended the dinner, and key activation will be convening an ongoing leaders housing roundtable to address housing inventory, zoning and code opportunities and legislative policies impacting growth paying for growth.
FY2026 Outcomes	Anticipate and have budgeted for continued support of housing discussions for 2026. Gem State Housing Alliance will held co-lead conversations with Healthy Impact Nampa to establish a housing focused leaders roundtable to advance feasible coding changes and development opportunities.

Strategy 4: Support services that assist people in remaining successfully housed	
Activities	**Ongoing collaboration with Region 3 Housing Coalition and other direct service providers to address St. Luke's patient needs and community needs**
Key Community Partner	**CATCH; HUD; IDHW; IHFA; Jesse Tree; Nampa and Caldwell Cities; Nampa and Caldwell School Districts; Nampa Housing Authority; Saint Alphonsus; Salvation Army; SICHA; Western Idaho Community Health Collaborative (WICHC); WICAP**
FY2024 Outcomes	St. Luke's Senior Director, Community Health & Engagement has been leading a housing subcommittee through WICHC and our site-based efforts consist of ongoing education and connection.
FY2025 Outcomes	WICHC Workgroup created educational materials, explored data, and identified key stakeholders to increase awareness around housing as a top priority health need.
FY2026 Outcomes	WICHC Housing Workgroup provided educational sessions on the connection between housing and health at the Region 3 Housing Coalition's Housing Provider Forum in October 2025. WICHC Housing Workgroup developed policy tools to be used for advocacy efforts with housing legislation in the 2026 Idaho Legislative Session.
Activities	**Continue support of BUILD Payette**
Key Community Partner	**BUILD Payette partners**
St. Luke's Resource	**$5,000 annually**
FY2024 Outcomes	Completed two focus groups identifying need for specialty care for children, youth support center, mental health services, child care, and affordable housing. Identified future housing site.
FY2025 Outcomes	Partner stakeholders and LEAP Housing laid the groundwork for an innovative housing project to integrate affordable housing for seniors, a medical facility, and community space.
FY2026 Outcomes	Three-year funding commitment has been satisfied. Funding support will not be provided in 2026, but St. Luke's engagement will continue.

Strategy 5: Community Health Improvement Fund Grant Program	
Key Community Partner	**The Salvation Army, Caldwell; The Salvation Army, Nampa.**
FY2024 Outcomes	St. Luke's invested $15,000.00 in Nampa for the priority of Housing / Homelessness.
FY2025 Outcomes	St. Luke's invested $10,000.00 in Nampa for the priority of Housing / Homelessness.
FY2026 Outcomes	St. Luke's invested $15,000.00 in Nampa for the priority of Housing / Homelessness.

Priority Area Need 2: Behavioral Health, Including Mental Health and Well-Being and Substance Misuse

Strategy 1: Awareness, Education and Skill-building	
Activities	**Continued support of gatekeeper trainings across Region 3**
Key Community Partner	**Caldwell Health Coalition, Healthy Impact Nampa, Southwest District Health, WICHC**
St. Luke's Resource	**$3,000**
FY2024 Outcomes	Grace Center, with Healthy Impact Nampa, will convene Treasure Valley faith leaders for a mental health awareness and suicide prevention training. A Question, Persuade, Refer (QPR) training will be offered. Estimate 75 attendees.
FY2025 Outcomes	About 50 people attended a mental health roundtable focused on how leaders should respond, community challenges, current knowledge base, reducing stigma, and identify resource gaps. Needs from St. Luke's include training and shared language, partnerships, training, collaboration and resources. Ongoing meetings will occur to create activation plan. WICHC Workgroup created an educational toolkit to be distributed in 2026, identified key regional stakeholders offering suicide prevention classes and creating a flyer which is updated quarterly to promote gatekeeper training classes to increase awareness and education, promote resources, and reduce stigma for seeking help around mental health and suicide prevention as a top priority health need. Distributed more than 300 St. Luke's "Help Is Here!" mental health guides to highlight area supports and connections.
FY2026 Outcomes	Anticipate and have budgeted for continued support in 2026, especially as need increases and behavioral health remains a CHNA high-priority health need.
Activities	**Support 2C Drug Free Coalition**
Key Community Partner	**2C Kids Succeed; Advocates Against Family Violence (AAFV); Canyon County Juvenile Probation; Intermountain Hospital; National Guard; Prevention Associates; Southwest District Health (SWDH); Vallivue School District; other local organizations**
St. Luke's Resource	**$1,000, St. Luke's Community Health Coordinator serves as 2C Drug Free Coalition Chair**
FY2024 Outcomes	Distribution of substance use prevention and coping skills educational materials and tools for parents at key community events. Collected survey data to inform efforts.
FY2025 Outcomes	More than 2,300 individuals were impacted through prevention and awareness activities including back-to-school events, lunch and learns, community partnership events, school open houses and more.
FY2026 Outcomes	Anticipate and have budgeted for continued support in 2026.
Activities	**Healthy Impact Nampa**
Key Community Partner	**CATCH; City of Nampa; Faith leaders; Nampa School District; Non-profits; Saint Alphonsus; Southwest District Health; Vallivue School District; service organizations**

St. Luke's Resource	**$24,000**
FY2024 Outcomes	Tyler Norris provided facilitation via support from St. Luke's. Cross-sector community collaborators developed a strategic plan, subcommittees are meeting to advance high priority health needs initiatives, and a presentation was provided to Nampa City Council. Provided collaborative funding to launch a community resource center a the Idaho Hispanic Community Center to provide resource connection and support for those needing immediate assistance.
FY2025 Outcomes	Collaborative partnership helped facilitate Leaders Housing Dinner, Faith Leaders Mental Health Roundtable and will help serve as a convener for Community for Youth data walk and action plan. Resource Center has been operating for two years and continue to serve community members with high priority health needs. In 2025 they have served more than 3,000 individuals. Of those more than 2,500 have needed food support, more than 600 families accessed clothing and hygiene support, 300 families were referred for health and mental health supports. Dozens participated in workshops addressing housing stability, financial literacy and wellness.
FY2026 Outcomes	Gem State Housing Alliance will help activate housing conversations in Nampa, and the faith leaders group will reconvene for next-steps in February of 2026. Anticipate and have budgeted for continued support in 2026.
Activities	**Support 2C Kids Succeed**
Key Community Partner	**Coalition of community partners spanning Region 3 that includes municipalities, school districts, health district, health care providers, non-profit organizations, and businesses**
St. Luke's Resource	**$1,500 annually**
FY2024 Outcomes	• Partners across Region 3 collaborated to promote suicide prevention and 988 Lifeline through the following in April of 2024 • More than 20,000 Suicide Prevention Lifeline stickers handed out • More than 300 decals affixed to first responder vehicles and school buses • Tomorrow Needs You billboard • Participation from every school in Nampa, Caldwell, Middleton, Vallivue, Homedale and Marsing to promote connection to a Trusted Adult • Social media and video promotion by Nampa Police Department, Caldwell Fire Department, Canyon County Paramedics and all school districts.
FY2025 Outcomes	• Partners across Region 3 continued to collaborate to promote suicide prevention and highlight protective and promoting factors • Suicide prevention decals continue to be added to new service first responder vehicles • Participation from every school in Nampa, Caldwell, Middleton, Vallivue, Homedale and Marsing to promote connection to a Trusted Adult • Social media and video promotion by Nampa Police Department to highlight Tomorrow Needs You to our communities and all school districts. Video received more than 5,000 total views and was shared more than 500 times
FY2026 Outcomes	Anticipate and have budgeted funds to continue support in 2026.

Strategy 2: Increase Access to Mental and Behavioral Health Services	
Activities	**Continued support of Children's school-based team embedding two mental health therapists within Nampa School District**
Key Community Partner	**Nampa School District**
St. Luke's Resource	**St. Luke's Behavioral Health Providers**
FY2024 Outcomes	Embedded two youth mental health therapists spring semester of 2024. They provided 190 behavioral health visits.
FY2025 Outcomes	Four behavioral health therapists embedded at four Nampa School district elementaries. The four therapists provided 1,425 therapy sessions for school district students in 2025. Clinical mobile school-based visits were provided in Nampa and Caldwell. Nampa School District • Provider Visits: 93 • Flu Vaccines: 91 • Sports Physicals: 25 Caldwell School District • Provider Visits: 20 • Flu Vaccines: 104
FY2026 Outcomes	Committed ongoing support of school-based mental health services for 2026.
Activities	**Canyon County Prosecuting Attorney Relationship and Southwest District Health (SWDH) Pre-Prosecution Diversion Program**
Key Community Partner	**Canyon County Prosecuting Attorney's Office, SWDH**
FY2024 Outcomes	Key provider partnerships have been established for MAT therapy and detox services. Program is operational through Southwest District Health. St. Luke's Nampa lead Emergency Department mental health nurse is serving on the case review committee.
FY2025 Outcomes	First graduate from the year-long pre-prosecution diversion program was recognized in fall of 2025. She was fleeing domestic violence and had a drug related charge, but successfully completed the program and charges were dismissed.
FY2026 Outcomes	Anticipate ongoing support in 2026.
Activities	**Continued participation and support for Region 3 Youth ROC! and Youth Crisis Center planning via coalition engagement and stakeholder connections.**
Key Community Partner	**CC Boys and Girls Club, Nampa Family Justice Center, SWDH**
St. Luke's Resource	**$2,500**
FY2024 Outcomes	Provided support for incentives for youth successfully completing six months of their individualized care plan. 28 youth have successfully completed their six month program with no additional involvement with the juvenile justice system. There were 66 new program referrals to Youth ROC between 7/1-9/30.
FY2025 Outcomes	We did not fund this year due to some process and staffing changes at SWDH.

	The collaborative has not been meeting but the work continues through SWDH.
FY2026 Outcomes	Anticipate ongoing support in 2026.
Activities	**Narcan Leave-Behind Program**
Key Community Partner	**Nampa Fire District**
St. Luke's Resource	**$5,000 annually**
FY2024 Outcomes	Year-One Outcomes Data: Sessions provide wrap-around support for those with substance misuse disorder that includes help with housing placement and stabilization supports; detox/residential referral coordination; transportation to court, treatment, and appointments; employment/workforce readiness; support group-based recovery accountability sessions. • 45 confirmed overdoses • 95 altered mental status (don't have a clear diagnosis, but have a likely substance overdose component) • 226 admissions into care by peer recovery specialist support (usually placed in a facility within 24 hours) • 245 unique contacts • 171 webform contacts via the QR code • 68 people have completed 90 days clean • 42 people have completed 180 days or more clean
FY2025 Outcomes	Year-Two Outcomes Data: Sessions provide wrap-around support for those with substance misuse disorder that includes help with housing placement and stabilization supports; detox/residential referral coordination; transportation to court, treatment, and appointments; employment/workforce readiness; support group-based recovery accountability sessions. • 540 treatment admissions into care by peer recovery specialist (usually placed in a facility within 24 hours) • 135 completed 90 days clean • 204 completed 180 days or more clean
FY2026 Outcomes	Anticipate and have budgeted for continued support in 2026

Strategy 3: Population-level Identification, Intervention and Measurement

Activities	**Icelandic Prevention Model - Communities for Youth (C4Y)**
Key Community Partner	**Boise State University, Communities for Youth**
St. Luke's Resource	**$2,500**
FY2024 Outcomes	Baseline survey of students using standardized depression screener indicated 65% of 6-12th graders screened positive for depression. Two years post- survey indicated a decrease in positive depression screenings to 30%. Held a Community Mental Health Night on April 25th with over 270 attendees with a focus on increasing connection, physical activity and decreasing substance use.

Key Community Partner	Boise State University, Communities for Youth Teams, SWDH
FY2024 Outcomes	Nampa School District has engaged to begin professional development with C4Y.
FY2025 Outcomes	New Plymouth and Payette School Districts have begun preliminary efforts to engage in Communities for Youth with both SWDH and private funding to support. They will likely advance the work in 2026.
FY2026 Outcomes	Anticipate continued engagement and support in 2026.

Strategy 4: Community Health Improvement Fund Grant Program

Key Community Partner	**Advocates Against Family Violence; Angel Wings Network, Inc; Assistance League of Boise, Canyon County Branch; Boys & Girls Clubs of Canyon County (BGC2C); Boys & Girls Clubs of Western Treasure Valley; Breaking Chains Academy of Development; CASA of Southwest Idaho (Legal name: Third District Guardian ad Litem Program); Family Justice Center Foundation of Idaho; Insight Matters Inc.; Marsing School District; Nampa Schools Foundation; Ride for Joy; The Mentoring Network Inc; The Salvation Army, Caldwell Nampa Schools Foundation; Ride for Joy; The Mentoring Network Inc; The Salvation Army, Caldwell; Angel Wings Network, Inc;**
FY2024 Outcomes	St. Luke's invested $47,180.00 in Nampa for the priority of Behavioral Health/Wellbeing.
FY2025 Outcomes	St. Luke's invested $109,047.57 in Nampa for the priority of Behavioral Health / Mental Wellbeing.
FY2026 Outcomes	St. Luke's invested $46,000.00 in Nampa for the priority of Behavioral Health / Mental Wellbeing.

Priority Area Need 3: Access to Affordable Health Care, Including Oral and Vision Health

Strategy 1: Addressing transportation barriers to care	
Activities	**Rides2Wellness**
Key Community Partner	**Valley Regional Transit**
St. Luke's Resource	**Financial Contribution**
FY2024 Outcomes	Assess for transportation resources available across our footprint, and their ability/capacity to serve the demand of SLHS patients screening as "at risk" for transportation needs on a social drivers of health screening. St. Luke's and Saint Alphonsus both provide financial support to Valley Regional Transit to operate Rides to Wellness to aid patient transportation access in Canyon County. Canyon County riders comprised about 17% of total rides for FY24.
FY2025 Outcomes	St. Luke's and Saint Alphonsus both provide financial support to Valley Regional Transit to operate Rides to Wellness to aid patient transportation access in Canyon County. Patients accessed medical facilities 3,524 times in 2025 and Canyon County trips accounted for about 20% of total rides. St. Luke's provided $104,500 in support funding for FY 25, and the average cost per trip is $38.91.
FY2026 Outcomes	Continue to support efforts in 2026. Provided $130,000 for continued support in 2026, with the anticipation of providing approximately 800 rides in Canyon County.

Strategy 2: Support mobile, telehealth and onsite health services	
Activities	**Children's Mobile Care Services**
Key Community Partner	**Boise School District; Nampa School District**
St. Luke's Resource	**Mobile unit and St. Luke's pediatric care teams providing services that are heavily subsidized**
FY2024 Outcomes	Partnered with Children's mobile team and Nampa School District to determine best service sites with consolidation and closure of schools. Provided 223 clinic visits as of 04/09/2024 for 2023-2024 school year. 331 flu vaccines were also provided.
FY2025 Outcomes	Expansion of weekly mobile primary care services to Mountain Home and Caldwell school districts.
FY2026 Outcomes	Continued support for 2026 has been committed.
Activities	**Continued support and engagement with school-based care collaborative and virtual care.**
Key Community Partner	**School based collaborative, and school districts**

St. Luke's Resource	
FY2024 Outcomes	Collaborative is meeting to improve collaboration among internal stakeholders that reflect improved service provision to school partners. Strategy and alignment efforts are ongoing.
FY2025 Outcomes	Collaborative continues to meet to improve alignment among internal stakeholders that reflect improved service provision to school partners. This year's outcomes resulted in professional education for West Ada school nurses, dedicated webpage on the St. Luke's site and ongoing participation in the School Friendly Health System cohort.
FY2026 Outcomes	Committed continued support in 2026.
Activities	**St. Luke's Mobile Mammography**
Key Community Partner	**Various community partners**
St. Luke's Resource	**Mobile breast care unit and provider team where services are heavily subsidized**
FY2026 Outcomes	St. Luke's will use community and patient data and insights to inform scheduling of the mobile mammography unit to communities of most need, and lowest access to exist breast cancer screening services.

Strategy 3: Support Community Health Worker models, resource navigation services and engagement with vulnerable populations	
Activities	**Idaho Coalition for Community Schools**
Key Community Partner	**Blue Cross of Idaho Foundation for Health; local school districts; State Department of Education; United Way of Treasure Valley; Western Idaho Community Health Collaborative (WICHC)**
St. Luke's Resource	**$20,000 annually to Idaho Coalition for Community Schools and $5,000 annually for local community school activities**
FY2024 Outcomes	Provided funding to Parma Community Schools, Wilder Community Schools and Homedale Community Schools to meet social drivers of health needs: mental health and food security initiatives. Homedale and Parma used the funds for the community schools pantries, and Parma used funds to support physical activity and mental well-being initiatives for elementary students. United Way was awarded a five-year, $46 million-dollar full-service community schools grant from the United States Department of Education focused on expansion of rural designation community schools. Currently 41 community schools in 25 districts. Five new schools in regions 3 and 4 indicated interest in new cohort.
FY2025 Outcomes	Provided funding to Parma, Wilder, Homedale and Notus community schools to meet social drivers of health needs: mental health and food security initiatives. Homedale and Parma used the funds for food insecurity and basic hygiene needs and some mental health supports, and Notus used the funds to purchase two pantry freezers, and Wilder used the funds for mental health and food insecurity supports. SupportedFruitland Grizzly Corridor, which provides food, clothing, school supplies and connects to resources such as mental health, housing, and health services. They served 1,400 families between 7/1/24 - 6/30/25.

	This catalytic funding is applied to grow schools' capacity to engage with local communities and meet the needs of their kids and families. In addition to these federal funds, St. Luke's contributed $5,000 directly to four community school districts to address social drivers of health identified by their community school coordinators. Several new schools in regions across the state indicated interest in new cohort. Additionally, there were: • 93 new opportunities for expanded learning • 70 Mental Health Programs • 179 Family Engagement Events Mobilized an estimated $3,444,484.78 in financial and in-kind donations, partner-led services, and volunteer hours to ensure every child and family can thrive
FY2026 Outcomes	Anticipate and have budgeted for continued support in 2026. United Way received a notice of continuation for the USDE Full-Service Community Schools grant for FY26. St. Luke's CH&E continues to be a partner and funder of the Idaho Coalition for Community Schools.

Strategy 4: Community Health Improvement Fund Grant Program	
Key Community Partner	**Angel Wings Network, Inc; CASA of Southwest Idaho (Third District Guardian ad Litem Program); Community Connection of Northeast Oregon, Inc.; Parma Area Senior Citizens Inc.; Weiser Memorial Hospital Foundation**
FY2024 Outcomes	St. Luke's invested $30,120.00 in Nampa for the priority of Access to Care.
FY2025 Outcomes	St. Luke's invested $13,000.00 in Nampa for the priority of Access to Care.
FY2026 Outcomes	St. Luke's invested $18,820.00 in Nampa for the priority of Access to Care.

COMMENTS

St. Luke’s did not receive any written comments on our most recently conducted 2023 CHNA or adopted implementation strategy.

Together, we can address our communities’ most significant health needs. If you have questions, comments, thoughts, or ideas on our CHNA or action plans, please contact us at slrmcchna@slhs.org.

DATE ADOPTED BY BOARD

St. Luke’s Regional Medical Center: June 24, 2026
St. Luke’s Elmore: June 23, 2026
St. Luke’s McCall: June 25, 2026
St. Luke’s Nampa: June 25, 2026

Appendix 3: Greater Treasure Valley 2025 Survey

WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE

For additional languages, or to request paper copies, contact survey@metop.io

Welcome to the 2025 Greater Treasure Valley community health survey.

This survey will take less than 10 minutes, please aim to complete the survey in one setting, or retake the survey. We will ask you questions about the health needs of your community. The information will help us:

- Understand problems that affect our community
- Better understand the needs of our community
- Work together to find solutions to our needs

Your answers will be private. We will not collect your personal information, and we will not share how you answered the survey with anyone. At the completion of the survey you will be entered in to a lottery for gift cards as a token of appreciation for your time, if you choose to share your email (this is optional).

In order to complete the survey, you must be at least 18 years old, and live in the Greater Treasure Valley region. We thank you for your time and input.

INTRODUCTION

1) What county do you live in?*

- ☐ Ada County
- ☐ Adams County
- ☐ Boise County
- ☐ Canyon County
- ☐ Elmore County
- ☐ Gem County
- ☐ Owyhee County
- ☐ Payette County
- ☐ Washington County
- ☐ Valley County

2) What is your home zip code? _____

3) What is your age? _____

YOUR COMMUNITY

All questions going forward are optional. The following questions will ask you about your health and household. Some of the topics discussed in this survey may be sensitive, you are able to skip any questions you prefer not to answer.

4) Which of the following health services are currently insufficient in your community? Check all that apply.

- ☐ Mental health care services
- ☐ Substance misuse services
- ☐ Family planning services
- ☐ Maternal health care
- ☐ Primary health care services
- ☐ Specialist care services
- ☐ Oral health care services
- ☐ I don't know
- ☐ __Something else (write in): _____

5) What health issues are having the biggest impact in your community? Please select your top three (3).

- ☐ Alzheimer's and dementia
- ☐ Autoimmune disease (multiple sclerosis, celiac disease, lupus, rheumatoid arthritis)
- ☐ Cancers
- ☐ Chronic pain
- ☐ Dental health
- ☐ Diabetes (high blood sugar)
- ☐ Education and resources to prevent disease and illness
- ☐ Family planning (birth control)
- ☐ Heart disease, hypertension (high blood pressure), and stroke
- ☐ Infectious diseases (tuberculosis or TB, flu, COVID-19)
- ☐ Lung disease such as asthma or chronic obstructive pulmonary disease (COPD)
- ☐ Mental health such as elevated stress, depression, anxiety, suicide, post-traumatic stress disorder (PTSD)
- ☐ Mother and infant health
- ☐ Unintentional injuries such as motor vehicle accidents, drowning, firearm-related injuries)
- ☐ Obesity
- ☐ Sexually Transmitted Infections STIs and STDs (chlamydia, gonorrhea, hepatitis, syphilis) including HIV and AIDs
- ☐ Substance misuse
- ☐ Women's health
- ☐ Other (Please list): _____

6) What are the most important community issues? Please select your top three (3).

- ☐ Access to affordable healthy food
- ☐ Affordable and safe housing
- ☐ Child care
- ☐ Education
- ☐ Access to nature
- ☐ Fitness (gym or place to be active)
- ☐ Health Care, such as being able to make an appointment
- ☐ Insurance access and affordability
- ☐ Issues related to youth well-being including abuse, neglect, education, exercise and nutrition
- ☐ Language services
- ☐ Medication affordability
- ☐ Older Adult Issues including housing, access to care, abuse and neglect, isolation and mental health
- ☐ Racism or other discrimination
- ☐ Safety or crime
- ☐ Transportation (the ability to get to medical appointments, work, errands) and traffic
- ☐ Other (Please list): _____

7) Please rate your agreement with the following statements. (Strongly Agree to Strongly Disagree)

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
There are affordable places for everyone to live in my community	__	__	__	__	__
Individuals are satisfied with the healthcare options in this community	__	__	__	__	__
My community has transportation options that fit individuals needs	__	__	__	__	__
Neighborhoods feel safe in my community	__	__	__	__	__
Healthy food options are available nearby	__	__	__	__	__
There are enough well-paying jobs in my community	__	__	__	__	__
Anyone in my community can access affordable, reliable internet	__	__	__	__	__
Individuals in my community know where to go to access resources	__	__	__	__	__

YOUR HEALTH

8) How many servings of fruits and vegetables do you eat daily? (A serving would equal one medium apple or a half cup of cooked broccoli. Please think about all forms of fruits and vegetables including cooked or raw, fresh, frozen, or canned.)

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ More than 5
- ☐ I don't know

9) In the past 30 days, did you use

	Yes	No	Prefer not to answer
Electronic cigarettes or vape	__	__	__
Smokeless tobacco or nicotine, including ZYN	__	__	__
Marijuana or cannabis	__	__	__
Cocaine, opioids such as fentanyl, or other drugs (not including marijuana)	__	__	__

10) Do you know how to use Narcan?

- ☐ Yes
- ☐ No
- ☐ I don't know what Narcan is

11) Over the past two weeks, how often have you been bothered by the following problems

	Not at all	Several days	More than half the days	Nearly every day
Feeling anxious, nervous, or on edge	__	__	__	__
Not being able to stop worrying	__	__	__	__

ACCESS TO CARE

12) In the past 12 months, did you receive the following care?

	Yes	No
Routine medical care (for example physical exam, checkups, visits due to illness)	__	__
Dental services (including routine dental cleaning)	__	__
Mental health services, therapy, or counseling	__	__
Substance use counseling or treatment	__	__
Specialist medical care (for example heart doctor, allergist)	__	__
Testing for any Sexually Transmitted Infections (STIs) including chlamydia, gonorrhea, HIV, or syphilis	__	__

13) If you did not receive any of the services listed above, why not? Check all that apply.

- ☐ I did not need it
- ☐ Cost of care
- ☐ Lack of insurance
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Lack of time
- ☐ Fear of bad results
- ☐ Wait is too long
- ☐ It isn't offered where I live
- ☐ Previous negative experience
- ☐ Health system is too complicated
- ☐ I don't feel safe, or don't trust providers in my community
- ☐ Providers don't speak my language
- ☐ Something else (write in): _____

YOUR HOUSEHOLD

14) What kind of place do you live in?

- ☐ Own my home
- ☐ Rent my home
- ☐ Emergency shelter
- ☐ Living outside
- ☐ Living with a friend or family member
- ☐ Prefer not to answer
- ☐ Something else: _____

15) In the past 12 months, have you ever

	Yes	No	Prefer not to answer
Eaten less than you felt you should because there wasn't enough money for food	__	__	__
Struggled to pay for necessities such as housing, food, or bills	__	__	__
Used SNAP (Supplemental Nutrition Assistance Program), WIC (Women, Infant, and Children), or EBT (Electronic Benefit Transfer) benefits	__	__	__
Accessed free or emergency food at a local food pantry or meal site	__	__	__
Participated in a Veggie Rx program, also known as Food as Medicine (produce "prescription" or voucher)	__	__	__

16) Do you feel physically and emotionally safe where you live?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

17) Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

ABOUT YOU

18) What sex were you assigned at birth?

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Prefer not to answer
- ☐ Another term: _____

19) How do you currently identify yourself?

- ☐ Woman
- ☐ Man
- ☐ Transgender Woman
- ☐ Transgender Man
- ☐ Non-binary
- ☐ Gender-nonconforming
- ☐ Prefer not to answer
- ☐ Another term: _____

20) Which of the following do you consider yourself? Select all that apply.

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ Latino or Hispanic
- ☐ White
- ☐ Prefer not to answer
- ☐ Prefer to self-describe: _____

21) What is the highest level of education you have completed?

- ☐ Less than high school graduation
- ☐ High school graduate or GED
- ☐ Some college or technical school
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Advanced degree (such as MS, MEd, MSW, MD, PhD, JD)
- ☐ Prefer not to answer

22) What is your yearly household income?

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 to $199,999
- ☐ $200,000 or more
- ☐ I don't know
- ☐ Prefer not to answer

23) Do you have a physical, mental or intellectual disability?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

24) How many children under the age of 18 live in your household? If none, please enter 0.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

CHILD HEALTH (SKIP THIS SECTION IF NO CHILDREN IN HOUSEHOLD)

25) Do you agree with the following statements

	Agree	Some-what agree	Neutral/ Not applicable	Some-what disagree	Disagree
My child(ren) is(are) physically active most days of the week	__	__	__	__	__
My community has enough after school/non-school day activities for children	__	__	__	__	__
My child(ren) have safe transportation to school	__	__	__	__	__

26) Please list any additional comments: _____

Thank you for taking our survey!

If you would like to be entered into a drawing for a gift card, please send us an email with your name, and Subject Line "Treasure Valley Survey Drawing" to survey@metop.io

To access community resources, go to findhelpidaho.org

Your response is very important to us and will help us plan ways to improve health in your community.

If you have any questions about the survey, please email survey@metop.io.

Appendix 4: Sources

The following is a list of datasets used during the analysis of secondary data. All datasets were accessed via the Metopio platform. A URL for each dataset is available upon request.

Environmental Protection Agency (EPA): Air Quality Index Report
The AirData Air Quality Index Summary Report displays an annual summary of Air Quality Index (AQI) values for counties. Air Quality Index is an indicator of overall air quality, because it takes into account all of the criteria air pollutants measured within a geographic area.

U.S. Census Bureau: American Community Survey (ACS)
The American Community Survey (ACS) is an ongoing survey of U.S. households and residents that provides a wide variety of information. It replaces the long-form Census questionnaire and is administered to 1 in 38 U.S. households each year. Responses from multiple years can be aggregated to provide information about very small geographies.

Health Resources & Services Administration: Area Health Resources Files (AHRF)
This dataset provides current as well as historic data for more than 6,000 variables for each of the nation's counties, as well as state and national data. It contains information on health facilities, health professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics.

Behavioral Risk Factor Surveillance System (BRFSS)
The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Centers for Disease Control and Prevention (CDC)

U.S. Census Bureau: County Business Patterns
An annual series that provides subnational economic data by industry. This series includes the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll.

University of Wisconsin Population Health Institute: County Health Rankings
County Health Rankings help us understand what influences how long and how well we live. They provide measures of the current overall health (health outcomes) of each county in all 50 states and the District of Columbia.

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP): Division of Nutrition, Physical Activity, and Obesity (DNPAO)
CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) invests in efforts to support healthy eating, active living, and healthy weight for all people. These investments advance public health strategies that prevent chronic diseases related to diet and inactivity to protect the health of people across the nation.

Idaho Oregon Community Health Survey
Surveys include: Treasure Valley Community Health Survey, Saint Alphonsus Community Health Survey, and South Central Idaho Community Health Survey

Feeding America: Map the Meal Gap
Map the Meal Gap generates two types of community-level data: Local food insecurity estimates among all individuals and children by income category and local food expenditure estimates among people who are food insecure and food secure Gundersen, C., A. Dewey, E. Engelhard, M. Strayer & L. Lapinski. Map the Meal Gap 2020: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2018. Feeding America, 2020.

Centers for Disease Control and Prevention (CDC): National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus
The National Center's vision is a future free of HIV, viral hepatitis, STDs, and TB.

Centers for Disease Control and Prevention (CDC): National Environmental Public Health Tracking Network
The National Environmental Public Health Tracking Network (Tracking Network) brings together health data and environmental data from national, state, and city sources and provides supporting information to make the data easier to understand.

Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)
A National Provider Identifier is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is the required identifier for Medicare services, and is also used by other payers, including commercial healthcare insurers. The NPI Registry provides information about all physicians in the country and their specialties.

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M)
Beginning in 2021, age-adjusted rates are no longer available from the CDC at a county level. All data from 2021 onward is presented as crude rates. Please use caution when directly comparing data from before 2021 to data from 2021 onward. The National Vital Statistics System Mortality component (NVSS-M) obtains information on deaths from the registration offices of each of the 50 states, New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and Northern Mariana Islands. The system is operated by the Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS). This data is available from the CDC Wonder data portal.

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Natality (NVSS-N)

In the United States, State laws require birth certificates to be completed for all births, and Federal law mandates national collection and publication of births and other vital statistics data. The National Vital Statistics System, the Federal compilation of this data, is the result of the cooperation between the National Center for Health Statistics (NCHS) and the States to provide access to statistical information from birth certificates.

Centers for Disease Control and Prevention (CDC): PLACES

The PLACES Project is a collaboration between CDC, the Robert Wood Johnson Foundation (RWJF), and the CDC Foundation (CDCF). PLACES will allow counties, places, and local health departments regardless of population size and urban-rural status to better understand the burden and geographic distribution of health-related outcomes in their jurisdictions and assist them in planning public health interventions. PLACES is an extension of the original 500 Cities Project that provided city and census tract estimates for chronic disease risk factors, health outcomes, and clinical preventive services use for the 500 largest US cities. The PLACES Project provides model-based population-level analysis and community estimates to all counties, cities, census tracts, and ZIP codes across the United States.

National Cancer Institute (NCI): State Cancer Profiles

State Cancer Profiles characterizes the cancer burden in a standardized manner to motivate action, integrate surveillance into cancer control planning, characterize areas and demographic groups, and expose health disparities. The focus is on cancer sites with evidence-based control interventions. Interactive graphics and maps provide support for deciding where to focus cancer control efforts.

Centers for Disease Control and Prevention (CDC): U.S. Opioid Dispensing Rate Maps

The data in the maps show the geographic distribution in the United States, at both state and county levels, of retail opioid prescriptions dispensed per 100 persons per year.

Centers for Disease Control and Prevention (CDC): United States Diabetes Surveillance System

The CDC's United States Diabetes Surveillance System contains data about diabetes, obesity, and physical activity. This data is modeled using data from the Behavioral Risk Factor Surveillance System (BRFSS).

US Department of Agriculture (USDA) - Food and Nutrition Service: WIC Data Tables