St. Luke’s McCall

2013 Community Health Needs Assessment
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Introduction

St. Luke’s McCall Community Health Needs Assessment (CHNA) is designed to help us better understand the most significant health challenges facing the individuals and families in our service area. The information, conclusions, and needs identified in our assessment will assist us in:

- Developing health improvement programs for our community
- Providing better care at lower cost
- Defining our operational and strategic plans
- Fulfilling our mission: “To improve the health of people in our region”

Stakeholder involvement in determining and addressing community health needs is vital to our process. We thank, and will continue to collaborate with, all the dedicated individuals and organizations working with us to make our community a healthier place to live.

For the purpose of sharing the results of this assessment with the community we serve, a full copy is available on our public website, www.mccallhosp.org.
Executive Summary

St. Luke’s McCall 2013 Community Health Needs Assessment (CHNA) provides a comprehensive analysis of our community’s most important health needs. Our complete CHNA offers trend, magnitude, and preventive information related to each community health need. This Executive Summary contains a brief overview of our process and terminology as well as a prioritized review of the community health needs we identified.

The first step in the process of defining our most important community health needs is to understand the health of our community. Two variables fundamental to understanding our community’s health are health outcomes and health factors.

Health outcomes help us determine the current health status of our community. Health outcomes include measures such as how long people live, how healthy people feel, rates of chronic disease, and the top causes of death. Health factors are key influencers of health outcomes. Examples of health factors are nutritional habits, exercise, substance abuse, and childhood immunizations.

Once we understand our community health outcomes and the factors that influence them, we use this information to define our community health needs. Community health needs are the programs, services, and policies needed to positively impact health outcomes and their related health factors. St. Luke’s views the fulfillment of our health needs as an essential opportunity to achieve better health, better patient care, and lower overall cost.

In our CHNA, we divide our health needs into four distinct categories: 1) health behaviors; 2) clinical care; 3) social and economic; and 4) physical environment. Each identified health need is included in one of these categories.

We employ a rigorous prioritization system designed to rank health needs based on the greatest potential to impact community health. Our health needs, factors, and outcomes are identified and measured through the study of a broad range of data, including:

- Primary research from focus groups and affected population surveys
- In-depth interviews and conversations with community leaders
- An extensive set of national, state, and local health information collected from governmental and other authoritative sources

The chart on the following page provides a graphical summary of the approach used to develop our CHNA.
St. Luke’s Approach to Improving Community Health

St. Luke’s Approach to Improving Community Health

Better Health Outcomes
(Examples: Length of life, chronic disease rates, causes of death)

Health Factors Improved
(Examples: Smoking, nutrition, exercise, etc.)

Implementation Plan Created and Needs Addressed
(Development of programs, policies, and services to improve health factors and outcomes)

Better Care
Health Behavior Needs
Clinical Care Needs
Social and Economic Needs
Physical Environment Needs

Lower Cost

Health Research
(Community input, health data, literature search)

Summary of Community Health Needs

The following tables provide a summary of the community health needs identified in our CHNA. Our health needs are ranked using a numerical prioritization system. Points are allocated to each need based on scores provided by our community leaders as well as scores for related health factors. The more points the health need and factor receive, the higher the priority and the higher the potential to positively impact community health when the need is effectively addressed. Health needs and factors scoring above the median are highlighted in light orange in the tables below. Health needs and factors with scores in the top 20th percentile are highlighted in dark orange and are considered to be high priorities.

The tables below also provide demographic information about the most affected populations. Demographic data about affected populations is important because it tells us when people with low incomes, no college education, or ethnic minorities suffer disproportionately from specific health conditions or from barriers to health care access.
Health Behavior Category Summary

Our community’s high priority needs in the health behavior category are: Substance abuse programs; and wellness and prevention programs for accidents, diabetes, and mental illness. Substance abuse ranks as a high priority need due to its high community leader score and because our community has an above average levels of alcohol and illicit drug use. Accident prevention ranks high largely due to an increase in motor vehicle accidents since 2007. Diabetes ranks as a high priority need because it is trending higher and is a contributing factor to a number of other health concerns. Mental illness ranks high because Idaho has one of the highest percentages (22.5%) of any mental illness (AMI) in the nation.

Some populations are more affected by these health needs than others. For example, low income individuals and those without high school diplomas have significantly higher rates of diabetes. Those not graduating from high school, the unemployed, and males 18 to 34 years of age have much higher rates of illicit drug use.

### Health Behavior Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse services and programs</td>
<td>Alcohol</td>
<td>Ages 18-64</td>
<td>18.8</td>
</tr>
<tr>
<td></td>
<td>Illicit drug use</td>
<td>Income &lt;$35,000, No high school diploma, Males 18-34</td>
<td>19.8</td>
</tr>
<tr>
<td></td>
<td>Vehicle crash death rate</td>
<td></td>
<td>19.8</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Accidents</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>Income &lt;$35,000, No high school diploma</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Exercise programs/education</td>
<td>Adult physical activity</td>
<td>Income &lt;$50,000, Hispanic, No college</td>
<td>15.7</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Teen nutrition</td>
<td></td>
<td>15.9</td>
</tr>
</tbody>
</table>
### Health Behavior Need Summary Table, Continued

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe-sex education programs</td>
<td>Teen birth rate</td>
<td></td>
<td>16.2</td>
</tr>
<tr>
<td>Tobacco cessation programs</td>
<td>Smoking</td>
<td>Income &lt;$35,000, No high school diploma</td>
<td>16.9</td>
</tr>
<tr>
<td>Weight management</td>
<td>Obese/Overweight adults</td>
<td>Income &lt;$35,000, Hispanic, No high school diploma</td>
<td>16.4</td>
</tr>
<tr>
<td>Weight management</td>
<td>Obese/Overweight teens</td>
<td>Income &lt;$35,000, Hispanic</td>
<td>17.4</td>
</tr>
<tr>
<td>Wellness/prevention</td>
<td>High cholesterol</td>
<td>Income &lt;$35,000, No high school diploma, Age 55 +</td>
<td>17</td>
</tr>
<tr>
<td>Wellness/prevention</td>
<td>Skin cancer</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Wellness/prevention</td>
<td>Suicide</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Exercise programs/education</td>
<td>Teen exercise</td>
<td></td>
<td>14.7</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Adult nutrition</td>
<td>No college</td>
<td>13.9</td>
</tr>
<tr>
<td>Safe-sex education programs</td>
<td>Sexually transmitted infections</td>
<td></td>
<td>13.2</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>AIDS</td>
<td>African American, Males &lt;24</td>
<td>14</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Alzheimer’s</td>
<td>Age 65 +</td>
<td>10</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Arthritis</td>
<td>Income &lt;$35,000, Non-Hispanic, No college, Overweight, Age 65 +</td>
<td>12</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Asthma</td>
<td>Income &lt;$35,000</td>
<td>15</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Breast cancer</td>
<td>Female</td>
<td>14</td>
</tr>
</tbody>
</table>
## Health Behavior Need Summary Table, Continued

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness and prevention</td>
<td>Cerebrovascular diseases</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Colorectal cancer</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Flu/pneumonia</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Heart disease</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65 +</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Leukemia</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Lung cancer</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Leukemia</td>
<td></td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>Nephritis</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Non-Hodgkin’s lymphoma</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Pancreatic cancer</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Prostate cancer</td>
<td>Male age 60+</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Respiratory disease</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Clinical Care Category Summary

High priority clinical care needs include: Affordable care for low income individuals; affordable health insurance; and chronic disease management for diabetes. Affordable care ranks as a high priority need due to its high community leader score and because an increasing number of people in our community are living in poverty (especially children). Affordable health insurance ranks as a top priority need in part because our service area has a high percentage of people who are uninsured and the trend is getting worse. Diabetes chronic disease management ranks high because the number of people with diabetes is trending higher, and it is a contributing factor to a number of other health concerns.

As shown in the table below, high priority clinical care needs are experienced most by people with low incomes and those who have not attended college. In addition, a number of our community leaders expressed concern about people just above the poverty level who are left without health insurance because they don’t qualify for Medicaid.

Clinical Care Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable care</td>
<td>Children in poverty</td>
<td>Income &lt; $50,000, Age &lt; 19</td>
<td>19.7</td>
</tr>
<tr>
<td>Affordable health Insurance</td>
<td>Uninsured adults</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>19.9</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Diabetes</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>19.5</td>
</tr>
<tr>
<td>Availability of behavioral health services</td>
<td>Mental health service providers</td>
<td>Income &lt; $50,000</td>
<td>18.5</td>
</tr>
<tr>
<td>More providers accept public health insurance</td>
<td>Children in poverty</td>
<td>Income &lt; $35,000</td>
<td>18</td>
</tr>
<tr>
<td>Prenatal care programs</td>
<td>Prenatal care 1st trimester</td>
<td>Hispanic, No high school diploma</td>
<td>15.1</td>
</tr>
<tr>
<td>Affordable dental care</td>
<td>Dental visits, preventive</td>
<td>Income &lt; $50,000</td>
<td>14.2</td>
</tr>
<tr>
<td>Availability of primary care providers</td>
<td>Primary care providers</td>
<td></td>
<td>14.1</td>
</tr>
<tr>
<td>Identified Community Need</td>
<td>Related Health Outcome or Factor</td>
<td>Populations Affected Most *</td>
<td>Total Score</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Arthritis</td>
<td>Income &lt; $35,000, Non-Hispanic, No college, Overweight, Age 65 +</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td>14.5</td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65 +</td>
<td>14.5</td>
</tr>
<tr>
<td>Immunization programs</td>
<td>Children immunized</td>
<td></td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td>Flu/pneumonia</td>
<td></td>
<td>8.4</td>
</tr>
<tr>
<td>Integrated, coordinated care (less fragmented)</td>
<td>Preventable hospital stays</td>
<td>Hispanics, Age 65 +</td>
<td>14</td>
</tr>
<tr>
<td>Improved health care quality</td>
<td>Preventable hospital stays</td>
<td></td>
<td>12.1</td>
</tr>
<tr>
<td>Prenatal care programs</td>
<td>Low birth weight</td>
<td>Hispanic &lt; High school</td>
<td>9.1</td>
</tr>
<tr>
<td>Screening programs</td>
<td>Cholesterol</td>
<td>Income &lt; $35,000, No high school diploma, Age 55 +</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>Colorectal screening</td>
<td>Income &lt; $35,000, No college, Age 50 +</td>
<td>12.3</td>
</tr>
<tr>
<td></td>
<td>Diabetic screening</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Mammography screening</td>
<td>Income &lt; $50,000</td>
<td>13.3</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Social and Economic Category Summary

Children and family services for low income populations is the only high priority social and economic health need. The increasing number of children living in poverty in our service area drives this need.

Social and Economic Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and family services</td>
<td>Children in poverty</td>
<td>Income &lt; $35,000</td>
<td>18.7</td>
</tr>
<tr>
<td>Job training services</td>
<td>Unemployment rate</td>
<td></td>
<td>15.6</td>
</tr>
<tr>
<td>Children and family services</td>
<td>Inadequate social support</td>
<td></td>
<td>13.7</td>
</tr>
<tr>
<td>Disabled services</td>
<td></td>
<td></td>
<td>12.3</td>
</tr>
<tr>
<td>Education assistance programs</td>
<td>Education</td>
<td></td>
<td>14.3</td>
</tr>
<tr>
<td>Homeless services</td>
<td>Unemployment rate</td>
<td></td>
<td>14.7</td>
</tr>
<tr>
<td>Senior services</td>
<td>Inadequate social support</td>
<td>Age 65 +</td>
<td>11.4</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>Inadequate social support</td>
<td></td>
<td>12.1</td>
</tr>
<tr>
<td>Violence and abuse services</td>
<td>Safety - homicide rate</td>
<td></td>
<td>12.2</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Physical Environment Category Summary

In the physical environment category, there are no identified high priority needs. Both our community leaders and the health factor data indicate we have a physical environment that supports good health.

**Physical Environment Need Summary Table**

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of recreation and exercise facilities</td>
<td>Recreational facilities</td>
<td>Income &lt; $50,000</td>
<td>10.6</td>
</tr>
<tr>
<td>Availability or access to healthy foods</td>
<td>Limited access to healthy foods</td>
<td>Income &lt; $50,000</td>
<td>11.9</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc.</td>
<td>Air pollution</td>
<td></td>
<td>11.4</td>
</tr>
<tr>
<td>Transportation to and from appointments</td>
<td></td>
<td>Income &lt; $35,000, Rural populations, Age 65 +</td>
<td>14.4</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.

Table Color Key

- Dark Orange = High priority (total score in the top 20th percentile)
- Light Orange = Total score above the median
- White = Total score below the median
Next Steps

The main body of this CHNA provides more in-depth information describing our community’s health as well as how to improve it. St. Luke’s will continue to collaborate with the people, leaders, and organizations in our community to carry out an Implementation Plan designed to address many of the most pressing community health needs identified in this assessment. Utilizing effective, evidence-based programs and policies, we will work together toward the goal of attaining the healthiest community possible.
St. Luke's McCall Overview

Background

St. Luke’s McCall (SLM) has been committed to serving the needs of a growing region for over 56 years. Founded in 1956 as a community hospital called McCall Memorial Hospital, the hospital has evolved through various management and funding structures to its current 501(c)3 status and membership in St. Luke’s Health System (SLHS).

SLHS is the only locally governed, Idaho-based, not-for-profit health system, with a network of six separately licensed full-service medical centers and more than 100 outpatient centers and clinics serving people throughout southern Idaho, eastern Oregon, and northern Nevada.

SLM is a 15-bed critical access hospital with physician clinics for family medicine, general surgery, internal medicine, integrative medicine, and orthopedic surgery. The medical staff is comprised of 16 local physicians and 24 visiting specialist physicians.

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

SLM has 221 full- and part-time employees, 62 hospital volunteers, and a 16-member governing board. On average, St. Luke’s McCall sees 4,500 emergency room patients annually, and an additional 37,000 patients for all other outpatient services. Our average daily in-patient census is 3.0.
Mission, Vision, and Core Values

All SLHS medical centers are committed to our overall mission, vision, and values.

Our mission is “To improve the health of people in our region.”

Our vision is to “transform health care by aligning with physicians and other providers to deliver integrated, seamless, and patient-centered quality care across all St. Luke’s settings.”

Our core values are:

- Integrity
- Compassion
- Accountability
- Respect
- Excellence

Governance Structure

Each SLHS hospital is responsive to the people it serves, providing a scope of service appropriate to community needs. Because leaders from within the community served know what’s best for their own families, friends, and neighbors, local control is one of the tenets of SLHS.

Local boards have oversight over their business affairs and have decision-making authority. Our volunteer boards include representatives from each SLHS service area, helping to ensure local needs and interests are addressed.
The Community We Serve

This section describes our community in terms of its geography and demographics. Adams and Valley counties represent the geographic area used to define the community we serve also referred to here as our primary service area or service area. The criteria used in selecting this area as the community we serve was to include the entire population of the counties where at least 70% of our inpatients reside. The residents of these counties comprise about 82% of our inpatients with approximately 60% of our inpatients living in Valley County and 22% in Adams County. Adams and Valley counties are part of Idaho Health Districts 3 and 4, as shown in the maps below.

Idaho Behavioral Risk Factor Surveillance System Annual Report 2009
Our patients in the surrounding counties are important to us as well. To help us serve these patients, we have built positive, collaborative relationships with regional providers where legal and appropriate. A philosophy of shared responsibility for the patient has been instrumental in past successes and remains critical to the future of SLHS. Partnerships, such as those shown below, allow us to meet patients’ medical needs close to home and family.

St. Luke’s Regional Relationships Map
Community Demographics

The demographic makeup of our nation, state, and service area populations are provided in the table below. This information helps us understand the size of various populations and possible areas of community need. Our goal is to reduce disparities in health care access and quality due to income, education, race, or ethnicity.

Both Idaho and our service territory are comprised of about a 95% white population while the nation as a whole is 72% white. The Hispanic population in Idaho represents 11% of the overall population and about 3.5% of our defined service area. Adams County is approximately 2.4% Hispanic, and Valley County is 3.9% Hispanic.

Population by Race and Ethnicity 2010²

<table>
<thead>
<tr>
<th>Residence</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>American Indian or Alaska Native</th>
<th>Asian or Pacific Islander</th>
<th>Non-Hispanic</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Service Area</td>
<td>13,838</td>
<td>13,605</td>
<td>31</td>
<td>138</td>
<td>64</td>
<td>13,358</td>
<td>480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.3%</td>
<td>0.2%</td>
<td>1.0%</td>
<td>0.5%</td>
<td>96.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Adams County</td>
<td>3,976</td>
<td>3,903</td>
<td>8</td>
<td>46</td>
<td>19</td>
<td>3,882</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.2%</td>
<td>0.2%</td>
<td>1.2%</td>
<td>0.5%</td>
<td>97.6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Valley County</td>
<td>9,862</td>
<td>9,702</td>
<td>23</td>
<td>92</td>
<td>45</td>
<td>9,476</td>
<td>386</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.4%</td>
<td>0.2%</td>
<td>0.9%</td>
<td>0.5%</td>
<td>96.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Idaho</td>
<td>1,567,582</td>
<td>1,496,784</td>
<td>15,104</td>
<td>29,801</td>
<td>25,893</td>
<td>1,391,681</td>
<td>175,901</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95.5%</td>
<td>1.0%</td>
<td>1.9%</td>
<td>1.7%</td>
<td>88.8%</td>
<td>11.2%</td>
</tr>
<tr>
<td>National (000)</td>
<td>308,746</td>
<td>223,533</td>
<td>38,929</td>
<td>2,932</td>
<td>15,187</td>
<td>258,268</td>
<td>50,478</td>
</tr>
<tr>
<td></td>
<td></td>
<td>72.4%</td>
<td>12.6%</td>
<td>0.9%</td>
<td>4.9%</td>
<td>83.7%</td>
<td>16.3%</td>
</tr>
</tbody>
</table>

² Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (1/2012). The bridged-race April 1, 2010 population estimates were produced by the Population Estimates Program of the U.S. Census Bureau in collaboration with the National Center for Health Statistics (NCHS). Internet release date November 17, 2011.
Idaho experienced a 21% increase in population from 2000 to 2010 ranking it as the fourth fastest growing state in the country. Adams and Valley Counties have followed that trend experiencing an even more rapid 24% increase in population within that timeframe. Our service area is expected to grow by about 10% again by the year 2020. St. Luke’s McCall is constantly working to manage the volume and scope of its services in order to meet the needs of an increasing population.

### Population Growth 2000-2010

<table>
<thead>
<tr>
<th>Region</th>
<th>Population April 1 2000</th>
<th>Population April 1 2010</th>
<th>Percent Change</th>
<th>Numeric Change</th>
<th>Ranked by Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>11,127</td>
<td>13,838</td>
<td>24%</td>
<td>2,711</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>1,293,953</td>
<td>1,567,582</td>
<td>21%</td>
<td>273,629</td>
<td>4</td>
</tr>
<tr>
<td>United States</td>
<td>281,421,906</td>
<td>308,745,538</td>
<td>10%</td>
<td>27,323,632</td>
<td></td>
</tr>
</tbody>
</table>

### Aging

Over the past ten years the 45 to 64 year old age group was the fastest growing segment of our community. Over the next ten years, however, the 65 years or older age group is expected to grow by about 50% making it the fastest growing segment. Currently, about 19% of the people in our community are over the age of 65, and by 2020 about 26% of our population is expected to be over the age of 65.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 0-19</td>
</tr>
<tr>
<td>2000</td>
<td>2,959</td>
</tr>
<tr>
<td></td>
<td>27%</td>
</tr>
<tr>
<td>2010</td>
<td>2,822</td>
</tr>
<tr>
<td></td>
<td>21%</td>
</tr>
</tbody>
</table>

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3 U.S. Census Bureau: [http://quickfacts.census.gov/qfd/index.html](http://quickfacts.census.gov/qfd/index.html)
4 Idaho Vital Statistics County Profile Year 2000
5 Idaho Economics, 2012 Forecasts, P.O. Box 45694 Boise, ID
6 Ibid
7 Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (1/2012)
**Poverty Levels**

The official United States poverty rate increased from 13.3% in 2005 to 15.3% in 2010. Our service area poverty rate has increased from 11.4% in 2005 to 13.5% in 2010, but it is still below the national average. However, the poverty rate in our community for children under the age of 18 is over 22% and is now above the national average.  

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**Small Area Income and Poverty Estimates (SAIPE)**  
Median Household Income

Median income in the United States has risen by 8% since 2005. However, growth in income was slower in Idaho and in Districts 3 and 4 during that period. Median income in Idaho and District 4 is about 10% below the national median, and in District 3 it is about 30% lower than the national median.\(^9\)

\[^9\] Ibid
Community Health Needs Assessment Methodology

We developed the St. Luke’s McCall 2013 Community Health Needs Assessment (CHNA) to help us better understand and meet our most significant community health challenges. The process and methodology used to accomplish this goal are described below.

The first step in our process for defining community health needs is to understand the health status of our community. Health outcomes help us determine overall health status. Health outcomes include measures of how long people live, how healthy people feel, rates of chronic disease, and the top causes of death. While measuring health outcomes is critical to understanding health status, defining health factors is essential to improving health. Health factors are key influencers of health outcomes. Examples of health factors are nutritional habits, exercise, substance abuse, and childhood immunizations.

Once we understand our community health outcomes and the factors that influence them, we use this information to define our community health needs. Community health needs are the programs, services, and policies needed to positively impact health outcomes and their related health factors. St. Luke’s views the fulfillment of our health needs as an essential opportunity to achieve better health, better patient care, and lower overall cost.

In our CHNA, we divide our health needs into four distinct categories: 1) health behaviors; 2) clinical care; 3) social and economic; and 4) physical environment. Each identified health need is included in one of these categories.

Our health needs, factors, and outcomes are identified and measured through the analysis of a broad range of research including:

1. The County Health Rankings methodology for measuring community health. The University of Wisconsin Population Health Institute in collaboration with the Robert Wood Johnson Foundation developed the County Health Rankings. The County Health Rankings provides a thoroughly researched process for selecting health factors that, if improved, can help make our community a healthier place to live. A detailed description of their recommended health outcomes and factors is provided in the following sections of our CHNA.

2. Building on the County Health Rankings measures, we gathered a wide range of community health outcome and health factor measures from national, state, and local perspectives. We added these measures to our CHNA to ensure a comprehensive appraisal of the underlying causes of our community’s most pressing health issues.

3. In addition, we collaborated with the United Way and Saint Alphonsus Health System to complete an extensive set of primary market research, taking into account input from affected population groups in our region. Utilizing the results from this primary research, we conducted in-depth interviews with local organizational leaders representing the
broad interests of our community. During this process our community leaders helped us define and rank our community’s most important health needs, and provided valuable input on programs and legislation they felt would be effective in addressing these needs.

4. Finally, we employed a rigorous prioritization system designed to identify and rank our most impactful health needs, incorporating input from our community leaders as well as the secondary research data collected on each health outcome and factor.

The chart below provides a graphical summary of the approach used to develop our CHNA.

**St. Luke’s Approach to Improving Community Health**

![Diagram showing the approach to improving community health](chart.png)
**Health Outcome and Health Factor Scoring System**

An important part of our CHNA methodology involves incorporating an objective way to measure each health outcome and factor’s potential to impact community health. Measuring the potential to impact community health is accomplished using the process described below.

- Each health outcome or factor receives a **trend** score from 0 to 4, based on whether the measured value is getting better or worse compared to previous years. If the trend is getting worse, community health may be improved by understanding the underlying causes for the worsening trend and addressing those causes.

- A **prevalence** score from 0 to 4 is assigned based on whether the community’s health outcome or factor measured value is better or worse than the national average. The worse the value is compared to the national average, the more room there is for improvement.

- The **severity** of the health outcome or factor is scored from 0 to 4 based on the direct influence it has on general health and whether it can be prevented. Therefore, leading causes of death or debilitating conditions receive high severity scores when the health problem is preventable. For example, there are few evidence-based ways to prevent pancreatic cancer. Since little can be done to prevent this health concern, its severity score potential is not as high as the severity score for a condition such as diabetes which has many evidence-based prevention programs available.

- The **magnitude** of the health outcome or factor is scored from 0 to 4 based on whether the problem is a root cause or contributing factor to other health problems. The magnitude score is the highest when the health outcome or factor is also manageable or can be controlled. For example, obesity is a root cause of a number of other health problems such as diabetes, heart disease, and high blood pressure. Obesity may also be controlled through diet and exercise. Consequently, obesity has the potential for a high point score for “magnitude.”

The scores for the four measures defined above are totaled up for each health outcome and factor – the higher the total score, the higher the potential impact on the health of our population. These scores are utilized as an important part of our prioritization process. Tables like the example below are used to score each health outcome and factor.

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Health Factor Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low score = Low potential for health impact</td>
<td>High score = High potential for health impact</td>
</tr>
<tr>
<td>Health Factor Name</td>
<td>Trend: Better/Worse</td>
</tr>
<tr>
<td>Example factor</td>
<td>0 to 4 points</td>
</tr>
</tbody>
</table>
Health Outcome Measures and Findings

Health outcomes represent a set of key measures that describe the health status of a population. These measures allow us to compare our community’s health to that of the nation as a whole and determine whether our health improvement programs are positively affecting our community’s health over time. The general, high level health outcomes recommended by County Health Rankings are based on one length of life measure (mortality) and a number of quality of life measures (morbidity).

Mortality Measure

- **Length of Life Measure: Years of Potential Life Lost**

  The length of life measure, Years of Potential Life Lost (YPLL), focuses on deaths that could have been prevented. YPLL is a measure of premature death based on all deaths occurring before the age of 75. By examining premature mortality rates across communities and investigating the underlying causes of high rates of premature death, resources can be targeted toward strategies that will extend years of life.  

  ![Years of Potential Life Lost Chart]

  The chart above shows our service area YPLL for 2010 is significantly lower (better) than the national average and only just above the national top 10th percentile. This is an excellent outcome, indicating that on average people in our service area are not dying prematurely. Adam’s County YPLL is well below the national benchmark. Both Valley

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10 County Health Rankings 2012. Accessible at www.countyhealthrankings.org (used for national YPLL 2006 - 2008 average)
County and the State of Idaho YPLL are better than the national average, although they did not quite make it into the top 10th percentile nationally.  

**Morbidity Measures**

Morbidity is a term that refers to how healthy people feel while alive. To measure morbidity, *County Health Rankings* recommends the use of the population’s health-related quality of life defined as people’s overall health, physical health, and mental health. They also recommend the use of birth outcomes – in this case, babies born with a low birth weight. The reasons for using these measures and the specific outcome data for our community are described below.

**Health Related Quality of Life (HRQOL)**

Understanding the health related quality of life of the population helps communities identify unmet health needs. Three measures from the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) are used to define health-related quality of life: The percent of adults reporting fair or poor health, the average number of physically unhealthy days reported per month, and the number of mentally unhealthy days reported per month.

Researchers have consistently found self-reported general, physical, and mental health measures to be informative in determining overall health status. Analysis of the association between mortality and self-rated health found that people with “poor” self-rated health had a twofold higher mortality risk compared with persons with “excellent” self-rated health. The analysis concludes that these measures are appropriate for measuring health among large populations.

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- "Fair or Poor" General Health

Fifteen point four percent (15.4%) of Idaho adults reported their health status as fair or poor in 2010, which is up from 13.4% in 2002. For our service area the percent of people reporting fair or poor health was just over 11% in 2010 which is significantly below (better than) national average. The BRFSS data show a large increase in reported poor or fair health occurred in District 3, especially since the economic downturn in 2008. Percentages in District 4 have remained well below (better than) the national average.  

The charts below show that income and education greatly affect the levels of reported fair or poor general health. For example, people with incomes of less than $15,000 are seven times more likely to report fair or poor general health than those with incomes above $75,000. In addition, Hispanics are significantly more likely to report fair or poor health than non-Hispanics.

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13 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
General Health - by Income

% of adults reporting fair or poor general health

- Less than $15,000
- $15,000 - $24,999
- $25,000 - $34,999
- $35,000 - $49,999
- $50,000 - $74,999
- $75,000+

Annual Income

District 3
District 4

General Health - by Education

% of adults reporting fair or poor general health

- K-11th Grade
- 12th Grade or GED
- Some College
- College Graduate+

Level of Education

District 3
District 4

*No K-11th grade data available for District 4

General Health - by Ethnicity

% of adults reporting fair or poor general health

- Non-Hispanic
- Hispanic

Ethnicity

District 3
District 4

* No Hispanic data available for District 4
• Poor Physical Health Days

The number of reported poor physical health days for Valley and Adams Counties and Idaho is slightly below the national average. The national top 10\textsuperscript{th} percentile is 2.6 days.\textsuperscript{14}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{poor_physical_health.png}
\caption{Poor Physical Health}
\end{figure}

• Poor Mental Health Days

The number of poor mental health days is below the national average for Valley and Adams Counties as well as Idaho. The national top 10\textsuperscript{th} percentile is 2.3 days per month.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{poor_mental_health.png}
\caption{Poor Mental Health Days}
\end{figure}

\textsuperscript{14} County Health Rankings 2012. Accessible at \url{www.countyhealthrankings.org}.
• **Low Birth Weight**

Low birth weight (LBW) is unique as a health outcome because it represents two factors: maternal exposure to health risks and the infant’s current and future morbidity, as well as premature mortality risk. The health associations and impacts of LBW are numerous.\(^{15}\)

The percent of LBW babies in our service area and in Idaho is significantly below (better than) the national average.\(^{16}\) This is a key indicator of future health. The national top 10\(^{th}\) percentile for LBW is 6.0% and our service area is also below that level.

Low birth weight can be addressed in multiple ways, including:\(^{17}\)

- Expanding access to prenatal care and dental services
- Focusing intensively on smoking prevention and cessation
- Ensuring that pregnant women get adequate nutrition
- Addressing demographic, social, and environmental risk factors

---

**Health Factor Score**

<table>
<thead>
<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S.</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td>0</td>
</tr>
</tbody>
</table>

---


17 America’s Health Rankings 2011, [www.americashealthrankings.org](http://www.americashealthrankings.org)
**County Health Rankings Health Outcomes Ranking for Our Community**

*County Health Rankings* ranks the counties within each state on the health outcome measures described above. Valley County’s 2012 overall outcome rank is 5th and Adams County’s rank is 14th out of a total of 42 counties in Idaho. Using the health factor and health needs information described later in our CHNA, programs will be developed to improve health outcome measures over the course of the next three years.
Additional Health Outcome Measures and Findings

In addition to the County Health Ranking general outcome measures, we collected a set of community health outcomes measures from national, state, and local perspectives to create a more specific set of health indicators and measures for our community.

The health outcome measures provided below include information on chronic disease prevalence and the top 10 causes of death. These outcomes help identify the underlying reasons why people in our community are dying or are in poor health. Knowing the trend, prevalence, severity, and magnitude of common chronic diseases and the top causes of death can assist us in determining what kind of preventive and early diagnosis programs are most needed or where adding health care providers would have the greatest impact on health.

Chronic Disease Prevalence

Chronic disease prevalence provides insights into the underlying reasons for poor mental and physical health. Many of these diseases are preventable or can be treated more effectively if detected early. Consequently, we added measurement and trend data on the following chronic conditions: AIDS, arthritis, asthma, diabetes, high blood pressure, high cholesterol, and mental illness.
• **AIDS**

The AIDS rate in Idaho is well below the national rate. The trend in Idaho has been flat from 2004 to 2009 with some uptick in 2010 that warrants watching in future years.

African Americans are more likely to have HIV than any other racial/ethnic group in the United States (US). In 2009, African Americans accounted for 44% of new HIV infections while representing only 14% of the population. In 2009, African American men accounted for 70% of the estimated new HIV infections among all African Americans. Young people in the US are also more at risk for HIV infection accounting for 39% of all new HIV infections in 2009. This risk is particularly high for young gay, bisexual, and other men who have sex with men (MSM). HIV prevention programs, including education on abstinence and safe sex, will be helpful to younger people who did not benefit from the outreach conducted in the 1980s and 1990s.

---

**Health Factor Score**

<table>
<thead>
<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S.</td>
</tr>
<tr>
<td>Aids</td>
<td>2</td>
</tr>
</tbody>
</table>

---

18 [www.statehealthfacts.org](http://www.statehealthfacts.org)
Arthritis

In 2009, 23.7% of Idaho adults had ever been told by a medical professional that they had arthritis. The prevalence of arthritis in our service area is below the national average and has not changed significantly since 2002.

The majority of those with arthritis (54.5 percent) reported that their activities were limited due to health problems. The likelihood of having arthritis increases with age. More than half of those surveyed ages 65 and older had been diagnosed with arthritis.

Other Highlights:
- Idaho residents with incomes below $35,000 per year were significantly more likely to have arthritis than those with incomes of $50,000 or higher (28.5% compared with 18.9%).
- College graduates were significantly less likely to have arthritis compared with those with some college or less education (19.7% vs 25.5%).
- Hispanics were significantly less likely than non-Hispanics to have been diagnosed with arthritis (13.0% compared with 24.5%).
- More than one-in-four (27.5%) of overweight adults (BMI ≥ 25) had arthritis compared to 18.1% of those who were not overweight.

Some types of arthritis can be treated and possibly prevented by making healthy lifestyle choices. Common tips for prevention and treatment include:

- Maintain recommended weight. Women who are overweight have a higher risk of developing osteoarthritis in the knees.
- Regular exercise can help by strengthening muscles around joints and increasing bone density.
- Avoid smoking and limit alcohol consumption to help avoid osteoporosis. Both habits weaken the structure of bone increasing the risk of fractures.

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22 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
Health Factor Score

Low score = Low potential for health impact
High score = High potential for health impact

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S.</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

*Data only available every other year; no U.S. data available for 2002-2003. Service area data not available.*
• Asthma

The percentage of people with asthma in our service area has risen from about 7% in 2002 to about 9% in 2010 and is now about the same as the national average. Asthma has a significant effect on how healthy people feel. Thirty percent (30%) of adults with current asthma reported their general health status as “fair” or “poor,” which is more than twice as high as people who did not have asthma (only 13.7% of people without asthma reported fair or poor health). Those with incomes below $35,000 are somewhat more likely to have current asthma. 24

Asthma is a long-term disease that can't be cured or prevented. The goal of asthma treatment is to control the disease. To control asthma, it is recommended that people partner with their provider to create an action plan that avoids asthma triggers and includes guidance on when to take medications or to seek emergency care. 25

![Asthma Graph]

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low score = Low potential for health impact</td>
<td>High score = High potential for health impact</td>
</tr>
<tr>
<td><strong>Trend:</strong> Better/Worse</td>
<td><strong>Prevalence versus U.S. Average</strong></td>
</tr>
<tr>
<td>Asthma</td>
<td>4</td>
</tr>
</tbody>
</table>

24 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
• **Diabetes**

Between 7% and 8.5% of the people living in Districts 3 and 4 report that they have been told they have diabetes. The percent of people living with diabetes in Districts 3 and 4 and in the United States is up by about 50% over the past ten years, indicating an opportunity for greater focus on prevention. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, and blindness and can even result in limb amputation or death.  

Other Highlights:

- Overweight (BMI ≥ 25) adults reported diabetes more than three times as often as those who were not overweight. Among overweight adults, 10.6% had diabetes compared with 3.4% of those who were not overweight or obese.
- Those who did not engage in leisure time physical activity reported diabetes more than twice as often as those who did have leisure time physical activity.
- Those with a high school diploma or less education were significantly more likely to have diabetes than college graduates.
- Those with lower incomes were significantly more likely to have diabetes than those with mid-level or high incomes.  

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26 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System

27 Ibid.
Studies indicate that the onset of type 2 diabetes can be prevented through weight loss, increased physical activity, and improving dietary choices. Diabetes can be managed through regular monitoring, following a physician-prescribed care regimen, adjusting diet, and maintaining a physically active life.\(^{28}\)

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Severe/Preventable</td>
<td>Magnitude: Root Cause</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Score</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

\(^{28}\) America’s Health Rankings 2011, www.americashealthrankings.org
• High Blood Pressure

The incidence of high blood pressure in the United States has continued to rise steadily through the years. Currently, about one in every three Americans suffers from high blood pressure. Idaho is ranked 6th (best) in the nation for high blood pressure. Although blood pressure rates in our service area are below the national level, the long-term trend is not improving. High blood pressure is a major risk factor for heart disease, stroke, congestive heart failure, and kidney disease.

Other Highlights:

- Those with incomes below $25,000 per year were significantly more likely to have been told they had high blood pressure than those with incomes of $50,000 or more.
- Those who were overweight (BMI > 25) reported having high blood pressure twice as often as those who were not overweight (BMI < 25). About 33 percent of overweight adults had high blood pressure compared with 13.9 percent of adults who were not overweight.
- Adults with high blood pressure reported their general health status as “fair” or “poor” nearly three times as often as those who did not have high blood pressure (29.7 percent compared with 10.1 percent).

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29 Ibid
Adults who had been told they had high blood pressure were significantly more likely to have been told by a health professional that they also have angina or coronary heart disease (11.4 percent compared with 1.3 percent).  

Healthy blood pressure may be maintained by changing lifestyle or combining lifestyle changes with prescribed medications.

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S.</td>
<td>Severe/Preventable</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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30 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
31 Ibid
**High Cholesterol**

Among those who had ever been screened for cholesterol in Idaho, 37.3% reported that they were told their cholesterol was high in 2009 which is 21st (a little better than average) in the nation. The percentage of screened adults with high cholesterol has increased significantly in our service area since 2001. Sustained, increased cholesterol levels can lead to heart disease, heart attack, and other circulatory problems.  

**Other Highlights:**

- Those with yearly incomes below $25,000 were significantly more likely to have high cholesterol than those with annual incomes above $75,000 (43.3% compared with 30.8%).
- Prevalence of high cholesterol decreased with higher levels of education. Among those with a high school diploma or less education, 41.3% had been told they had high cholesterol compared with 32.9% of college graduates.
- Adults who had been screened and told they had high cholesterol reported their general health status as “fair” or “poor” significantly more often than those who had not been told they had high cholesterol (26.9% compared with 14.4%).
- Forty-three percent (43%) of those who were overweight had been told they had high cholesterol. This compares with 26.6% of those who were not overweight.
- Adults aged 55 and older were almost twice as likely to have had high blood cholesterol levels as those under age 55 (50.6% compared with 28.2 %).  

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32 Ibid.  
33 Ibid.
While some factors that contribute to high cholesterol are out of our control, like family history, there are many things a person can do to keep cholesterol in check, such as following a healthy diet, maintaining a healthy weight, and being physically active. For some individuals, a physician-recommended pharmacological intervention may be necessary.  

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<thead>
<tr>
<th>Health Factor Score</th>
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<tbody>
<tr>
<td>Low score = Low potential for health impact</td>
</tr>
<tr>
<td>Trend: Better/Worse</td>
</tr>
<tr>
<td>High Cholesterol</td>
</tr>
</tbody>
</table>

34 America’s Health Rankings 2011, www.americashealthrankings.org
• Mental Illness

Community mental health status can help explain suicide rates as well as help us understand the need for mental health professionals in our service area. The percentage of people aged 18 or older having any mental illness (AMI) (2008-2009 latest year available) was 22.5% for Idaho. This was the third highest percentage of mental illness in the nation. The percentage of people having any mental illness for the United States as a whole was 19.7%.  

Idaho, along with other western and rural states, provided a disproportionate number of military service members to the wars in Iraq and Afghanistan. Up to fifty percent of soldiers returning from active duty report psychological problems and depression symptoms. Returning veterans and our slow economy are likely to put pressure on levels of mental illness in Idaho in the coming years.

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<thead>
<tr>
<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tbody>
<tr>
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<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

36 Idaho Council on Suicide Prevention, Report to Governor C.L. Otter, November 2009
Top 10 Causes of Death

The top 10 causes of death can help identify opportunities to improve community health by comparing the local death rates and trends to the national average. The section below provides data and analysis for the top 10 causes of death for Idaho and our community.

- **Cancer (malignant neoplasms)**

  Cancer is the leading cause of death in Idaho and the second leading cause of death in the United States. In Idaho, about one in two men and one in three women will be diagnosed with cancer sometime in their lives. About 22% of all deaths in Idaho each year are from cancer.

  Although cancer may occur at any age, it is generally a disease of aging. Nearly 80% of cancers are diagnosed in persons 55 or older. Cancer is caused both by external factors such as tobacco use and exposure, chemicals, radiation and infectious organisms, and by internal factors such as genetics, hormonal factors, and immune conditions.

  Cancer is among the most expensive conditions to treat. Individuals face financial challenges because of lack of insurance or underinsurance, resulting in high out-of-pocket expenses.  

  The chart below shows that cancer death rates in Idaho and our service area are 10% below the national average (7th best in the nation). The trend for cancer deaths is down slightly nationally and down substantially in our service area.

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The CDC estimates that if tobacco use, poor diet, and physical inactivity were eliminated, 40% of cancers would be prevented. Therefore, opportunities exist to reduce the risk of developing some cancers. \(^{39}\)

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<tr>
<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
<td>Severe/Preventable</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Although our service area’s cancer rate is low compared to the nation, cancer is a term that includes more than 100 different diseases. Some cancer death rates may be relatively high in our service area, so we have collected data on the most common forms of cancer in Idaho below.

\(^{39}\) America’s Health Rankings 2011, www.americashealthrankings.org
- **Lung Cancer**

Lung cancer is the leading cause of cancer death in Idaho. However, the trend for lung cancer deaths in our service area is improving and the death rate is well below the national average.\(^4\) Current science does not support population-based efforts to screen for lung cancer, even among those at higher risk for the disease. Because of the invasive nature of diagnostic testing and the possibility of false-positive tests, there is potential for significant harm from screening. More than 80% of lung cancers occur because of tobacco smoking.\(^1\)

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**Health Factor Score**

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<tr>
<th></th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tbody>
<tr>
<td><strong>Trend:</strong></td>
<td>Trend: Better/Worse</td>
<td></td>
</tr>
<tr>
<td><strong>Prevalence</strong></td>
<td>Prevalence versus U.S. Average</td>
<td></td>
</tr>
<tr>
<td><strong>Severe/Preventable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Magnitude:</strong></td>
<td>Magnitude: Root Cause</td>
<td></td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Lung Cancer** | 2 | 0 | 4 | 1 | 7 |

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Colorectal Cancer

In Idaho, colorectal cancer is the second most common cancer-related cause of death among males and females combined. The trend for colorectal cancer deaths in our service area is flat, and the death rate is well below the national average.\textsuperscript{42} There is evidence that cancers of the colon are associated with obesity and that preventing weight gain can reduce the risk. Early detection is effective in reducing colorectal cancer death rate.\textsuperscript{43}

\begin{center}
\begin{tabular}{|c|c|c|c|c|}
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\textbf{Health Factor Score} & \\ \\
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\textbf{Low score} = Low potential for health impact & \textbf{High score} = High potential for health impact & \\ \\
\hline
\textbf{Trend} & \textbf{Prevalence versus U.S. Average} & \textbf{Severe/Preventable} & \textbf{Magnitude} & \textbf{Total Score} & \\ \\
\hline
Colorectal Cancer & 2 & 0 & 4 & 0 & 6 & \\
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\end{tabular}
\end{center}

\textsuperscript{42} Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010

\textsuperscript{43} America's Health Rankings 2011, www.americashealthrankings.org
Breast Cancer

Breast cancer is the second leading cause of cancer death after lung cancer among Idaho women. The breast cancer death rate in our service area is well below the national average. Although nationally breast cancer rates have continued to rise since 1980, there has been a steady decline in the death rate from breast cancer. Survival rates differ significantly by stage of diagnosis. For women under age 65, uninsured women have the highest rates of more advanced stages of breast cancer (48%) compared to those with private insurance (33%), Medicare (25%), and Medicaid (43%).

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Health Factor Score

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Cancer</strong></td>
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<td>0</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

*Service area data not available for 2000-2004

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45 America’s Health Rankings 2011, www.americashealthrankings.org
Prostate cancer is the second overall cause of death in Idaho men and is the most common cancer among males. The prevalence of prostate cancer deaths is nearly twice as high in our service area as it is in the nation as a whole or Idaho. Known risk factors for prostate cancer that are not modifiable include age, ethnicity, and family history. One modifiable risk factor is a diet high in saturated fat and low in vegetable and fruit consumption. While good evidence exists that prostate-specific antigen (PSA) screening along with digital rectal exam can detect early-stage prostate cancer, the evidence is inconclusive that early detection improves health outcomes.

**Health Factor Score**

<table>
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<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tr>
<td>Trend: Better/Worse</td>
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<td></td>
<td>Total Score</td>
</tr>
<tr>
<td>Prostate Cancer</td>
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</tr>
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<td></td>
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<td>8</td>
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</tbody>
</table>

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**Pancreatic Cancer**

In our service area, the pancreatic cancer death rate is much lower than the national average.\(^{48}\) There are no established guidelines for preventing pancreatic cancer and the survival rate is low. Possible factors increasing the risk of pancreatic cancer include smoking and type 2 diabetes, which is associated with obesity.\(^ {49}\)

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**Health Factor Score**

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<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tbody>
<tr>
<td></td>
<td>Trend</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Pancreatic Cancer</td>
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<td>0</td>
</tr>
</tbody>
</table>

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- **Skin Cancer (Melanoma)**

In 2008, more than 1 million people were diagnosed with skin cancer, making it the most common of all cancers. More people were diagnosed with skin cancer in 2008 than with breast, prostate, lung, and colon cancer combined. About 1 in 5 Americans will develop skin cancer during their lifetime. For people born in 2005, 1 in 55 will be diagnosed with melanoma—nearly 30 times the rate for people born in 1930.\(^{50}\)

Idaho had the highest melanoma death rate nationally from 2001-2005—26% higher than the U.S. average. About 50 people in the state die of melanoma every year. New diagnoses of melanoma increased at a rate of about 3.6% per year in Idaho from 1975 to 2006. The rate of increase was higher for males (4.2% per year) than for females (2.8% per year).

The chart shows that melanoma death rates continue to be higher in Idaho than in the rest of the nation, and our service area death rate is significantly higher than both Idaho and the nation.\(^{51}\) In addition, the *incidence rates* for people diagnosed with melanoma are statistically significantly higher for Health Districts 3 and 4 than for the rest of the state.\(^{52}\)

Exposure to ultraviolet (UV) radiation appears to be the most significant factor in the development of skin cancer. Less than one-third of youth aged 11-18 practiced any sun protection behavior, and only 31% of adults surveyed in 1998 reported wearing protective clothing, staying in the shade, or using sunscreen (national data).

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50 [www.epa.gov/sunwise/statefacts.html](http://www.epa.gov/sunwise/statefacts.html)
52 Cancer Data Registry of Idaho – December 2011 release
Skin cancer is largely preventable when sun protection measures are used consistently. These results highlight the need for effective interventions that reduce harmful UV light exposure.\(^{53}\)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Low score = Low potential for health impact</td>
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<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S.</td>
</tr>
<tr>
<td>Skin Cancer Death Rate</td>
<td>3</td>
</tr>
</tbody>
</table>

Leukemia

The leukemia death rate in our service area is about the same as the national average.\textsuperscript{54} Leukemia is a cancer of the bone marrow and blood. Scientists do not fully understand all the causes of leukemia, although researchers have found some associations. Chronic exposure to benzene at work, large doses of radiation, and smoking tobacco all are risk factors associated with some forms of leukemia.\textsuperscript{55} Because the causes are not well understood, evidence-based preventive programs are not available (other than avoiding the risk factors described above).

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\begin{tabular}{|c|c|c|c|c|}
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 & Health Factor Score &  &  &  \\
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 & Low score = Low potential for health impact & High score = High potential for health impact &  &  \\
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 & Trend: Better/Worse & Prevalence versus U.S. Average & Severe/Preventable & Magnitude: Root Cause & Total Score \\
\hline
Leukemia & 2 & 2 & 1 & 0 & 5 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{54} Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010
\textsuperscript{55} www.cdc.gov/Features/HematologicCancers/
Non-Hodgkin’s Lymphoma

The non-Hodgkin’s lymphoma death rate in our service area is about the same as the national average. Lymphoma is a general term for cancers that start in the lymph system; mainly the lymph nodes. The causes of lymphoma are unknown. Because the causes are not understood, evidence-based preventive programs are not available.

![Non-Hodgkin Lymphoma Deaths](chart)

<table>
<thead>
<tr>
<th>Health Factor Score</th>
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<th>High score = High potential for health impact</th>
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<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>Non-Hodgkin’s lymphoma</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

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57 www.cdc.gov/Features/HematologicCancers/
• Diseases of the Heart

The heart disease death rate has been in steady decline over the past 10 years. It’s important to note that even though mortality rates are declining, many individuals are living with chronic cardiac disease as new procedures prolong their lives.

Heart disease remains the leading cause of death in the United States for both men and women. It is the second leading cause of death in Idaho. Idaho has the 7th lowest rate (best) of heart disease in the nation. The death rate from heart disease in our service area is greater than 30% below the national average.

Heart disease is a long-term illness that many individuals can manage through lifestyle changes and healthcare interventions. However, many interventions place a burden on affected individuals by constraining options and activities available to them and can result in costly and ongoing expenditures for health care. It’s important to keep cholesterol levels and blood pressure in check to prevent heart disease.

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<thead>
<tr>
<th>Health Factor Score</th>
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<tbody>
<tr>
<td>Trend: Better/Worse</td>
</tr>
<tr>
<td>Heart disease deaths</td>
</tr>
</tbody>
</table>

59 America’s Health Rankings 2011, www.americashealthrankings.org
60 Ibid.
- **Chronic Lower Respiratory Diseases**

The chronic lower respiratory diseases death rate in our service area is below the national average and the trend has been improving since 2004. Chronic lower respiratory diseases are the third leading cause of death in Idaho. Of the diseases included in the data, chronic bronchitis and emphysema account for the majority of the deaths. The main risk factors for these diseases are smoking, repeated exposure to harsh chemicals or fumes, air pollution, or other lung irritants.

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**Health Factor Score**

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<thead>
<tr>
<th>Low score = Low potential for health impact</th>
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<tr>
<td>Trend: Better/Worse</td>
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<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Respiratory disease deaths</td>
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</tr>
</tbody>
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• Accidents

Accidents are the fourth leading cause of death in Idaho and include unintentional injuries which comprise both motor vehicle and non-motor vehicle accidents. The trend for accidents has been going up since 2004 and is now significantly above the average for the nation and Idaho. Specifically, the 7 year average rate of motor vehicle accident deaths has gone up over 50% since 2006.

<table>
<thead>
<tr>
<th>Health Factor Score</th>
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<tr>
<td>Low score = Low potential for health impact</td>
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<tr>
<td>Trend</td>
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<tr>
<td>-------</td>
</tr>
<tr>
<td>Accidental deaths</td>
</tr>
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</table>

• Cerebrovascular Diseases

The number of deaths due to cerebrovascular diseases has decreased substantially over the past 10 years. However, they are still the 5th leading cause of death in Idaho and the nation. In our service area, the cerebrovascular diseases death rate has been trending lower since the year 2004 and is now slightly lower than the national average.\(^{64}\)

Cerebrovascular diseases include a number of serious disorders, including stroke and cerebrovascular anomalies such as aneurysms. Cerebrovascular diseases can be reduced when people lead a healthy lifestyle that includes being physically active, maintaining a healthy weight, eating well, and not using tobacco.\(^{65}\)

![Cerebrovascular Deaths](chart.png)

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
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</thead>
<tbody>
<tr>
<td>Cerebrovascular Deaths</td>
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<td>2</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

\(^{64}\) Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010

• Alzheimer’s Disease

Alzheimer’s is the sixth leading cause of death in Idaho. The death rate from Alzheimer’s in Idaho and the nation has increased significantly over the past 10 years. The death rate in our service area is much lower than the national rate.66

Alzheimer’s is the most common form of dementia, a general term for serious loss of memory and other intellectual abilities. Alzheimer’s disease accounts for 50 to 80% of dementia cases. Alzheimer’s is not a normal part of aging, although the greatest known risk factor is increasing age, and the majority of people with Alzheimer’s are 65 and older. Although current treatments cannot stop Alzheimer’s from progressing, they can temporarily slow the worsening of dementia symptoms and improve quality of life for those with Alzheimer’s and their caregivers.67

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67 Alzheimer’s Association, www.alz.org
• Diabetes Mellitus

The number of people dying from diabetes has increased significantly in our service area over the past ten years, and the death rate is how higher than the average for the nation and Idaho. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, and blindness and can even result in limb amputation or death. It is the seventh leading cause of death in Idaho.  

![Diabetes Death Rate Graph](image)

### Health Factor Score

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<tr>
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<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tbody>
<tr>
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<td>Severe/Preventable</td>
</tr>
<tr>
<td>Diabetes Deaths</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

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• Suicide

In 2009 Idaho’s suicide rate of 19.7 per 100,000 people was the fourth highest in the nation. Suicide is the eighth leading cause of death in Idaho. The suicide death rate per 100,000 people in Idaho was 18.5 in 2010 which is more than 50% higher than the national average rate of 12.2. The 5 year average suicide rate for our service area was 16.7 which is better than our state’s rate but still over 35% higher than the national average. As shown in the chart below, the suicide rate in our service area has been decreasing while it has been trending up in Idaho and the nation since the recession in 2008. A strong relationship exists between unemployment, economy, and suicide.

The suicide rate for males is over four times higher than the rate for females. U.S. male veterans are twice as likely to die by suicide as males without military service. Idaho, along with other western and rural states, provided a disproportionate number of military service members to the wars in Iraq and Afghanistan. Farmers are also at increased risk of suicide due to farm-related stressors and relative isolation.

Many suicides can be prevented by ensuring people are aware of warning signs, risk factors, and protective factors.

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S.</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

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70 Idaho Council on Suicide Prevention, Report to Governor C.L. Otter, November 2009
- **Influenza and Pneumonia**

  The death rates from flu and pneumonia have been decreasing in our service area and are significantly lower than the national average.\(^71\)

  Influenza is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. It can cause mild to severe illness, and at times can lead to death. The best way to prevent the flu is by getting a flu vaccination each year.\(^72\)

  Pneumonia is an infection of the lungs that is usually caused by bacteria or viruses. Globally, pneumonia causes more deaths than any other infectious disease. However, it can often be prevented with vaccines and can usually be treated with antibiotics or antiviral drugs. People with health conditions, like diabetes and asthma, should be encouraged to get vaccinated against the flu and bacterial pneumonia.\(^73\)

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### Health Factor Score

<table>
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<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S.</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu/ Pneumonia</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

\(^72\) [http://www.cdc.gov/flu/keyfacts.htm](http://www.cdc.gov/flu/keyfacts.htm)
\(^73\) [http://www.cdc.gov/Features/Pneumonia/](http://www.cdc.gov/Features/Pneumonia/)
• **Nephritis**

The death rate for nephritis is much lower in our community than it is nationally. The trend is flat in our community while increasing steadily in both the nation and Idaho over the past ten years.\(^{74}\)

Nephritis is an inflammation of the kidney, which causes impaired kidney function. A variety of conditions can cause nephritis, including kidney disease, autoimmune disease, and infection. Treatment depends on the cause. Kidney disease damages kidneys, preventing them from cleaning blood effectively. Chronic kidney disease eventually can cause kidney failure if it is not treated.\(^{75}\)

Because chronic kidney disease often develops slowly and with few symptoms, many people aren’t diagnosed until the disease is advanced and requires dialysis. Blood and urine tests are the only ways to determine if a person has chronic kidney disease. It's important to be diagnosed early. Treatment can slow down the disease, and prevent or delay kidney failure.

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\(^{74}\) Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010

\(^{75}\) [www.cdc.gov/Features/WorldKidneyDay/](http://www.cdc.gov/Features/WorldKidneyDay/)
Steps to help keep kidneys healthy include:

- Keep blood pressure below 130/80 mm/Hg. If blood pressure is high, it should be checked regularly and brought under control through diet, exercise, or blood pressure medication.
- Stay in target cholesterol range.
- Eat less salt and salt substitutes.
- Eat healthy foods.
- Stay physically active.

If a person has diabetes, they should take these steps, too:

- Meet blood sugar targets.
- Have an A1c test at least twice a year, but ideally up to four times a year. An A1c test measures the average level of blood sugar over the past three months.

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
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</thead>
<tbody>
<tr>
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<td>4</td>
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<td>6</td>
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</tbody>
</table>

Health Factor Measures and Findings

The health outcomes described in the previous section tell us how healthy we are now. Health factors give us clues about how healthy we are likely to be in the future.

Health factors represent key influencers of poor health that if addressed with effective, evidence-based programs and policies can improve health outcomes. Diet, exercise, educational attainment, environmental quality, employment opportunities, quality of health care, and individual behaviors all work together to shape community health outcomes and well being.

The County Health Rankings uses four categories of health factors: Health behaviors, clinical care, social and economic, and physical environment factors. In turn, these health factors each have a number of measures:

- Health behaviors (6 measures)
- Clinical care (5 measures)
- Social and economic (7 measures)
- Physical environment (4 measures)

In addition to County Health Ranking measures, we collected community health factors from national, state, and local perspectives to create a broader set of health indicators and measures for our community. These additional indicators were determined by the Department of Health and Welfare, the Centers for Disease Control and Prevention (CDC), or other authoritative sources to represent important health risk factors.

One tool we utilized was the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing surveillance program developed and partially funded by the CDC. The tool’s recent data and comprehensive scope make it an ideal mechanism to monitor and track key health factors nationally and throughout Idaho.

Health Behavior Factors

County Health Rankings Health Behavior Factors

The six measures for community health behavior are described below. This next section also includes the specific data trends for our community and when possible compares our local data to state and national averages.

---

- **Adult Smoking**

The relationship between tobacco use, particularly cigarette smoking, and adverse health outcomes has been well known for decades. In fact, cigarette smoking is the leading cause of preventable death. Smoking causes or contributes to cancers of the lung, pancreas, kidney, and cervix. An average of 1,500 people die each year in Idaho as a direct result of tobacco use.\(^{78}\)

County-level measures from the Behavioral Risk Factor Surveillance System (BRFSS) provided by the CDC were used to obtain the number of current adult smokers who have smoked at least 100 cigarettes in their lifetime. The trend for smoking nationally and in Idaho is down, but the number of smokers in our service area is well above the national average with almost 22% of our population reporting having smoked at least 100 cigarettes in their lifetime. However, the sample size of this measurement for our service area was small so it is very possible that the percent of smokers is much lower than reported. Therefore, some caution will be used in scoring the prevalence of this measure.\(^{79}\)

![Smoking Chart](image)

The percent of people who smoke declines significantly with higher levels of income and education, as shown in the charts below.

---

\(^{79}\) Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
Health Factor Score
Low score = Low potential for health impact           High score = High potential for health impact

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Trend: Better/Worse</th>
<th>Prevalence U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>
**Adult Obesity**

The obesity measure represents the percent of the adult population that has a body mass index greater than or equal to 30. Obesity is used as a key health factor because it is an issue that can be addressed within communities by changing unhealthy conditions that contribute to poor diet and exercise. Being overweight or obese increases the risk for a number of health conditions: Coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, gynecological problems (infertility and abnormal menses), and poor health status. Additionally, there are direct and indirect economic costs associated with obesity. In 1998, the U.S. spent 9.1% of total medical expenses on obesity- and overweight-associated medical costs.\(^8^0\)

The trend for obesity has been increasing steadily for the past 10 years both nationally and in Idaho. However, our community ranks in the top 10% (best) nationally with only 13.9% of people surveyed reporting having a BMI ≥ 30. The top 10\(^{th}\) percentile nationally is 25%.\(^8^1\)

---


\(^8^1\) Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
In Districts 3 and 4, those with incomes below $35,000 annually are more likely to be obese.  

---

**Health Factor Score**

<table>
<thead>
<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S.</td>
</tr>
<tr>
<td>Severe/Preventable</td>
<td>Magnitude: Root Cause</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
</tr>
</tbody>
</table>

| Obese Adults | 2 | 0 | 4 | 4 | 10 |

---

82 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
- **Physical Inactivity: Adults**

Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. A person is considered physically inactive if during the past month, other than a regular job, they did not participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise.\(^{83}\)

As shown in the chart below, physical inactivity in our community is about the same as the national average and the trend for Idaho has been relatively flat since 2002.\(^{84}\)

Physical inactivity is significantly higher among those people with annual incomes below $50,000, those without a college degree, and among Hispanics as shown in the charts below.\(^{85}\)

---


\(^{84}\) Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System

\(^{85}\) Ibid.
**Health Factor Scoring**

<table>
<thead>
<tr>
<th></th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S.</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical inactivity Adults</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

*No Hispanic data available for District 4*
Alcohol Use

Two measures are combined to assess alcohol use in a county: Percent of excessive drinking in the adult population and the crude motor-vehicle death rate per 100,000 people.

- **Excessive Drinking**

The excessive drinking statistic comes from the Behavioral Risk Factor Surveillance System (BRFSS). The measure aims to quantify the percentage of females that consume four or more and males who consume five or more alcoholic beverages in one day at least once a month. Excessive drinking is a risk factor for a number of adverse health outcomes. These include alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes. From 2001–2005, there were approximately 80,000 deaths annually attributable to excessive drinking. It is the third leading lifestyle-related cause of death for people in the U.S.\(^{86}\)

The percent of people engaging in excessive drinking for Valley and Adams Counties is well above the national average with the trend being flat over the past five years. The top 10\(^{th}\) percentile (best) is 8% nationally, so our community is well above that level.\(^{87}\)

---

### Health Factor Scoring

<table>
<thead>
<tr>
<th></th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S.</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive Drinking</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

---


\(^{87}\) Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System.
● Motor Vehicle Crash Death Rate

Motor vehicle crash deaths are calculated by the National Vital Statistics System (NVSS) at CDC. Motor vehicle crash deaths are reported as the crude mortality rate per 100,000 people due to on- or off-road accidents involving a motor vehicle. Over the past several years, the motor vehicle crash death rate has increased significantly for our community. Our crash death rate is now well above the Idaho and national average.\(^{88}\)

---

**Health Factor Score**

<table>
<thead>
<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Motor vehicle crash death rate</td>
<td>4</td>
</tr>
</tbody>
</table>

---

Unsafe Sex

Two measures are used to represent the Unsafe Sex focus area: Teen birth rates and sexually transmitted infection incidence rates. First, the birth rate per 1,000 female population ages 15-19 as measured and provided by the National Center for Health Statistics (NCHS) is reported. Additionally, the chlamydia rate per 100,000 people was provided by the Centers for Disease Control and Prevention (CDC). Measuring teen births and the chlamydia incidence rate provides communities with a sense of the level of risky sexual behavior.

- Teen Birth Rate

Evidence suggests teen pregnancy significantly increases the risks for repeat pregnancy and for contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mother and child as well as for the families and community. A systematic review of the sexual risk among pregnant and mothering teens concludes that pregnancy is a marker for current and future sexual risk behavior and adverse outcomes. The review found that nearly one-third of pregnant teenagers were infected with at least one STI. Furthermore, pregnant and mothering teens engage in exceptionally high rates of unprotected sex during pregnancy and postpartum, and are at risk for additional STIs and repeat pregnancies.

Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery and low birth weight, increasing the risk of child developmental delay, illness, and mortality.\(^{89}\)

Our rate of teen pregnancy is increasing and is now about the same as the national average. The national top 10\(^{th}\) percentile rate is 22.\(^{90}\)

---


Health Factor Score

Low score = Low potential for health impact           High score = High potential for health impact

Trend:
Better/Worse

Prevalence
versus U.S. Average

Severe/
Preventable

Magnitude:
Root Cause

Total Score

<table>
<thead>
<tr>
<th>Teen birth rate</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

Teen Birth Rate

Service Area 5 Year Avg
Idaho
United States
• Sexually Transmitted Infections

Sexually transmitted infections (STI) data are important for communities because the burden of STIs is not only on individual sufferers, but on society as a whole. Chlamydia, in particular, is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. Additionally, STIs in general are associated with significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, pelvic inflammatory disease, involuntary infertility, and premature death.\(^{91}\)

The rate of chlamydia infections has decreased over the past six years in our community and is now significantly below the national average. We are, however, still above the national top 10\(^{th}\) percentile rate which is 84.\(^{92}\)

\[\text{Sexually Transmitted Infections Rate}\]

\[\text{Service Area} \quad \text{Idaho}\]

\[\begin{array}{c|c|c|c|c|c}
\text{Rate Per 100,000} & 2004 & 2005 & 2006 & 2007 & 2008 \\
\hline
\text{Service Area} & 150 & 200 & 250 & 300 & 350 \\
\text{Idaho} & 200 & 250 & 300 & 350 & 400 \\
\hline
\end{array}\]

\[\text{Health Factor Score}\]

\[\begin{array}{c|c|c|c|c|c}
\text{Low score} = \text{Low potential for health impact} & \text{Trend: Better/Worse} & \text{Prevalence versus U.S.} & \text{Severe/Preventable} & \text{Magnitude: Root Cause} & \text{Total Score} \\
\hline
\text{Sexually Transmitted Infections} & 1 & 0 & 3 & 3 & 7 \\
\hline
\end{array}\]

\(^{91}\) County Health Rankings 2012. Accessible at [www.countyhealthrankings.org](http://www.countyhealthrankings.org).


Idaho and Service Area Source: Idaho Reported Sexually Transmitted Disease, 2004-2010

Additional Health Behavior Factors

- Overweight and Obese Adults

In addition to the percent of obese adults we included as part of our County Health Rankings factors, we added the percentage of overweight and obese adults. Being overweight or obese increases the risk for a number of health conditions: Coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, gynecological problems (infertility and abnormal menses), and poor health status.

The trend for overweight and obese adults has been increasing steadily for the past 10 years both nationally and in Districts 3 and 4. However, the percent of adults who were overweight or obese in our service area was at half the national level in 2010 the only year data was available for our service area.\(^9^3\)

---

\(^9^3\) Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
Nutritional Habits: Adults – Fruit and Vegetable Consumption

Eating a diet high in fruits and vegetables is important to overall health, because these foods contain essential vitamins, minerals, and fiber that may help protect from chronic diseases. The current dietary guidelines recommend that at least half of your plate consist of fruit and vegetables and that half of your grains be whole grains. This combined with reduced sodium intake, fat-free or low-fat milk and reduced portion sizes lead to a healthier life. Data collected for this measure focus on the consumption of vegetables and fruits at the recommended five portions per day. These data are collected through the Behavioral Risk Factor Surveillance System.

To estimate the number of people who did not eat five servings of fruits and vegetables each day, we used BRFSS data from Districts 3 and 4 since county and service area data was not available. As shown in the chart below, 78% of people in District 3 and 73% of people in District 4 did not eat the recommended amounts of fruits and vegetables. The national average was about 77%. The trend is improving in District 4 and in Idaho but is relatively flat in District 3. People with college educations are about 10% more likely to eat the recommended amount of fruits and vegetables, but there are no large differences in nutritional habits based on income.

<table>
<thead>
<tr>
<th>Health Factor Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
</tr>
<tr>
<td>Nutritional habits adults</td>
</tr>
</tbody>
</table>

94 America’s Health Rankings 2011, www.americashealthrankings.org
95 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
Overweight and Obese Teens

We included the percentage of obese and overweight teenagers in our community to ensure an understanding of youth health behavior risks. People who were already overweight in adolescence (14-19 years old) have an increased mortality rate from a range of chronic diseases as adults: endocrine, nutritional and metabolic diseases, cardiovascular diseases, colon cancer, and respiratory diseases. There were also many cases of sudden death in this group.\textsuperscript{96} Overweight children and adolescents:

- Are more likely than other children and adolescents to have risk factors associated with cardiovascular disease (e.g., high blood pressure, high cholesterol and type 2 diabetes).
- Are more likely to be obese as adults.
- Are more likely to experience other health conditions associated with increased weight including asthma, liver problems and sleep apnea.
- Have higher long-term risk of chronic conditions such as stroke; breast, colon, and kidney cancers; musculoskeletal disorders; and gall bladder disease.

Some methods of preventing and treating overweight children are listed below:

- Reducing caloric intake is the easiest change. Highly restrictive diets that forbid favorite foods are likely to fail. They should be limited to rare patients with severe complications who must lose weight quickly.
- Becoming more active is widely recommended. Increased physical activity is common in all studies of successful weight reduction. Create an environment that fosters physical activity.
- Parents' involvement in modifying overweight children's behavior is important. Parents who model healthy eating and physical activity can positively influence their children's health.\textsuperscript{97}

The percent of overweight or obese teens in Idaho is much lower than the average percent of overweight teens across the nation. However, the trend for obesity and overweight youth is increasing both in Idaho and across the United States. Overweight youth are defined as being \( \geq 85\text{th} \) percentile but <95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts. Obese youth are defined by the CDC as being \( \geq 95\text{th} \) percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts. We have no service area data available. However due to the exceptionally low scores for overweight and obese adults in our service area, we assumed our teens also were less overweight and obese than the average for Idaho.\textsuperscript{98}

\textsuperscript{96} Overweight In Adolescence Gives Increased Mortality Rate, ScienceDaily (May 20, 2008)
\textsuperscript{97} American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF
\textsuperscript{98} Youth Risk Behavior Surveillance, United States, 2001 – 2011, www.cdc.gov/yrbs/
### Overweight Teens

- **Graph**
  - Y-axis: % of students who were overweight (≥ 85th percentile for BMI)
  - Idaho vs. United States

- **Legend**
  - Idaho
  - United States

- **Note**
  - Data collected every other year. No district or service area data available.

### Teen Obesity

- **Graph**
  - Y-axis: % of students who were obese (≥ 95th percentile for BMI)
  - Idaho vs. United States

- **Legend**
  - Idaho
  - United States

- **Note**
  - Data collected every other year. No district or service area data available.

### Health Factor Score

<table>
<thead>
<tr>
<th>Obese Teens</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

**Notes**

- Low score = Low potential for health impact
- High score = High potential for health impact
**Nutritional Habits: Youth – Fruit and Vegetable Consumption**

More than 80% of Idaho youth do not eat the recommended amount of fruits and vegetables. This is slightly worse than the national average and has been relatively flat for the past ten years.\(^99\)

---

Levels of Physical Activity: Youth

Physical activity helps build and maintain healthy bones and muscles, control weight, build lean muscle, reduce fat, and improve mental health (including mood and cognitive function). It also helps prevent sudden heart attack, cardiovascular disease, stroke, some forms of cancer, type 2 diabetes and osteoporosis. Additionally, regular physical activity can reduce other risk factors like high blood pressure and cholesterol.

As children age, their physical activity levels tend to decline. That’s why it’s important to establish good physical activity habits as early as possible. A recent study suggests that teens who participate in organized sports during early adolescence maintain higher levels of physical activity during late adolescence compared to their peers, although their activity levels do decline. And youth who are physically fit are much less likely to be obese or have high blood pressure in their 20s and early 30s.\(^{100}\)

The chart below shows that about 50% of Idaho teens do not exercise as much as recommended. However, the trend is improving and the percentage of Idaho youth who exercise less than what is recommended is slightly below (better than) the national average.\(^{101}\)

---

### Health Factor Score

<table>
<thead>
<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td></td>
<td>Severe/Preventable</td>
</tr>
<tr>
<td></td>
<td>Magnitude: Root Cause</td>
</tr>
<tr>
<td></td>
<td>Total Score</td>
</tr>
<tr>
<td>Teen exercise</td>
<td>1</td>
</tr>
</tbody>
</table>

---

\(^{100}\) American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF

Illicit Drug Use

The use of illicit drugs has harmful and sometimes devastating effects on individuals, families, and society. The percent of people who reported using illicit drugs in our service area is much higher than the average percent in Idaho. Illicit drug use is significantly higher among males less than 34 years old, the unemployed, and those without a high school degree. Income levels did not have a large effect on illicit drug use.

---

102 www.samhsa.gov/newsroom/advisories/1109075503.aspx
103 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
### Health Factor Score

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Illicit Drug Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low score = Low potential for health impact</td>
<td>High score = High potential for health impact</td>
</tr>
<tr>
<td>Trend: Better/Worse</td>
<td>2</td>
</tr>
<tr>
<td>Prevalence versus U.S. Average</td>
<td>4</td>
</tr>
<tr>
<td>Severe/Preventable</td>
<td>4</td>
</tr>
<tr>
<td>Magnitude: Root Cause</td>
<td>2</td>
</tr>
<tr>
<td>Total Score</td>
<td>12</td>
</tr>
</tbody>
</table>
Clinical Care Factors

*County Health Rankings* Clinical Care Factors

Health Care Access

- **Uninsured Adults**

Health care access is represented with two measures. The first measure is the adult population without health insurance.

Evidence shows that uninsured individuals experience more adverse outcomes (physically, mentally, and financially) than insured individuals. The uninsured are less likely to receive preventive and diagnostic health care services, are more often diagnosed at a later disease stage, and on average receive less treatment for their condition compared to insured individuals. At the individual level, self-reported health status and overall productivity are lower for the uninsured. The Institute of Medicine reports that the uninsured population has a 25% higher mortality rate than the insured population.⁹⁴

The chart shows the number of adults without health care coverage has been trending up for the past ten years nationally and in Idaho. The number of uninsured in Idaho and our service area is higher than the national average.⁹⁵

---


¹⁰⁵ Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
The charts below show that income and education greatly affect the likelihood of people having health insurance. For example, those with incomes of less than $25,000 are about 10 times more likely to report being without health care coverage than those with incomes above $50,000. In addition, Hispanics are less likely to have health insurance coverage compared to non-Hispanics.\textsuperscript{106}
### Health Factor Score

Low score = Low potential for health impact
High score = High potential for health impact

<table>
<thead>
<tr>
<th></th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured adults</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

### Health Care Coverage - by Ethnicity

- **Non-Hispanic**
- **Hispanic**

- **District 3**
- **District 4**
• Primary Care Providers

The second measure of health care access reports the ratio of population in a county to primary care providers in a county (i.e., the number of people per primary care provider). The measure is based on data obtained from the Health Resources and Services Administration (HRSA). While having health insurance is a crucial step toward accessing the different aspects of the health care system, health insurance by itself does not ensure access. In addition, evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. One analysis found that primary care physician supply was associated with improved health outcomes including reduced all-cause cancer, heart disease, stroke, and infant mortality; a lower prevalence of low birth weight; greater life expectancy; and improved self-rated health. The same analysis also found that each increase of one primary care physician per 10,000 people is associated with a reduction in the average mortality by 5.3%.

The chart below shows the population to primary care provider ratio was below (better than) the national average for our service area as a whole but significantly worse in Adam’s County.

---

Health Care Quality

- **Preventable Hospital Stays**

Three separate measures are used to report health care quality. The first measure is preventable hospitalizations, or the hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees. Ambulatory-care sensitive conditions (ACSC) are usually addressed in an outpatient setting and do not normally require hospitalization if the condition is well managed.

The rate of preventable hospital stays for our service area is significantly below (better than) the national average and is even well below (better than) the national top 10th percentile (top 10th percentile rate is 49) for both Adams and Valley Counties. The trend is also improving over time in our service area and nationally. This indicates a high level of health care quality in our service area.108

![Graph of Preventable Hospital Stays](image)

**Legend**

- Idaho
- United States
- Adams County
- Valley County


<table>
<thead>
<tr>
<th>Preventable Hospital Stays</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
</table>

• Diabetes Screening

The second measure of health care quality, diabetes screening, records the percent of diabetic Medicare enrollees that receive HbA1c screening. Regular HbA1c screening among diabetic patients is considered the standard of care. When high blood sugar, or hyperglycemia, is addressed and controlled, complications from diabetes can be delayed or prevented.\textsuperscript{109}

The chart shows the trend for diabetes screening is improving nationally and in our service area with the percent of people receiving A1c screening about the same in our service area as in the nation.\textsuperscript{110} The top 10\textsuperscript{th} percentile (best) is 89% of the people with diabetes receiving screening.

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
& Trend: Better/Worse & Prevalence versus U.S. Average & Severe/Preventable & Magnitude: Root Cause & Total Score \\
\hline
Diabetes screening & 1 & 2 & 3 & 3 & 9 \\
\hline
\end{tabular}
\caption{Health Factor Score}
\end{table}

\textsuperscript{109} University of Wisconsin Population Health Institute. \textit{County Health Rankings 2012}. Accessible at \url{www.countyhealthrankings.org}.

\textsuperscript{110} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
• Mammography Screening

The third measure of health care quality, mammography screening, is the percent of female Medicare enrollees age 67-69 having at least one mammogram over a two-year period. Evidence suggests that screening reduces breast cancer mortality, especially among older women. A physician’s recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain mammograms.

The trend for the overall percent of women aged 67 to 69 receiving mammography screenings has generally been flat for the past several years except in Adams county where there has been a significant increase since 2007. The percent for our service area is about the same as the national average.\(^\text{111}\)

![Mammography Screening - Medicare](chart)

The data underlying all three measures comes from the Dartmouth Atlas, a project that documents variations in health care throughout the country through use of Medicare claims data.

The National Cancer Institute recommends that women aged 40 and older receive screening for breast cancer with mammography every one to two years. To obtain the percentage of Idaho women aged 40 and older that had received this breast cancer screening, we used data from BRFSS. As shown in the chart below, the percentage has not changed significantly over the past decade and overall is consistent with the percentage of women ages 65 to 67 receiving breast cancer screenings. Women with

annual incomes of less than $50,000 are significantly less likely to have had a mammogram and breast exam in the last two years.\textsuperscript{112}

### Mammography Screening

<table>
<thead>
<tr>
<th>Year</th>
<th>Idaho 4 year avg</th>
<th>District 3 4 year avg</th>
<th>District 4 4 year avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td></td>
<td></td>
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<td>2007</td>
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<td>2008</td>
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<tr>
<td>2010</td>
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<td></td>
</tr>
</tbody>
</table>

*No U.S. or service area data available

### Health Factor Score

<table>
<thead>
<tr>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Mammography screening</td>
<td>2</td>
</tr>
</tbody>
</table>

### Additional Clinical Health Factors

In this section, we include a number of additional preventive and screening measures as quality of care health factors influencing community health.

- **Cholesterol Screening**

  Cholesterol screening is important for good health because knowing cholesterol levels can spur actions to control it. Idaho is ranked 49\textsuperscript{th} in the nation for cholesterol screening.\textsuperscript{113} District 3, District 4, and Idaho each have a lower percent of people receiving cholesterol checks than the national average.\textsuperscript{114}

\textsuperscript{112} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
\textsuperscript{113} America’s Health Rankings 2011, www.americashealthrankings.org
\textsuperscript{114} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
Lower income people and those without college educations are significantly less likely to have their cholesterol checked.\textsuperscript{115}

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
 & Trend: & Prevalence & Severe/ & Magnitude: & Total Score \\
 & Better/Worse & versus U.S. & Preventable & Root Cause & \\
\hline
Cholesterol Screening & 1 & 4 & 3 & 2 & 10 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{115} Ibid.
Colorectal Screening

The five-year survival rate in early localized stage colorectal cancer is 90%. Only 35% of colorectal cancers are detected at the early localized stage. Many organizations are working to raise awareness about the importance of colorectal cancer screening and the serious nature of the disease.

The trend for people receiving colorectal screening has been improving over the past ten years. The percent of people receiving colorectal screening for Districts 4 is about the same as it is for the nation as a whole; however, District 3 has a much higher (worse) percent than the nation.116

People with annual incomes of less than $25,000 as well as those with no college education are significantly less likely to have ever had a colonoscopy when compared to people with higher incomes or with a college education.117

116 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
117 Ibid.
Prenatal Care Begun in First Trimester

Prenatal care measures how early women are receiving the care they require for a healthy pregnancy and development of the fetus. Mothers who do not receive prenatal care are three times more likely to deliver a low birth weight baby than mothers who received prenatal care, and babies are five times more likely to die without the care. Early prenatal care allows health care providers to identify and address health conditions and behaviors that may reduce the likelihood of a healthy birth, such as smoking and drug and alcohol abuse.

\[\text{118 America's Health Rankings 2011, www.americashealthrankings.org}\]
As shown in the chart below, more women in our community have historically been receiving early prenatal care than Idaho or the nation. The trend in our service area for receiving early prenatal care had been decreasing from 2004 to 2008 but has increased in 2009 and 2010.

![Prenatal Care 1st Trimester Chart]

When it comes to receiving early prenatal care, there is a large disparity between women graduating from high school and those not graduating from high school. For Idaho, 76.6% of women graduating from high school received early prenatal care whereas only 57.3% of those not graduating from high school received early care. Although the difference is not as large as high school graduation status, there is also a disparity between Hispanic and non-Hispanic women receiving early prenatal care. For Idaho as a whole in 2010, 75.8% of non-Hispanic women and 62.1% of Hispanic women received prenatal care in the first trimester. Also, only 63.3% of women who smoked received early prenatal care in Idaho. High school graduation, ethnicity, and smoking data related to early prenatal care was not available on a county or health district level.119

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Health Factor Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low score = Low potential for health impact</td>
<td>High score = High potential for health impact</td>
</tr>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Prenatal care 1st Trimester</td>
<td>2</td>
</tr>
</tbody>
</table>

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**Dental Visits**

Oral health is vital to a comprehensive preventive health program. Nearly 1/3 of all adults in the U.S. have untreated tooth decay, while one in seven adults aged 35 to 44 years has gum disease. This increases to one in every four adults aged 65 years and older. Oral cancers, if caught early, are more responsive to treatment. Annual dental visits are one part of a healthy regimen of oral care.120

According to the Behavioral Risk Factor Surveillance System surveys, the percentage of people not receiving preventive dental visits in our service area is about the same as it is in the nation as a whole. The trend appears to have been flat over the past ten years.121

Those with incomes below $50,000 are significantly less likely to have preventive dental visits than those with incomes above $75,000. In addition, those with less than a college degree are significantly less likely to have preventive dental visits.122

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120 America’s Health Rankings 2011, www.americashealthrankings.org
121 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
122 Ibid.
**Health Factor Score**

Low score = Low potential for health impact

High score = High potential for health impact

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Visits</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>
Childhood Immunizations

Almost 90% of children ages 19 to 35 months in the United States are immunized. Vaccines protect children from illnesses and death caused by infectious diseases by helping prepare their bodies to fight serious and, at times, deadly diseases.

In the US, vaccines have reduced or eliminated many infectious diseases that once routinely killed or harmed many infants, children, and adults. However, the viruses and bacteria that cause vaccine-preventable disease and death still exist and can be passed on to people who are not protected by vaccines. Vaccine-preventable diseases have many social and economic costs: sick children miss school and this can cause parents to lose time from work. These diseases also result in doctor’s visits, hospitalizations, and even premature deaths.

The immunization coverage measure used here is the average of the percentage of children ages 19 to 35 months who have received the following vaccinations: diphtheria, tetanus, pertussis (DTP), poliovirus, meningococcal conjugate vaccine (MCV) and hepatitis B (HepB). The immunization rate in Idaho has been improving over the past two years and in 2010 was about the same as the national average. In the past, Idaho’s immunization rates have often been among the worst in the nation.123

There are proven methods to increase the rate of vaccinations that include ways to increase demand or improve access through provider-based innovations.

<table>
<thead>
<tr>
<th>Health Factor Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
</tr>
<tr>
<td>Childhood immunizations</td>
</tr>
</tbody>
</table>

123 America’s Health Rankings 2011, www.americashealthrankings.org
- Mental Health Service Providers

The percentage of Idaho’s population facing a high shortage of mental health providers in 2006 (latest year available) was 31.6%. This represents the largest percentage shortage of mental health professionals in the nation.

In 2006, over 97% of Idaho’s population lived in a county with a high shortage of prescribing mental health professionals. Adams and Valley counties both have areas listed as mental health professional shortage areas as of March 2012. The shortage of mental health professionals is especially concerning given the high suicide and mental illness rates in Idaho as documented earlier in those sections of our CHNA.

Specifically, the rate of psychiatrists per 100,000 people in Idaho was 6.6 in 2006. This is the lowest rate of psychiatrists in the nation and less than half of the national average of 14.4 psychiatrists per 100,000 people. Idaho’s rate of psychologists was 14.1 per 100,000, which also represented less than half the national average of 30.9. The rate of family therapy counselors and social workers in Idaho was also below the national average (although the rate of general counselors was above the national average).

<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
<td>Severe/Preventable</td>
</tr>
<tr>
<td>Mental health service providers</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

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125 Health Services and Resource Administration Data Warehouse, Mental Health Care HPSAs PDF [http://datawarehouse.hrsa.gov/hpsadetail.aspx#table](http://datawarehouse.hrsa.gov/hpsadetail.aspx#table)
126 Mental Health, United States, 2010 Report SAMHSA [www.samhsa.gov](http://www.samhsa.gov)
Social and Economic Factors

County Health Rankings Social and Economic Factors

- Education: High School Graduation and Some College

Several theories attempt to explain how education affects health outcomes. First, education often results in higher incomes, on average, and more resources than a job that does not require education. Access to health care is a particularly important resource that often is linked to jobs requiring a certain level of educational attainment. However, when income and health care insurance are controlled for, the magnitude of education’s effect on health outcomes remains substantive and statistically significant.

The labor market environment is also thought to contribute to health outcomes. People with lower educational attainment are more likely to be affected by variations in the job market. Unemployment rates are highest for individuals without a high school diploma compared with college graduates. Evidence shows that the unemployed population experiences worse health and higher mortality rates than the employed population.

Health literacy can help explain an individual’s health behaviors and lifestyle choices. There is a striking difference between health literacy levels based on education. Only 3% of college graduates have below basic health literacy skills, while 15% of high school graduates and 49% of adults who have not completed high school have below basic health literacy skills. Adults with less than average health literacy are more likely to report their health status as poor.

One’s education level affects not only his or her health, but education can have multigenerational implications that make it an important measure for the health of future generations. Evidence links maternal education with the health of her children. The education of parents affects their children’s health directly through resources available to the children, and also indirectly through the quality of schools that the children attend.

Finally, education influences a variety of social and psychological factors. Evidence shows the more education an individual has, the greater his or her sense of personal control. This is important to health because people who view themselves as possessing a high degree of personal control also report better health status and are at lower risk for chronic disease and physical impairment.

Two measures are used in an attempt to capture the formal years of education within the population. The first measure reports the percent of the ninth grade cohort that graduates high school in four years. The measure is from the National Center for Education Statistics (NCES) as well as from some state data sources that are not represented in the NCES. The second measure reports the percentage of the population
ages 25-44 with some post-secondary education. These data are from the American Community Survey (ACS).\textsuperscript{127}

The Adams and Valley county high school graduation rates for our service area have been above and below the national average since 2008. The rate is below the national average at this time; however, on a three year average basis it is not substantially below the average. Due to the volatility of this indicator, it is one we should watch closely in future years. Service area post-secondary education is slightly better than the national average.

However, public higher education in Idaho received low marks from a state report titled “Leaders and Laggars,” issued in 2012 by the Institute for a Competitive Workforce at the U.S. Chamber of Commerce. The state’s public four-year postsecondary schools received poor rankings for “Student Access & Success” and “Efficiency & Cost-Effectiveness.” Bill Goesling, a member of the Idaho State Board of Education who sits on the board’s Instruction, Research, and Student Affairs Committee, suggested that part of the reason for Idaho’s generally low rankings could be that we’re fairly rural. He said that many of the young men and women that do go to college are called back to the family farm to work especially when the economy is poor.\textsuperscript{128}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{high_school_graduation_rate.png}
\caption{High School Graduation Rate}
\end{figure}


\textsuperscript{128} http://www.idahoreporter.com/2012/idaho-education-board-member-reacts/
**Health Factor Score**

- Low score = Low potential for health impact
- High score = High potential for health impact

**Trend:**
- Better/Worse

**Prevalence versus U.S. Average**

**Severe/Preventable**

**Magnitude: Root Cause**

**Total Score**

<table>
<thead>
<tr>
<th></th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

*Prior to 2009, County Health Rankings recorded the rate of adults with a college degree. Starting in 2009, they recorded adults with some college.
• Unemployment

For the majority of people, employers are their source of health insurance and employment is the way they earn income for sustaining a healthy life and for accessing healthcare. Numerous studies have documented an association between employment and health. Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality.\textsuperscript{129}

The unemployment rate in Idaho and our service area, although trending down for the last year, is well above the long term rate for our area.\textsuperscript{130}

\begin{table}[h]
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\begin{tabular}{|c|c|c|c|c|c|}
\hline
Health Factor Score & Low score = Low potential for health impact & High score = High potential for health impact \\
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 & Trend: Better/Worse & Prevalence versus U.S. Average & Severe/Preventable & Magnitude: Root Cause & Total Score \\
\hline
Unemployment & 2 & 4 & 1 & 3 & 10 \\
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\end{tabular}
\end{table}

\textsuperscript{129} University of Wisconsin Population Health Institute. *County Health Rankings* 2012. Accessible at \url{www.countyhealthrankings.org}.

\textsuperscript{130} National Source: National Bureau of Labor Statistics, \url{www.bls.gov}. Idaho Source: Idaho Department of Labor \url{www.bls.gov}
- **Children in Poverty**

Income and financial resources enable individuals to obtain health insurance, pay for medical care, afford healthy food, safe housing, and access other basic goods. A 1990s study showed that if poverty were considered a cause of death in the U.S., it would have ranked among the top 10. Data on children in poverty is used from the Census' Current Population Survey (CPS) Small Area Income and Poverty Estimates (SAIPE).\(^{131}\)

The percent of children in poverty increased substantially since 2008. The prevalence of children in poverty for our service area as a whole is just over the national average.\(^{132}\)

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**Health Factor Score**

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<tr>
<th></th>
<th>Trend: Better/Worse</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude: Root Cause</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in Poverty</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

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• Inadequate Social Support and Single-Parent Households

Evidence has long demonstrated that poor family and social support is associated with increased morbidity and early mortality. Family and social support are represented using two measures: (1) percent of adults reporting that they do not receive the social and emotional support they need and (2) percent of children living in single-parent households.

The association between socially isolated individuals and poor health outcomes has been well-established in the literature. One study found that the magnitude of risk associated with social isolation is similar to the risk of cigarette smoking for adverse health outcomes. The social isolation measure reports the percentage of adults without social/emotional support.\textsuperscript{133}

The percent of people with inadequate social support in Valley County is well below the national average. Adams County’s is about the same as the national average.\textsuperscript{134}

Similar to socially isolated individuals, adults and children in single-parent households are at risk for both adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors (including smoking and excessive alcohol use). Not only is self-reported health worse among single parents,


\textsuperscript{134} Ibid
but mortality risk also is higher. Likewise, children in these households also experience increased risk of severe morbidity and all-cause mortality.

The percent of people living in single parent households is well below the national average for Valley County and just above the national average for Adams County.¹³⁵

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¹³⁵ Ibid
• **Homicide Rate/ Community Safety**

The health impacts of community safety are far-reaching, from the obvious impact of violence on the victim to the symptoms of post-traumatic stress disorder (PTSD) and psychological distress felt by those who are routinely exposed to violence. Community safety impacts various other health factors and outcomes as well, including birth weight, diet and exercise, and family and social support. In an effort to understand community safety, homicide death rate per 100,000 residents was used.\textsuperscript{136}

The homicide rate in our service area is substantially below the national average and from 2008 to 2010 was the lowest it has been in the past ten years.\textsuperscript{137}

\begin{center}
\begin{figure}[h]
\begin{tikzpicture}
\begin{axis}[
    width=\textwidth,
    height=0.5\textwidth,
    title={Homicide Rate},
    xlabel={Rate per 10,000},
    ylabel={Year},
    ytick={0,1,2,3,4,5,6,7,8},
    yticklabels={0,1,2,3,4,5,6,7,8},
    legend style={at={(0.5,-0.05)},anchor=north},
]
\addplot+[mark=triangle,mark options=solid] coordinates {
};
\addplot+[mark=triangle,mark options=solid] coordinates {
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\addplot+[mark=triangle,mark options=solid] coordinates {
};
\addplot+[mark=triangle,mark options=solid] coordinates {
};
\addplot+[mark=triangle,mark options=solid] coordinates {
(2000,0.5)(2002,1.0)(2004,1.5)(2006,2.0)(2008,2.5)(2010,3.0)
};
\addplot+[mark=triangle,mark options=solid] coordinates {
(2000,0.0)(2002,0.5)(2004,1.0)(2006,1.5)(2008,2.0)(2010,2.5)
};
\legend{Idaho, United States, District 3, District 4}
\end{axis}
\end{tikzpicture}
\end{figure}
\end{center}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\textbf{Health Factor Score} & \textbf{Trend: Better/Worse} & \textbf{Prevalence versus U.S. Average} & \textbf{Severe/Preventable} & \textbf{Magnitude: Root Cause} & \textbf{Total Score} \\
\hline
Homicide rate/Community safety & 2 & 0 & 2 & 2 & 6 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{136} Ibid.
\textsuperscript{137} Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010
Physical Environment Factors

County Health Rankings Physical Environment Factors

Environmental Quality

- Air Pollution Particulate Matter

Population-based and cohort studies have demonstrated that several pollutants, notably ozone and fine particulate matter, can contribute to increased morbidity and mortality. The health risks of ambient air pollution were based on these two commonly measured pollutants. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. Exposure to excess levels of ozone or fine particulate matter are correlated with increased hospital emergency room visits and hospitalizations among asthmatics and others with compromised respiratory function. Increases in these pollutants are associated with greater risk of death due to cardiopulmonary and cardiovascular conditions and ischemic heart disease. All-cause mortality also is associated with greater concentrations of ozone and fine particulate matter.¹³⁸

Particulate matter air pollution in our service area is well above the national average with no well defined trend indicating improvement. The 90th percentile (worst) is four (4) unhealthy air particulate days and Adam and Valley County readings are more than 5 times that level.

![Air Pollution: Particulate Matter](image)

• **Air Pollution Ozone Days**

Our community is in the top 10th percentile (0 days) for ozone days.\(^{139}\)

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<table>
<thead>
<tr>
<th>Health Factor Score</th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Air pollution</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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**Built Environment**

The built environment refers to human-made (versus natural) resources and infrastructure designed to support human activity, such as buildings, roads, parks, and other amenities. The characteristics of the built environment can affect the health of residents in multiple ways. This focus area seeks to measure the availability of healthy food and recreational facilities in the local built environment.\(^{140}\)

- **Fast Food Restaurants**

There is strong evidence that access to fast food restaurants correlates with a high prevalence of overweight, obesity, and premature death. Fast food density is a measure of the amount of fast food restaurants in a certain area such as a county. Ratios of fast food stores compare the number of fast food sources to the total number of restaurants in a specific area. Adams and Valley counties have a much lower percentage of restaurants that are fast food than the nation as a whole.\(^{141}\)


\(^{141}\) Ibid
Limited Access to Healthy Foods

The County Health Rankings measure of food insecurity takes into account both proximity and income – two important barriers to consuming healthy food. The specific measure is the percent of population in poverty and greater than 10 miles from a grocery store. This measure is an indication of whether or not individuals have access to healthy foods such as fruits and vegetables. These are commonly available in large grocery stores, but not as available in convenience stores or small grocery stores where a large percentage of Americans purchase their food. Adams and Valley counties have a much lower percentage of people in poverty who live more than 10 miles from a grocery store than the nation as a whole.¹⁴²

• **Access to Recreational Facilities**

Similarly, recent research demonstrates a strong relationship between access to recreational facilities and physical activity among adults and children. Studies have demonstrated that proximity to places with recreational opportunities is associated with higher physical activity and lower obesity levels. The evidence is so strong that the Centers for Disease Control and Prevention (CDC) recommend improving access to recreational facilities as one of the 24 environmental- and policy-level strategies to reduce obesity in its Common Community Measures for Obesity Prevention Project.

Drawbacks of the County Business Patterns data used for this measure is that the method used to identify recreational facilities does not include YMCAs and intramural/amateur sports clubs, both of which may be important venues for physical activity in many communities, and especially for low- and middle-income members of communities. Furthermore, this measure does not account for the opportunity to engage in natural fitness activities, such as parks or other public areas. These other venues and opportunities for recreation vary in importance depending on characteristics of the community such as proximity to other urban and rural areas, socioeconomic composition, and weather patterns. ¹⁴² Not recognizing these venues will result in an under estimation of recreational venues in our community because we have many parks and an abundance of outdoor recreational opportunities.

<table>
<thead>
<tr>
<th>Health Factor Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend: Better/Worse</td>
</tr>
<tr>
<td>Access to recreational facilities</td>
</tr>
</tbody>
</table>

Community Input

Community input for our needs assessment was obtained through two primary research methods:

- First, affected population surveys and focus groups.
- Second, in-depth interviews with local community leaders.

These primary research studies, their findings, and how the information was used are described in detail below.

Affected Population Group Research and Findings

In the summer of 2011, the United Way of Treasure Valley in collaboration with St. Luke’s Health System and Saint Alphonsus Health System, contracted with Boise State University to conduct affected population group surveys and focus groups. During this process, 934 affected population intercept surveys and two affected population focus groups on health needs were completed. The lead researcher was Carole Nemnich, associate director, The Public Policy Center, Boise State University. We utilized the information gathered from the affected population surveys and the focus groups to help us create an initial set of potential community health needs as a starting point for our CHNA community leader input process.

Affected Population Survey Findings

The affected population survey was targeted (not a random sample) to groups such as parents, youth, the homeless, senior citizens, and groups using medical and mental health services in the communities served by United Way agencies. Specifically, the affected population survey research included people from these constituencies:

- 20% Homeless
- 10% Medical Health
- 19% Mental Health
- 24% Other
- 13% Parents and Children
- 14% Seniors

Fifty-three percent (53%) of the affected population survey constituents reported having health insurance and 47% indicated that they did not have health insurance coverage. When the affected populations were asked to rank the most important aspects of living a healthy and productive life, “access to all types of medical services” was the most frequently

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144 The United Way of Treasure Valley 2011 Community Assessment Health and Wellness Findings
chosen option as shown in the chart below. However, “access to affordable health care insurance coverage” was selected more times as most important.  

Which three of the following statements describe best what you and your family need to live healthy and productive lives?

The affected population survey also asked respondents to rank which basic needs were most important to them. The results are shown below:

145 United Way 2011 Community Health Needs Assessment, Affected Population Survey Results
<table>
<thead>
<tr>
<th>Affected Population Survey: Basic Services that Helped Their Family Most</th>
<th>Percent of Answers Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency food assistance such as food stamps or a food pantry</td>
<td>24%</td>
</tr>
<tr>
<td>Basic health care services such as a clinic that charges based on ability to pay</td>
<td>23%</td>
</tr>
<tr>
<td>Emergency shelter</td>
<td>13%</td>
</tr>
<tr>
<td>Transportation assistance</td>
<td>9%</td>
</tr>
<tr>
<td>Legal assistance</td>
<td>8%</td>
</tr>
<tr>
<td>Case management such as having one agency coordinate care</td>
<td>7%</td>
</tr>
<tr>
<td>Crisis child care services such as when your child is sick and you need to work</td>
<td>5%</td>
</tr>
<tr>
<td>Elder care assistance such as an in-home aide or a day care program for seniors</td>
<td>5%</td>
</tr>
<tr>
<td>Long term and comprehensive services for those with disabilities</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

Affected Population Focus Group Concerns

- Lack of affordable health insurance was a major concern across all groups and their most often mentioned comments are listed below:
  - Those with limited income but ineligible for Medicaid/Medicare were particularly frustrated with not being able to get and keep health insurance
  - Frustrations were expressed with restrictive Medicaid criteria
  - Finding providers who accept Medicaid or public insurance was an issue for some
  - High costs of medical care that insurance does not cover was an issue
  - Jobs that do not offer adequate health insurance benefits was a frustration

- Transportation barriers

- Frustration at lack of case management and fragmentation of care

- Cost of basic care (and out of pocket costs)

- Better access to:
  - Dental care
  - Mental health care
  - Substance abuse services
  - Follow-up care after medical visits
We utilized the information gathered from the affected population surveys and the focus groups along with information from prior community health needs assessments to help us create an initial set of potential community health needs. These potential needs were integrated into the questionnaire developed for our community leader interviews described below.

Community Leader Interview Summary

A series of interviews with organizational leaders representing the broad interests of our community were conducted in order to assist us in further defining, prioritizing, and understanding our most important community health needs. Many leaders participating in our process are individuals who have devoted decades to helping others lead healthier and more independent lives. We greatly appreciate their contributions to our community and for the time, thought, and valuable input they provided during our community health needs assessment process. The openness of our community leaders allowed us to explore a broad range of health needs and issues.

All of the leaders we interviewed have significant knowledge of our community. To ensure they came from distinct and varied backgrounds, we included multiple representatives from each of these categories:

Category I: Persons with special knowledge of or expertise in public health

Category II: Federal, regional, State, or local health or other departments or agencies (with current data or other information relevant to the health needs of the community served by the hospital)

Category III: Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs

Appendix I contains information on how and when we consulted with each community health leader and representative as well as each individual’s organizational affiliation.
Leader Interview Findings

Using the questionnaire in Appendix II, we asked our community leaders to help us further define and prioritize the list of potential community health needs compiled from the results of our affected population surveys, focus groups, and prior community health needs assessments. In addition, we invited the leaders to suggest programs, legislation, or other measures they believed to be effective in addressing the needs. The table below summarizes the list of potential health needs identified through our research, the affected population surveys, and by our community leaders during the interview process.

Each potential need was scored by the community leaders on a scale of 1 to 10. Higher scores represent potential needs our leaders believed were important to address with additional resources. Lower scores usually meant our leaders thought our community was healthy in that area already or we had relatively good programs addressing the potential need. Specifically, a score below 5 represents an item our leaders, in general, did not believe required additional programs or services over the next three years.

The community leaders’ scores were added together for each need and an average score was calculated. The average leader score is shown in the second column of the table below. Finally, the leaders’ comments about each need as well as suggested solutions are documented in the third column of the table.

<table>
<thead>
<tr>
<th>Potential Needs</th>
<th>Leader Score</th>
<th>Leader Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise programs/education</td>
<td>5.7</td>
<td>There are a lot of exercise programs available in our community. However, we need find ways to make people aware of them and effectively motivate people to exercise. Suggested solutions: Partner with college athletes at the University of Idaho to promote exercise, especially among children. Invite Dr. Andy Weil from the University of Arizona to provide education on nutrition and exercise to our providers.</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>5.9</td>
<td>There is a lot of information available on nutrition. Suggested solution: Partner with schools to provide more nutrition education for children. Invite Dr. Andy Weil from the University of Arizona to provide education on nutrition and exercise to our providers.</td>
</tr>
<tr>
<td>Program Type</td>
<td>Index</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Safe-sex education programs</td>
<td>6.2</td>
<td>Our teen birth rate is high. Suggested solution: Provide safe-sex education before kids are seniors in high school.</td>
</tr>
<tr>
<td>Substance abuse services and programs</td>
<td>7.8</td>
<td>Tobacco cessation programs are available, but they aren’t effective unless people are ready to quit. Prevention programs are more effective than cessation. Suggested solutions: Emphasize prevention programs in schools. The government needs to raise taxes on tobacco again and make smoking more expensive.</td>
</tr>
<tr>
<td>Tobacco cessation programs</td>
<td>4.9</td>
<td>Our community needs more effective and creative wellness programs that begin at younger ages. We need to figure out how to motivate people to make long lasting behavior change. Preventive programs could use more funding. Suggested solutions: Emphasize prevention programs in schools. Provide education to physicians on wellness. There is a program from Harvard available, called Institute of Lifestyle Medicine. It is an online course available to doctors. Have people other than physicians available to provide wellness assistance. Support employer-based wellness and exercise programs that encourage participation. Support school nutrition, exercise, and wellness education. Medicare needs to increase the number of wellness visits per year from 1 to 12.</td>
</tr>
<tr>
<td>Wellness and prevention programs</td>
<td>7.0</td>
<td>Weight management programs are very important, but current programs are not effective. Suggested solution: Focus on weight management for children and nutrition programs. Look at using NICHQ obesity for children’s programs.</td>
</tr>
<tr>
<td>Potential Needs</td>
<td>Leader Score</td>
<td>Leader Comments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Affordable health insurance         | 7.9          | The population just over the poverty-level is the most vulnerable because they don’t qualify for Medicaid or have their own insurance. Medicaid has been cut and is the main health insurance option for people with disabilities.  
Suggested solutions: Universal coverage is important to avoid high cost emergency care. Available insurance options need to be promoted so people know they exist. Support legislation that would increase Medicaid funding. |
| Affordable care for low income individuals | 7.7          | Community Care Clinic fills up every week, and they can’t provide for all of the people needing care. We need to make health care more efficient and lower cost.  
Suggested solutions: Support safety net clinics with more consulting access to specialists to help care for low-income patients. Make sure affected populations are aware of clinics with income based sliding fee schedules. Use Medicaid to lead the health care industry away from service-based fee systems. |
| Availability of primary care providers | 5.1          | There are not enough primary care providers in rural areas. Primary care clinics are often only open during people’s work hours forcing them to go to the ER.  
Suggested solutions: Partner with Family Medicine Residency of Idaho (FMRI), use telemedicine for rural areas, and extend hours at primary care clinics. The state Joint Finance Committee needs to continue to fund FMRI so we can attract and maintain our primary care provider base. |
<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable dental care for low income individuals</td>
<td>6.2</td>
<td>There is only one Medicaid dental provider in McCall. We need more low income dental providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested solution: Medicaid adult dental needs to be expanded. More dentists accept Medicaid.</td>
</tr>
<tr>
<td>Availability of behavioral health services (providers, suicide hotline, etc)</td>
<td>7.5</td>
<td>Adding mental health services providers is a top priority for our community.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested solutions: The local Health and Welfare office doesn’t exist anymore. We need more state support, especially for mental health services.</td>
</tr>
<tr>
<td>Chronic disease management programs</td>
<td>6.5</td>
<td>We have good programs for chronic disease management, but low income people still have problems with affordability.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested solutions: Promote our chronic disease management programs more effectively and put them on a sliding fee schedule based on ability to pay for low income individuals.</td>
</tr>
<tr>
<td>Immunization programs</td>
<td>4.4</td>
<td>Our community has good immunization programs, but not enough people are being immunized. People don’t know about them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested solutions: We need to educate people on the importance of immunizations and tell them there are low cost options available.</td>
</tr>
<tr>
<td>Improved health care quality</td>
<td>5.1</td>
<td>We have good quality health care in our community.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested solution: Make consulting with physician specialists for available in McCall.</td>
</tr>
<tr>
<td>Integrated, coordinated care (less fragmented care)</td>
<td>7.0</td>
<td>We need to improve coordination of care and follow-up care. Discharge planning needs improvement. We need case management resources and coordination of care to help people access resources. Better communication between hospitals, clinics, specialists, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested solution: Having a universal medical record that everyone can share would be a huge benefit to more coordinated care and better health. Copar program can work with insurers to help pay</td>
</tr>
</tbody>
</table>
for case management for people with chronic conditions. For better integrated, coordinated care we need a single person to coordinate each person’s care using a concept like the medical home. CASSP from NIH is a program to provide coordinated care for children across agencies.

<p>| More providers accept public health insurance (example: Medicaid) | 6.0 | Not enough dentists or mental health providers accept Medicaid. There are currently only two Medicaid mental health providers in Valley County. Need Ph.D. to be reimbursed by Medicare; there is only one Ph.D. in Valley County. |
| Prenatal care programs | 4.1 | Women have excellent prenatal programs available to them in our community. |
| Screening programs (cholesterol, diabetes, mammography, etc) | 4.3 | We have screening programs available in our community – affordability might be an issue with some of them. Diabetes and hypertension screening programs are the most important needs. Suggested solutions: Promote the availability and importance of screening programs and affordable options for low income individuals. |</p>
<table>
<thead>
<tr>
<th>Potential Needs</th>
<th>Leader Score</th>
<th>Leader Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and family services</td>
<td>6.7</td>
<td>Family needs center around childcare and mentoring. We need more supportive adults in the community to help children in need. Healing the family will help overall health and community wellbeing. Suggested solutions: Support MYST (Mentoring Youth Supporting Teens), Donnelly Bible Church’s food program for low income families, and the “Community Health Advocacy Team” for social and economic needs. Subsidized daycare is important for people to be able to work full time.</td>
</tr>
<tr>
<td>Disabled services</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>High school and college education support and assistance programs</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>Homeless services</td>
<td>4.7</td>
<td>Homeless services for families is a greater need than for individuals.</td>
</tr>
<tr>
<td>Job training services</td>
<td>5.6</td>
<td>College of Western Idaho is doing a good job with job training.</td>
</tr>
<tr>
<td>Senior services</td>
<td>4.4</td>
<td>Locally we do not have the funding to take care of the senior needs. McCall Rehabilitation &amp; Care Center is important and does not have adequate funding to take care of all the senior needs we have in this community. Suggested solutions: Partner with McCall Rehabilitation and Care Center.</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>5.1</td>
<td></td>
</tr>
</tbody>
</table>
Violence and abuse services

6.2

Instead of emphasizing counseling of the victims, we need better programs to reform the perpetrators.

Suggested solution: Idaho Coalition Against Sexual and Domestic Violence has a program called Start Strong that helps foster healthy relationships and behavioral responsibility.

<table>
<thead>
<tr>
<th>Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Potential Needs</strong></td>
</tr>
<tr>
<td>Availability of recreation and exercise facilities</td>
</tr>
<tr>
<td>Availability or access to healthy foods</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc</td>
</tr>
<tr>
<td>Transportation to and from appointments</td>
</tr>
</tbody>
</table>
We utilized the community leader interviews in a number of ways. First, the leaders’ input ensured we collected a comprehensive list of potential health needs. Second, their score was an important component of our overall prioritization process. The community leader need score was weighted with more than twice as many points (10 points) as the individual health factor data scores for magnitude, severity, prevalence, or trend. Therefore, the health leader input had a significant influence on the overall prioritization of our health needs.

During the interview process, many leaders espoused a philosophy for how they believe we could effectively improve community health. Their philosophies acted as the underlying driver for the way they selected and scored the potential health needs. A summary of some of their philosophies is provided below.

- A number of leaders held the belief that the best way to improve the health of the people in our community was to offer more social programs such as affordable universal health insurance and/or offering more clinics that charged based on the ability for a person to pay. For example, many of these leaders saw significant impacts to community health due to the cuts to state Medicaid programs. Some leaders felt that programs to change health behavior, such as weight loss, were not effective. They did not believe there is good evidence that behavioral change programs are able to motivate most people to change. They felt that unless people want to change, they won’t. Leaders with this view tended to give low scores to potential health behavior needs.

- Many leaders felt the largest determining factor in community health was how people behaved. These leaders held the belief that the kind of behaviors leading to teen pregnancy, obesity, and drug abuse would cause our population to be unhealthy even if health care were free. These leaders thought that unless people take responsibility for their own wellness, we would see rising health care costs and poor community health. In their view, the key to better community health was to provide programs able to influence health behavior. These leaders believed social programs were unaffordable, unless we held people accountable to a central wellness component. Without accountability for healthy behavior, they felt social programs create unhealthy dependencies that could be passed on from generation to generation.

- Finally, some leaders thought that neither social programs nor health behavior programs would solve the health care crisis our nation faces. These leaders believed we need a profound reorganization of our health care system making it more efficient and cost-effective. For example, these leaders thought we needed a single health care advisor to coordinate each person’s care using a concept like the medical home. Others thought we needed to do away with the fee-for-service model entirely.
The leaders’ philosophies demonstrate the complexity of community health. There is, however, wisdom in each of these philosophies and together they add up to a course of action that can enable lasting change.

- Improving social programs may be the most effective way to ensure a safety net for those who have special needs and where health behavior change is not effective.

- We do need more effective ways to motivate people to adopt healthy behaviors. Our current programs are not turning the tide fast enough for unhealthy behaviors such as obesity and smoking. There is, therefore, a need to innovate around behavioral change. For example, employers who offer benefit plan incentives encouraging health and wellness, such as St. Luke’s Healthy U, may help pioneer more effective behavioral change. The eating and exercise habits learned as children last a lifetime. Could parents be motivated to change their behavior out of a desire to help their children?

- Finally, our health care system needs to be more efficient. There is evidence that medical homes and population health management programs are effective in providing better health at a lower cost for the chronically ill portion of our population, who are the largest consumers of health care resources.
Community Health Needs Prioritization

This section combines the community leader need scores with the health factor scores to arrive at a single, ranked set of health needs and factors. The more points a combined health need and factor receive, the higher the overall priority. The process for combining the health leader and health factor scores is described in the steps below.

1. **Matching Health Needs to Related Health Factors**

   First, each health leader need is matched to one or more health factors or outcomes. For example, the leader need “wellness and prevention” is matched to related health outcomes such as diabetes, heart disease, and high blood pressure.

2. **Combining the Community Leader and Health Factor Scores to Rank the Needs**

   Next, the community leader need score is added to its related health factor score to arrive at a combined total score. This process effectively utilizes both the community leader information and the secondary health factor data to create a transparent and balanced approach for prioritization. The health leader score represents insights based on direct community experience while the health factor score provides an objective way to measure the potential impact on population health.

   The combined results offer information relevant to determining what specific kinds of programs have the greatest potential to improve population health. For instance, if the combined score for wellness and prevention programs for diabetes is 21 and the wellness and prevention score for arthritis is 12, it becomes clear that wellness and prevention programs for diabetes have the higher potential population health impact. Combining leader and health factor scores can also help prioritize adult versus teen needs allowing us to build programs for the most affected population groups.

**Key Takeaways**

**The median value for the total of the leader and health factor scores is 14.7.** Scores above the median are highlighted in orange in the tables below. Six (6) out of the 31 potential health needs have scores of 18.7 or higher. These needs represent the top 20th percentile and are considered to be high priority. The high priority needs are highlighted in dark orange in the tables.

The tables below provide the prioritization score as well as demographic information about the most affected populations. Demographic data about affected populations is important because it tells us when people with low incomes, no college education, or ethnic minorities suffer disproportionally from specific health conditions or from barriers to health care access.
Health Behavior Category Summary

Our community’s high priority needs in the health behavior category are: Substance abuse programs; and wellness and prevention programs for accidents, diabetes, and mental illness. Substance abuse ranks as a high priority need due to its high community leader score and because our community has an above average levels of alcohol and illicit drug use. Accident prevention ranks high largely due to an increase in motor vehicle accidents since 2007. Diabetes ranks as a high priority need because it is trending higher and is a contributing factor to a number of other health concerns. Mental illness ranks high because Idaho has one of the highest percentages (22.5%) of any mental illness (AMI) in the nation.

Some populations are more affected by these health needs than others. For example, low income individuals and those without high school diplomas have significantly higher rates of diabetes. Those not graduating from high school, the unemployed, and males 18 to 34 years of age have much higher rates of illicit drug use.

Health Behavior Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse services and programs</td>
<td>Alcohol</td>
<td>Ages 18-64</td>
<td>18.8</td>
</tr>
<tr>
<td></td>
<td>Illicit drug use</td>
<td>Income &lt;$35,000, No high school diploma, Males 18-34</td>
<td>19.8</td>
</tr>
<tr>
<td></td>
<td>Vehicle crash death rate</td>
<td></td>
<td>19.8</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Accidents</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Exercise programs/education</td>
<td>Adult physical activity</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>15.7</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Teen nutrition</td>
<td></td>
<td>15.9</td>
</tr>
<tr>
<td>Identified Community Need</td>
<td>Related Health Outcome or Factor</td>
<td>Populations Affected Most *</td>
<td>Total Score</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Safe-sex education programs</td>
<td>Teen birth rate</td>
<td></td>
<td>16.2</td>
</tr>
<tr>
<td>Tobacco cessation programs</td>
<td>Smoking</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>16.9</td>
</tr>
<tr>
<td>Weight management</td>
<td>Obese/Overweight adults</td>
<td>Income &lt;$35,000, Hispanic, No high school diploma</td>
<td>16.4</td>
</tr>
<tr>
<td></td>
<td>Obese/overweight teens</td>
<td>Income &lt;$35,000, Hispanic</td>
<td>17.4</td>
</tr>
<tr>
<td>Wellness/prevention</td>
<td>High cholesterol</td>
<td>Income &lt;$35,000, No high school diploma, Age 55 +</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Skin cancer</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Exercise programs/education</td>
<td>Teen exercise</td>
<td></td>
<td>14.7</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Adult nutrition</td>
<td>No college</td>
<td>13.9</td>
</tr>
<tr>
<td>Safe-sex education programs</td>
<td>Sexually transmitted infections</td>
<td></td>
<td>13.2</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>AIDS</td>
<td>African American, Males &lt;24</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Alzheimer’s</td>
<td>Age 65 +</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Arthritis</td>
<td>Income &lt; $35,000, Non-Hispanic, No college, Overweight, Age 65 +</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Breast cancer</td>
<td>Female</td>
<td>14</td>
</tr>
</tbody>
</table>
### Health Behavior Need Summary Table, Continued

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness and prevention</td>
<td>Cerebrovascular diseases</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Colorectal cancer</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Flu/pneumonia</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Heart disease</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65 +</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Leukemia</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Lung cancer</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Leukemia</td>
<td></td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>Nephritis</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Non-Hodgkin’s lymphoma</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Pancreatic cancer</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Prostate cancer</td>
<td>Male age 60+</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Respiratory disease</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Clinical Care Category Summary

High priority clinical care needs include: Affordable care for low income individuals; affordable health insurance; and chronic disease management for diabetes. Affordable care ranks as a high priority need due to its high community leader score and because an increasing number of people in our community are living in poverty (especially children). Affordable health insurance ranks as a top priority need in part because our service area has a high percentage of people who are uninsured and the trend is getting worse. Diabetes chronic disease management ranks high because the number of people with diabetes is trending higher, and it is a contributing factor to a number of other health concerns.

As shown in the table below, high priority clinical care needs are experienced most by people with low incomes and those who have not attended college. In addition, a number of our community leaders expressed concern about people just above the poverty level who are left without health insurance because they don’t qualify for Medicaid.

Clinical Care Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable care</td>
<td>Children in poverty</td>
<td>Income &lt; $50,000, Age &lt; 19</td>
<td>19.7</td>
</tr>
<tr>
<td>Affordable health insurance</td>
<td>Uninsured adults</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>19.9</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Diabetes</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>19.5</td>
</tr>
<tr>
<td>Availability of behavioral health services</td>
<td>Mental health service providers</td>
<td>Income &lt; $50,000</td>
<td>18.5</td>
</tr>
<tr>
<td>More providers accept public health insurance</td>
<td>Children in poverty</td>
<td>Income &lt; $35,000</td>
<td>18</td>
</tr>
<tr>
<td>Prenatal care programs</td>
<td>Prenatal care 1st trimester</td>
<td>Hispanic, No high school diploma</td>
<td>15.1</td>
</tr>
<tr>
<td>Affordable dental care</td>
<td>Dental visits, preventive</td>
<td>Income &lt; $50,000</td>
<td>14.2</td>
</tr>
<tr>
<td>Availability of primary care providers</td>
<td>Primary care providers</td>
<td></td>
<td>14.1</td>
</tr>
</tbody>
</table>
## Clinical Care Need Summary Table, Continued

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic disease management</td>
<td>Arthritis</td>
<td>Income &lt; $35,000, Non-Hispanic, No college, Overweight, Age 65 +</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td>14.5</td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65 +</td>
<td>14.5</td>
</tr>
<tr>
<td>Immunization programs</td>
<td>Children immunized</td>
<td></td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td>Flu/pneumonia</td>
<td></td>
<td>8.4</td>
</tr>
<tr>
<td>Integrated, coordinated care (less fragmented)</td>
<td>Preventable hospital stays</td>
<td>Hispanics, Age 65 +</td>
<td>14</td>
</tr>
<tr>
<td>Improved health care quality</td>
<td>Preventable hospital stays</td>
<td></td>
<td>12.1</td>
</tr>
<tr>
<td>Prenatal care programs</td>
<td>Low birth weight</td>
<td>Hispanic &lt; High school</td>
<td>9.1</td>
</tr>
<tr>
<td>Screening programs</td>
<td>Cholesterol</td>
<td>Income &lt; $35,000, No high school diploma, Age 55 +</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>Colorectal screening</td>
<td>Income &lt; $35,000, No college, Age 50 +</td>
<td>12.3</td>
</tr>
<tr>
<td></td>
<td>Diabetic screening</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Mammography screening</td>
<td>Income &lt; $50,000</td>
<td>13.3</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Social and Economic Category Summary

Children and family services for low income populations is the only high priority social and economic health need. The increasing number of children living in poverty in our service area drives this need.

Social and Economic Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and family services</td>
<td>Children in poverty</td>
<td>Income &lt; $35,000</td>
<td>18.7</td>
</tr>
<tr>
<td>Job training services</td>
<td>Unemployment rate</td>
<td></td>
<td>15.6</td>
</tr>
<tr>
<td>Children and family services</td>
<td>Inadequate social support</td>
<td></td>
<td>13.7</td>
</tr>
<tr>
<td>Disabled services</td>
<td></td>
<td></td>
<td>12.3</td>
</tr>
<tr>
<td>Education assistance programs</td>
<td>Education</td>
<td></td>
<td>14.3</td>
</tr>
<tr>
<td>Homeless services</td>
<td>Unemployment rate</td>
<td></td>
<td>14.7</td>
</tr>
<tr>
<td>Senior services</td>
<td>Inadequate social support</td>
<td>Age 65 +</td>
<td>11.4</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>Inadequate social support</td>
<td></td>
<td>12.1</td>
</tr>
<tr>
<td>Violence and abuse services</td>
<td>Safety - homicide rate</td>
<td></td>
<td>12.2</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Physical Environment Category Summary

In the physical environment category, there are no identified high priority needs. Both our community leaders and the health factor data indicate we have a physical environment that supports good health.

Physical Environment Need Summary Table

<table>
<thead>
<tr>
<th>Identified Community Need</th>
<th>Related Health Outcome or Factor</th>
<th>Populations Affected Most *</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of recreation and exercise facilities</td>
<td>Recreational facilities</td>
<td>Income &lt; $50,000</td>
<td>10.6</td>
</tr>
<tr>
<td>Availability or access to healthy foods</td>
<td>Limited access to healthy foods</td>
<td>Income &lt; $50,000</td>
<td>11.9</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc.</td>
<td>Air pollution</td>
<td></td>
<td>11.4</td>
</tr>
<tr>
<td>Transportation to and from appointments</td>
<td></td>
<td>Income &lt; $35,000, Rural populations, Age 65 +</td>
<td>14.4</td>
</tr>
</tbody>
</table>

* Information on affected populations included in table when known.
Implementation Plan Overview

St. Luke’s will continue to collaborate with the people, leaders, and organizations in our community to carry out an implementation plan designed to address many of the most pressing community health needs identified in this assessment. Utilizing effective, evidence-based programs and policies, we will work together to improve community health outcomes and well-being toward the goal of attaining the healthiest community possible.

Future Community Needs Assessments

We intend to reassess the health needs of our community on an ongoing basis and conduct a full community health needs assessment once every three years. St. Luke’s next Community Health Needs Assessment is scheduled to be completed in 2016.
Resources Available to Meet Community Needs

This section provides a description of resources available within our community to meet the needs identified in this CHNA. For ease in locating a resource addressing a particular need, the resources have been organized into the following categories:

Abuse/Violence Advocacy & Services
After School Programs / Youth Mentoring
At-Risk Youth Services
Behavioral Health and Substance Abuse Services
Childcare
Chiropractic
Dental Services
Disability Services
Educational Services
Government Contacts
Homeless Services
Housing
Hospices
Hospitals
Legal Services
Low Income Medical Resources
Nursing Homes
Public Health Resources
Referral and Miscellaneous Services
Refugee Services
Senior Services
Veteran Services
Abuse/Violence Advocacy & Services

**Family Advocate Program**  
3010 W. State Street, Suite 104  
Boise, Idaho 83703  
Phone: (208) 345-3344  
[www.familyadvocate.org](http://www.familyadvocate.org)  
**Description:** Family Advocates works to keep abused children out of danger and in safe homes, while partnering with parents to build strong families.

**Health and Welfare Mental Health Mobile Crisis Team**  
1-800-600-6474  
**Description:** After hours contact for emergency services for mental health patients.

**Rose Advocate (Adams County)**  
Domestic Violence  
(208) 253-4949  
**Description:** Crisis intervention, short term counseling and support for domestic violence victims

**Rose Advocate (Valley County)**  
Domestic Violence  
(208) 382-5310, cell (208) 315-4671  
**Description:** Crisis intervention, short term counseling and support for domestic violence victims,

**Women’s and Children’s Alliance**  
720 W. Washington Street  
Boise, Idaho 83702  
Phone: (208) 343-3688  
Fax: (208) 343-8475  
[www.wcaboise.org](http://www.wcaboise.org)  
**Description:** The WCA is proud to be a community leader in providing critically needed services to women and children victimized by domestic and sexual violence.

After School Programs/Youth Mentoring

**Payette Lakes Community Association**  
PO Box 1118  
McCall, ID 83638  
208-634-3418  
[http://PLCA4Kids.org](http://PLCA4Kids.org)
Description: After school and summer day-long programs:
Academic enrichment, homework assistance, health and science, outdoor play, arts and crafts, bicycle safety rodeo, sports clinics

At-Risk Youth Services

**Children’s Home Society of Idaho**
Boise Office
740 Warm Springs Avenue
Boise, Idaho 83712
Phone: (208) 343-7813
Fax: (208) 342-8268
www.childrenshomesociety.com
Description: The Children’s Home Society accomplishes its mission by operating Warm Springs Counseling Center which provides superior emotional and behavioral health services to at-risk children and the families that care for them.

**Idaho Youth Ranch**
5465 W. Irving Street
Boise, Idaho 83706
Phone: (208) 377-2613
Fax: (208) 377-2819
www.youthranch.org
Description: The Idaho Youth Ranch provides troubled children a bridge to a valued, responsible, and productive future.

Behavioral Health and Substance Abuse

**Allumbaugh House**
400 N. Allumbaugh Road
Boise, ID 83704
(208) 377-9669
Description: Terry Reilly operates Allumbaugh House program. Specialized mental and behavioral health care services including medically monitored detoxification and short-term residential crises mental health.

**Boise Behavioral Health Hospital**
8050 Northview
Boise, ID 83704
(208) 327-0504
Description: Secure hospital providing acute care for patients needing short-term psychiatric intervention and stabilization.

Eric Mikkelsen Counseling
321 N. 3rd St.
McCall, Idaho 83638
(208) 634-7272
Description: Licensed counselor for behavioral health and relationship issues.

Human Supports of Idaho
4477 W. Emerald Street, #100
Boise, Idaho 83706
(208) 321-0160
www.humansupports.com

Health and Welfare Mobile Crisis Team
Mental Health
1-800-600-6474
Description: After hours contact for emergency services for mental health patients.

Intermountain Hospital
303 N. Allumbaugh
Boise, Idaho 83704
(800) 321-5984
www.intermountainhospital.com
Description: Psychiatric crisis interventions for those with symptoms such as grief, depression, loss of independence, social isolation, mood disorders, psychiatric illnesses, substance abuse and more.

Joe Wilson Counseling
301 Deinhard
McCall, Idaho 83638
(208) 634-7272
Description: Licensed counselor for behavioral health and relationship issues.

Kim Batt-Lincoln Counseling
301 Deinhard
McCall, Idaho 83638
(208) 634-7272
Description: Licensed counselor for behavioral health and relationship issues.
Morningside Recovery
1720 N. Westgate Drive, #A
Boise, Idaho 83704
(208) 334-0808
www.morningsiderecovery.com

Omega Health Services
5985 W. State Street
Boise, ID 83703
(208) 853-0071
http://omegahealthservices.com

St. Luke's Canyon View Behavioral Health Services
228 Shoup Avenue West
Twin Falls, Idaho 83301
24-hour Help-Line: (208) 734-6760
Toll free: 1-800-657-8000
www.stlukesonline.org/magic_valley/services/mental_health.php
Description: Intensive inpatient programs for adolescents, adults, and seniors that address acute psychiatric issues in addition to medical detoxification from alcohol and drugs.

Support Housing and Innovative Partnerships
1405 W. Grove Street
Boise, Idaho 83707
Phone: (208) 331-0900
Fax: (208) 331-0904
www.shipinc.org
Description: Supportive Housing and Innovative Partnerships, Inc (SHIP) is a private non-profit organization located in Boise, Idaho dedicated to developing a holistic system to serve the needs of persons working in recovery from alcohol, drug addiction and substance abuse. Through innovative and inclusive partnerships SHIP helps those in recovery to develop skills, find jobs, and rebuild lives.

Childcare

Child Protection Services – McCall
(208) 634-8001
800-600-6474
Description: Hotline for child abuse intervention and reporting
Shepard’s Home
260 N. Mission
McCall, Idaho 83638
634-1152
www.shepherds-home.org
Description: A residential care facility for children aged 3 to 18 who are subject to neglect or abuse.

Chiropractic Services

Backcountry Chiropractic & Wellness Center
201 Park St.
McCall, Idaho 83638
(208) 634-8129

Back in Motion
313 McBride St.
McCall, Idaho 83638
(208) 634-4878

McCall Chiropractic
501 Lake Side
McCall, Idaho 83638
(208) 634-8271

Dental Services

Adams County Health Clinic
205 Berkley Street, Council, ID 83612
(208) 253-4242
Description: Adams County Health Clinic is a Federally Qualified Health Clinic providing dental care and prevention services to anyone on a sliding scale payment basis.

Miles of Smiles Children’s Free Dental Clinic
3210 E. Chinden Boulevard, Suite 115-413
Eagle, Idaho 83616
Phone: (208) 392-8181
cfdc@yahoo.com
Description: The Miles of Smiles Clinic provides emergency and preventive dentistry to underserved elementary school children in a safe environment.
Terry Reilly Dental Clinic Boise
2301 N. 36th, Suite 102
Boise, Idaho 83703
(208) 336-8801
Description: TRHS Dental is dedicated to providing quality, affordable dental care. A special program targets pregnant women, patients with diabetes and children, to eliminate or lessen the effect of dental disease.

Terry Reilly Dental Clinic Canyon
11136 Moss Lane
Nampa, Idaho 83651
(208) 466-0515
Description: TRHS Dental is dedicated to providing quality, affordable dental care. A special program targets pregnant women, patients with diabetes and children, to eliminate or lessen the effect of dental disease.

Disability Services

Idaho Assistive Technology Project
121 W. Sweet Avenue
Moscow, Idaho 83843
Phone: (800) 432-8324
www.idahoat.org
Description: The Idaho Assistive Technology Project (IATP) is a federally funded program administered by the Center on Disabilities and Human Development at the University of Idaho. Their goal is to increase the availability of assistive technology devices and services for older persons and Idahoans with disabilities.

Idaho Commission for the Blind
1-208-334-3220

The Arc
4402 Albion Street
Boise, Idaho 83705
Phone: 208-343-5583
Fax: 208-343-5683
www.thearcinc.org
Description: The Arc is committed to securing the opportunity to choose and realize their goals of where and how to learn, live, work and play for all people with intellectual and developmental disabilities. The Arc works to ensure that people with intellectual and developmental disabilities and their family have the support they need to live an ordinary and decent life.
Educational Services

Learning Lab
308 E. 36th Street
Garden City, Idaho 83714
Phone: (208) 344-1335
www.learninglabinc.org
Description: Learning Lab teaches and encourages adults who struggle with literacy; helps families discover the joy of learning so all children start kindergarten ready to read; creates hope for brighter futures; builds stronger, more self-sufficient students; and engages community for all of us.

Government Contacts

Adams County
Adams County Courthouse
PO Box 48
Council, ID 83612
www.co.adams.id.us.com

City of Cascade
P.O. Box 649
105 S. Main Street
Cascade, ID 83611
(208) 382-4279
www.cascade.id.us/

City of McCall
City Hall
216 East Park St.
McCall, Idaho 83638
Phone: (208) 634-7142
www.mccall.id.us/

Valley County
219 N. Main St.
PO Box 1350
Cascade, Idaho 83611
(208) 382-7100
www.co.valley.id.us.com
Homeless Services

Boise Rescue Mission
575 S. 13th Street
Boise, Idaho 83702
Phone: (208) 343-2389
Fax: (208) 343-7607
www.boiserm.org
Description: Boise Rescue Mission Ministries has been reaching out to the community by teaching the word of God and providing food, shelter, clothing, counseling and education for those in need. We have also implemented education and counseling programs to provide opportunities for healing, growth, and employment for the homeless population.

CATCH
1276 W. River Street, Suite 201
Boise, Idaho 83702
(Or)
6121 E. Cleveland Boulevard, Suite 102
Caldwell, ID 83607
www.cityofboise.org/Departments/PDS/CATCH
Description: CATCH is a community, collaborative effort, administrated by the City of Boise and designed to assist homeless families with children.

Housing

Housing Southwest
(208) 467-7461
Description: McCall senior housing and low income

Irwin Center
628-3582
Description: Subsidized house for seniors in Riggins

Jesse Tree of Idaho
1025 S. Capitol Boulevard
Boise, Idaho 83706
Phone: (208) 383-9486
www.jessetreeidaho.org
Description: The Jesse Tree of Idaho is dedicated to preventing homelessness through the Emergency Rent and Mercy Assistance (ERMA) program. The Jesse Tree of Idaho serves as a “safety-net” by providing a one-time rent payment along with
case management which helps get families back on track and able to regain self-sufficiency and financial stability within a few short months.

**Riggins Manor**  
(208) 628-3508  
Description: Subsidized house for adults in Riggins

**The Springs**  
(208) 634-8152  
McCall Low income housing

**Hospices**

**St. Luke’s Homecare and Hospice**  
301 Deinhard  
McCall, Idaho  83636  
(208) 634-2440  
Description: Skilled home health and hospice services

**Hospitals**

**Adams County Health Center**  
205 Berkley Street  
Council, ID 83612  
(208) 253-4242  
[http://adams-county-health-center.org](http://adams-county-health-center.org)  
Description: A federally Qualified Health Center providing primary care, dental, social services, x-ray, lab, physical therapy

**Cascade Medical Center**  
402 Old State Highway  
Cascade, Idaho 83611  
208-382-4242  
[www.cascademedicalcenter.net](http://www.cascademedicalcenter.net)  
Description: A Critical Access Hospital providing acute care, long-term care, laboratory and x-ray services and 24-hour emergency room services.

**Complex Care Hospital of Idaho**  
2131 S. Bonito Way  
Meridian, Idaho 83642  
(877) 801-2244  
[www.lifecare-hospitals.com](http://www.lifecare-hospitals.com)
Idaho Elks Rehabilitation Center
600 N. Robbins Road
Boise, Idaho 83702
208-489-4444
www.idahoelksrehab.org

Intermountain Hospital
303 N. Allumbaugh
Boise, Idaho 83704
208-377-8400
www.intermountainhospital.com

Saint Alphonsus Regional Medical Center
1055 N. Curtis Road
Boise, Idaho 83706
(208) 367-2121
www.saintalphonsus.org

Saint Alphonsus Medical Center-Nampa
1512 12th Avenue
Nampa, Idaho 83686
(208) 463-5000
www.mercynampa.org

St. Luke's Boise Medical Center
190 E. Bannock Street
Boise, Idaho 83712
(208) 381-2222
www.stlukesonline.org

St. Luke's Children's Hospital
190 E. Bannock Street
Boise, Idaho 83702
(208) 381-2804
www.stlukesonline.org/childrens_hospital

Saint Luke’s Meridian Medical Center
520 S. Eagle Road
Meridian, Idaho 83642
(208) 381-9000
www.stlukesonline.org/meridian
St. Luke’s McCall Medical Center
1000 State Street
McCall, Idaho 83638
(208) 634-2221
www.mccallhosp.org

Treasure Valley Hospital
8800 W Emerald Street
Boise, Idaho 83704
(208) 373-5000
www.treasurevalleyhospital.com

West Valley Medical Center
1717 Arlington Avenue
Caldwell, Idaho 83605
(208) 459-4641
www.westvalleymedctr.com

Veterans Administration Medical Center
500 Fort Street
Boise, Idaho 83702
208-422-1000
www.boise.va.gov

Legal Services

Idaho Legal Aid Services
310 N. 5th Street
Boise, Idaho 83702
Phone: 208.336.8980
Fax: 208.342.2561
www.idaholegalaid.org
Description: Idaho Legal Aid Services, Inc. (ILAS) provides free legal services to low income Idahoans. Every year we help thousands of Idahoans with critical legal problems such as escaping domestic violence and sexual assault, housing (including wrongful evictions, illegal foreclosures, and homelessness), guardianships for abused/neglected children, legal issues facing seniors (such as Medicaid for seniors who need long term care and Social Security), and discrimination issues. Our Indian Law Unit provides specialized services to Idaho's Native Americans. The Migrant Farmworker Law Unit provides legal services to Idaho's migrant population.
Low Income Medical Resources

Community Care Clinic
703 N. 1st St.
McCall, Idaho, 83638
(208) 630-3023
Description: Primary and urgent care. Accepts uninsured patients only from Adams and Valley Counties.

Community Council of Idaho
317 Happy Day Boulevard
Caldwell, Idaho 83607
Phone: (208) 454-1652
www.communitycouncilofidaho.org
Description: Community Council of Idaho serves the Latino community and other low income families with resources and opportunities in education, housing, health, and employment.

Family Medicine Residency of Idaho
777 N. Raymond Street
Boise, Idaho 83704
Phone: (208) 367-4524
www.fmridaho.org
Description: Provide health services to the underserved in a high quality federally designated teaching health center and patient-centered medical home.

Genesis World Mission
215 W. 35th Street
Boise, Idaho 83714
Phone: (208) 384-5200
Fax: (208) 384-5205
www.genesisworldmission.org
Description: Garden City Community Clinic (GCCC) provides medical services to low income, uninsured patients by utilizing volunteer health care professionals. On site basic dental services, social work consultations, patient medical education, and mental health counseling are also available.

Rx Idaho.org
Phone: (888) 477-2669
www.rxidaho.org
Description: RxIdaho.org helps low income, uninsured Idaho residents get access to patient assistance programs where they qualify for free or nearly free prescription medicines.
Rx Outreach
Phone: (800) 769-3880
www.rxoutreach.com
Description: Rx Outreach is a patient assistance program that offers low cost prescription drugs to uninsured individuals and families, as well as those who have limited prescription coverage.

Terry Reilly Health Services
211 16th Avenue North
Nampa, Idaho 83653
Phone: (208) 467-4431
Fax: (208) 467-7684
www.trhs.org
Description: Terry Reilly Health Services (TRHS) is a private not-for-profit organization which provides medical, dental, and behavioral health care to all, based on their ability to pay.

Vineyard Clinic
4950 N. Bradley
Garden City, Idaho
(208) 954-2059
www.vineyardboise.org/benevolence/
Description: Vineyard Boise’s free medical clinic is one of the few free clinics serving Boise and the surrounding Treasure Valley. The clinic was created in the year 2000, and remains completely staffed by volunteers. Our mission is to provide quality Christ-centered health care to those in need and never to have to turn away people in need because of a lack of finances or insurance.

Nursing Homes

Cascade Medical Center
402 Old State Highway
Cascade, Idaho 83611
208-382-4242
Description: Long-term care facility attached to a medical center providing acute care

Cottages of McCall
700 Reedy Lane,
McCall, Idaho 83638
634-3883
Description: Long term and day care assisted living facility, accepts Medicaid,
McCall Rehabilitation and Care Center
418 Floyde Street,
McCall, ID 83638
Description: Long-term and day care facility with skilled nursing for injury, illness and memory issues.

Idaho State Veterans Home
320 N. Collins Road
Boise, Idaho 83702
(208) 334-5000
www.veterans.idaho.gov

Public Health Resources

Idaho South District Health, District 3
13307 Miami Lane
Caldwell, Idaho 83607
Phone: (208) 455-5300
www.publichealthidaho.com
Description: Idaho South District Health provides community health programs including Women, Infants, and Children (WIC), prevention for a range of health conditions, as well as immunization programs. District 3 provides services for Adams, Canyon, Gem, Owyhee, Payette, and Washington counties.

Idaho Central District Health, District 4
703 N. 1st St.
McCall, Idaho 83704
(208) 634-7194
www.cdhd.org
Description: Idaho Central District Health provides community health programs including Women, Infants, and Children (WIC), prevention for a range of health conditions, as well as immunization programs. District 4 provides services for Ada, Boise, Elmore, and Valley counties.

Idaho Department of Health and Welfare, Region 3
3402 Franklin Road
Caldwell, Idaho 83605
Phone: (208) 455-7088
Description: Idaho State Department of Health and Welfare Region 3 oversees Medicaid, food stamps, child welfare, mental health, and other programs for Adams, Canyon, Gem, Owyhee, Payette, and Washington counties.
Idaho Department of Health and Welfare, Region 4
1720 Westgate Drive
Boise, Idaho 83704
Phone: (208) 334-6801
Description: Idaho State Department of Health and Welfare Region 4 oversees Medicaid, food stamps, child welfare, mental health, and other programs for Adams, Canyon, Gem, Owyhee, Payette, and Washington counties.

Regional Medicaid Services
1720 Westgate Drive, Suite A
Boise, Idaho 83704
(208) 334-0960
http://healthandwelfare.idaho.gov/ContactUs/Region4

Referral & Miscellaneous Services

Western Idaho Community Action Partnership
Adams County
110 Moser/P.O. Box 337
Council, Idaho 83612
Phone: (208) 253-4300
Description: Referral and advocacy agency for Head Start /Early Head Start, Food Banks, Family Development, Emergency Services, Home Weatherization Referrals, Energy Assistance, Telephone Assistance, Affordable Housing, Children and Youth, Seniors Services, Area Agency on Aging, Employment

Valley County
110 W. Pine/P.O. Box 129
Cascade, Idaho 83611
Phone: (208) 382-4577
Description: Referral and advocacy agency for Head Start /Early Head Start, Food Banks, Family Development, Emergency Services, Home Weatherization Referrals, Energy Assistance, Telephone Assistance, Affordable Housing, Children and Youth, Seniors Services, Area Agency on Aging, Employment

2-1-1 Idaho CareLine
Phone: Dial 2-1-1 or (800) 926-2588
www.211.idaho.gov
Description: A free statewide community information and referral service program of the Idaho Department of Health and Welfare. This comprehensive database includes programs that offer free or low cost health and human services or social services, such as rental assistance, energy assistance, medical assistance, food and clothing, child care resources, emergency shelter, and more.
Easter Seals Goodwill
1465 S. Vinnell Way
Boise, Idaho 83702
Phone: (208) 376-9924
http://esgw-nrm.easterseals.com
Description: Easter Seals Goodwill provides direct services such as vocational, workforce development, and offender reentry programs; autism services, pediatric therapy, and early intervention services for young children; adult day care, case management, home care, home health services, hospice, support groups, equipment loan, and information and referral service.

Salvation Army Treasure Valley
1904 W. Bannock Street
Boise, Idaho 83702
Phone: (208) 343-5420
Fax: (208) 336-0283
www1.usw.salvationarmy.org
Description: The Salvation Army provides a variety of social, rehabilitation, emergency disaster, and youth services.

Refugee Services

Create Common Good
1161 W. River Street, Suite 220
Boise, Idaho 83702
Phone: (208) 954-0641
www.createcommongood.org
Description: Provides training and employment to refugees and others in need.

Idaho Office for Refugees
1607 W. Jefferson
Boise, Idaho 83702
Phone: (208) 336-4222
Fax: (208) 331-0267
www.idahorefugees.org
Description: The Idaho Office for Refugees (IOR) provides statewide assistance and services to refugees. IOR is a private sector initiative, replacing the traditional State-administered program for refugee assistance. IOR endeavors to ease the difficult transition refugees experience as they adjust to life in the USA. IOR supports the provision of interim financial assistance, English language training, employment services, immigration assistance, language assistance, case management, and social adjustment services in the communities where refugees are resettled.
Senior Services

**Alzheimers Idaho**
5922 N. Brooklet Avenue
Boise, Idaho 83713
Phone: (208) 914-4719
[www.alzid.org](http://www.alzid.org)
Description: Alzheimer’s Idaho is a standalone non-profit 501(c)3 organization providing a variety of services and support locally to our affected Alzheimer’s population and their families and caregivers.

**McCall Senior Center**
701 1st St.
McCall, Idaho 83638
(208) 634-5408
Description: Education, entertainment, health activities, meals for seniors

**Cascade Senior Center**
409 N. School St.
Cascade, Idaho 83638
(208) 382-4256
Description: Education, entertainment, health activities, meals for seniors

**New Meadows Senior Center**
102 N. Commercial
New Meadows, Idaho 83654
(208) 347-2363
Description: Education, entertainment, health activities, meals for seniors

**Council Senior Center**
103 S. Main
Council, Idaho 83612
(208) 253-4282
Description: Education, entertainment, health activities, meals for seniors

**Elderly Opportunity Agency**
134 N. Washington Avenue
Emmett, Idaho 83617
Phone: (208) 365-4461
Fax: (208) 365-0892
[www.eoaidaho.org](http://www.eoaidaho.org)
Description: Elderly Opportunity Agency provides quality services and programs to senior adults in southwest Idaho through nutritional, social, and recreational activities that enhance their well-being, independence, and community involvement.
Friends in Action
1607 W. Jefferson Street
Boise, Idaho 83702
Phone: (208) 333-1363
http://www.fiaboise.org
Description: Friends in Action is a non-profit, collaborative organization dedicated to sustaining quality of life, dignity, and independence for older persons and their families through education and volunteerism.

Sage Community Resources
Area Agency on Aging (Idaho County)
1-800-326-4843
www.sageidaho.com
Description: As the Southwest Idaho local Area Agency on aging, Sage Community Resources designs, develops, and maintains comprehensive, coordinated, community based senior services for southwest Idaho, which assists elders in leading independent, meaningful, and dignified lives.

Senior Health Insurance Benefits Advisors
Phone: (800) 247-4422
www.doi.idaho.gov
Description: The Idaho Department of Insurance offers free information and counseling to help answer senior health insurance questions.

Senior Solutions
3010 W. State Street, Suite 120
Boise, Idaho 83703
http://www.seniorsolutions.bz
Description: Senior Solutions is a non-profit agency that provides services for senior citizens primarily in the City of Boise and Ada County, Idaho, to help them live independently as long as possible.

Veteran Services

Veterans Administration Medical Center
500 Fort Street
Boise, Idaho 83702
(208) 422-1000
www.boise.va.gov
Description: Provides health care and behavioral health services to veterans.

Valley County Veteran Services Officer
(208) 382-3842
Description: Provides information on where and how to receive benefits for veterans.
Appendix I: Community Leader Descriptions

The process of developing our CHNA included obtaining and taking into account input from persons representing the broad interests of our community. This appendix contains information on how and when we consulted with community health leaders and representatives as well as each individual’s organizational affiliation. We interviewed community leaders and representatives in each of the following categories and indicated which category they were in.

Category I: Persons with special knowledge of or expertise in public health
Category II: Federal, tribal, regional, State, or local health or other departments or agencies (with current data or other information relevant to the health needs of the community served by the hospital facility)
Category III: Leaders, representatives, or members of medically underserved, low income, and minority populations and populations with chronic disease needs

Community Leaders/Representatives Contacted

1. **Affiliation:** St. Luke’s Health System  
   **Date contacted:** 4/17/12  
   **How input was obtained:** Phone interview and questionnaire  
   **Health leader category:** Category I  
   **Description of expertise:**  
   Senior health care executive serving the Valley and Adams County area for over thirty years.

   Populations represented/served:

   - Yes  Children
   - Yes  Disabled
   - Yes  Hispanic population
   - Yes  Homeless
   - Yes  Low income individuals and families
   - Yes  Migrant and seasonal farm workers
   - Yes  Populations with chronic conditions
   - Yes  Refugees
   - Yes  Senior citizens
   - Yes  Those with behavioral health issues
   - Yes  Veterans
2. **Affiliation:** St. Luke’s McCall  
**Date contacted:** 4/16/2012  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Category I  
**Description of expertise:**  
Medical director for St. Luke’s McCall Integrative Medicine Clinic, Center for Health Promotion, and McCall Rehabilitation and Care Center.

Populations represented/served:

- [X] Children  
- _ Disabled  
- _ Hispanic population  
- _ Homeless  
- [X] Low income individuals and families  
- _ Migrant and seasonal farm workers  
- [X] Populations with chronic conditions  
- _ Refugees  
- [X] Senior citizens  
- [X] Those with behavioral health issues  
- [X] Veterans

3. **Affiliation:** St. Luke’s McCall  
**Date contacted:** 4/24/2012  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Category I and III  
**Description of expertise:**  
Internal medicine physician at St. Luke’s McCall, as well as a City Council member and past medical director for Hospice and Home Health in McCall.

Populations represented/served:

- _ Children  
- _ Disabled  
- _ Hispanic population  
- _ Homeless  
- _ Low income individuals and families  
- _ Migrant and seasonal farm workers  
- [X] Populations with chronic conditions  
- _ Refugees  
- [X] Senior citizens
Those with behavioral health issues
Veterans

4. **Affiliation:** Idaho Central District Health, District 4  
**Date contacted:** 4/16/2012  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Categories I, II, and III

Populations represented/served:

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<thead>
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<th>Yes</th>
<th>Children</th>
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<td>___</td>
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<tr>
<td>___</td>
<td>Migrant and seasonal farm workers</td>
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<tr>
<td>Yes</td>
<td>Populations with chronic conditions</td>
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<tr>
<td>Yes</td>
<td>Refugees</td>
</tr>
<tr>
<td>___</td>
<td>Senior citizens</td>
</tr>
<tr>
<td>___</td>
<td>Those with behavioral health issues</td>
</tr>
<tr>
<td>___</td>
<td>Veterans</td>
</tr>
</tbody>
</table>

5. **Affiliation:** McCall Donnelly School District  
**Date contacted:** 4/12/12  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Category I and II

Populations represented/served:

<table>
<thead>
<tr>
<th>Yes</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
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<td>___</td>
<td>Hispanic population</td>
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<td>Low income individuals and families</td>
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<tr>
<td>___</td>
<td>Migrant and seasonal farm workers</td>
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<tr>
<td>Yes</td>
<td>Populations with chronic conditions</td>
</tr>
<tr>
<td>___</td>
<td>Refugees</td>
</tr>
<tr>
<td>___</td>
<td>Senior citizens</td>
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<tr>
<td>___</td>
<td>Those with behavioral health issues</td>
</tr>
<tr>
<td>___</td>
<td>Veterans</td>
</tr>
</tbody>
</table>

6. **Affiliation:** Adams County Health Center (FQHC)  
**Date contacted:** 4/17/2012
How input was obtained: Phone interview and questionnaire
Health leader category: Category I, II, and III

Populations represented/served:

___ Children
___ Disabled
___ Hispanic population
___ Homeless
Yes Low income individuals and families
___ Migrant and seasonal farm workers
Yes Populations with chronic conditions
___ Refugees
Yes Senior citizens
Yes Those with behavioral health issues
Yes Veterans

7. Affiliation: Psychologist Private practice
Date contacted: 4/24/2012
How input was obtained: Phone interview and questionnaire
Health leader category: Category I and III

Populations represented/served:

Yes Children
___ Disabled
___ Hispanic population
___ Homeless
Yes Low income individuals and families
___ Migrant and seasonal farm workers
___ Populations with chronic conditions
___ Refugees
___ Senior citizens
Yes Those with behavioral health issues
___ Veterans

Date contacted: 4/16/2012
How input was obtained: Phone interview and questionnaire
Health leader category: Category I
Description of expertise:
Family medicine physician, previous assignments with CDC to study risk factors and prevention in vulnerable populations. Sits on the board of directors for McCall’s Community Care Clinic for low income patients, and is a member of the wellness community for the local school system.

Populations represented/served:

- Yes Children
- Yes Disabled
- Yes Hispanic population
- Yes Homeless
- Yes Low income individuals and families
- Yes Migrant and seasonal farm workers
- Yes Populations with chronic conditions
- Yes Refugees
- Yes Senior citizens
- Yes Those with behavioral health issues
- Yes Veterans

   Date contacted: 4/6/2012
   How input was obtained: Phone interview and questionnaire
   Health leader category: Category III

Populations represented/served:

- Yes Children
- Yes Disabled
- Yes Hispanic population
- Yes Homeless
- Yes Low income individuals and families
- Yes Migrant and seasonal farm workers
- Yes Populations with chronic conditions
- Yes Refugees
- Yes Senior citizens
- Yes Those with behavioral health issues
- Yes Veterans

10. Affiliation: Southwest District Health, Idaho District 3
    Date contacted: 4/10/2012
    How input was obtained: Phone interview and questionnaire
Health leader category: Categories I, II, and III

Populations represented/served:

Yes  Children
Yes  Disabled
Yes  Hispanic population
___  Homeless
Yes  Low income individuals and families
Yes  Migrant and seasonal farm workers
___  Populations with chronic conditions
___  Refugees
Yes  Senior citizens
___  Those with behavioral health issues
___  Veterans

11. Affiliation: Boise VA Medical Center
   Date contacted: 4/11/2012
   How input was obtained: Phone interview and questionnaire
   Health leader category: Category III

Populations represented/served:
___  Children
___  Disabled
___  Hispanic population
___  Homeless
___  Low income individuals and families
___  Migrant and seasonal farm workers
___  Populations with chronic conditions
___  Refugees
___  Senior citizens
___  Those with behavioral health issues
Yes  Veterans

12. Affiliation: Idaho Department of Labor
   Date contacted: 3/5/2012 and 3/23/2012
   How input was obtained: Phone and email
   Health leader category: Categories II
   Description of expertise:
   State of Idaho Department of Labor helped obtain specific unemployment related information for our service area.

   Date contacted: Contacted numerous times from November 2011 through February 2012
to obtain and ensure appropriate collection of Behavioral Risk Factor Surveillance System data for our service area.

How input was obtained: Phone conversations, emails, in person meeting

Health leader category: Category II

   Date contacted: Contacted numerous times from November 2011 through February 2012 to obtain and insure appropriate collection of Vital Statistics data for our service area.
   How input was obtained: Phone conversations, emails, in person meeting
   Health leader category: Category II

15. Affiliation: Idaho Department of Health and Welfare
   Date contacted: 6/6/12
   How input was obtained: Phone interview and questionnaire
   Health leader category: Categories I and II

   Populations represented/served:
   Yes Children
   Yes Disabled
   ___ Hispanic population
   ___ Homeless
   Yes Low income individuals and families
   ___ Migrant and seasonal farm workers
   Yes Populations with chronic conditions
   Yes Refugees
   ___ Senior citizens
   Yes Those with behavioral health issues
   ___ Veterans

   Date contacted: 4/26/2012
   How input was obtained: Phone interview and questionnaire
   Health leader category: Categories I and III

   Populations represented/served:
   Yes Children
   Yes Disabled
   Yes Hispanic population
   Yes Homeless
   Yes Low income individuals and families
17. **Affiliation:** Family Medicine Residency of Idaho  
**Date contacted:** 6/28/12  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Category III

Populations represented/served:

- Yes Migrant and seasonal farm workers
- Yes Populations with chronic conditions
- Yes Refugees
- Yes Senior citizens
- Yes Those with behavioral health issues
- Yes Veterans

18. **Affiliation:** Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services, Region X  
**Date contacted:** 4/16/2012  
**How input was obtained:** Email and phone  
**Health leader category:** Category II
Appendix II: Community Leader Interview Questions

Leader Name:
Title:
Affiliation:
Date:

Thank you for agreeing to participate in St. Luke’s 2012/2013 Community Health Needs Assessment. We will utilize the valuable information you provide to help us better understand and address the health needs of our community.

We are required to publish the names and qualifications of the community leaders we interview. So, with your permission, we would like to start by asking you a few questions about your professional background.

1) Please briefly describe any special knowledge or expertise you have in public health in terms of degrees, positions, experience, or affiliations

2) Please briefly describe data or other information your organization may collect relevant to helping us understand the health needs of our community.

3) What geography does your expertise apply to? (If your expertise pertains to more than one St. Luke’s hospital location, we will ask you to note where your response differs by location.)
4) Do you feel able to represent the current health needs of any of the following population groups?

_____ Children  
_____ Disabled  
_____ Hispanic population  
_____ Homeless  
_____ Low income individuals and families  
_____ Migrant and seasonal farm workers  
_____ Populations with chronic conditions  
_____ Refugees  
_____ Senior citizens  
_____ Those with behavioral health issues  
_____ Veterans

If you are able to represent the health needs of any additional affected population groups, please specify the group(s):

Briefly describe your experience with, qualifications, or knowledge of the groups you selected.
5) We have compiled a list of potential community health needs, based on the results of health assessments and surveys conducted in our community and across the nation. We would like your feedback on the relative importance to our community of each of the potential health needs. As you review the list, please provide us with a score on a scale of 1 to 10 for each potential need. A score of 10 would mean you believe addressing this need with additional resources is highly important to people leading healthy, productive lives in our community. A score below 5 would represent an item you believe is not as important for our community to address with additional resources over the next three years. Also in the space provided, please define and score additional health needs you believe are important to our community.

**Clinical care access and quality** (potential needs)
- _____ Affordable health insurance
- _____ Affordable care for low income individuals
- _____ Availability of primary care providers
- _____ Affordable dental care for low income individuals
- _____ Availability of behavioral health services (providers, suicide hotline, etc)
- _____ Chronic disease management programs
- _____ Immunization programs
- _____ Improved health care quality
- _____ Integrated, coordinated care (less fragmented care)
- _____ More providers accept public health insurance (example: Medicaid)
- _____ Prenatal care programs
- _____ Screening programs (cholesterol, diabetes, mammography, etc)

Please describe and score any additional clinical care needs you believe are important:

_____  
_____  
_____  
_____  


**Health behavior** (potential needs)
- Exercise programs/education
- Nutrition education
- Safe-sex education programs
- Substance abuse services and programs
- Tobacco cessation programs
- Wellness and prevention programs
- Weight management programs

Please describe and score any additional health behavior needs you believe are important:


**Social and economic** (potential needs)
- Children and family services
- Disabled services
- High school and college education support and assistance programs
- Homeless services
- Job training services
- Senior services
- Veterans’ services
- Violence and abuse services

Please describe and score any additional social/economic needs:


**Physical environment** (potential needs)
- Availability of recreation and exercise facilities
- Availability or access to healthy foods
- Healthier air quality, water quality, etc
- Transportation to and from appointments

Please describe and score any additional physical environment needs:


6) Please describe any programs, legislation, organizations, or other measures you believe are effective in addressing these needs.

a. Affected/vulnerable population programs/legislation

b. Clinical care access and quality programs/legislation

c. Health behavior programs/legislation

d. Social and economic programs/legislation

e. Physical environment programs/legislation

7) What additional feedback do you have for St. Luke’s on our community health needs?
### Appendix III: Summary Scoring Table: Leader Need Scores Combined with Related Health Outcomes and Factors

**Health Behavior Category**

<table>
<thead>
<tr>
<th>Community Identified Needs</th>
<th>Leader Score</th>
<th>Related Health Factors and Outcomes</th>
<th>Health Factor Score</th>
<th>Combined Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exercise programs/education</strong></td>
<td>5.7</td>
<td>Adult physical inactivity</td>
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<td>15.7</td>
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<tr>
<td></td>
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<td>Teen exercise</td>
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<td><strong>Nutrition education</strong></td>
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<td>Adult nutrition</td>
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<td>13.9</td>
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<td></td>
<td>Teen nutrition</td>
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<td>15.9</td>
</tr>
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<td><strong>Safe-sex education programs</strong></td>
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<td>Sexually transmitted infections</td>
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<td>13.2</td>
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<td></td>
<td></td>
<td>Teen birth rate</td>
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<td>16.2</td>
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<tr>
<td><strong>Substance abuse services and programs</strong></td>
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<td>Excessive drinking</td>
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<td>Illicit drug use</td>
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<td>19.8</td>
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<tr>
<td></td>
<td></td>
<td>Vehicle crash death rate</td>
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<td>19.8</td>
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<td><strong>Tobacco cessation programs</strong></td>
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<td>Obese/overweight teenagers</td>
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<td>17.4</td>
</tr>
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<td><strong>Wellness and prevention programs</strong></td>
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<td>Accidents</td>
<td>12</td>
<td>19</td>
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<tr>
<td></td>
<td></td>
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<td>Alzheimer’s</td>
<td>3</td>
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<td></td>
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<td>Arthritis</td>
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<td>12</td>
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<tr>
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<td>Asthma</td>
<td>8</td>
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<td>Breast cancer</td>
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<td>Pancreatic cancer</td>
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<td>Skin cancer (melanoma)</td>
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<tr>
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<td>10</td>
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## Clinical Care Category

<table>
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<tr>
<th>Community Identified Needs</th>
<th>Leader Score</th>
<th>Related Health Factors and Outcomes</th>
<th>Health Factor Score</th>
<th>Combined Score</th>
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<td>Availability of behavioral health services (providers, suicide hotline, etc)</td>
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<td>Mental health service providers</td>
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<td>Preventable hospital stays</td>
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<td>Cholesterol screening</td>
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<tr>
<td></td>
<td></td>
<td>Colorectal screening</td>
<td>8</td>
<td>12.3</td>
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<td>Diabetic screening</td>
<td>9</td>
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<td>Mammography screening</td>
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<td>13.3</td>
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</tbody>
</table>
### Social and Economic Category

<table>
<thead>
<tr>
<th>Community Identified Needs</th>
<th>Leader Score</th>
<th>Related Health Factors and Outcomes</th>
<th>Health Factor Score</th>
<th>Combined Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and family services</td>
<td>6.7</td>
<td>Children in poverty</td>
<td>12</td>
<td>18.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inadequate social support adults</td>
<td>7</td>
<td>13.7</td>
</tr>
<tr>
<td>Disabled services *</td>
<td>4.3</td>
<td>* See note below</td>
<td>8</td>
<td>12.3</td>
</tr>
<tr>
<td>High school and college education support and assistance programs</td>
<td>5.3</td>
<td>Education</td>
<td>9</td>
<td>14.3</td>
</tr>
<tr>
<td>Homeless services</td>
<td>4.7</td>
<td>Unemployment rate</td>
<td>10</td>
<td>14.7</td>
</tr>
<tr>
<td>Job training services</td>
<td>5.6</td>
<td>Unemployment rate</td>
<td>10</td>
<td>15.6</td>
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<tr>
<td>Senior services</td>
<td>4.4</td>
<td>Inadequate social support adults</td>
<td>7</td>
<td>11.4</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>5.1</td>
<td>Inadequate social support</td>
<td>7</td>
<td>12.1</td>
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<tr>
<td>Violence and abuse services</td>
<td>6.2</td>
<td>Safety - homicide rate</td>
<td>6</td>
<td>12.2</td>
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</table>

* Disabled services did not have an objective health factor measure associated with it. Therefore, we used a health factor value in the middle of the possible range of scores.
**Physical Environment Category**

<table>
<thead>
<tr>
<th>Community Identified Needs</th>
<th>Leader Score</th>
<th>Related Health Factors and Outcomes</th>
<th>Health Factor Score</th>
<th>Combined Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of recreation and exercise facilities</td>
<td>4.6</td>
<td>Recreational facilities</td>
<td>6</td>
<td>10.6</td>
</tr>
<tr>
<td>Availability or access to healthy foods</td>
<td>5.4</td>
<td>Limited access to healthy foods</td>
<td>6.5</td>
<td>11.9</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc</td>
<td>2.4</td>
<td>Air pollution</td>
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<td>11.4</td>
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<tr>
<td>Transportation to and from appointments *</td>
<td>6.4</td>
<td>* See note below</td>
<td>8</td>
<td>14.4</td>
</tr>
</tbody>
</table>

* Transportation did not have an objective health factor measure associated with it. Therefore, we used a health factor value in the middle of the possible range of scores.