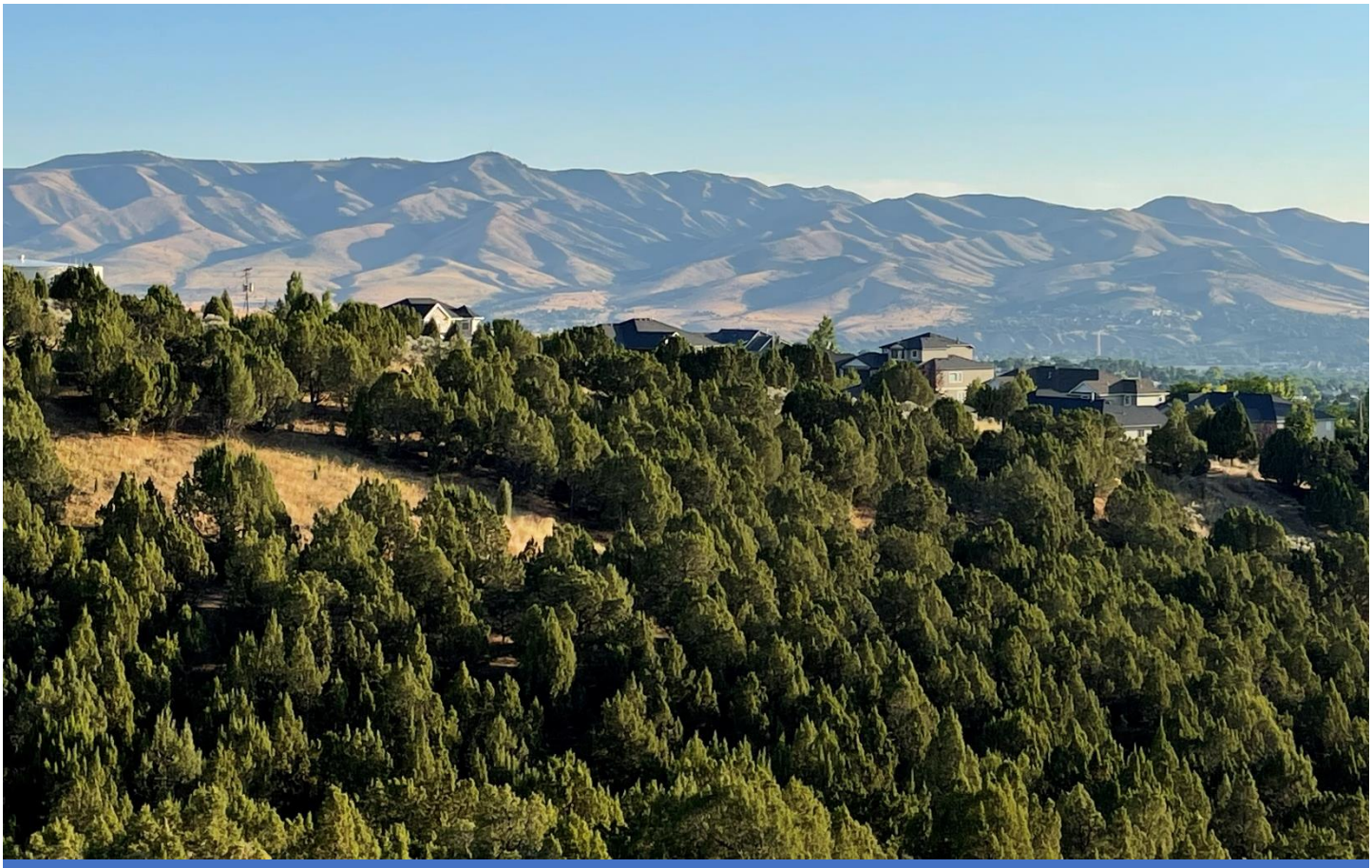
BANNOCK COUNTY COMMUNITY ACTION PLAN



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I. EXECUTIVE SUMMARY

Bannock County Health Assessment: The primary activities of the first year of the Bannock County Health Collaborative project consisted in completing a community assessment of the health needs and social determinants of health driving those needs. This assessment consisted of a review of the existing health service landscape and a new assessment of information gathered in the spring of 2022. The new information includes data collected from a survey (a modified version of the PRAPARE tool) and from four focus groups. Primary data were collected using a convenience sampling approach where community members known to experience barriers to good health were selected. Data collection sites were selected after a review of existing data. Each site was identified because it was likely to serve community members experiencing social determinants of health identified in secondary data. These social determinants included housing insecurity, food insecurity, local access to health and social services, living in rural environments, and advanced age.

Existing information indicates that many of the health challenges faced by the Bannock County Community result from complex issues related to the fragmented structure of health care services and to the limited number of providers available. This information, presented in Section II.A, helped the Community Action Team to understand the current policy landscape shaping the lived experiences of participants in the assessment. The Community Action Team focused its assessment on local health needs and on the social determinates of health. Those findings are presented in full in section II.C. Key insights included finding that the younger population, namely those under 50, were more likely to experience barriers to good health driven by social determinants. For example, about one third of the surveyed population under 50 experiences housing insecurity (36.6%) and food insecurity (35%). About a quarter of this population experiences needs associated with utilities (25.2%), transportation (23.6%), and clothing (27.6%). They are also more likely than older respondents to have limited social interactions, higher levels of stress, lower overall perceptions of their health, more likely to be uninsured, less likely to have a primary care provider, less likely to receive routine medical care, and more likely to have unmet healthcare needs.

Four focus groups were held throughout the community. These focus groups were designed to help the Community Action Team better understand the unmet needs identified above. Focus group participants were drawn primarily from the Pocatello Free Clinic, Aid for Friends, Valley Mission and online. Key findings in this area indicated that for the more vulnerable community members, overcoming barriers to good health often feels like navigating a “maze” and requires significate time, energy, and resources. Participants defined “help,” as a resource, service, or person who can end the experience of continually seeking care. This showed the Community Action Team that they could support downstream health improvements for Bannock County’s most vulnerable communities by supporting care seeking behavior. Given that transportation services can help community members to more quickly close these gaps the Community Action Team decided to pursue this solution. In Bannock County transportation services are limited in general and are especially limited for community members under 65 (as summarized in III.C). Thus, our intervention will be designed to close this gap by leveraging existing resources and providing additional services to community members who currently fall into the transportation service gap.

Project Description: The first year of the project involved collecting relevant county-level data to develop an updated assessment on the status of health equity in Bannock County. The assessment has been anchored in community dialogue to formulate collaborative solutions among stakeholders and partners. The year one assessment led to the development of the proposed pilot outlined below. This pilot includes components to the project that are aimed to proposed new interventions in gap areas where no current sustainable solutions are available and/or operational.

Our community's year-two plan will consist in three interrelated components: continued community engagement via a multi-faceted outreach strategy, a public information campaign to promote wider understanding of health equity, and standing up a new service to close transportation gaps that are limiting access to healthcare services and lifestyle activities known to be associated with good health. Key project deliverables will include:

- Increase community engagement by establishing new partnerships to increase access to healthcare services and to other activities that support health and wellbeing.
- Leverage existing resources, such as findhelpidaho.org, to meet local transportation needs.
- Mobilize community resources to address emerging and outstanding healthcare needs
- Promote on-going community conversations about health promotion and health equity using advertising and social media.
- Host community events to promote knowledge of existing transportation services that can promote health.
- Launch Ride United to help the nonprofit community support clients who are not currently served by existing transportation resources.
- Create a new infrastructure to deliver in-kind support to nonprofits in the form of rides, vouchers, and honoraria.

The year two plan also includes accounting for how the project will impact various segments of our community (see section V), determining how emerging issues will be addressed (section VI), and anticipating risks and outlining solutions (section VII). All of this information is then leveraged to develop the year two evaluation plan (section VIII).

II. STRATEGIC CONTEXT

A. County Context

1. Bannock County is the 6th largest County by population in the State of Idaho. In 2020, Bannock County's population was 87,018, which is mainly distributed between Pocatello and Chubbuck. Pocatello has a population of 56,320 and Chubbuck has a population of 15,570. The County and its two largest cities have witnessed continuous growth, which is a pattern common to the entire state of Idaho. Idaho leads the U.S. in population growth at 2.9% from 2020 to 2021 (Associated Press, 2021). At this rate, the County's population is expected to exceed 100,000 in 2025.

2. Bannock County is the 6th largest contributor to State of Idaho's GDP. With a 2020 GDP $2.57 billion, the county is only behind Ada, Canyon, Kootenai, Bonneville, and Twin Falls counties in terms of GDP contribution to the State. Its economic base is comprised of 6,403 nonfarm business firms according to the most recent data (United States Census Bureau, 2022). Economic activity occurs in 2,154 employer establishments, which excludes government, and where 25,109 people are employed as of 2019 (*ibid).*

3. The median household income of Bannock County is less than the U.S. median income. At $51,734, Bannock County's 2019 median household income is only at 75.7% of the U.S. 2019 median income of $68,324. In 2020, the U.S. median household income decreased to $67,521. Whether there has been a corresponding dip in Bannock County median household income is unclear due to lack of data. The direct impact of the lower median household income to disposable income is also unclear since this is a function of subtracting regular household expenses. Anecdotal information suggests that the affordability of regular household expenses (i.e., the "cost of living,") may be lower in Bannock County, thus allowing local residents to preserve disposable income on par to higher median income areas. However, whether this is still the case requires further data collection.

4. Housing unit ownership versus rent vary significantly across income distribution. More than two-thirds of Bannock County households own their homes, with 67.9% owning their housing unit versus 32.1% renting. However, the distribution of ownership versus rent is associated with income levels. Of those making less than $20,000, 65.1% rent their unit with 93.6% of them paying more than 30% of their household income to rent (which is a common indicator of an unstable long-term financial situation for families). A similar ratio occurs for those who own their homes; 80.2% report paying more than 30% of their household income on mortgage payments. For households with incomes between $20,000 and $34,999, 51.6% rent their homes. In this income bracket, 45.9% of those renting report to paying more than 30% of their household income to rent. Similarly, 48.5% of those who own their homes in this income bracket report paying more than 30% of their income to mortgage payments. When incomes rise above $35,000, more households own their housing. More than half of households that fall within the income brackets of $35,000 to $49,999, $50,000 to $74,000, and $75,000 or more own their homes (67.0%, 74.0%, and 90.9% respectively). Also, the proportion of those paying more than 30% of their income to housing costs falls to below 20%. This pattern holds for both those owning their housing units and those that are renting.

5. Highest education level attainment in Bannock County rests disproportionally to mandatory education relative to the rest of the country. Bannock county's population over 25 years fares better

than the national average when it comes to education; it is estimated that 94.0% graduated from high school. This is higher than the national average of 88.6%. However, this high school graduation advantage does not translate to more college degrees as only 29.5% of the Bannock County population over 25 years old possesses a Bachelor's degree. This is lower than the national average of 33.1%. Of concern is the fact that this figure does not significantly improve when limiting the Bannock County population to a more recent high school graduates 25 to 34 years of age, as the college degree figure only increases to 30.6%. At the national level, the corresponding figure jumps to 36.9% from 33.1%. This indicates less up-take of college education by Bannock County's 25-to-34 year old population relative to the rest of the U.S.

6. 13.2% of Bannock County Population fall under the poverty line. The overall poverty figure for Bannock County is higher than the comparable 2019 national rate of 10.5% and higher than the State average estimate of 11.2%. It is estimated that 8,307 to 14,135 people living in Bannock County are currently experiencing poverty according the latest 2019 figure (United States Census Bureau, 2022). The poverty distribution is unequal between sex and age. Fewer males experience poverty (10.5%) relative to women (16.0%). When broken down in age categories, 15.6% of children under 18 years are experiencing poverty. The poverty rates start to decrease with age; 13.3% of those between 18-to-64 years of age experience poverty. This figure decreases to 8.1% for those over 65 years. However, within a narrower age group, 18-to-34-year-olds experience the greatest level of poverty with 20.7% likely experiencing poverty.

7. 16.2% of Bannock County children under 18 years old are in poverty. This is higher than the Idaho average of 14.4% for the same age category. Bannock County's child poverty rate is higher than the state's average poverty rate of 14.4% for the adult population between 18 to 64 years old. When the adult population is segmented to 18-to-34 year old and 35-to-64 year old, the poverty rate is again higher at 19.5% for the former segmented population relative to the 10.8% of the latter. The disparity suggests child poverty is a conjoined consequence of adult poverty in the 18-to-34-year-old population. Given that this population is typically just starting their careers or in the process of advancing their education, their experience of poverty is likely to decline with age. However, careful attention should be paid to the unique challenges of this population.

8. 43% of Bannock County households fall into the ALICE index. U.S. Census poverty methodology does not capture all needs arising from households experiencing poverty. In response, the national branch of the United Way, known as the United Way Worldwide (UWW), developed a more comprehensive measure called the ALICE index. ALICE stands for Asset-Limited, Income-Constrained, Employed. In other words, this figure is used to describe the working poor, who often do not qualify for benefits but nevertheless struggle to make ends meet. It is also inclusive of the poverty rate. In 2019, Bannock County has an ALICE rate of 43%, indicating that roughly 30,635 households no not have enough resources to meet their needs. This ALICE figure is higher than the state level of 40%.

9. 9.7% of Bannock County population are not covered by health insurance. This is higher than the national average of 9.2%. Notable is that sex composition variation in coverage. At the national level, the percentage of uninsured individuals is higher for males (10.2%) than females (8.2%). This is flipped for Bannock County where fewer males (8.9%) are uninsured relative to the female (10.5%) population.

10. Key health indicators specific to Bannock County are incomplete and direct use of proxy indicators raise concerns. Dedicated health indicators collected at the State level are not always available at the County level. In some cases, the closest proxy indicators are Public Health District (PHD) level information. However, because PHDs are comprised of multiple counties with different population compositions the collected indicators are loose proxies. That is, the validity in generalizations draws from overall average PHD figure requires further investigation due to unique distribution of collected statistics. This is evident for PHD6, which Bannock County is a member of as indicated in Table 1.

Table 1: County Populations and Urbanization

County	Population	Largest city	Second largest city	% Urban	% Rural
Bannock	87,018	Pocatello (56,320)	Chubbuck (15,570)	82.6%	17.4%
Bear Lake	6,372	Monteplier (2,643)	Paris (541)	50.0%	50.0%
Bingham	47,992	Blackfoot (12,346)	Shelley (4,785)	35.7%	64.3%
Butte	2,574	Arco (879)	Moore (162)	40.4%	59.6%
Caribou	7,027	Soda Springs (3,133)	Grace (920)	57.7%	42.3%
Franklin	14,197	Preston (5,591)	Franklin (1,025)	46.6%	53.4%
Oneida	4,564	Malad (4,244)	N/A	93.0%	7.0%
Power	7,878	American Falls (4,568)	Rockland (242)	61.1%	38.9%
Total	177,622			63.6%	36.4%

Source: United State Census Bureau. (2022). *2020 Decennial Census.* Washington, DC: United States Census Bureau. Retrieved from https://data.census.gov/cedsci/all.

11. In absence of direct indicators, proxy health indicators are used but cautious interpretation is warranted. In some cases, health indicators dedicated to Bannock County are unavailable, and that information should be interpreted with caution. The only health related census data are the prevalence of disability in the population and health insurance possession. These are overly broad indicators to assess the health status of Bannock County population. Thus, proxy indicators are used as needed. Available proxy health indicator data are presented in Table 2.

Table 2: Idaho's Leading Health Indicators[1]

	Bannock County	PHD6	Idaho	National
Percentage (%) of adults without health care coverage	12%	N/A	15.4%	10.9%
Premature Death (per 100,000)	7,900	N/A	5,600	N/A
Death Rate – Coronary heart disease (per 100,000) (2017)	N/A	78.6	78.7	90.9
Death Rate – Stroke (per 100,000) (2018)	N/A	43.5	36.4	37.1
Death Rate – Suicide (per 100,000) (2018)	39	33.2	23.8	14.5
Death Rate – Unintentional injury (per 100,000) (2018)	26.9	63.0	53.9	54.2
% – Adult colorectal cancer screening (2018)	N/A	N/A	67.1%	69.6%
% – Adult dental visits (past year) (2018)	N/A	N/A	34.4%	32.4%
% – Adult female breast cancer screening (2018)	35%	N/A	68.2%	77.6%

[1] Source: County Health Rankings: https://www.countyhealthrankings.org/app/idaho/2022/rankings/bannock/county/outcomes/overall/snapshot; Get Healthy Idaho. (2022). *Idaho's Leading Health Indicators.* Boise, Idaho: Department of Health and Welfare. Retrieved from https://www.gethealthy.dhw.idaho.gov/ghi-leadinghealthindicators

% – Adults diagnosed with coronary heart disease (2018)	N/A	N/A	3.7%	4.3%
% – Adults ever been diagnosed with diabetes (2018)	8.9%	N/A	10.2%	11.0%
% – Adults who are obese (2018)	32%	N/A	28.4%	30.9%
% – Adults who are overweight (but not obese) (2018)	N/A	N/A	35.7%	34.9%
% – Adults who consume 5 or more servings fruit & vegetables (daily) (2017)	N/A	19.0%	18.5%	16.8%
% – Adults who currently smoke (2018)	18%	N/A	14.7%	16.1%
% – Adults who have a usual health care provider (2018)	N/A	N/A	28.9%	22.3%
% – Adults who have ever had a stroke (2018)	N/A	N/A	3.1%	3.4%
% – Adults who use smokeless tobacco (2018)	N/A	N/A	4.4%	4.1%
% – Adults with no leisure time activity (2017)	N/A	27.7%	24.2%	25.6%
% – Idaho resident live births with a low birthweight (2018)	N/A	9.3%	7.3%	8.2%
% – Idaho resident live births with a pre-term delivery (<37 weeks) (2018)	N/A	11.0%	9.1%	10.0%
% – Mothers who receive adequate (or more) prenatal care (2018)	N/A	82.9%	83.3%	N/A
Rate – Incidence of pertussis (whooping cough) reported to public health (per 100,000) (2017)	N/A	4.1	5.2	N/A
Rate – Incidence of enteric diseases reported to public health (per 100,000) (2017)	N/A	43.5	37.6	N/A
Rate – Incidence of sexually transmitted diseases (STDs) reported to public health (per 100,000) (2017)	N/A	357.8	424.8	N/A
% – Adolescents that had sexual intercourse for the first time at 15 years or younger (2019)	N/A	N/A	20.3%	N/A
Rate – Adolescent pregnancy (ages 15-17) (per 1,000) (2018)	N/A	5.5	7.4	N/A
% – Adolescents who attempted suicide (past year) (2019)	N/A	N/A	9.6%	7.4%
% – Adolescents who currently smoked cigarettes	N/A	N/A	5.3%	8.8%
% – Adolescents who were obese (2019)	N/A	N/A	12.1%	14.8%
% – Adolescents who were overweight (but not obese) (2019)	N/A	N/A	12.4%	15.6%

12. It is unclear to what extent Bannock County population's health needs has expanded in scope and is harnessing innovations and alternative emerging service delivery mechanisms. It is unclear to what extent health care facilities in Bannock County are fully serving the health needs of its population. Board certified healthcare specialties has grown over time and reflect the larger set of threats to health and well-being that require specialized training to properly diagnose and to treat. Health aid technologies has evolved to complement existing services as more people overcome and live with their illness. To what extent these developments are accounted for and strategized is unclear. This includes also to what extent the population is aware and access these developments.

B. Sectoral and Institutional Context

13. Healthcare is decentralized and pluralistic in the United States and Bannock County healthcare parallels the arrangement. Myriad of actors operate within the health sector in the United States. These include the doctors and clinicians that work at the front lines of healthcare service delivery. They are both the locus and implementation pipeline to respond and treat acute illnesses. However, due to the highly technically nature service delivery and advancement in the field of medical science, these actors require

laboratory support, advanced diagnostic machinery, and pharmaceutical partners. These complementary services are industries onto themselves and their arrangements with providers are complex, highly variable, and typically not disclosed to the public. The acute illness response system operates separate yet complementary to chronic illness responses and mitigation. In the latter, a wider set of the societal resources and actors are mobilized where the emphasis is less on diagnosis and immediate response but rather on continuous monitoring, pain mitigation support, and timely detection and transfer to appropriate health service facilities as complications arise associated with their chronic illnesses. See appendix A for additional information.

14. Effective health service delivery depends on availability and access to establishment service providers. Due to the highly technical nature of health diagnosis and treatment, availability and access to service providers for individuals for health-related inquiries and responses are critical. Health service establishments such as hospitals and specialty clinics are vital and more so due to the highly regulated nature of interventions. Healthcare service providers has expanded in scope with nursing homes, long-term hospitals, and home care. See Appendix B for a broad list of specialties. More recently telehealth is also gaining traction and increasing in scale considering the COVID-19 pandemic from 2020 onwards. See appendix B for additional information.

15. Pluralistic healthcare actors and the public sector interact via arms-length entitlement reimbursement schemes rather than direct government provision. Due the pluralistic nature and expanded scope of the healthcare service delivery in Bannock County which parallels that of the U.S. in general, claim to services operate using a cost- reimbursement format. Health insurance is the primary mechanism through which individuals seek healthcare services. The reimbursement mechanism will vary depending on funding behind the health insurance schemes. For private healthcare insurance, the funding rests on spreading costs among subscribers. The public sector complements and in certain cases replaces such schemes with entitlement programs. Medicaid and Medicare are two primary healthcare reimbursement programs where eligibility is strictly defined by legislation as it relies on publicly pooled funds. The Affordable Care Act, passed in 2010, has expanded public sector interventions for health insurance and is expected to further expand coverage to the uninsured via Idaho's recent Medicaid expansion.

a) The totality of healthcare expenses in Bannock County is unknown. Due to the various channels involved in healthcare reimbursement, the exact amount expended by the Bannock County population on healthcare needs is unclear. There is no aggregate healthcare expense figure, as the costs vary by subscribed insurance packets with different service coverages, deductible ceilings, and out-of-pocket expenses. These are proprietary information where reporting is limited to voluntary disclosure for tax calculation purposes to the IRS.

b) Medicaid, a co-funded program in partnership with the State and federal government, provides coverage for eligible household below a designated monthly income level. There are no specifically reported figures for Bannock County. However, in the year 2021-2022, Idaho spent $769,728,500 on Medicaid and the Federal Government spent $3,795,364,400 on Medicaid. Idaho Department of Health and Welfare appropriates 82.26% of its budget to Medicaid. Most Medicaid participants are enrolled in the "Basic Plan". This plan is for people who do not have

major health issues, and it provides coverage for wellness and prevention as well as emergency and sick cases. The provided coverage has limitations and tends to offer more services to those under 21 particularly to children. There are services, prescriptions, equipment, etc. that require prior authorization from Medicaid before it can be covered. Parents of children who participate in the basic plan may be responsible for a premium of up to $15/month that is refundable if the child stays up to date on their wellness exams and immunizations. In some cases, Medicaid is able to provide reimbursement for travel to and from appointments or arrange and pay for transportation. Vision coverage for those over 21 is limited to acute needs or specific disease related needs such as diabetes. For young adults and children, Medicaid will cover exams and typically only glasses from the Medicaid supplier. Some Medicaid participants are in the "Enhanced Plan". This plan includes the services from the basic plan, but it also provides additional services for particularly vulnerable populations. Additional information on these programs is available in Appendix A.

c) **Medicare is a federal program primarily for those over age 65 or older.** Medicare is a federally funded program to take care of people 65 or older. It is comprised of "Parts," which refers to different insurance components within the program. These "Parts" are bundled to two major options. The Original Medicare option include Part A and Part B with a choice to include Part D. Part A is a hospital insurance. Part B is a medical insurance. Part D is drug coverage. They are all intended to help cover costs when seeking medical attention and treatment. The second option is Medicare Advantage where people 65 or older can sign up for a private alternative. This is a market option that is intended to transfer cost savings from using in-network service providers. Medicare Advantage typically include Parts A, B, and C. Exceptions to the age requirement for Medicare exists. People with disabilities covered under the Social Security Disability Insurance are covered. This is due to the federally funded nature of the Social Security program. This age exception is relevant since it broadens eligibility of those who could sign up for the Medicare Medicaid Coordinate Plan and Idaho Medicaid Plus (IMPlus). IMPlus is a mandatory program for Bannock County.

16. Pluralistic healthcare provision means translates to corresponding variation in out-of-pocket healthcare costs to the individual. The variation in out-of-pocket fees to the individual depends on the insurance structure and/or government health program. Many private insurance uses deductibles to curb moral hazard behaviors. The deductible thresholds vary by companies as it is tied to determining insurance premiums. The variation in insurance schemes combined by the personalized cost formulation of health services by providers further structures in variation in out-of-pocket costs to individuals. Consequentially, standard costs for medical procedure and intervention are often unknown to the individual prior to service delivery. "Good faith estimate" policies have been put in place as of January 1, 2022.[2] To what extent it has been utilized to generate knowledge on standard costs are yet unknown.

17. The effectiveness of the reimbursement scheme relies on availability of service providers. Reimbursement scheme is a form of contracted out services to service delivery organizations. This requires an equity investment by an entrepreneurship, whether it be nonprofit or private. Viability and

[2] Centers for Medicare & Medicaid Services. (2022). *Understanding costs in advance.* http:// https://www.cms.gov/nosurprises/consumers/understanding-costs-in-advance

consequentially availability of specialized services in the local area depends on the size of the market due to its financial sustainability requirement. Thus, providing very specialized services for a smaller market, for which case in the health sector are people with those needs, is structurally going to be a challenge due to the mismatch between smaller demand and higher staff costs trained to deliver those specialized services.

18. Primary care and dental care are available in Bannock County. As shown in Appendix A, primary care and dental care service providers exist in Bannock County. This is a good sign when recognizing the positive impact of primary care to adult health.[3] However, there are no additional data on whether this is sufficient to meet the need of the community as the latter would require accessing demand, which is discussed in the subsequent sections of this report, and comparing it to service delivery and availability. Availability assessment would require collecting additional data on waitlists and coverage.

19. Comprehensive health services delivery includes specialized health services. Due to advances in medical science, medical services have specialized. As shown in Appendix B, there are 23 board governed specialties in the medical services sector. When broken down into subspecialities, the list expands to 131 board governed specialties. Specialization is reflective of the advances in medical science. It is important to note that these specializations are occupational specializations and does not fully capture advances in complementary industries of medical equipment, pharmaceuticals, or prosthetics as their advancement does not strictly fall under the broader American Medical Association governance structure.

20. A limited number of organizations accepts Medicaid patients in Bannock County. Appendix C lists the organizations servicing Medicaid patients in Bannock County. Whether this group satisfies the health needs of the community is unknown due to lack of data. Additional data on coverage and community demand is warranted to have evidence-based discussions on optimization of service delivery organizations and local need. Given the population growth experienced by the local area, these discussions also need to factor in future needs of the community within its optimization discussions.

21. Long-term care facilities exist but are limited. Appendix D lists the nursing homes, home health services, and hospices in the area. There are no long-term care hospitals operating in Bannock County. To what extent these facilities are sufficient to serve the resident population is unknown. Recognizing the challenges Idaho is facing with nursing home facilities and assisted living facilities, there are reasons to assume a study to assess their optimization in meeting County resident needs.[4]

22. Not all specialties are represented and available to Medicaid patients in Bannock County. Figure 1 captures listed specialties accepting Medicaid in Bannock County. Despite not featuring all 23 medical specialties, the list includes non-AMA listed specialties of chiropractic, clinical social worker, nurse practitioner, and optometry. Thus, when subtracting these specialties, the available medical specialties in the local area to service Medicaid are further reduced. It is unknown to what extent this reflects shortages to 131 medical subspecialties.

[3] Levine, D.M., Landon, B.E., and Linder J.A. (2019). *"Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care." JAMA Internal Medicine.* 179(3): 363-372.
[4] Office of Performance Evaluations. (2018). *Residential Care.* Idaho Legislature.

Figure 1: Distribution of Medicaid Servicing Healthcare Specialists

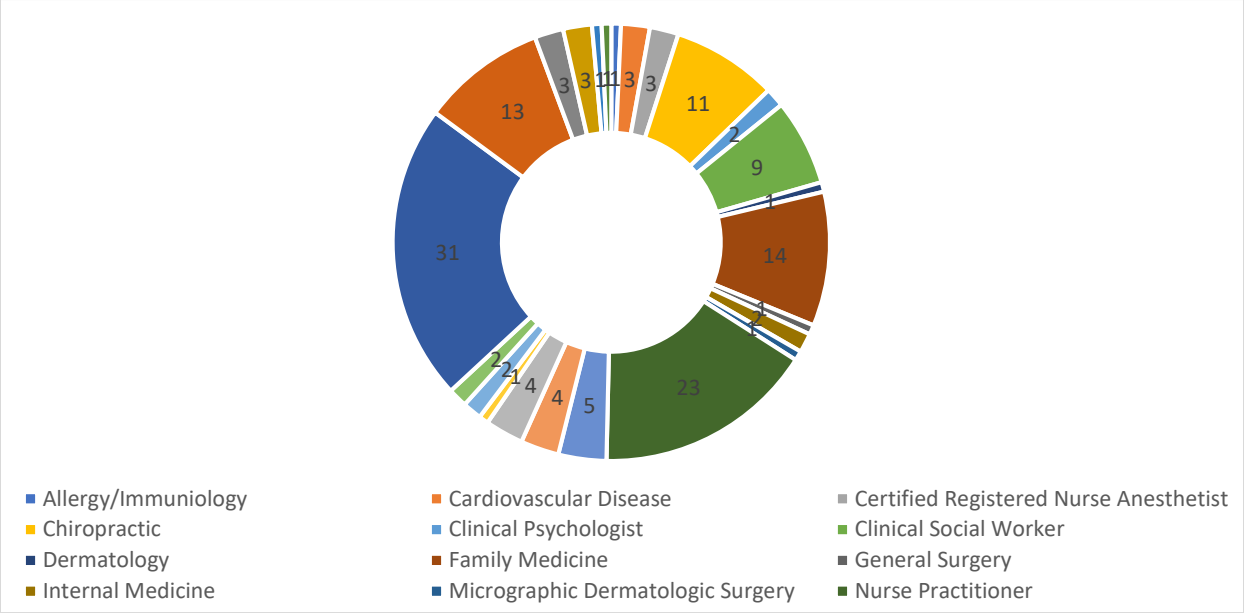


Table 6: Medicaid Coverage Specialists in Pocatello and Chubbuck

Specialty	Number	Per 10,000 people	Shortage Problematic for
Allergy/Immunology	1	0.114919	
Cardiovascular Disease	3	0.344756	High Stroke Rate
Certified Registered Nurse Anesthetist	3	0.344756	
Chiropractic	11	1.264106	
Clinical Psychologist	2	0.229838	High Suicide Rate
Clinical Social Worker	9	1.034269	
Dermatology	1	0.114919	
Family Medicine	14	1.608863	
General Surgery	1	0.114919	
Internal Medicine	2	0.229838	
Micrographic Dermatologic Surgery	1	0.114919	
Nurse Practitioner	23	2.643131	
Occupational Therapy	5	0.574594	High Unintentional Injury
Ophthalmology	4	0.459675	
Optometry	4	0.459675	
Oral Surgery/Pain Management	1	0.114919	
Otolaryngology	2	0.229838	
Pediatric Medicine	2	0.229838	
Physical Therapy	31	3.562481	
Physician Assistant	13	1.493944	
Podiatry	3	0.344756	
Radiation Oncology	3	0.344756	Low Cancer Screening
Registered Dietitian/Nutritionist	1	0.114919	Overweight/Obesity
Rheumatology	1	0.114919	
Total Specialty Service Staff	141		

23. Coverage challenges within existing health service organizations raise concerns. It is unclear to what extent available specialties in Bannock County are optimized to address local health challenges. Based on the focus areas of Get Healthy Idaho program, which corresponds to known public health issues, the coverage and availability is questionable and warrants further inquiry. Most specialties have less than 1 specialty staff per 10,000 people. To what extent these figures are sufficient to address known local challenges of high stroke rate, high suicide rate, high unintentional injury, low cancer screening, and overweight/obesity is unknown.

24. Health determinants expand beyond health service infrastructure and system. Idiosyncratic local healthcare infrastructure and access processes serve as linchpin to health. However, they are not exclusive drivers of health. Burgeoning research expands studies into other critical factors. Most notably, there is growing series of research grouped under five key social determinants of health.[5] They are: 1) Economic Stability, 2) Education Access and Quality, 3) Health Care Access and Quality, 4) Neighborhood and Built Environment, and 5) Social and Community Context. Health service infrastructure and system overlaps with one of the five social determinants.

25. Local characteristics of known relevant social determinants and its impact are understudied. The impact and extent of known social determinants outside of health care access and quality are undetermined. That is, it is unknown how economic stability, education access and quality, neighborhood and built environment, and social and community context impresses their impacts on individual health. Furthermore, the lack of such investigation befuddles whether there are clustering effects and/or interaction effects among the various determinants. There are macrolevel census data. However, a more detailed local level investigation is warranted to identify the pervasiveness of known factors among County residents.

C. Findings from the Community Health Assessment

26. The primary activities of the first year of the Bannock County Health Collaborative project consisted in completing a community assessment of the health needs and social determinants of health driving those needs. This assessment consisted of a review of the existing health service landscape as summarized above and a new review of information summarized below. The new information includes data collected from a survey (a modified version of the PRAPARE tool) and from four focus groups. Primary data were collected using a convenience sampling approach where community members known to experience barriers to good health were selected. Data collection sites were selected after a review of existing data. Each site was identified because it was likely to serve community members experiencing social determinants of health identified in secondary data. These social determinants included housing insecurity, food insecurity, local access to health and social services, and advanced age. The original version of the PRAPARE tool is in Appendix E.

The chart below indicates how the community health assessment collected information on the spectrum of issues that make-up the "social determinants of health."

[5] U.S. Department of Health and Human Services. (2022). *Social Determinants of Health Literature Summaries.* http:// health.gov/ healthypeople/priority-areas/social-determinants-health/literature-summaries

Topic	Subtopics	Variables	Survey	Other source
Demographic	Identified sex	Identified sex	What is your gender?	Secondary data (American Community Survey)
	Age	Age	What is your age?	Secondary data (American Community Survey)
	Ethnicity	Hispanic	PRAPARE #1	Secondary data (American Community Survey)
	Race	Race	PRAPARE #2	Secondary data (American Community Survey)
Economic Stability	Employment	Current employment	PRAPARE #11	Secondary data (American Community Survey) UWSEI: Data dashboard Secondary data
	Income	Income level	PRAPARE #6, 13	Secondary data (American Community Survey)
	Expenses/Debt	Ability to access basic needs	PRAPARE #14	Secondary data (American Community Survey)
	Support	Access to social programs		Focus Group Findhelpidaho.org
Neighborhood and Built Environment	Housing	Housing situation	PRAPARE #7	Secondary Data (American Community Survey, HUD) UWSEI: Data dashboard Secondary data
		Housing stability	PRAPARE #8	UWSEI: Data dashboard Secondary data (American Community Survey, County Health Rankings)
	Transportation	Access to reliable transportation	PRAPARE #15	PFC: Intake form SICOG Secondary data (American Community Survey)
	Safety	Safety at home	PRAPARE #20, 21	Secondary data (County Health Rankings)
		Crime rates		Secondary data

	Neighborhood conditions	Zip code/ Geography (proxy)	PRAPARE #9 Data collection location	
	Recreational and leisure opportunities	Parks/Playgrounds		Secondary data (American Community Survey, County Health Rankings, CHNAs)
		Walkability		Secondary data (American Community Survey, County Health Rankings, CHNAs)
Education	Literacy			UWSEI: Education Needs Assessment, Data Dashboard
	Language		PRAPARE #5	
	Education level		PRAPARE #10	Secondary data (Idaho Department of Education) UWSEI: Education Needs Assessment, Data Dashboard
	Early childhood education			Secondary data (Idaho Department of Education) UWSEI: Education Needs Assessment, Data Dashboard
	Educational Opportunities			Secondary data (Idaho State Board of Education) UWSEI: Education Needs Assessment, Data Dashboard
	Vocational training			UWSEI: Education Needs Assessment
Food	Hunger		PRAPARE #14	UWSEI: Data Dashboard Secondary Data (Idaho Foodbank, CHNAs)
	Access to healthy options			UWSEI: Data Dashboard Secondary Data (Idaho Foodbank, CHNAs)
	Family situation	Household size	PRAPARE #6	UWSEI: Data Dashboard

Social and Community Context				Secondary Data (American Community Survey)
		Caregiving responsibilities	PRAPARE #14	
		Changes in family situation		
		Domestic violence	PRAPARE #21	
	Social integration/ discrimination	Populations at increased risk (proxy)	PRAPARE #1, 2, 3, 4, 18, 19	Focus Groups UWSEI: Data Dashboard
	Social support		PRAPARE #16	Findhelpidaho.org Focus Groups
	Community engagement			
	Stress		PRAPARE #17	Focus Groups
Health Care Access and Quality	Health Care Utilization	Contact with Health Care System	Over the past year, have you received any medical care?	Focus Groups Landscape Analysis Secondary Data (County Health Rankings, CHNAs)
		Receiving Preventive Services	Over the past year, have you received a routine medical checkup?	Focus Groups Landscape Analysis Secondary Data (County Health Rankings, CHNAs)
	Health Care Access	Access to Health Care Services	Over the past year, have you needed to get medical care for an illness, injury, or condition, and were not able to get it as soon as needed?	Focus Groups Landscape Analysis Secondary Data (County Health Rankings, CHNAs)
		Access to Preventive Services	Over the past year, have you needed to get a routine medical checkup and were not able to get it as soon as needed?	Focus Groups Landscape Analysis Secondary Data (County Health Rankings, CHNAs)

	Barriers to Accessing Health Care	Health Care Coverage	PRAPARE #12	Landscape Analysis Secondary Data (American Community Survey, County Health Rankings, CHNAs)
		Regular Primary Care Provider	Do you have a primary doctor or clinic that you go to receive general, non-emergency medical care?	Focus Groups Landscape Analysis Secondary Data (County Health Rankings, CHNAs)
		Other Barriers (explore through open-ended questions)	What prevented you from getting the medical care you needed? What prevented you from getting a routine medical checkup?	Focus Groups Landscape Analysis Secondary Data (American Community Survey, County Health Rankings, CHNAs)
	Quality of Care			Focus Groups Landscape Analysis Secondary Data (County Health Rankings)
Health	Health Status	Health status	Has your health ever held you back from working or taking care of your family?	Focus Groups Landscape Analysis Secondary Data Secondary data (American Community Survey, County Health Rankings, CHNAs)
		Perceived health	In general, how would you describe your health?	Focus Groups Secondary data (American Community Survey, County Health Rankings, CHNAs)

i. Survey Results

Surveys were administered across Bannock County to ensure that responses reflect the views of both urban, suburban, and rural community members. In addition, populations from groups at high-risk of experiencing unmet needs stemming from the social determinants of health (i.e., individuals without health insurance, older community members, those experiencing food insecurity, and those experiencing housing insecurity) were over sampled using a convenience strategy. The survey was developed using the PRAPARE tool, a validated measure used to assess social determinants. Addition

questions were added to collect demographic information, neighborhood location, healthcare access, and social inclusion.

27. Table 1 summarizes where surveys were collected, Table 1a describes each location, and Table 2 summarizes where community members reside. Individuals not living in Bannock County were allowed to participate as they came to Bannock County for services. Location descriptions are available in the images below. Images are provided on the second page to provide approximate locations of cities and communities discussed. The first image is a map of Bannock County with key city locations. The second image is a map of the Pocatello-Chubbuck community, with color-coded circles around the sub-communities used in the survey. This image is a very rough estimate and was not provided to survey respondents.

Table 7: Surveys completed by location and mode of administration (n = 313)

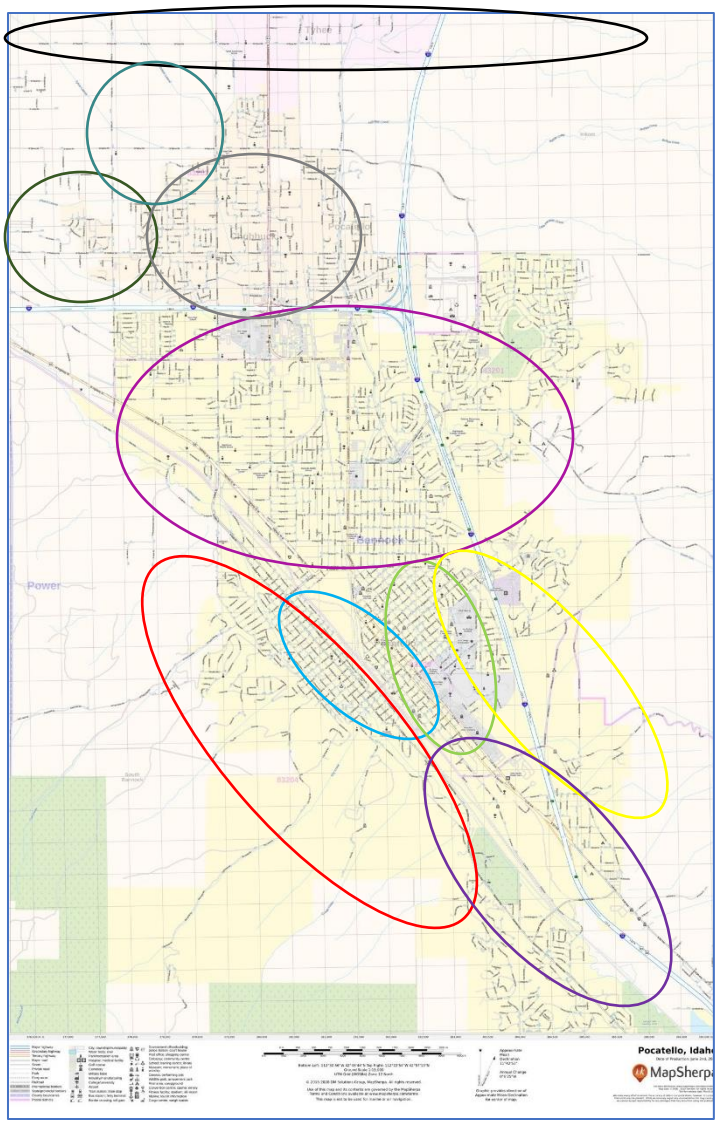
	Mode of Administration				
Location	Paper	Web	Tablet	Unknown	**Total**
Valley Mission	94		9		**103**
Pocatello Senior Center	63				**63**
Pocatello Free Clinic				50	**50**
Bisharat's Market	24				**24**
Aid for Friends	11				**11**
ISU Health Fair			6		**6**
Other		56		0	**56**
Total	**192**	**56**	**15**	**50**	**313**

Table 8: Location Descriptions

Locations	**Descriptions**
Valley Mission	A church that provides weekly food boxes and community education classes, located in downtown Pocatello.
Pocatello Senior Center	A community center that serves individuals over 65 with meals, community, and entertainment (e.g., bingo, pool, etc.), located in the University neighborhood.
Pocatello Free Clinic	A free clinic serving those who are uninsured and under 300% of the federal poverty line, located in the University neighborhood.
Bisharat's Market	A community store located in Inkom, in the southern part of Bannock County.
Aid for Friends	A non-profit that operates and emergency housing shelter and long-term housing for formerly homeless individuals, located in Downtown Pocatello.
ISU Health Fair	A community health fair held at Idaho State University.
Other	Data collected from Facebook via paid advertisements targeting low-income individuals in southern Bannock County.

Table 9: Neighborhood of Survey Respondents (n = 264)

Neighborhood	Frequency, n (%)
Downtown Pocatello	41 (15.5%)
University Area	40 (15.2%)
North Pocatello	37 (14.0%)
East Pocatello	29 (11.0%)
West Pocatello	21 (8.0%)
South Pocatello	18 (6.8%)
Chubbuck (near Yellowstone)	18 (6.8%)
Inkom	18 (6.8%)
Chubbuck (away from Yellowstone)	7 (2.7%)
Fort Hall	7 (2.7%)
Tyhee	4 (1.5%)
McCammon	2 (0.8%)
Portneuf/Blackrock	1 (0.4%)
Lava Hot Springs	1 (0.4%)
South Bannock	1 (0.4%)
Other, Bannock	6 (2.3%)
Other, not Bannock	13 (4.9%)



28. Below, Table 3 provides a demographic overview of survey respondents. Careful attention was paid to the racial and ethnic make-up of the sample to ensure that the data reflects the diversity of our community. However, it is important to note that the survey was only administered in English, thus non-English speakers were implicitly excluded. In this and all subsequent tables, the populations are subdivided into two groups, those who are over-50 and those who are under-50. This was done to account for the fact that this sample is slightly older than the overall population. However, by doing this the Community Action Team found that younger participants were more likely to experience unmet health needs (see tables 4, 5, and 6).

Table 10: Selected Sociodemographic Characteristics of Survey Respondents

Characteristic	**<50y (n = 123)**	**50y+ (n = 172)**	**All (n = 313)**
Gender			
Female	77 (63.6%)	91 (53.9%)	179 (58.5%)
Male	42 (34.7%)	77 (45.6%)	124 (40.5%)
Nonbinary	2 (1.7%)	1 (0.6%)	3 (1%)
Age			
<20y	5 (4.1%)	---	5 (1.7%)
20-29y	37 (30.1%)	---	37 (12.5%)
30-39y	34 (27.6%)	---	34 (11.5%)
40-49y	47 (38.2%)	---	47 (15.9%)
50-59y	---	55 (32.0%)	55 (18.6%)
60-69y	---	58 (33.7%)	58 (19.7%)
70y+	---	59 (34.3%)	59 (20.0%)
Race			
White	114 (92.7%)	165 (95.9%)	263 (84.3%)
American Indian/Alaskan Native	18 (14.6%)	18 (10.5%)	37 (11.9%)
Black/African American	4 (3.3%)	3 (1.7%)	8 (2.6%)
Asian	2 (1.6%)	0 (0.0%)	2 (0.6%)
Native Hawaiian/Pacific Islander	0 (0.0%)	1 (0.1%)	2 (0.6%)
Hispanic	17 (13.8%)	10 (5.8%)	28 (9.1%)
Education			
<High School	16 (13.0%)	20 (11.7%)	35 (11.3%)
High School Diploma/GED	38 (30.9%)	46 (26.9%)	91 (29.4%)
>High School	69 (56.1%)	105 (61.4%)	184 (59.4%)
Employment			
Full-time	47 (38.5%)	24 (14.2%)	73 (23.8%)
Part-time/Temporal	28 (23.0%)	22 (13.0%)	53 (17.3%)
Unemployed	27 (22.1%)	22 (13.0%)	54 (17.6%)
Unemployed, Not Seeking	20 (16.4%)	101 (59.8%)	127 (41.4%)
Retired	0 (0.0%)	65 (64.4%)	68 (53.5%)
Disabled	5 (25.0%)	9 (8.9%)	16 (12.6%)
Full-time Caregiver	3 (15.0%)	2 (2.0%)	5 (3.9%)
Student	1 (5.0%)	0 (0.0%)	2 (1.6%)
Undefined	11 (55.0%)	25 (24.8%)	36 (28.4%)
Selected Populations			
Armed Forces (discharged)	3 (2.4%)	34 (19.8%)	39 (12.5%)
Veteran	1 (0.8%)	31 (18.0%)	35 (11.2%)
Formerly Incarcerated (within 1y)	18 (14.6%)	7 (4.1%)	26 (8.3%)
Seasonal/Migrant Worker	4 (3.3%)	5 (2.9%)	11 (3.5%)
Refugee	1 (0.8%)	1 (0.6%)	2 (0.6%)
Any	24 (19.5%)	42 (24.4%)	71 (22.7%)

Missing: gender=7, race=19, education=2, FPL=XX

29. Beginning with Table 4, we can begin to see the extent to which the Bannock County community is experiencing unmet needs related to social determinants of health. Namely, housing, food, utilities, transportation, clothing, and communication technology were all found to be associated with significant gaps experienced by this population, particularly those under 50.

Table 11: Unmet Needs among Survey Respondents

Unmet Need	**<50y (n = 123)**	**50y+ (n = 172)**	**All (n = 313)**
Housing	45 (36.6%)	43 (25.0%)	92 (29.4%)
Food	43 (35.0%)	41 (23.8%)	89 (28.4%)
Utilities	31 (25.2%)	36 (20.9%)	69 (22.0%)
Transportation	29 (23.6%)	33 (19.2%)	66 (21.1%)
Clothing	34 (27.6%)	28 (16.3%)	64 (20.4%)
Phone	27 (22.0%)	30 (17.4%)	61 (19.5%)
Childcare	15 (12.2%)	4 (2.3%)	20 (6.4%)
Other	4 (3.3%)	7 (4.1%)	13 (4.2%)
Any	**72 (58.5%)**	**70 (41.0%)**	**150 (47.9%)**

30. Table 5 reveals that the population under 50 is also more likely to experience challenges related to health and well-being. They are more likely to have limited social interactions, higher levels of stress, and lower overall perceptions of their health. Importantly, each measure is self-reported and should be understood as a measure of the participants subjective experience of health.

Table 12: Physical, Social, Mental, and Emotional Health among Survey Respondents

Health Measure	**<50y (n = 123)**	**50y+ (n = 172)**	**All (n = 313)**
Social Interaction with Close Friends/Family			
≤2/wk	55 (45.8%)	64 (38.8%)	74 (41.1%)
Stress			
Quite a Bit / Very Much	67 (55.8%)	52 (31.1%)	126 (41.5%)
Feeling Unsafe			
Physical	14 (11.7%)	17 (10.2%)	32 (10.2%)
Emotional	24 (19.8%)	23 (13.5%)	48 (15.3%)
Physical or Emotional	26 (21.7%)	27 (16.1%)	54 (17.3%)
Afraid of partner/ex-partner *			
Afraid	15 (13.9%)	13 (11.3%)	29 (12%)
Unsure	10 (9.3%)	3 (2.6%)	13 (5.4%)
General Health			
Fair/Poor	50 (43.5%)	60 (36.1%)	115 (38.5%)
Affecting work/taking care of family	51 (42.2%)	69 (40.5%)	127 (40.6%)

** Estimated among those who had a partner within the last year*

Missing: age = 18, social=11, stress=9, unsafe =8, afraid=5, general health= 13, health affecting=6

31. As above, the Community Action Team found that the segment of the sampled population under 50 was more likely to experience significant unmet needs. Namely, they were much more likely to be uninsured, much less likely to have a primary care provider, less likely to receive routine medical care, and more likely to have unmet healthcare needs. For those who lack a primary healthcare provider, there are very few community resources available to promote access; this situation is likely made worse by the fact that nearly all of southeastern Idaho is a Health Resources Service Administration designated primary healthcare shortage area.

Table 13: Healthcare Access among Survey Respondents (n = 313)

Healthcare Access Measure	**<50y (n = 123)**	**50y+ (n = 172)**	**All (n = 313)**
Insurance			
Uninsured	31 (25.2%)	16 (9.4%)	49 (15.7%)
Medicaid	49 (39.8%)	53 (31.0%)	109 (34.8%)
Medicare	9 (7.3%)	94 (55.0%)	112 (35.8%)
Private	33 (26.8%)	40 (23.4%)	76 (24.3%)
Other	9 (7.3%)	17 (10.0%)	27 (8.6%)
Has Primary Care Provider	80 (66.1%)	148 (88.6%)	242 (77.3%)
Received Medical Care Within Past Year	103 (84.4%)	145 (86.8%)	264 (84.3%)
Received Routine Medical Visit within Past Year	69 (56.6%)	128 (76.2%)	211 (67.4%)
Delayed Healthcare Services Within Past Year			
Medical	46 (38.0%)	51 (30.4%)	101 (32.3%)
Routine	28 (23.0%)	30 (17.9%)	61 (19.5%)
Unmet Healthcare Needs*	70 (56.9%)	75 (43.6%)	152 (48.6%)

** Due to service unavailability, cost, lack of insurance, time, transportation, etc.*
Missing: insurance=4, primary care provider=7, received medical care=6,

ii. Focus Group Results

32. Four focus groups (n=38) were held throughout the community. (Note that because focus group participants were able to come and go from the sessions, the actual number of participants varied through out the conversations.) These focus groups were designed to help the Community Action Team better understand the nature of the unmet needs identified above. Focus group participants were drawn primarily from the Pocatello Free Clinic, Aid for Friends, Valley Mission and online. Below is a list of the focus group questions asked to community members:

TOPIC	**QUESTION(S)**
Perceptions Of Health	What do you consider healthy? How do you define healthy?
Community Health	What are the biggest problems that you see in the community? What are some of the biggest health problems that you see in the community?
Resources	What kind of resources are available in the community to help people if they're struggling? What types of resources are missing? How do we address those?

Economic Stability	What are some of the reasons why you have not sought care when you needed it? Are there other ways that money or income have affected your health?
Other Social Determines	If you were looking for a place to live with your family, what kinds of features would you look for? Has transportation ever affected your ability to access needed healthcare services?
Concluding Questions	What are we missing? What is important that we didn't talk about? Is there anything we missed that you want to share?

33. All focus groups began by asking participants how they defined health. This information helped the community action team to better understand the participants perspectives and figured into the design of the intervention described below. Findings include activities associated with physical health ("hygiene," "taking the right medications," "having nutritional food, having a healthy diet," "getting enough rest, getting enough exercise," and "no pain"), mental health ("keeping stress down," and "having a positive attitude,"), managing health, ("taking the right medications,) interpersonal health ("having a healthy relationship with other people,") and economic wellbeing ("financial health"). These responses indicate that a multisector, multifaceted approach to improving health is needed to address the participants complex experience of health.

34. Following that, participants were asked to describe the health problems that they see in our community. Those problems cover five categories:

- Poor food choices: "Pop, and candy"
- Addiction: "prescription drugs and drug addiction, is horrible right now."
- Cannot access housing: "because I could not find a place to rent, I could not - nobody would rent to me."
- Social stigma: "Most of them [people experiencing homelessness] don't even panhandle, you know what I mean, they are just out there, and they, people look at me and say, 'well you don't look like you're homeless,' so what is a homeless person supposed to look like?"
- Not knowing what resources are available: "I don't think the community even knows about the resources until they have been in the position of needing the resources. You have to kind of ask around in order to get the resource. There is not a whole bunch of like, signs up, or billboards or anything like that, [that say] like, hey if you're homeless and need shelter or whatever, there isn't anything like that."

35. Continuing the theme of resources, community members were asked to summarize resources in the community that help. Their answers revealed that they understand "help," as a resource, service, or person who can end the experience of continually seeking care. As one participant explains:

> *when I was in the hospital... I didn't have insurance and everything, this gal from this RCA, contacted me and said, you know, give me your information and I could help you to get on Medicaid to help pay for all this stuff. She did all the legwork for me, next thing I know she even called my boss and everything… Yeah, and she said now that you're on Medicaid you can apply for food stamps, so a person for food stamps would be calling us in the next day or two. So yeah, that helped. I wouldn't have had any of this stuff going on if it weren't for her.*

36. Agencies that function as "hub" that facilitated access to many services were also perceived to be particularly valuable. Participants explained that "Aid for Friends ended up being a hub to getting into touch. These guys were my hub." Another added, "[Southeast Idaho Community Action Agency] helped me get on disability." In other words, which agencies take a "holistic approach" to providing help, thus resolving multiple challenges, participants feel as though they can have their needs met.

37. While agencies that take a holistic approach are perceived as an essential resource, the participants identified a number of important service gaps that align with their understanding of health:

- Housing: "Pricing has went up so high, being able to afford a house has went up like double in the past couple of years."
- Long-term support: "Also I think like kind of a halfway thing, for, people who have been chronically homeless have a really hard time getting back to society. If they have some kind of program, like an in-between thing where they can get some skills, maybe even get them a job. You know, something like that would really help too."
- Recreation: "A rec center for the community. Something that is open to the people who live in Pocatello."
- Hygiene: "There needs to be a laundromat downtown. There are so many people downtown, without vehicles that don't have access to. There needs to be a laundromat downtown."
- Inefficient government systems: "Also government agencies, Social Security dragging their feet, making you wait forever, when the evidence for like disability, I filed a disability claim. They are slower than molasses."
- Education: "Getting some of that education around would probably help people know more about how they can be mobile, but also helping people understand, you know there are a lot of people who really don't understand their own finances."

38. The participants perceptions indicate that these service gaps are worsening their overall experience of health. Furthermore, they explained how these needs are interconnected:

> *I think more housing and more medical help. Because when you're homeless they do have a lot of medical issues. Transportation, because when we become homeless we lose everything. When we come back to ask the community for help, we need everything.*

39. Unsurprisingly, unmet social needs translate into health barriers for the participants. When community members are forced to spend all of their time trying to meet their basic needs, then their health and emotional wellbeing suffer:

> *if you don't have money, you're usually just worried about surviving day to day, and your health kind of sits on the backburner.*

Given that our health system requires individuals to pay for services, chronic need can translate into limited access to health services and increased perceptions of social stigma:

> *I've got a lot of fear about going. If I'm not dying, I'm not going to the hospital. If it is not literally like life-threatening, I am not going to the hospital. I just won't do it.* [unclear comments taken out…] *It's like I'm either going to get rejected, or I am going to get sent to the mental ward*

because they expect that I am not mentally stable, and I'm like seriously, I don't know what's going on with me, I'm coming to you to tell you there is something wrong, I have no idea.

Health professionals can further exacerbate these experiences as one participant explained:

doctors [don't] *understand that not everybody's wealthy, you know, a lot of us are struggling.*

40. Following discussions related specifically to health issues, participants were asked to discuss other essential unmet needs in greater depth. Five themes emerged from this: The transportation system is not meeting participants' needs, the cost of housing is too high relative to income, mental health needs are unmet, and there is not enough access to healthy food. The table below provide quotes that summarize each theme:

Table 14: Quotes by Theme

Transportation	*The current bus system is not working for Bannock County's high-needs community*: "Some of the bus routes are kitty-wampus now." "Bus system is horrible.: "Well, and later bus travel. And we just get in at six, and then you are like stranded. … I think the last drop-off should be 9:30 [pm]." *Transportation is too expensive and that prevents individuals from accessing employment*: It's hard to get to work, when you've got to pay everything you make just to make it to work. Which doesn't really make it profitable to go to work, especially if you have any children. *The existing public transit system is not well understood by the community*: " there's a little bit of public transportation, you know, Pocatello's not great, but there's some. But you know, it does seem that very few people know about it, and Pocatello hasn't been great about giving bus routes posted, ya know, there's a couple bus stop signs, but you know there is no bus route next to the sign. So, you don't know when the bus is showing up or where it's going to go or anything like that." *Limited transportation is impacting health*: "Yeah, yeah transportation for medical use and housing is probably the biggest thing. If they actually had taxis or shuttles, a van, to get us to these places, because we really do need it, that would help us a lot."
Housing and Income	*Quality housing is too expensive:* "…when we refuse to pay people a livable wage, and we allow corporations and big business to rake the prices of everything, so people can't afford to live. You know, well come on, I saw an ad for a house that was like dilapidated, …[that] they wanted $250,000 for." *Affordable housing is not well-maintained:*

	You get people like, some are slumlords, … the city allows … people like him to continue to have properties – he wouldn't sleep in them, most people would go to jail for letting their dog sleep in something like that. And he is allowed to continue to business and people like it? You know, no, he should be forced to live in his buildings, a product of __. You know, you want to rent stuff like that, then you need to live in it." *Community members' who have struggled will face additional obstacles with limited protection:* Well and the problem is too, they have 20 to 30 applications, and they have got to pick from – so they are not going to pick someone who is at the homeless shelter, and you know, they are discriminatory, as far as I am concerned. I've run up against that a lot, so I think that that's something I think should – well they tried to pass up a law through the legislature, it didn't pass, so they could regulate the landlords, but it didn't pass this last time – it got kicked down, so.
Mental Health	*Low-income community members experience chronic stress, which impairs their mental health*: "… once you start to worry so much, you know what I mean you start worrying, then you get stressed out, then you start getting into depression, then you start getting into all of these mental health problems that start happening that can stem from that." *Community members who are struggling need more access to mental health resources*: "Counseling. Yeah I think that a lot of people would need a lot of counseling because a lot of them are afraid they do have trauma, they do have – there is something going on inside. They're depressed, or sad, I mean there is something going on with each person. That they become homeless like he was saying like ____ came from addiction. He might have been going through depression, or me, I lost my father – I lost everything. I mean I was sad and depressed for a long time, and then I have my own diagnoses, so I have to take care of those. So like counseling, more case managers, more people that are dealing with behavior and mental health." *For those who face mental health challenges, they are likely to experience social stigma as well*: "Maybe more education for the general public, so they understand the problem a little bit better. So they don't stereotype so much."
Food	*Community members are continuing to go without food*: "You're worried about what you're going to eat today. There were times I just went hungry, and drink water, that sucks. When you get that hungry that you want to puke, you know that feeling, it's terrible. Nobody should have that." *A poor diet limits the community's ability to thrive*: "And your diet has a lot to do with how much energy you have and how much drive you have. If you're going to sit here and live on Top-ramen noodles, you know, you are not going to have any, you know, any real energy, it's all carbs."

	Community members are falling into gaps: " … Food Stamps – they are kind of discriminatory, because either you make too much money for them to give it to you, or they say, "oh you are not working, you can't have food stamps". They make it hard for you to get your food stamps."

41. Importantly, all these themes are interconnected in the lived experience of community members. And as these issues pile up, the challenges multiply, further restricting their ability to escape the experience of poverty:

> *Yeah if you don't have a place to stay every night, you don't, and that means you don't have an address which means that it's hard to get money and it's hard to find a job where they are like, oh well nobody wants to hire someone that's just drug off the street homeless, you know what I mean, and being able to sustain a financial stability is almost impossible there too, so it's kind of like, once you're dwindled down to nothing, it's really hard to get back up.*

42. These issues are made worse because the system is "so complicated," or like a "maze." This leads to eviction and unemployment, which begins the downward spiral of poverty. Some participates suggested that this high level of complexity is intentional: "they are made that way to discourage people from seeking services, which is sad."

D. Partners and Project Roles in Year 1

43. Idaho Department of Health and Welfare (IDHW) is dedicated to strengthening the health, safety, and independence of Idahoans. The Division of Public Health serves as the administrator of the Get Healthy Idaho Initiative.[6] It oversees the implementation of health regulations set and funded by the Idaho State legislature and signed by the Governor. IDHW oversees the Get Healthy Idaho program and serves as a coordinator, funder, and evaluator of the collective grant. It convenes funder meetings with the grant recipient to clarify the funding sources and their tied objectives. These meetings also serve to hear updates regarding the grant recipient progress along with providing technical troubleshooting by sharing experiences of the other grant recipients. IDHW involvement is indispensable not only because they are the funders but also because of their role as coordinators and best practice conduits.

44. At the Bannock County level, three key partners are involved in designing and executing the grant funded project. They are the United Way of Southeastern Idaho, Pocatello Free Clinic, and Idaho State University. All three entities are based in Pocatello and bring unique strengths and insights that are vital for the success of the Project. UWW is a historically recognized national nonprofit organization that dates to 1887. The Southeastern Idaho branch is the local nonprofit organization serving Bannock County and the larger region. It operates in four focus areas of impact: 1) addressing the Cradle-to-Career opportunity gap, 2) access to mental health and healthcare, 3) housing stability, and 4) food insecurity. Due to its strong ties with health and work with the community on influential downstream and upstream barriers to health, the organization serves as the key conduit and coordinator on the grant. It serves as a grant

[6] https://healthandwelfare.idaho.gov/about-dhw/our-mission

assessor and evaluator while providing the necessary administrative and staff support to execute the components.

45. Pocatello Free Clinic is a nonprofit organization that provides free medical and dental care to eligible regional residents. Due to its continuous engagement with the uninsured and those under 300% of the Federal Poverty Level, it possesses unique insights to the trials and difficulties faced by their patients. The patient pool are key beneficiaries to which the Project aims to serve. Thus, they are the starting point of the survey sample to undercover the needs of the medically and dentally underserved residents. Due to its long engagement with the community, like the United Way of Southeastern Idaho, the organization owns resources accumulated over time and tied to their existing services that could be utilized to bring down costs while maximizing impact. Furthermore, the Pocatello Free Clinic is the medical and dental expertise partner. Thus, provides feasibility checks and requirement snapshots in designing health interventions.

46. Idaho State University is a R2 (Doctoral Universities – High Research Activity) Carnegie classified state university with the public health mandate in the State of Idaho. As its status as a research institution, its involvement lends analytical capacity for intervention development. Its involvement is represented through a professor with expertise in public administration, which encapsulates knowledge subfields such as public-private partnerships and program evaluation. The analytical contribution is reflected in a relatively encyclopedic input on various known frameworks and best practices for community collaborations and pilots launches. The knowledge contribution is a value-addition that helps reduce known risks resulting in project delay and failures. The university involvement also helps in student contributions to the various Project components and deliverable outputs.

47. Southeastern Idaho Public Health (SIPH) is an invaluable public funded partner serving the public health needs in eight counties in southeastern Idaho, including Bannock County.[7] Created by the 1970 Idaho Legislature, it is one of seven public health districts to assure basic health services necessary to help individuals improve and maintain their health status. The organization carries out public health programs under four major divisions: 1) Community Health, 2) Clinical Services, 3) Women, Infants & Children (WIC), and 4) Environmental Health. The clinic is staffed by Nurse Practitioners and Public Health Nurses, overseen by one MD physician. Outside the clinic, forty-one staff members are engaged in various community and environment health programs. Organizationally, non-clinical staff are organized as follows: 1) epidemiology, 2) COVID investigation, 3) health promotion, 4) public information, 5) public health preparedness, 6) home visitation, 7) environmental health, and WIC. Comprehensively, the staff work on thirty different programs.

48. The list of partners sitting within the community collaborative are many. Initial partners include Housing Alliance & Community Partnerships, Human Rights Collective, Aid for Friends, Valley Mission, The Pocatello Senior Activity Center, Southeast Idaho Council of Government, Southeastern Idaho Public Health, Rehabilitative Health Services, Southeastern Idaho Community Action Agency, and Pocatello Neighborhood Works.

[7] https://siphidaho.org/

49. Additional partners who could be included are Southeast Idaho Public Health, Shoshone Bannock Tribe, Portneuf Valley Interfaith Fellowship, Gateway Habitat for Humanity, Pocatello Military Affairs Committee, Idaho Foodbank, Saint Vincent DePaul, Salvation Army, Desert Industries, Bannock Youth Foundation, Idaho Youth Ranch, Adult Protective Services, CASA, Family Services Alliance, Idaho Legal Aid, NAACP Chapter Pocatello, All Under One Roof, Portneuf Health Trust, National Alliance on Mental Illness Idaho, the Hospital Cooperative, Bingham Health Care Foundation, the JRM Foundation for Humanity, and representatives from municipal and county governments. This list is not exhaustive. However, this list combines all those that either have worked with the three core partners of the grant or operate at a conspicuous scale in the community on matters directly tied with the grant objective. The rationale for supporting outreach activities to these partners lies in them already being involved in acute healthcare delivery or improving the circumstantial factors of beneficiaries that are tied with health and well-being.

E. Conclusion

50. When the secondary data presented in section C is considered in tandem with the primary data described in section B, we can begin to see a clear picture of how health needs affect the Bannock County community. Bannock County has a high proportion of low-income community members. Those community members are more likely to be rent-burdened (i.e., to spend more than 30% of their income on rent) and to be younger than their wealthier peers. Their children are also more likely to grow up in poverty or as part of the ALICE community, where they experience chronic unmet need. While some of these community members will improve their circumstances overtime, many will not.

51. The healthcare system in Bannock County is dependent on income and employment. Like the rest of the county, many residents of Bannock County depend on private health insurance to cover a portion of their healthcare expenses. This is for health services for those ineligible to utilize services from publicly funded public health service entities such as SIPH. Those with lower incomes or who are over 65 are more likely to rely on Medicaid and Medicare respectively. Due to the complex nature of the reimbursement model of care delivery, the number of providers who accept the various health insurance options can vary widely. Furthermore, the Health Services and Resources Administration has designated Bannock County as a health professional shortage area for both mental and primary healthcare. Shortages persist for specialty care, but are more difficult to quantify. Thus, it is not surprising to find that on a number of key health outcome measures Bannock County is under performing its peers. However, existing data painted only a patchy picture of the health needs of Bannock County's most vulnerable community members.

52. To better understand the unique needs of Bannock County's most vulnerable community members, the Community Action Team designed a mixed-methods assessment. This assessment was targeted at community members known to experience poor overall health and challenges accounted with the social determinants of health. Findings from this assessment complemented the secondary data reviewed as part of the landscape analysis. Quantitative findings highlighted that younger community members indeed experienced poor health outcomes, poor perceptions of their own health, social isolation, increased challenges associated with mental health, and significant barriers associated with obtaining the material goods needed to maintain their health.

53. For Bannock County's most vulnerable community members, the experience of meeting their most basic needs is both time-consuming and frustrating. One challenge can quickly cascade into several

new issues all of which require immediate resolution. Sometimes their experience feels like trying to navigate an endless maze where no one has all of the tools they need. However, these participants did identify solutions. The system needs to be easier to navigate, with more information made available and with increased access to needed goods and services. By helping to close the gaps associated with accessing the existing resources in Bannock County, we can make a challenging situation easier and promote access to health care services and to the resources needed to maintain health.

III. YEAR TWO PROJECT DESCRIPTION

A. Project Development Objectives

54. The Project objectives are aligned to the Get Healthy Idaho: Building Healthy and Resilient Communities program.

55. Project development objective (PDO) statement: To establish and utilize community collaboration to improve health equity in Bannock County.

56. PDO level indicators: The PDO will be monitored through the following PDO level outcome indicators.

- Increase community engagement by establishing new partnerships to increase access to healthcare services and to other activities that support health and wellbeing.
- Leverage existing resources, such as findhelpidaho.org, to meet local transportation needs.
- Mobilization of community resources to address emerging and outstanding healthcare needs
- Promote on-going community conversations about health promotion and health equity using advertising and social media.
- Host community events to promote knowledge of existing transportation services that can promote health.
- Launch Ride United to help the nonprofit community support clients who are not currently served by existing transportation resources.
- Create a new infrastructure to deliver in-kind support to nonprofits in the form of rides, vouchers, and honoraria.

B. Project Components

57. The first year of the project involved collecting relevant county-level data to develop an updated assessment on the status of health equity in Bannock County. The assessment has been anchored in community dialogue to formulate collaborative solutions among stakeholders and partners. The year one assessment led to the development of the proposed pilot outlined below. This pilot includes components to the project that are aimed to proposed new interventions in gap areas where no current sustainable solutions are available and/or operational.

58. Our community's year-two plan will consist in three interrelated components: continued community engagement via a multi-faceted outreach strategy, a public information campaign to promote wider understanding of health equity, and standing up a new service to close transportation gaps that are limiting access to healthcare services and lifestyle activities known to be associated with good health.

Component 1: Building an environment of community collaboration

59. This component encapsulates all activities related to creating a meaningful community dialogue associated with launching the target intervention. It involves outreach and network maintenance activities such as meeting partners to identify synergy opportunities, updates regarding the collaborative meetings, and conducting the necessary studies prior to meetings to properly anchor and define emerging and outstanding agendas.

Subcomponent 1.1: Network Management: Leverage existing health environments to support ongoing community collaboration and achieve continued by-in for the programs outlined in subcomponents 2 and 3.

60. Maintaining effectiveness in public networks are neither organic or automatic.8 Thus, covering and performing known public network management activities are essential. They include but not restricted to establishing and maintaining the collaborative network by performing the various communication activities which include but are not restricted to email, internal & external website, internal web posting, external newsletter, external publications, news releases, project reports/studies. Of these activities, deliberation is required to perform project report/studies as it draws methodological expertise for reliable and replicable findings.

61. The primary goal of this component includes ensuring that community members, nonprofit agencies, health providers and other stakeholder groups have the opportunity to continue to connect with the Community Action Team as needed and in a manner that is responsive to their desired level of involvement. The matrix below summarizes five levels of communication that this group will use to support continued stakeholder involvement. Importantly, stakeholders will move through different levels of this matrix throughout different phases of this project; no level should be regarded as better or worse than any other level. Rather, these distinctions exist to help us calibrate our approach to collaboration.

62. To provide flexible collaboration opportunities for partners, our team will offer community outreach opportunities for each of the five levels of the matrix illustrated in Table 15.

A. Inform: The team will launch a newsletter to share the results of the community assessment and maintain an on-going social media presence to provide on-going information about health equity and the planned intervention.
    a. Outcome: On-going community information campaigns will help to support wide-spread buy in and use of the new system. This aspect of our work associated with cross sector partnerships will help to build trust across wide segments of the population to promote usage among nonprofits and community members.
B. Consult: Throughout the process the team will solicit information from community partners. Specifically, we will work with leaders from across Bannock County to continue sharing the results of the assessment, explain the proposed intervention, and solicit feedback.
    a. Outcome: The United Way of Southeast Idaho serves on various committees and community-based collaboratives; our plan is to leverage these existing networks to share information about the project and to continually solicit feedback from community and governmental agencies. Partners will include staff from city/county government, the Pocatello Free Clinic, Southeast Idaho Public Health, Aid for Friends, the Southeast Idaho Behavioral Health Crisis Center, health care administrators, and more.

[8] Many studies reaffirm this reality, particularly the public network management literature with cannons such as Agranoff, R. 2012. Collaborating to Manage: A Primer for the Public Sector. Georgetown University Press: Washington, D.C. and Kickert, W. J. M., Klijn, E-H., and Koppenjan, J. F. M. (Eds.). 1997. *Managing Complex Networks: Strategies for the Public Sector.* Sage Publications: London.

C. Involve: As the project grows, our team anticipates that we will continue to need to meet with partners from across Bannock County. In some cases, these partnerships will grow from levels 1 and 2 as individuals/agencies decide to participate directly in at least one aspect of the program. We anticipate that individuals/agencies who operate at this level of partnership will help us to offer services in the form of transportation as either transportation companies or as service providers.
    a. To stand-up Ride United, the Community Action Team and the United Way of Southeast Idaho will need to establish working relationships with transportation providers. These will range from developing bulk purchasing agreements, establishing MOUs, and otherwise working together to provide rides for clients who would otherwise be unable to access needed services. In addition, the CAT will work to find non-traditional partners.

D. Collaborate: The United Way of Southeast Idaho will continue to participate in collaborative meetings to discuss the status of the project, identify barriers, and develop strategies to overcome challenges. Partners who fall into this category will support program design, participate in trouble shooting, and help to monitor the overall success of the program. There will always be a standing invitation for individuals/agencies to join the Community Action Team.
    a. Outcome: As the United Way of Southeast Idaho and our partners work to establish Ride United, we have begun to partner with organizations already working in the transportation sector. Our partners at the Southeast Idaho Council of Governments have recently launched a collaborative dedicated to advancing safe transportation systems. Given this collaborative included many members from the Bannock County Health Collaborative, we have decided to work together to achieve our shared goals. Currently, this group includes city planners, health care leaders, nonprofit executive directors, officials from our public transportation system, and more. The United Way of Southeast Idaho is already working to help add more nonprofit and community voices to this collaborative.

E. Empower: We are already working to invite community members and representatives from partner agencies into the Community Action Team. We will continue to extend this invitation to partners from across the spectrum.
    a. Outcome: We are already working to invite community members and representatives from partner agencies into the Community Action Team. We will continue to extend this invitation to partners from across the spectrum outlined above. This team will also develop a strategy to leverage findhelpidaho.org to deliver rides

Table 15: Five Levels of Communication

	Inform	Consult	Involve	Collaborate	Empower
Goal	To provide balanced and objective information in	To obtain feedback on analysis, issues, and decisions.	To work with by making sure that concerns and aspirations are	To involve partners in each aspect of decision making.	To place the final decision-making authority in the

	a timely manner.		considered and understood.		hands of partners.
Promise	"We will keep you informed."	"We will listen to and acknowledge your concerns."	"We will work with you to make sure that your views are directly reflected in our decisions."	"We will look to you for advice and innovation and incorporate this in decisions as much as possible.	"We will implement what you decide."
Example	The general public, sponsors, newsletter recipients.	Survey participants, community members at a town hall event.	Independently working with stakeholders.	Attend Bannock County Collaborative meetings.	Attend Community Action Team meetings.

63. This subcomponent will focus on maintaining the community relationships established in the first year of the grant and leveraging those relationships to support a variety of different types of community involvement. In addition, we expect the work completed as part of this sub-component to work synergistically to achieve lasting improvements in community health.

Component 2: Public Awareness & Education Engagement on Health Equity

64. This component involves the multi-prong communication and education initiatives to broaden and enhance awareness. U.S. healthcare delivery system is not equipped to respond to the full spectrum of community health needs such as food, housing, and transportation. Also, it is dependent on voluntary proactive engagement by clients. This is due to the reimbursement mechanism in which it operates. Thus, promoting awareness on community health challenges, availability of resources, and accessibility of care to individuals and community groups are indispensable and vital to make the necessary linkages between need and response. The activities include (i) designing and marketing advertisements on high visibility outlets and (ii) organizing community outreach engagements to and/or in coordination with stakeholders and partners.

Subcomponent 2.1: Promote increased knowledge of health and Ride United via advertisements.

65. This component includes all pre-production works and actual marketing launch. Pre-production works includes analytical work surveying the various means of the communication, as it is known that different socioeconomic groups consume and interact with different media.[9] The traditional mediums include television, radio, print, and online. However, alternative mediums such as billboard and bus side panel advertisement could be relevant for the community due to dependence on cars for transportation and the high reliability of the public transportation for lower income groups, especially during times of high gas prices.

[9] The changing mean and medium of news are elaborated in Barbour, C. and Wright, G. C. 2020.Keeping the Republic: Power and Citizenship in American Politics. 8th Ed. Sage Publications: Thousand Oaks, CA.

66. In year one of the project, the Community Action Team began translating the results of the Community Health Assessment into a publicly accessible advertising campaign. This campaign includes radio ads, billboards, and social media. We will build on this success by continuing these strategies to promote increased public understanding of the health needs affecting disadvantaged community members in Bannock County and of solutions to those challenges. These activities will be done as part of the inform and consult phases outlined above. The specific outcomes are listed below:

- Maintain and update ads on billboards, radio, and other electronic communication systems.
- Create and execute on going social media campaigns to help the community better understand the health needs of Bannock County
- Create and execute a media campaign to promote Ride United with two separate components.
    - The first component will increase the knowledge of the general public
    - The second component will help nonprofit and healthcare partners understand how to access rides to support client needs.

Subcomponent 2.2: Work with stakeholders and partners to promote knowledge and use of existing transportation resources.

67. Advertisements are still passive unidirectional interactions. Thus, proactive bidirectional interactions with community members will further expand and broaden the reach in awareness. The active engagement will enhance reach as its leverages both the knowhow of partners via their long-standing resident membership. Activities involve strategizing engagement events, as it requires clear planning processes.[10] This aspect of the project is necessary given that Bannock County has a public transportation system (see section C); we believe that Ride United will be most useful if it supplements this existing system. Thus, to ensure maximum impact, we will provide additional support to the transportation sector by increasing community awareness of services. The key deliverables associated with this subcomponent are listed below:

- Work with the Southeast Idaho Council of Governments to create and implement novel transportation outreach. This can include both traditional media and in-person demonstrations of using the existing transportation infrastructure.

Component 3: Meeting an identified need via a transportation pilot

68. This component includes all necessary and complementary activities to launch, operate, and maintain a transportation pilot. The transportation need is high in Bannock County based on the community needs assessment carried out in year one of the Get Healthy Idaho grant-funding period. People requiring medical attention and care identify transportation availability and affordability as barriers to receiving necessary healthcare service. Missed appointments occur due to lack of means to reach and return from the healthcare service facility. Transportations needs also stretch to pharmaceutical, nutritional, housing, and other essential needs known to be upstream influences of

[10] Various practitioner-oriented means to organize knowledge engagement events are compiled and organized in Step 3 within the World Bank. 2015. The Art of Knowledge Exchange: A Results-Focused Planning Guide for Development Practitioners. World Bank: Washington, D.C.

health outcomes. This component launches a pilot to address the need through a public-private partnership.

Subcomponent 3.1: Launch Ride United to address the unmet transportation needs in Bannock County.

69. Ride United is a program established in 2018 by UWW to reduce transportation barriers.[11] It has recently been launched in Bannock County, but has not been locally brought to scale. The various activities falling under this subcomponent include developing the infrastructure to realize the program in the local area. This includes setting up a communications strategy to promote the program, recruiting collaborators (see subcomponent 2.1), working with the collaborators to distribute rides (see subcomponents 1.1 and 2.2), monitoring usage, and refining the program as needed. A complimentary aspect of this program will involve a public-private partnership; The United Way of Southeastern Idaho will work with the Southeast Idaho Council of Governments' (SICOG) Transportation Director to promote existing transportation services that are underutilized and not well understood. Thus, this implementation will strive to take a targeted approach to addressing local transportation needs. Dedicated staff working on this subcomponent would also study the reimbursement methods to outline future sustainability plans for this project.

70. In line with the "involve" section of subcomponent 1.1, the United Way of Southeastern Idaho will establish relationships with local transportation providers to understand the local capacity to fill in the existing transportation gaps. Preliminary information presented in section C below shows that there is capacity that could be effectively used to support increased access to transportation. In the first part of year 2, we will work to refine that understanding to design a system that addresses unmet needs without undermining the existing transportation infrastructure. To effectively distribute rides to those most in need, the United Way of Southeastern Idaho will retool its existing infrastructure to provide in-kind support to community-based agencies to distribute to clients as needed. We anticipate that these resources will include bus passes, taxi vouchers, food delivery, and ride shares. Given the geographically disbursed nature of Bannock County, we believe that a multifaceted approach will be best suited to closing our community's transportation gaps. Specific project outcomes are listed below:

- Establish partnerships with public and private transportation companies.
- Build out the Community Investment portal to facilitate transfer of ride vouchers and other support (e.g., honoraria to support added cost to partner agencies) to community-based partners.

Subcomponent 3.2: Monitoring usage and troubleshooting the pilot.

71. Progress on the pilot will be closely monitored to ensure transparency and effectiveness. By leveraging our existing Community Investment infrastructure, the United Way of Southeastern Idaho will also be able to collect data from all community-based organizations who agree to take part in the Ride United pilot. This method of data collection is already familiar to many community-based agencies in Bannock County and can be tailored as needed to meet project requirements.

- Develop and implement data collection processes at two timepoints (August and March) for the Ride United pilot. This will include both quantitative and qualitative data and will allow for tracking/dispersing ride vouchers and funding that go out to agencies. Tracking will be completed

[11] Details are found at the national United Way's website (https://www.unitedway.org/our-impact/featured-programs/2-1-1/ride-united).

in partnership with community-based organizations; the team will strive to capture participant experiences.

C. Integration with Existing Transportation Resources

72. Geographically, the Pocatello and Chubbuck area is spread out with most residential areas located miles away from important resources such as hospitals, doctors' offices, grocery stores, exercise facilities, and even schools. This challenge increases in rural areas such as Lava Hot Springs, Inkom, and McCammon. Community members who do not have access to a private vehicle have limited other options.

73. **Few public transportation options exist in the Pocatello-Chubbuck cities.** Pocatello Regional Transit (PRT) is based in Pocatello. They have several fixed routes and generally buses run during business hours with the earliest bus route beginning at 7:00 AM and the latest bus ending at 6:30 PM. It is important to note here that not every bus stop and route is available at these times. Typically, each bus stop is visited once an hour. Routes are longer than in many urban areas with riders needing to spend 15 minutes to one hour on the bus in order to reach their destination in many cases. PRT has routes that touch the edge of Chubbuck near North Pocatello providing service to the shopping center of Bannock County. Routes do not dip very far into the south end of Pocatello, but they do cover the public library and near Century High School on S 5th.

74. A common concern with public transit providers and users is the "first and last mile". Often, users must travel the first mile to a bus stop, and then they must travel the last mile from the bus stop to their destination. Many users do these miles on foot or via bicycle, but a barrier exists here for those who have difficulty doing so. This includes public transit users who are disabled or who have other difficulties such as parents with young children. Pocatello and Chubbuck have few roads with dedicated bicycle lanes which presents a concern for safety as drivers often struggle to safely share the road with cyclists.

75. In the more rural parts of Chubbuck in particular, there is virtually no practical access to public transportation options. This is also a problem in Pocatello for residential areas that are in the southern parts of town and other areas that are further away from the primary shopping centers.

76. For private transportation options aside from owning a personal vehicle, community members may seek to utilize ride share services such as Uber or Lyft. Pocatello and Chubbuck are also serviced by private, non-emergency medical transportation companies and taxi companies. The challenge with these options is that they are often too expensive for those experiencing poverty or for those who are reliant on social security income.

77. PRT provides a few commuter services that allow rural residents to travel to and from Pocatello. However, they do not currently operate a route that goes from Lava Hot Springs into Pocatello. There is also a gap in services for Inkom and McCammon. Even those who may have access to a personal vehicle may not have the ability to pay for gas to access services particularly in the current environment of record-high gasoline prices.

78. Current solutions to known barriers include PRT offering point-to-point services for a select group of at-risk community members. PRT offers point-to-point services for a select group of at-risk community members. To qualify for this service, they must be elderly or disabled and be able to arrange their ride in advance. Those who wish to use this service have to do some qualification paperwork through PRT prior to beginning use of this service.

79. Some organizations in Bannock County have a limited number of bus passes that they are able to offer to their clients. Organizations such as Health West, Aid for Friends, Family Services Alliance, and Pocatello Free Clinic all report that they offer this service occasionally. It seems that funding to be able to do this is relatively limited.

80. Medicaid covers non-emergency transportation in some situations, but the patient must make these arrangements in advance of the appointment. Some parts of Medicare may cover non-emergency transportation as well, but they would be supplemental to the basic coverage. Some private insurance companies may also cover this type of transportation, but we suspect that it is underutilized due to the lack of widely available information on the subject.

81. There are other known barriers to transportation in the local area. One of the largest concerns expressed by community members and community partners was the infrequency of bus stops and the lack of extended operational hours. Many reported that it was difficult to use the bus system for transportation to work and to run basic errands because of this. Additionally, many in our community lack knowledge about available bus routes and how to use PRT. This includes potential users of the bus system as well as employees of various community agencies. PRT has a well-developed website that includes video tutorials, bus route information, and even route mapping with connectivity to Google Maps. Part of the challenge seems to be a need for many community members to access printed route information as well as for agency employees to understand how the buses work so that they can offer education as well.

82. There are certainly gaps in service that PRT is able to provide. Regionally, they are the sole provider of public transportation which is also a unique difficulty. PRT also struggles to hire new bus drivers which limits their capacity to offer new routes and services.

83. Many of the bus stops in Pocatello and Chubbuck are unshaded and unsheltered which makes waiting for the bus to come in inclement weather challenging. Further, route and bus arrival times are not provided at bus stops currently. This presents an access challenge for many community members as well.

84. The proposed intervention will target the barriers that members of our community have in using transportation to access important services. One common scenario is a patient at the Pocatello Free Clinic who needs an urgent, same-day appointment at the hospital but lacks transportation to get there. This individual would not have time to access transportation that may be covered by private insurance, Medicaid, or Medicare, and they are often ineligible for point-to-point services offered by PRT. If they are eligible for those, they would not be able to schedule in advance in this particular situation. The team will make rides as accessible as possible by avoiding eligibility criteria and will initially work with community-based organizations to deliver rides, as this will allow for a controlled scale-up of Ride United.

D. Project Beneficiaries

85. The Project scope is limited to Bannock County and to those traveling into the County for services. Expected primary beneficiaries will be individuals within and outside of Bannock County utilizing healthcare services, collaborative partnerships participants, and healthcare service providers. Rides will be offered to increase access to healthcare services and to allow community members to address the social determinants of health. Thus, rides will provide increased access to healthcare organizations as well as housing services, educational resources, food, and more. We expect their demographics to be similar to the surveyed population under 50, as outlined in table 1 above. Secondary beneficiaries will include family and friends of those in need as certain components such as the transportation pilot is directly aimed to relieve and substitute service delivery that had to be filled by those members. Other secondary beneficiaries are larger jurisdiction public sector policy designers, as localized data and pilot initiative will clarify the outstanding need of the specific county. The Project lends greater insights to the resources and limitations of local-level actors that may be addressed either through a regulatory or budgetary reform.

E. Timeline for Year 2 Activities

86. Year 2 activities are framed within the period starting September 2022 and will span until August 2022. Each component contains accountable deliverables. The deliverables are tied and reflect the results chain that contributes to the overarching project development objectives.

Table 16: Project Timeline and Deliverables

Timeframe	**Project Deliverable**		
	Component 1	*Component 2*	*Component 3*
September 2022	Obtain signed MOU with SICOG. Continue attending community collaborative meetings and work with SICOG to promote buy-in from community agencies and government programs.	Outline plan to maintain and update ads on billboards, radio, and other electronic communication systems through August 2023. Help establish newsletter and plans for social media campaigns.	Develop backend technology to collect Ride United Applications. Help establish partner MOUs/contracts as needed.
October 2022	Lead partnership development for Ride United and establish partner MOUs/contracts based on capacity assessment. Share Year 1 data and results with community agencies.	Create and execute first social media campaigns to help the community better understand the health needs of Bannock County.	

	Manage Community Action Team.		
November 2022	Continuing sharing year 1 findings. Conduct outreach to each of the five levels of partners in subcomponent 1.1. to solicit Ride United applications. Finalize partnerships with public and private transportation companies	Create and execute a media campaign to promote Ride United to nonprofit and healthcare partners understand how to access rides to support client needs.	Support advertising of Ride United as needed and promote application. Finalize partnerships with public and private transportation companies.
December 2022	Continuing sharing year 1 findings. Conduct outreach to each of the five levels of partners in subcomponent 1.1. to solicit Ride United applications.		
January 2023	*Application opens: All members of the Community Action Team work to support the application process as needed.*		
February 2023	Continue attending community collaborative meetings and work with SICOG to solicit feedback on Ride United from partners.	Create and execute a media campaign to promote Ride United to the general public	Application closes Awards are made.
March 2023			Rides Begin
April 2023			On-going technical project monitoring.
May 2023		Create and execute second social media campaigns to help the community better understand the health needs of Bannock County. Share Ride United success stories with the public.	
June 2023	Review findings from technical project monitoring and from community feedback. Work with partners to develop year three plans.		
July 2023			
August 2023	Complete final project assessment.		First data collection timepoint.

F. Results Chain

87. Results chain summaries the program theory tying proposed components to objective outcomes. All components are designed upon known linkages to improving individual health for Bannock County residents. Due to the limitations in grant resources and with specific focus on leveraging community resources to address known social determinants of health, the components work within the limitation that they are not comprehensive. However, they are optimized within the given parameters of existing local healthcare infrastructure and institutionalized processes of healthcare availability and accessibility.

Table 17: Results Chain

Components	**Implementation Activities**	**Outputs**	**Short-Term Outcomes (Year 2 of funding)**	**Long-Term Outcomes (Years 3-4 of funding and beyond)**
Component 1: Network Management	Leverage existing health environments to support ongoing community collaboration and achieve continued by-in for the programs outlined in subcomponents 2 and 3.	Regular Community Action Team Meetings. Develop a strategy to leverage findhelpidaho.org to deliver rides Present Year 1 findings and continue the discussion of results. Attendance at the safe systems collaborative. Establishing MOUs and other forms of partnerships with transportation stakeholders. Creating on-going feedback opportunities at community meetings. Launch a newsletter to keep	Increase community engagement by establishing new modes of partnership Draft strategy to use findhelpidaho.org to meet transportation needs. Develop partnerships needed to expand the transportation infrastructure. Mobilize of community resources to address emerging and outstanding healthcare needs # of newsletters circulated	A community-based group that continues to work together to address on-going health needs. Create the infrastructure to integrate findhelp.org's marketplace feature into findhelpidaho.org to support increased access to transportation. Leverage partnerships to create and implement collaborative fundraising strategies that will be used to support Ride United over the long-term. Ensure that Ride United continues to fill gaps and not

		community members informed about the project.		replace our existing transportation infrastructure.
Component 2: Public Awareness & Education Engagement on Health Equity	Promote increased knowledge of health and Ride United via advertisements Work with stakeholders and partners to promote knowledge and use of existing transportation resources	Maintain and update ads on billboards, radio, and other electronic communication systems. Create and execute on going social media campaigns to help the community better understand the health needs of Bannock County Create and execute a media campaign to promote Ride United with two separate components. The first component will increase the knowledge of the general public The second component will help nonprofit and healthcare partners understand how to access rides to support client needs. Work with the SICOG to create and implement novel transportation outreach.	# of unidirectional advertisement products maintained # of new advertisements # of bidirectional (i.e., in person or conversation-based) events # of applications to Ride United Two completed social media campaigns. # of educational events health in collaboration with SIGOC.	On-going and informed community conversations about creating equitable access to healthcare and resources that improve the SDoH. Wide-spread awareness of Ride United and it's impact among nonprofit agencies and the public. Increased knowledge of existing transportation resources and infrastructure.

Component 3: Meeting an identified need via a transportation pilot	Launch Ride United to fill the immediate transportation needs in Bannock County Monitoring usage and troubleshoot the pilot.	Launch Ride United to address the unmet transportation needs in Bannock County Establish partnerships with public and private transportation companies. Build out the Community Investment portal to facilitate transfer of ride vouchers and other support (e.g., honoraria to support added cost to partner agencies) to community-based partners.	# of one-way Rides provided # number of partner agencies served. New Community Investment infrastructure created. New data collection methods launched.	Offer enough rides to meet the needs of partner agencies. Increase access to needed services by expanding the geographical reach of Ride United. Use data to continue to develop Ride United.

G. Year 1 Evaluation and Lessons Reflected in the Year 2 Project Design

88. Lessons were gathered from multiple partners and participations in project component designs. At its foundation, the Get Healthy Idaho program for Bannock County follows its on-going predecessor in Elmore County. Several meetings were held between grant recipients of Elmore County and Bannock County which were moderated by IDHW. Shared lessons include (i) meeting minority groups separately, (ii) thinking carefully about engagement instruments, (iii) paying attention to the urban-rural divide as there exists health infrastructure/staffing challenges and relatability challenges between the urban-based healthcare service delivery staff and the local population, (iv) strategically approaching to overcome health literacy challenges among the population with considerations on developing a conducive environment to make the connection on nonintuitive health linkages and resource accessibility awareness, (v) formulating a plan to fill the service void when residents are on mental health waitlist, which include developing toolkits and addressing transportation needs, (vi) doing the upstream work of asking people what they want to build buy-in traction, and (vii) sharing a holistic and collaborative vision for health that works towards system change, policy chance, and environmental change. Utilization of many of these insights will be grafted during the community collaborative design discussions. Of these, health literacy promotion and transportation pilot are direct manifestations that build on shared lessons.

89. Due to the multiplicity of funding streams that the Get Healthy Idaho grant draws from, a meeting was setup to directly speak and consult with the managers to receive input and hear best practices. Three

sources of funding have primary focus areas which are prevention, substantive abuse prevention and treatment, and maternal & child health. Prevention funded project lessons include developing measures for essential data particularly in identifying emerging health gap using the Healthy People 2030 objectives, thinking about work to promote sexual violence prevention, and tackling low hanging fruit such as the free-to-low-cost fall prevention classes for the elderly population. The wide spectrum and funded activities that fall under public health and Healthy People 2030 objectives, incorporation and adoption of best practices will anchor discussions within the community collaborative.

90. Substantive abuse prevention funds are utilized to address opioid crisis and launch suicide prevention program. Overdose response and awareness funding is a collaboration between the Centers for Disease Control and Prevention (CDC) and the Bureau of Justice Administration (BJA). The latter has a program on NARCAN, the opioid overdose treatment. Prevention programs for excessive alcohol consumption also is funded with this line. Data and analysis are also supported to examine both the upstream blind spots such as prescription practices and immediate response to prevent overdose deaths. Furthermore, preventive and rehabilitative activities such as getting to care and safe syringe programs are covered as well. Awareness advertisements on buses are supported and funded. Fund eligibility is widened to cover kids and foster care challenges as well. Many of these lessons are integrated into the components. For example, the United Way team has created the infrastructure to use the Ride United delivery program, a small pilot project operating in Pocatello and Chubbuck that uses Door Dash to deliver food and other goods, to deliver pharmaceuticals such as NARCAN. In year one, this small program was not integrated with the Get Healthy Idaho program; we have decided to integrate the projects to allow for increased coordination and community outreach.

91. The third funding source objectives rests on maternal & child health which covers a wide spectrum. Wide spectrum in the sense that it includes projects to address child poverty, support for home visits, attention to children and youth with special healthcare needs, women and infant health, and reproductive and adolescent health. Specific project design lessons were not shared but flexibility to local conditions were emphasized, as the funding source has the flexibility to incorporate innovative solutions tailored to the local context. Tailoring to idiosyncratic local conditions was emphasize in Bannock County Get Healthy Idaho grant. The first step being collecting local-level data to trim to local circumstances. As for the incorporating beneficiaries to be explicit on mother and children, it will be addressed via substantive health content in health and wellbeing awareness program, outreach to promote utilization by mothers on transportation initiatives, and working with community collaborative partners to improve services with the specific beneficiaries in mind. For example, a community partner wishes to strengthen their book giving program to young mothers to promote reading. In addition, partnerships with Southeast Idaho Public Health (SIPH) lead to the development of the Ride United Transportation program described in Component 3; in these conversations we discovered that WIC participants have difficulty keeping program appointments and access their benefits because SIPH offices are not served by PRT. In addition, discussions revealed that parents using WIC services would benefit from point-to-point services as the WIC offices sit atop a large hill outside of the Pocatello City limits.

92. Lessons learned are also drawn from the United Way of Southeastern Idaho, Pocatello Free Clinic, and Idaho State University. All have longstanding on community engagement, service delivery, and knowledge-based expertise. The United Way of Southeastern Idaho served as the lead agency for this

project and was primarily responsible for managing the Community Action Team (CAT), the community collaborative, and other supporting agencies as they all worked to achieve the goals, objectives, and strategies outlined in the proposal. Below is a short self-assessment that includes lessons learned in working towards goals 1 and 2 as provided in the grant proposal.

- Goal 1: Establish an action-focused collaborative within the first two months of phase one of the grant funding period.
    - Objective 1.1: Host first collaborative meeting by November 30th, 2021 and prepare the members to work together to discuss data and to develop shared community-based solutions.
    - Objective 1.2: Assure diverse community voices are invited to participate in the collaborative.
    - *Lessons learned*: The set of objectives associated with this goal turned out to be some of the most difficult challenges faced by the project team. While there was significant interest in the vision of the project, a number of interrelated issues delayed the start of the community collaborative.
    - First, UWSEI prioritized building meaningful relationships with organizations and individuals from traditionally underrepresented groups, and particularly the Shoshone Bannock tribe. We met with several representatives from Tribal Health and from an independent clinic owned by tribal members located on tribal land. In all cases, tribal members expressed interest in participating in the project, but there were significant barriers associated with obtaining the required approvals that our team did not adequately consider when planning the timeline for this project. To provide more time for outreach, our team delayed convening the collaborative. In the context of this project, we found that Tribal Health officials did not feel comfortable participating in any aspect of the project unless data collection was paused to pursue a second IRB approval. In addition, many tribal agencies were working diligently to respond the to the COVID-19 pandemic and were in the midst of managing their own grant-funded projects. This also appears to have limited their availability to participate in this project. To address this issue, the team will use a more expansive outreach strategy (see Component 1) that will allow for community members to vary their level of involvement in response to the many demands on their time. The UWSEI team will continue to connect with Tribal partners wherever possible and will always invite them to participate in our project where appropriate.
    - Second, UWSEI hoped to bring other marginalized populations into the collaborative, particularly low-income community members with lived experience. A fund was set up to support their participation. However, we did not successfully anticipate the extent to which chronic resources gaps would prevent members of this community from participating in collaborative meetings. For example, a number of focus group participants wanted to join collaborative meetings, but they had no device that we could use to reliably contact them. In this way we didn't fully appreciate the structural barriers faced by this part of our community. To address this in the second year, we plan to work more closely with the organizations that have established relationships and methods of communication with these community members. In addition, we hope that the multilevel approach to offering communication options will increase the level of

access community members will have to this project. UWSEI continues to be committed to inviting community members with sufficient interest to join the CAT team.
    - Lastly, while a number of organizations joined our community collaborative, UWSEI received feedback that representatives from these organizations thought that there are already too many collaboratives and community meetings competing for their time. To avoid this issue, UWSEI decided to merge their collaborative with SICOG's Safe Systems group.
- Goal 2: Mobilize the CAT, lead by Dr. Wuest, Dr. Ryu, and Dr. Mispireta by October 2021 to plan to implement the Community Health Assessment and continue to build the team throughout phase one.
    - Objective 2.1: Begin Community Health Assessment by November 2021 using the findings to identify the root causes driving poor health outcomes in our community.
    - Objective 2.2: Work with the collaborative to continue to build the Community Action Team.
    - The CAT was highly successful throughout the project. This team met regularly to develop the assessment, monitor data collection, and review the results. A key strength of this team has been the diverse areas of expertise of each member, which resulted in the use of a multiplicity of methods at every phase of the project. Given the CAT's diverse backgrounds, methodological assumptions rarely went unchecked. Another strength of the CAT was the involvement of students who greatly assisted the project though out. Their unique intellectual and personal backgrounds was invaluable to collecting and analyzing the data. Key lessons learned include the importance of building in time at every meeting for CAT team members to both discuss the project and to discuss their unique perspectives. By doing this, the CAT came to better understand how each member's area of expertise uniquely contributed to the project and to incorporate those views into this document.
    - The CAT learned a number of practical lessons related to data collection as well. First was that while technology may streamline the process, participants from vulnerable populations seem to prefer paper surveys. We also found that this population struggles to report their income levels. The PRAPARE survey asks participants to estimate their annual income. Research indicates that community members from vulnerable populations tend to estimate their monthly income more accurately, so the CAT asked community members to provide their monthly income levels. However, when cleaning the data, the responses were difficult to interpret. For example, if a participate indicated that their monthly income was $20,000 then there are two possible interpretations. The response could have come from a high-earning community member or from a low-income community member who misread the question. Thus, this data was excluded from the quantitative data presented above and the CAT was not able to use it to determine the poverty level of the respondents as planned.

IV. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

93. As the primary funder of the project, Idaho Department of Health and Welfare's Get Healthy Idaho program enables the project. It serves as a conduit and coordinator between the grant recipient and the various program lines funding the joint initiative. It also serves as a knowledge management and exchange moderator between different grantees to ensure best practices are shared and reflected upon to hone project effectiveness. It coordinates with the primary grant recipient, the United Way of Southeast Idaho based in Pocatello, to receive project progress reports and offer troubleshooting when overseeing compliance to associated administrative regulations.

94. At the project execution stage, multiple entities are involved. This is deliberate and by design. It is most evident in Component 1 since the activities and pooled resources have clear short-term goals of coalescing the collaborate partnership among community actors involved in improving health of Bannock County residents. Due to the diversity of the entities involved, the institutional arrangements discussed in this document are restricted to the network management arrangements. The collaborative partnership is a voluntary consortium. Thus, the level of voluntary engagement by its members are dictated by each organization's unique circumstance both on staffing and resources. This is something outside the risk management control of the recipients listed in the grant. Cognizant of this operating environment, the grant recipient parties need to partake in necessary coordinating and incentivizing measures to elicit voluntary participation from community entities.

95. Network management functions needs to be assumed by a dedicated party for its reliable execution. This secretariat-equivalent role is assumed by the United Way of Southeastern Idaho with strategic input from Pocatello Free Clinic and Idaho State University. In addition to coordinating logistics, meetings need to be meaningful and beneficial to its members for continued engagement and partnership. This requires dedication staffing on two fronts. First, staff time is required for working out logistics and moderating the meetings. Second, it requires staff time to identify and update participating organization's operating circumstances and new initiatives. The latter an important function as it help determine necessary institutional incentives that needs to be in place in the on-going meetings.

96. The United Way of Southeastern Idaho assumed another key institutional role for designing Component 2 activities. Awareness activities and its associated marketing activities requires communication expertise. This is supplied and coordinated by a dedicated communication specialist within the organization. Various associated and relevant activities such as medium choice decisions in light of the potential exposure and reach will be handled internally. Institutionally, the internalization of these activities is preferred as it is production process where a single risk management entity is in a better position to make expertise-based design decisions in a timely fashion to meet production timelines. Substantive health related inputs will be drawn from complementary information sourcing activities with grant partners entities of Pocatello Free Clinic and Idaho State University.

97. United Way of Southeastern Idaho is responsible for the implementing Component 3 in partnership with Pocatello Free Clinic, other healthcare delivery institutions, and community agencies that service clients from communities that struggle to access services that promote health and wellbeing.

Since the component involves a point-to-point transportation, a working relationship must be maintained with destination healthcare delivery entities along with transportation service delivery units. Since the component works as a reimbursement scheme, it requires eligibility checks to prevent inadvertent disruption to normal market activities and to maximize service provision to those most in need.

B. Sustainability

98. The project is economically sustainable overtime as the project promotes timely and preventative activities of its beneficiaries. It also draws and leverages community resources that is beyond the funded scope of the project but that are still linked to the overall project objective. Thus, the economic benefits for the community are large relative to the financial costs launching the project. Also, timely information sharing among community partners on actionable items and promoting valuable healthcare information to individuals for timely responsive and voluntary action reduces negative externality costs of inaction. The opportunity costs of not launching the project are high based on concerning health indicator patterns.

99. The project will be financially sustainable with critical developments during the 4-year project tenure. For Component 1, the collaborative partnership could either impose membership fees or include coverage of staff hour costs in subsequent grant project that arise from the meetings. The latter would be equivalent to the grant consultancy fee and remove the burden of membership fees that may be prohibited by organization charters of the partners. Another means would be to do a rotational secretariat model whereby different key partners will dedicate staff for logistics and outsource activity costs. These suggestions on alternative financing models require that there are clear outputs and actionable items benefitting the collaborative community partners.

100. Component 2 could become financially sustainable either by dedicated budget from the government or via a contribution means through beneficiary healthcare service entities. The former would ensure the independence of focusing on high priority health inequality issues as the latter would be tied more directly to healthcare service delivery usage. For the former, progress indicators on community health would justify the intervention as a necessary social infrastructure initiative.

101. Financial sustainability of Component 3 beyond the project period will depend on a number of factors, most important, will be the cost of the service. Ride United is currently designed to the be a free program. Thus, on going sustainability would require the development of new revenue streams. This could include creating formal relationships with for-profit stakeholder services, such as health insurance companies. These companies could benefit from supporting Ride United as that might serve their business interests as the American health care system moves toward a value-based payment system. In addition, there is precedent for United Ways to work with nonprofit hospital systems to complete the community health needs assessments required by the IRS to maintain tax-exempt status. Alternatively, Ride United could collect some fees. If that option were to be considered, then the CAT could complete a financial modeling exercise once multi-year ride usage statistics are collected. The financial modeling would construct a minimum fee structure for its users. A multi-year statistic is required since usage volume scales up with awareness over time. A short-term usage figure will be inaccurate assessment of demand and revenue projections with implications of over estimating minimum fees for sustainability. Furthermore, any reimbursement eligibility or grant would further bring down the minimum fee. Thus, financial sustainability assessment and calculations needs to be done when more data is collected.

102. Institutional sustainability will be established during the project period as each component consequentially build internal capacity of involved entities to collectively work to address inequity in healthcare access. By strengthening internal capacity via continuing to work with and across community partners while delivering on specific component outputs, Bannock County will have an institutionalized initiative on healthcare inequity. The project establishes a focal point for such collective action while experience layered on expertise will enhance the local knowledge reservoir on the subject.

V. PROJECT APPRAISAL SUMMARY

A. Economic and Financial Analysis

103. Total healthcare spending for Bannock County residents is unknown. Tallying the annual aggregate costs is difficult due to myriad reimbursement structure in which the healthcare sector operates upon. To come up with an aggregate tally, it requires collecting information three major sources, which are private health insurance companies, Medicaid, and Medicare. Out-of-pocket costs incurred by those without health insurance needs to be added on top of this tally. Without an aggregate tally of annual healthcare spending, it is difficult to create a baseline figure for economic and financial analysis. Data collected through this project will shed light to the population experiencing disenfranchisement from the system.

104. The economic justification of the project is satisfied when reviewed within the broader framework of social infrastructure investment. Due to the social infrastructure nature of the project where cost-benefit linkage lags, externalities exist, and opportunity costs are present, project justification comes from an economic analysis rather than a financial analysis. It also is typically publicly funded since government has a longer time horizon and are in a better position to weigh in positive externality elements. For this project, inaction has direct non-monetary consequences to the beneficiary population and partner entities.

105. Inaction in setting up a dedicated collaborative partnership among Bannock County community actors results in opportunity costs of duplication and loss in synergistic ventures. It also results in splintered and fragmented outreach activities. The loss of potential synergy gains is difficult to measure monetarily as it involves estimations on counterfactuals. However, once the project is launched the project by design will accrue data on potential synergy gains and provide valuable information to the funders on assessing potential benefit in replicating such initiative on other Counties.

106. Similarly, failure to launch this project raises opportunity costs for timely behavior change action. Due to the reimbursement and eligibility nature of healthcare service delivery system of the United States, voluntary proactive initiative by the individual is required to trigger preventative healthcare from being delivered. Within an environment of high healthcare costs and opaque pricing for healthcare services, the individual errs on the side of inaction in seeking health services rather than proactive action. The burden of taking care of those who needs medical attention are often unaccounted monetarily as it often falls upon family members.

107. Calculating the cost of inaction for Component 3 is more straightforward than the first two components. There are direct costs incurred by the healthcare service entity for missing appointments. There are clear health consequences for those not able to make it to their appointments. However, since the CAT does not currently have access to this data, it may take time to understand the extent to which Ride United add value for health services.

B. Technical

108. Technical expertise for healthcare delivery rests upon health sector professionals and its housing organizations. The reimbursement mechanism rests upon the respective private insurance, Medicaid, and Medicare program managers and their staff. Healthcare priority items are compiled by quasi-public health boards and corollary committees. Among the grant partners, Pocatello Free Clinic assumes the technical expertise role on healthcare service delivery within the project.

109. Project management technical expertise for project rests upon the United Way of Southeastern Idaho. As the nonprofit with many years of grant management expertise under its belt, the necessary project risk management and reporting will be lead and if necessary, handled by the organization. It also supplies technical expertise on data collection and community engagement. Idaho State University complements the United Way of Southeastern Idaho by providing input on project management and analysis.

C. Procurement

110. All subcontract procurement is handled by the United Way of Southeastern Idaho in accordance with guidelines set by Idaho Department of Health and Welfare. All procurement requires review and clearance by Idaho Department of Health and Welfare.

D. Social

111. As a healthcare intervention project to abate inequity in healthcare access, beneficiaries are skewed toward vulnerable and neglected populations. The overarching objective is to partner with community entities to serve those in need but lacking resources and requiring assistance.

E. Environment

112. 117. There are no large noticeable environmental consequences from the project. No alternation of the environmental landscape is expected.

VI. GRIEVANCE REDRESS SERVICES

113. Potential areas where grievances may arise are during community partnership meetings and transportation service delivery. Grievances are unlikely to emerge during awareness programs and it is limited to sharing information on health and healthcare access. For community partnership meetings, like all network management, grievances may emerge when participants feel they are not being heard and their agenda not being treated as a priority. A capable moderator would avoid such scenarios from emerging. However, certain members may be more vocal and assertive than others. Such happenings crowd out time for others to speak. Thus, separate channels are developed to deliver grievance redress services. The hosting nonprofit may serve this role as well as the representative from Idaho State University.

114. Grievances may arise when executing Component 3. Due to the skewed nature of the beneficiary coverage on vulnerable populations, questions may arise on eligibility. This is a more complicated nature requiring case-by-case review. A protocol on documentation and reporting will be maintained to prevent both abuse of service by those with resources and by outright denial of requests stemming from unique circumstances. A dedicated staff at the project management unit, the United Way of Southeastern Idaho, will handle such grievance situations.

VII. KEY RISKS

115. Project-related risks are allocated to the appropriate risk management parties. For Component 1, key risks exist in holding together the network membership and eliciting participation. To ensure continued participation in regularized meetings, it is vital that network participation aligns with each of the member's own organizational goals and preferences. These are not always explicit as staffing and resource capacity varies among the members. Thus, a dedicated network management staff needs to both moderate and cater to the meeting to ensure amicable and cooperative atmosphere before, during, and after the meetings. Risk allocation and management is tied with grievance redress channels and its timely operations.

116. Risk for Component 2 lies in unreached potential beneficiaries within selected awareness medium. Digital content requires digital literacy. Sheet signs requires crossing the specific area for visibility. Public transportation adverts also require usage and interaction. Also, depending on specific need and target population, language literacy may be a challenge, especially when requiring following up oral and written communication. Identification of these communication exposure blind spots is covered and addressed by the communication specialist. Also, due to the complicated medical terminology, alternative forms of communication such as using infographics and alternative forms of communicating health data will also be strategized by the communication specialist to minimize risk of not reaching the intended population.

117. Component 3 risk lies in promotion, timely request processing, and transportation service outsourcing availability. Strategic promotion is required to optimize servicing those in most need. Thus, making sure those in need are aware of the service is critical. Timely request processing is required whether it be through an online platform and/or agencies. Of the three, transportation service outsourcing carries the greatest risk as it requires entrepreneurs to make investment responding to the rise in demand. Since it requires mobilization of investment resources by third parties outside of the project scope, a close monitoring of service availability in local area is required. Risk management fall upon the issuing unit, as it is in the best position to monitor gaps in issuance and utilization of ride-vouchers.

118. Outside of component activity risks, general project management unit risks exist. Capacity building within the project execution units is a natural by-product since there are pilot dimensions. Thus, retaining responsible party members are essential to economy and efficiency as the project builds on past knowledge and forged relationships. Any changes to the project management unit, which is the grant recipient body, should be reported.

VIII. YEAR TWO EVALUATION PLAN

119. The evaluation that will be used in year two mirrors the chain results table and builds upon the insights generated in section V. The evaluation framework for year two is provided in Table 18 below. While the overarching goal of this Get Healthy Idaho place-based initiative will continue to be to address the root causes of health disparities, it will take some time to collect enough information to outline a causal nexus. Therefore, in Year 2, the continued evaluation of the project will include goals designed to help the team to eventually build a complete picture of how each component is measurably improving health outcomes by addressing upstream barriers.

Table 18: Year Two Evaluation Plan

Outputs	**Short-Term Outcomes (Year 2 of funding)**	**Monitoring and Assessment Strategies**
Component 1		
Regular Community Action Team Meetings. Develop a strategy to leverage findhelpidaho.org to deliver rides Present Year 1 findings and continue the discussion of results. Attendance at the safe systems collaborative. Establishing MOUs and other forms of partnerships with transportation stakeholders. Creating on-going feedback opportunities at community meetings.	Increase community engagement by establishing new modes of partnership Draft strategy to use findhelpidaho.org to meet transportation needs. Develop partnerships needed to expand the transportation infrastructure. Mobilize of community resources to address emerging and outstanding healthcare needs # of newsletters circulated	This component will be assessed using a network management approach. This will include collecting information of effort, communication, and outreach strategies. Feedback and guidance will be provided on a regular basis help the implementation team balance the diverse strategies being used. Key features of this assessment will include: • How well is the core network defined? • What key sectors are represented? • What key sectors are missing? • What issues exist amongst partnerships at all levels? • Do knowledge gaps exist within the partnership? • Are there barriers limiting the effectiveness of the network? • Does the network have potential to work together to raise funds to support the future sustainability of the program? After each question is answered, we will work to identify strategies to address any emergent issues[12].

[12] BetterEvaluation (n.d.) Network Evaluation. Retrieved from http://betterevaluation.org/themes/network_evaluation

Launch a newsletter to keep community members informed about the project.		
Component 2		
Maintain and update ads on billboards, radio, and other electronic communication systems. Create and execute on going social media campaigns to help the community better understand the health needs of Bannock County Create and execute a media campaign to promote Ride United with two separate components. The first component will increase the knowledge of the general public The second component will help nonprofit and healthcare partners understand how to access rides to support client needs. Work with the SICOG to create and implement novel transportation outreach.	# of unidirectional advertisement products maintained # of new advertisements # of bidirectional (i.e., in person or conversation-based) events # of applications to Ride United Two completed social media campaigns. # of educational events health in collaboration with SIGOC.	The goal of the component is to build awareness in the general public about existing health inequity in Bannock County and how those inequities can be addressed. This component will primarily be evaluated by achieving the outcomes on time. Whenever possible, we will also assess these efforts by providing surveys at in-person events. At the conclusion of year two, we will also review the following questions: • Define key audience segments that we connected with where possible (i.e., when targeted ads were using, direct mail, and other audience-specific strategies). • Where there gaps in outreach that limited the effectiveness of the outreach? • What could we have done differently? • What aspects of the public education strategy can be continued in this project or expanded to increase impact? • What public events were successful, what were not? How can they be improved? • What did we learn in this process?
Component 3		
Launch Ride United to address the unmet transportation needs in Bannock County	# of one-way Rides provided # number of partner agencies served.	This component will be assessed by determining if the number of rides provided met the community need and by trying to understand how increased access to transportation services improves the health and wellbeing of the

Establish partnerships with public and private transportation companies. Build out the Community Investment portal to facilitate transfer of ride vouchers and other support (e.g., honoraria to support added cost to partner agencies) to community-based partners.	New Community Investment infrastructure created. New data collection methods launched.	Bannock County community. Since there will only be limited information available at the end of year 2, this assessment will focus on helping the Ride United Team to understand emerging strengths and weaknesses in the approach. At the end of year two, we will outline how the rides were used to promote access to good and services that promote health and well-being. Then the team will assess the extent that increased access addressed known gaps related to the social determinates of health. In this way, the team will build a picture of how Ride United can and cannot address the upstream causes of Bannock county's health inequity.

120. In addition to indicators drawn from the results chain table, progress toward overarching Get Healthy Idaho program objectives should be reported. More specifically, progress should be reported in conjunction of how on-going activities are conducive in utilizing community collaboration to improve health equity in Bannock County. Activity completion and output generation are closely monitored by the grant recipient parties on a quarterly timeline. The reporting frequency will be predetermined, as data collection, clarification over data, analysis, and the actual editorial work of compiling the report do take away staff time from other activities.

121. The overall project objective is to establish and utilize community collaboration to improve health equity in Bannock County. The following three key indicators serve as interlocutors between this overarching objective and the specific components comprising the project: 1) continued participation in a community collaborative and on-going outreach to stakeholders, 2) percentage reduction of both downstream and upstream barriers to healthcare, and 3) mobilization of community resources to address emerging and outstanding healthcare needs. Sub-level project progression indicators are further developed based on expected outputs. However, due to the non-perfect substitution of numerical values, i.e. not every meeting is identical in terms of content and participatory dynamics despite being counted to be identical, a complementary qualitative reporting is necessary to better assess progress and potential pothole obstructions. The qualitative results monitoring is critical since progress towards to the final objective involves a behavior change component of beneficiaries. Since behavior change decisions involve individualized information absorption variations, it is important to capture and discuss these risk factors via a qualitative report.

122. Idaho State University involvement is called during analysis and evaluation of the results. It is tasked with follow-up studies regarding the emerging patterns associated with the project and will lead the year-two evaluation. Since the project operates within an open-system, factors outside of the project design do impact the potential beneficiary population and their behaviors. The analysis and evaluation need to filter out project related explanations behind the patterns from other factors impacting the beneficiary population.

Appendix A. Primary care and dental care providers servicing Bannock County

Table 19: Primary Care Providers in Bannock County

Name	# of Providers	Specialty	Address
Southeastern Idaho Public Health	3	Family Practice	1901 Alvin Ricken Drive, Pocatello
Aurora Medical	1	Family Practice	348 W Clark St, Pocatello
Portneuf Medical Group Specialized Family Medicine-055	2	Family Practice	151 N. 4th Ave, Suite B, Pocatello
Bingham Healthcare Specialty Clinic-4th Ave Ste 110-003	3	Family Practice	353 N 4th Ave, Suite 110, Pocatello
Idaho State University Health Center	6	Family Practice	990 Cesar Chavez Ave, Pocatello
Bella-Nacole Mental Health Services LLC-001	1	Family Practice	850 East Young Street, Pocatello
Health West Pocatello – SL01	7	Family Practice	1000 N 8th Ave, Pocatello
Portneuf Primary Care-036	5	Family Practice	500 S 11th #303, Pocatello
Health West Pediatrics & OBGYN-003	6	Pediatrics	500 S 11th Ave Ste 204, Pocatello
1st Choice Urgent Care Bannock Highway-003	3	Family Practice	1595 Bannock Hwy, Pocatello
Health West Inc Family Medicine FFS Clinic-003	55	Family Practice	465 Memorial Drive, Pocatello
Wise, David	1	Family Practice	115 S 15th Ave, Pocatello
Amerihealth Pocatello-003	5	Family Practice	396 Yellowstone Ave, Pocatello
Health Innovations	1	Family Practice	240 N 18th Ave Ste 1, Pocatello
MVH PIC LLC	13	Family Practice	495 Yellowstone Ave, Pocatello
Physicians Optimal Health-Pocatello-003	3	Family Practice	495 Yellowstone Ste A, Pocatello
Physicians & Surgeons Clinic of Pocatello-SL01-001	1	Family Practice	1151 Hospital Wy Bldg D-100, Pocatello
Pocatello Childrens Clinic	11	Pediatrics	1151 Hospital Way, Bldg F, Pocatello
Pocatello Women's Health Clinic-002	14	OB/GYN	777 Hospital Way Ste 300, Pocatello
Primary Care Specialists	3	Family Practice	110 Vista Drive, Pocatello
Mountain View Family Medicine, Inc.	4	Family Practice	2006 Birdie Thompson Dr, Pocatello
Idaho Modern Medicine-PPLC	1	Family Practice	1000 Pocatello Creek Rd Ste E10, Pocatello
West Family Medicine	3	Family Practice	1133 Call Creek Place, Suite A, Pocatello
Pocatello Wellness Clinic	2	Family Practice	115 Yellowstone Ave, Suite D, Pocatello
CC Pocatello LLC	19	Family Practice	1595 Yellowstone Ave, Pocatello
Health West Chubbuck-002	20	Family Practice	880 W Quinn Rd, Pocatello
Brizzee Family Medicine Inc	1	Family Practice	2010 Flandro Dr, Pocatello
Intermountain Medical Clinic-Family Practice Group, P.A.	14	Family Practice	1951 Bench Rd, Suite B, Pocatello
Clifford, Clark, and Walker Family Medicine-002	3	Family Practice	4750 Yellowstone Ave, Pocatello

Family Medical Clinic of Chubbuck-001	1	Family Practice	476 E Chubbuck Rd, Pocatello
Physicians Immediate Care Chubbuck-002	12	Family Practice	134 W Chubbuck Rd Ste B, Pocatello
Physicians Optimal Health-Chubbuck-004	2	Family Practice	134 W Chubbuck Rd Ste C, Chubbuck
Total number of Healthy Connections Primary Care Providers in Pocatello and Chubbuck	**223**		

Source: https://healthandwelfare.idaho.gov/clinics

Table 20: Dental Care Providers in Bannock County

Dentist with MCNA Plan Coverage	
Fackrell Family Dentistry	415 N 3 Ave, Suite A, Pocatello
Health West Community Dental Care	1000 N 8 Ave, Pocatello
Oak Mountin Dental PLLC	135 Warren Ave, Pocatello
Idaho State University Dental Hygienist Clinic	999 Martin Luther King Jr Way, Pocatello
Oral Surgery Specialist of Idaho	165 N 14 Ave, Pocatello
Endeavor Dental Group	1541 E Clark St, Pocatello
Dentures by Design	115 South 15 Ave, Suite D, Pocatello
Desert Valley Dentistry	716 Yellowstone Ave, Pocatello
Sugar Bugs Pediatric Dentistry	716 Yellowstone Ave, Pocatello
Children's Dentistry of Pocatello	425 E Alameda Rd, Pocatello
Comfort Care Dental of Pocatello	485 E Alameda Rd, Pocatello
Dentistry for Kids Pocatello PLLC	625 E Alameda Rd, Pocatello
Idaho Center for Oral and Facial Surgery	1777 Vista Dr, Pocatello
Yellowstone Dental Associates PLLC	115 E Chapel Rd, Pocatello
Care Creek Dental	1169 Call Creek Dr, Suite A, Pocatello
Williams Family Dentistry	1130 Call Creek Dr, Pocatello
Portneuf Valley Dental	1246 Yellowstone Ave, Suite D3
Bringhurst Family Dentistry PLLC	1175 Call Pl, Suite 200, Pocatello
Adventure Orthodontics	732 W Quinn Rd, Suite 200, Pocatello
Just 4 Kidds Dentistry for Children	732 W Quinn Rd, Suite 100, Pocatello
Modern Smiles	1800 Flandro Dr, Suite 340, Pocatello
Total number of dental facilities in Bannock County servicing Idaho Smiles Medicaid and CHIP Plan	**21**

Source: https://locator.mcna.net/

Appendix B. American Medical Association governed specialties and subspecialties

Table 22: Medical Board Governed Specialties and Subspecialties

Specialty	Subspecialty
1. Anesthesiology	1. Adult Cardiac Anesthesiology 2. Critical Care Medicine 3. Hospice and Palliative Medicine 4. Neurocritical Care 5. Pain Medicine 6. Pediatric Anesthesiology 7. Sleep Medicine
2. Colon and Rectal Surgery[a]	
3. Dermatology	8. Dermatopathology 9. Micrographic Dermatologic Surgery 10. Pediatric Dermatology
4. Emergency Medicine	11. Anesthesiology Critical Care Medicine 12. Emergency Medical Services 13. Hospice and Palliative Medicine 14. Internal Medicine – Critical Care Medicine 15. Medical Toxicology 16. Neurocritical Care 17. Pain Medicine 18. Pediatric Emergency Medicine 19. Sports Medicine 20. Undersea and Hyperbaric Medicine
5. Family Medicine	21. Adolescent Medicine 22. Geriatric Medicine 23. Hospice and Palliative Medicine 24. Pain Medicine 25. Sleep Medicine 26. Sports Medicine
6. Internal Medicine	27. Adolescent Medicine 28. Adult Congenital Heart Disease 29. Advance Heart Failure and Transplant 30. Cardiology 31. Cardiovascular Disease 32. Clinical Cardiac Electrophysiology 33. Critical Care Medicine 34. Endocrinology, Diabetes and Metabolism 35. Gastroenterology 36. Geriatric Medicine 37. Hermatology 38. Hospice and Palliative Medicine 39. Infectious Diseases 40. Interventional Cardiology 41. Medical Oncology 42. Nephrology 43. Neurocritical Care

	44. Pulmonary Disease 45. Rheumatology 46. Sleep Medicine 47. Sports Medicine 48. Transplant Hepatology
7. Medical Genetics and Genomics[b] - Clinical Biochemical Genetics - Clinical Genetics and Genomics (MD) - Laboratory Genetics and Genomics	49. Medical Biochemical Genetics 50. Molecular Genetic Pathology
8. Neurological Surgery - Neurocritical Care	
9. Nuclear Medicine[a]	
10. Obstetrics and Gynecology	51. Complex Family Planning 52. Critical Care Medicine 53. Female Pelvic Medicine and Reconstructive Surgery 54. Gyneocologic Oncology 55. Maternal-Fetal Medicine 56. Reproductive Endocrinology and Infertility
11. Ophthalmology[a]	57.
12. Orthopaedic Surgery	58. Orthopaedic Sports Medicine 59. Surgery of the Hand
13. Otolaryngology-Head and Neck Surgery	60. Complex Pediatric Otolaryngology 61. Neurotology 62. Plastic Surgery within the Head and Neck 63. Sleep Medicine
14. Pathology - Pathology – Anatomic/Pathology – Clinical - Pathology – Anatomic - Pathology – Clinical	64. Blood Banking/Transfusion Medicine 65. Clinical Informatics 66. Cytopathology 67. Dermatopathology 68. Hermatopathology 69. Neuropathology 70. Pathology – Chemical 71. Pathology – Forensic 72. Pathology – Medical Microbiology 73. Pathology – Molecular Genetic 74. Pathology – Pediatric
15. Pediatrics	75. Adolescent Medicine 76. Child Abuse Pediatrics 77. Developmental-Behavioral Pediatrics 78. Hospice and Palliative Medicine 79. Medical Toxicology 80. Neonatal – Perinatal Medicine 81. Pediatric Cardiology 82. Pediatric Critical Care Medicine 83. Pediatric Emergency Medicine 84. Pediatric Endocrinology

	85. Pediatric Gastroenterology 86. Pediatric Hermatology – Oncology 87. Pediatric Hospital Medicine 88. Pediatric Infectious Diseases 89. Pediatric Nephrology 90. Pediatric Pulmonology 91. Pediatric Rheumatology 92. Pediatric Transplant Hepatology 93. Sleep Medicine 94. Sports Medicine
16. Physical Medicine and Rehabilitation	95. Brain Injury Medicine 96. Neuromuscular Medicine 97. Pain Medicine 98. Pediatric Rehabilitation Medicine 99. Spinal Cord Injury Medicine 100. Sports Medicine
17. Plastic Surgery	101. Plastic Surgery within the Head and Neck 102. Surgery of the Hand
18. Preventive Medicine - Aerospace Medicine - Occupational Medicine - Public Health and General - Preventive Medicine	103. Addiction Medicine 104. Clinical Informatics 105. Medical Toxicology 106. Undersea and Hyperbaric Medicine
19. Psychiatry and Neurology - Psychiatry - Neurology - Neurology with Special Qualification in Child Neurology	107. Addiction Psychiatry 108. Brain Injury Medicine 109. Child and Adolescent Psychiatry 110. Clinical Neurophysiology 111. Consultation – Liaison Psychiatry 112. Epilepsy 113. Forensic Psychiatry 114. Geriatric Psychiatry 115. Neurocritical Care 116. Neurodevelopmental Disabilities 117. Neuromuscular Medicine 118. Pain Medicine 119. Sleep Medicine 120. Vascular Neurology
20. Radiology - Diagnostic Radiology - Interventional Radiology and Diagnostic Radiology - Medical Physics (Diagnostic, Nuclear, Therapeutic) - Radiation Oncology	121. Neuroradiology 122. Nuclear Radiology 123. Pain Medicine 124. Pediatric Radiology
21. Surgery - General Surgery	125. Complex General Surgical Oncology 126. Pediatric Surgery

- Vascular Surgery	127. Surgery of the Hand 128. Surgical Critical Care
22. Thoracic Surgery - Thoracic and Cardiac Surgery	129. Congenital Cardiac Surgery
23. Urology	130. Female Pelvic Medicine and Reconstructive Surgery 131. Pediatric Urology

Source: https://www.abms.org/wp-content/uploads/2021/12/ABMS-Guide-to-Medical-Specialties-2022.pdf

Appendix C: Organizations that accept Medicaid:

Finding a provider that accepts Medicaid can be a possible barrier for seeking healthcare services. For this reason, we have compiled a list of organizations that accept Medicaid patients. The number of providers limits the number of available appointment slots and can increase waiting times.

Table 23: Medicaid Servicing Organizations

Name	Number of Registered Doctors and Clinicians	Expertise Composition	Address
Heritage Physician and Resource Group LLC	1	1 Nurse Practitioner	1009 W Quinn Rd
Michael T. Callaghan M.D. and Associates, P.A.	3	3 Radiation Oncology	777 Hospital Way
University of Utah Pediatric Services	3	3 Pediatric Medicine	110 Vista Dr
High Country Behavioral Health	3	1 Clinical Social Worker, 2 Nurse Practitioner	1777 E Clark St
Treasure Valley Psychiatry and Mental Health PLLC	3	3 Nurse Practitioner	333 Mountain Psychiatry
Kokua Rehabilitation	3	3 Occupational Therapy	444 Hospital Way
Stoddard Medical Inc.	4	1 Dermatology, 1 Micrographic Dermatologic Surgery, 2 Physician Assistant	147 W Chubbuck Rd
Need-A-Nurse Medical Staffing, LLC	2	2 Nurse Practitioners	476 E Chubbuck Rd
Brandon A West Do PLLC	3	1 Family Medicine, 2 Nurse Practitioner	1133 Call Creek Dr
Meadowland Therapy	3	3 Physical Therapy	1033 W Quinn Rd
Idaho Eye Center PA	2	1 Optometry, 1 Ophthalmology	1157 Call Pl
Cardiovascular Specialists of America LLC	2	1 Cardiovascular Disease, 1 Nurse Practitioner	1515 E Clark St
Family Practice Group, P.A.	13	6 Family Medicine, 2 Nurse Practitioner, 4 Physician Assistant, 1 Registered Dietitian/Nutritionist	1951 Bench Rd
Mental Health Specialists	3	1 Clinical Psychologist, 2 Clinical Social Worker	210 W Burnside A
Intermountain Healthcare Services, Inc.	1	1 Cardiovascular Disease	777 Hospital Way

Highland Physical Therapy LLC	2	2 Physical Therapy	1951 Bench Rd
Spencer J Hardenbrook MD PC	4	3 Nurse Practitioner, 1 Physician Assistant	500 S 11th Ave
McDonald Rehab, PC	15	15 Physical Therapy	1800 Flandro Dr 128 Vista Dr 500 S 11th Ave
MV Pocatello Ent, LLC	3	2 Otolaryngology, 1 Physician Assistant	333 N 18th Ave
Bluebird Family Eye Care PLLC	1	1 Optometry	360 S Arthur Ave
John Fornarotto PLLC	2	2 Ophthalmology	246 N 18th Ave
Mountain View Family Medicine, Inc.	2	2 Family Medicine	2006 Birdie Thompson Dr
Arthritis Specialty Center, Inc.	5	1 Rheumatology, 1 Nurse Practitioner, 3 Physician Assistant	1448 E Center St
Brizzee Family Medicine Inc	2	1 Family Medicine, 1 Nurse Practitioner	2010 Flandro Dr
Physical Therapy Specialist of Idaho	5	5 Physical Therapy	675 Yellowstone Ave
High Desert Physical Therapy LLC	4	4 Physical Therapy	820 W Chubbuck Rd
Independent (No affiliation)	48	11 Chiropractic 4 Family Medicine 2 Physical Therapy 5 Nurse Practitioner 6 Clinical Social Worker 2 Internal Medicine 2 Occupational Therapy 3 Podiatry 3 Certified Registered Nurse Anesthetist 2 Optometry 1 Allergy/Immuniology 1 Clinical Psychologist 1 Oral Surgery/Pain Management 1 Cardiovascular Disease 2 Physician Assistant 1 Ophthalmology	

		1 General Surgery	
Total number of registered doctors and clinicians servicing Medicaid in Pocatello and Chubbuck	**141**		

Source: https://data.cms.gov/provider-data/search

Appendix D: Long-term health care facilities in Bannock County

Table 24: Nursing Homes

Gateway Transitional Care Center	527 Memorial Drive, Pocatello
Idaho State Veterans Home – Pocatello	1957 Alvin Ricken Drive, Pocatello
Monte Vista Hills Healthcare Center	1071 Renee Avenue, Pocatello
Quinn Meadows Rehabilitation and Care Center	1033 West Quinn Road, Pocatello

Table 25: Home Health Services

Advance Home Health	(208) 346-7807	All indicate they will accept Medicare. However, none of them list an address. All they list are phone numbers.
Alliance Home Health Care	(208) 552-0249	
Brio Idaho Home Health LLC	(208) 538-2223	
Eden Home Health – Idaho Falls	(208) 523-1980	
Encompass Health Home Health of Eastern Idaho	(208) 528-8100	
Encompass Health Home Health of Idaho	(208) 461-1600	
Hands of Hope Home Health, Inc	(208) 523-7441	
Heritage Home Health	(208) 238-0088	
Home Helpers Home Health	(208) 234-2380	
Horizon Home Health East	(208) 733-2840	
Integricare of Eastern Idaho	(208) 529-0800	
Onesource Home Health	(208) 524-0685	
Symbii Home Health	(208) 637-2273	

Table 26: Hospice Care

Alliance Hospice of Idaho	(208) 733-2234	All indicate they will accept Medicare. However, none of them list an address. All they list are phone numbers.
Aspen Hospice	(208) 529-0800	
Brio Idaho Hospice LLC	(801) 361-4381	
Encompass Health Hospice of Eastern Idaho	(208) 637-1100	
Heritage Hospice	(208) 238-0088	
Homestead Home Health & Hospice LLC	(208) 497-7384	
Horizon Hospice East	(208) 344-6500	
Hospice of Eastern Idaho	(208) 529-0342	
Oncesource Hospice	(208) 524-0685	
Salmon Valley Hospice	(208) 993-8050	
Signature Healthcare at Home	(208) 637-2273	
Solace Healthcare	(208) 757-8444	

Appendix E. PRAPARE Tool

The Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool is a nationally standardized tool designed to equip healthcare and their community partners to better understand and act on individuals' social determinants of health. A blank copy of the PRAPARE tool is below.

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
   Street:_____
   City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

	I choose not to answer this question

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings).

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		5 or more times a week
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question

19. Are you a refugee?

	Yes		No		I choose not to answer this question

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				