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Introduction

St. Luke’s Jerome 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.slrmc.org/jerome.
Executive Summary

St. Luke’s Jerome 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

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 wellness and prevention programs for diabetes, obesity, and mental illness. Diabetes and obesity rank as high priority needs because both are trending higher and are contributing factors 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, obesity, and high cholesterol. 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>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</th>
<th>Populations Affected Most</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight management</td>
<td>Obese</td>
<td>Income &lt;$35,000, Hispanic, No high school diploma</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>Obese/overweight teens</td>
<td>Income &lt;$35,000, Hispanic</td>
<td>20.1</td>
</tr>
<tr>
<td>Wellness/prevention</td>
<td>Diabetes</td>
<td>Income &lt;$35,000, No high school diploma</td>
<td>20.2</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
<td></td>
<td>20.2</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Teen nutrition</td>
<td></td>
<td>16.2</td>
</tr>
<tr>
<td>Safe-sex education programs</td>
<td>Sexually transmitted infections</td>
<td></td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td>Teen birth rate</td>
<td></td>
<td>18.9</td>
</tr>
<tr>
<td>Community Identified Needs</td>
<td>Related Health Factors or Outcomes</td>
<td>Populations Affected Most</td>
<td>Total Score</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Substance abuse services and programs</td>
<td>Illicit drug use</td>
<td>Income &lt; $35,000, No high school diploma, Males 18-34</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Vehicle crash death rate</td>
<td></td>
<td>17.5</td>
</tr>
<tr>
<td>Wellness and Prevention</td>
<td>High cholesterol</td>
<td>Income &lt; $35,000, No high school diploma, Age 55+</td>
<td>17.2</td>
</tr>
<tr>
<td></td>
<td>Respiratory disease</td>
<td></td>
<td>16.2</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
<td></td>
<td>17.2</td>
</tr>
<tr>
<td>Exercise programs/education</td>
<td>Adult physical activity</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Teen exercise</td>
<td></td>
<td>14.9</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Adult nutrition</td>
<td>No college</td>
<td>15.2</td>
</tr>
<tr>
<td>Substance abuse services and programs</td>
<td>Alcohol</td>
<td>Ages 18-64</td>
<td>14.5</td>
</tr>
<tr>
<td>Tobacco cessation programs</td>
<td>Smoking</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>13.5</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Accidents</td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td></td>
<td>AIDS</td>
<td>African American, Males &lt;24</td>
<td>14.2</td>
</tr>
<tr>
<td></td>
<td>Alzheimer’s</td>
<td>Age 65 +</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>Arthritis</td>
<td>Income &lt; $35,000, Non-Hispanic, No college, Overweight, Age 65 +</td>
<td>12.2</td>
</tr>
</tbody>
</table>
Health Behavior Need Summary Table, Continued

<table>
<thead>
<tr>
<th>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</th>
<th>Populations Affected Most</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness and prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td></td>
<td>13.2</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>Female</td>
<td></td>
<td>14.2</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td></td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td></td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td>Flu/pneumonia</td>
<td></td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college,</td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td></td>
<td>Overweight, Age 65 +</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td></td>
<td></td>
<td>11.2</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Income &lt; $35,000, No high school</td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td></td>
<td>diploma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephritis</td>
<td></td>
<td></td>
<td>14.2</td>
</tr>
<tr>
<td>Non-Hodgkin’s lymphoma</td>
<td></td>
<td></td>
<td>12.2</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td></td>
<td></td>
<td>12.2</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Male age 60+</td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td>Skin cancer</td>
<td></td>
<td></td>
<td>14.2</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; affordable health insurance; and increased availability of behavioral health services. 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 not improving. Availability of behavioral health services ranked as a top priority due to our health leader scores and because Idaho has a shortage of behavioral health professionals.

As shown in the table below, high priority clinical care needs are often 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>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</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>20</td>
</tr>
<tr>
<td>Affordable health insurance</td>
<td>Uninsured adults</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>20.5</td>
</tr>
<tr>
<td>Availability of behavioral health services</td>
<td>Mental health service providers</td>
<td>Income &lt; $50,000</td>
<td>19.3</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Diabetes</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>19.1</td>
</tr>
<tr>
<td>More providers accept public health insurance</td>
<td>Children in poverty</td>
<td>Income &lt; $35,000</td>
<td>17.4</td>
</tr>
<tr>
<td>Screening programs</td>
<td>Mammography screening</td>
<td>Income &lt; $50,000</td>
<td>16.5</td>
</tr>
<tr>
<td>Community Identified Needs</td>
<td>Related Health Factors or Outcomes</td>
<td>Populations Affected Most</td>
<td>Total Score</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Affordable dental care</td>
<td>Dental visits, preventive</td>
<td>Income &lt; $50,000</td>
<td>15.8</td>
</tr>
<tr>
<td>Availability of primary care providers</td>
<td>Primary care providers</td>
<td></td>
<td>14.9</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>11.1</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td>12.1</td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65 +</td>
<td>14.1</td>
</tr>
<tr>
<td>Immunization programs</td>
<td>Children immunized</td>
<td></td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>Flu/pneumonia</td>
<td></td>
<td>11.5</td>
</tr>
<tr>
<td>Improved health care quality</td>
<td>Preventable hospital stays</td>
<td></td>
<td>12.5</td>
</tr>
<tr>
<td>Integrated, coordinated care (less fragmented)</td>
<td>Preventable hospital stays</td>
<td>Refugees, Hispanics, Age 65 +</td>
<td>15.2</td>
</tr>
<tr>
<td>Prenatal care programs</td>
<td>Low birth weight</td>
<td></td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td>Prenatal care 1st trimester</td>
<td>Hispanic, No high school diploma</td>
<td>15.4</td>
</tr>
<tr>
<td>Screening programs</td>
<td>Cholesterol</td>
<td>Income &lt; $35,000, No high school diploma, Age 55 +</td>
<td>14.5</td>
</tr>
<tr>
<td></td>
<td>Colorectal screening</td>
<td>Income &lt; $35,000, No college, Age 50 +</td>
<td>13.5</td>
</tr>
<tr>
<td></td>
<td>Diabetic screening</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>13.5</td>
</tr>
</tbody>
</table>

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

Children and family services is the only social and economic health needs scoring above the median. The increasing number of children living in poverty in our service area drives the need for more children and family services in our community.

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>19.3</td>
</tr>
<tr>
<td>Children and family services</td>
<td>Inadequate social support</td>
<td>Age &lt; 18</td>
<td>15.9</td>
</tr>
<tr>
<td>Disabled services</td>
<td></td>
<td></td>
<td>15.3</td>
</tr>
<tr>
<td>Education support and assistance programs</td>
<td>Education</td>
<td></td>
<td>13.3</td>
</tr>
<tr>
<td>Homeless services</td>
<td>Unemployment rate</td>
<td></td>
<td>13.5</td>
</tr>
<tr>
<td>Job training services</td>
<td>Unemployment rate</td>
<td></td>
<td>13.5</td>
</tr>
<tr>
<td>Senior services</td>
<td>Inadequate social support</td>
<td>Age 65 +</td>
<td>14</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>Inadequate social support</td>
<td></td>
<td>14.2</td>
</tr>
<tr>
<td>Violence and abuse services</td>
<td>Safety - homicide rate</td>
<td></td>
<td>12.9</td>
</tr>
</tbody>
</table>

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

In the physical environment category, transportation to and from appointments ranked above the CHNA median health need score. This need was identified during our affected population focus groups and was reinforced during our community leader interview process. Low income, senior, and rural populations are most affected by the need for transportation to and from appointments.

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>Transportation to and from appointments</td>
<td></td>
<td>Income &lt; $35,000, Rural populations, Age 65+</td>
<td>16.1</td>
</tr>
<tr>
<td>Availability of recreation and exercise facilities</td>
<td>Recreational facilities</td>
<td>Income &lt; $50,000</td>
<td>12.7</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>13.7</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc.</td>
<td>Air pollution</td>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>

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

Background

St. Luke’s Jerome has been committed to serving the needs of our community for over 60 years. Founded in 1952, we strive to provide the best health care for the entire family.

St. Luke's Jerome offers a range of services, from primary care and wellness and prevention programs such as diabetes education, to surgery, obstetrics, geriatrics and transitional care, diagnostics, and an emergency department.

We care about our patients, their health, and what’s best for individuals and families. St. Luke's Jerome partners with our patients to provide excellent and compassionate care.

St. Luke’s Jerome is part of St. Luke’s Health System (SLHS). Today, SLHS is the only locally governed, Idaho-based, not-for-profit health system, with a network of five separately licensed full service medical centers and more than 100 outpatient centers and clinics serving people throughout southern Idaho, eastern Oregon, and northern Nevada.

St. Luke’s Jerome is fortunate to have caring and committed volunteers, more than 100 physicians on the medical staff, and a dedicated governing board comprised of independent civic leaders who volunteer their time to serve.
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. Gooding, Jerome, and Lincoln 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 75% of our inpatients reside. The residents of these counties comprise about 79% of our inpatients with approximately 58% of our inpatients living in Jerome County, 14% in Gooding County, and 7% in Lincoln County. All three counties are part of Idaho Health District 5, as shown in the maps below.

1 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 30% of our defined service area. Gooding County is approximately 28% Hispanic, Jerome County 31%, and Lincoln County is 28% 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>Service Area</td>
<td>43,046</td>
<td>41,632</td>
<td>256</td>
<td>879</td>
<td>279</td>
<td>30,297</td>
<td>12,749</td>
</tr>
<tr>
<td>Gooding County</td>
<td>15,464</td>
<td>14,990</td>
<td>77</td>
<td>264</td>
<td>133</td>
<td>11,120</td>
<td>4,344</td>
</tr>
<tr>
<td>Jerome County</td>
<td>22,374</td>
<td>21,560</td>
<td>145</td>
<td>549</td>
<td>120</td>
<td>15,445</td>
<td>6,929</td>
</tr>
<tr>
<td>Lincoln County</td>
<td>5,208</td>
<td>5,082</td>
<td>34</td>
<td>66</td>
<td>26</td>
<td>3,732</td>
<td>1,476</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>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>
</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. Our service area followed that trend experiencing an 18% increase in population within that timeframe and is expected to grow by an additional 16% by the year 2020. St. Luke’s Jerome 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>Rank by Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>36,639</td>
<td>43,046</td>
<td>18%</td>
<td>6,505</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 0 to 19 year old age group was the fastest growing segment of our community. Over the next ten years, the 0 to 19 year old age group is expected to grow by about 34% making it the fastest growing and by far the largest population segment. Currently, about 32% of the people in our community are between the ages of 0 - 19 and by 2020 about 38% of our population is expected to be in that age group. The age 65+ segment is expected to grow by 29% over the next 10 years and make up about 14% of our population by 2020.

### Population by Age

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Age 0-19</th>
<th>Age 25-44</th>
<th>Age 45-64</th>
<th>Age 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>36,639</td>
<td>11,916</td>
<td>11,293</td>
<td>8,535</td>
<td>4,895</td>
</tr>
<tr>
<td>Percent of total</td>
<td>33%</td>
<td>31%</td>
<td>23%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>43,046</td>
<td>14,449</td>
<td>13,360</td>
<td>9,829</td>
<td>5,408</td>
</tr>
<tr>
<td>Percent of total</td>
<td>34%</td>
<td>31%</td>
<td>23%</td>
<td>13%</td>
<td></td>
</tr>
</tbody>
</table>

---

3 U.S. Census Bureau: 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 12.5% in 2003 to 15.3% in 2010. Our service area poverty rate has increased more than the national average since 2003. In 2003 it was at the national average and by 2010 it was above the national average at over 17%. The poverty rate in our community for children under the age of 18 is about 24%, which is also now above the national average.  

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

Median income in the United States has risen by 8% since 2005. Growth in income was slower in Idaho and in our service area during that period. Median income in our service area is substantially below the national median and below the median income for Idaho as well.\(^9\)

\(^9\) Ibid
Community Health Needs Assessment Methodology

We developed the St. Luke’s Jerome 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.

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**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

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

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

- Community Health Needs Identified
  - Programs, policies, and services “NEEDED” to impact community health

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21
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 Name</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>Example factor</td>
<td>0 to 4 points</td>
<td>0 to 4 points</td>
<td>0 to 4 points</td>
<td>0 to 4 points</td>
<td>0 to 16 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 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.\(^\text{10}\)

<table>
<thead>
<tr>
<th>Years of Potential Life Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>YPLL Rate</td>
</tr>
<tr>
<td>Service Area</td>
</tr>
<tr>
<td>Jerome</td>
</tr>
<tr>
<td>Gooding</td>
</tr>
<tr>
<td>Lincoln</td>
</tr>
<tr>
<td>Idaho</td>
</tr>
<tr>
<td>National Average</td>
</tr>
<tr>
<td>National Benchmark 10th Percentile</td>
</tr>
</tbody>
</table>

The chart above shows our service area YPLL for 2010 is about the same as the national average. This indicates that on average people in our service area are not dying prematurely compared to the nation as a whole. However, our YPLL measurement is well above (worse than) the average for Idaho and above the top 10th percentile nationally.\(^\text{11}\)

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\(^{10}\) County Health Rankings 2012. Accessible at [www.countyhealthrankings.org](http://www.countyhealthrankings.org) (used for national YPLL 2006 - 2008 average)

\(^{11}\) Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (1/2012) (Idaho and county data provided for 2010 YPLL)
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.12

"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 is down since 2002 and is now 17% which is slightly above the national average.\textsuperscript{13}

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.

\textsuperscript{13} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
- **Poor Physical Health Days**

  The number of reported poor physical health days for the counties in our service area and for Idaho is about the same as the national average. The national top 10\textsuperscript{th} percentile is 2.6 days.\textsuperscript{14}

![Poor Physical Health Days Graph](image)

- **Poor Mental Health Days**

  The number of poor mental health days for the counties in our service area is below (better than) the national average overall. The national top 10\textsuperscript{th} percentile is 2.3 days per month.

![Poor Mental Health Days Graph](image)

\textsuperscript{14} County Health Rankings 2012. Accessible at [www.countyhealthrankings.org](http://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.  

The percent of LBW babies in our service area and in Idaho is well below (better than) the national average. This is a key indicator of future health. The national top 10th percentile for LBW is 6.0%.

Low birth weight can be addressed in multiple ways, including:

- 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

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

17 America’s Health Rankings 2011, 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. Jerome County’s overall outcome rank is 33rd, Gooding County’s rank is 40th, and Lincoln County’s rank is 29th 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.\(^{18}\) The trend in Idaho has been flat from 2004 to 2009 with some uptick in 2010 that warrants watching in future years.\(^{19}\)

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.\(^ {20}\) 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.\(^ {21}\)

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\(^{18}\) [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.²²

  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.²³

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

Percent of adults who have ever been told they have arthritis

Trend:
Better/Worse

Prevalence versus U.S.

Severe/Preventable

Magnitude: Root Cause

Total Score

Arthritis

<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 slightly from about 8% in 2002 to about 9% in 2010 and is slightly above 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

### Health Factor Score

<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>Asthma</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

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

About 8% of the people in Idaho report that they have been told they have diabetes, which ranks as 18th (a little better than average) in the nation. The percent of people living with diabetes in the U.S. and in our service area 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.26

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.27

26 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
27 Ibid.
% of adults who had ever been told they had diabetes

Diabetes - by Income

- Annual Income

- District 5

Diabetes - by Education

- Level of Education

- District 5

Diabetes - by Ethnicity

- Ethnicity

- District 5
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.\textsuperscript{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. Average</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

- **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 6\textsuperscript{th} (best) in the nation for high blood pressure. Blood pressure rates in District 5 are below the national level and have remained flat for the past ten years. High blood pressure is a major risk factor for heart disease, stroke, congestive heart failure, and kidney disease.\textsuperscript{29}

\textsuperscript{28} America’s Health Rankings 2011, www.americashealthrankings.org

\textsuperscript{29} Ibid
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 annual 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% of overweight adults had high blood pressure compared with 13.9% 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% compared with 10.1%).
- 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% compared with 1.3%).

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

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

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 since 2001 in District 5, Idaho, and nationally. Sustained, increased cholesterol levels can lead to heart disease, heart attack, and other circulatory problems.\(^{32}\)

![High Cholesterol Graph](image)

*Data collected every other year. No service area data available.*

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.

\(^{32}\) Ibid.
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%).\(^3^3\)

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.\(^3^4\)

<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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<tbody>
<tr>
<td></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

\(^3^3\) Ibid.  
\(^3^4\) 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%.³⁵

![Mental Illness Chart]

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. ³⁶ Returning veterans and our slow economy are likely to put pressure on levels of mental illness in Idaho in the coming years.

### Health Factor Score

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<th>Health Factor Score</th>
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<th>High score = High potential for health impact</th>
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<tr>
<td></td>
<td><strong>Trend:</strong> Better/Worse</td>
<td><strong>Prevalence versus U.S. Average</strong></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 are 10% below the national average (7th best in the nation). However, the cancer rate in our service area is about the same as the national average. The trend for cancer deaths is down nationally and has been relatively flat in our service area for the past ten years.

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.\textsuperscript{39}

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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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<tr>
<td></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
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<td></td>
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<td>Severe/Preventable</td>
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<tr>
<td></td>
<td></td>
<td>Magnitude: Root Cause</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Score</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
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<td>1</td>
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<tr>
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<td>8</td>
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</tbody>
</table>

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.

\textsuperscript{39} America’s Health Rankings 2011, www.americashealthrankings.org
Lung Cancer

Lung cancer is the leading cause of cancer death in Idaho. For our service area, the lung cancer death rate trend is flat and is below the national average.\(^40\) 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.\(^41\)

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 about the same as 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}

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<th>Health Factor Score</th>
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<tr>
<td>Low score = Low potential for health impact</td>
</tr>
<tr>
<td>Trend</td>
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<tr>
<td>Colorectal Cancer</td>
</tr>
</tbody>
</table>

\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.\textsuperscript{44} 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%).\textsuperscript{45}

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\textbf{Breast Cancer Deaths}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{breast_cancer_deaths.png}
\caption{Breast Cancer Deaths}
\end{figure}

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\textbf{Health Factor Score} & \textbf{Low score = Low potential for health impact} & \textbf{High score = High potential for health impact} \\
\hline
\textbf{Trend: Better/Worse} & Prevalence versus U.S. Average & Severe/Preventable & Magnitude: Root Cause & Total Score \\
\hline
Breast Cancer & 2 & 0 & 4 & 1 & 7 \\
\hline
\end{tabular}
\caption{Health Factor Score for Breast Cancer}
\end{table}

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\textsuperscript{44} Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010

\textsuperscript{45} America’s Health Rankings 2011, www.americashealthrankings.org
Prostate Cancer

Prostate cancer is the second overall cause of death in Idaho men and is the most common cancer among males. In our service area, the prostate cancer death rate is above the national average. 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.

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


Pancreatic Cancer

In our service area, the pancreatic cancer death rate is about the same as the national average. 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.

### Health Factor Score

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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>
<td>Trend</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Severe/Preventable</td>
<td>Magnitude</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
</tr>
</tbody>
</table>

| Pancreatic Cancer | 2       | 2       | 1       | 0       | 5       |

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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.  

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. However, in 2010 our service area death rate dropped below the national average for the first time in at least six years. In 2010, the rate of people diagnosed with melanoma was significantly lower for Health District 5 than the rest of the state.

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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
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).

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>
<th></th>
<th>Low score = Low potential for health impact</th>
<th>High score = High potential for health impact</th>
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<tr>
<td><strong>Health Factor Score</strong></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
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<td></td>
<td>Severe/Preventable</td>
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<td></td>
<td>Magnitude: Root Cause</td>
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<tr>
<td>1 4 0</td>
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</table>

sistently. These results highlight the need for effective interventions that reduce harmful UV light exposure.

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Leukemia

The leukemia death rate in our service area is below 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).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{leukemia_deaths.png}
\caption{Leukemia Deaths}
\end{figure}

\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
Leukemia & 2 & 1 & 1 & 0 & 4 \\
\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.

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**Health Factor Score**

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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></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Non-Hodgkin’s lymphoma</td>
<td>2</td>
<td>2</td>
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</tbody>
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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.\(^{58}\) 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 7\(^{th}\) lowest rate (best) of heart disease in the nation.\(^{59}\) The death rate from heart disease in our service area is also well 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.\(^{60}\)

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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></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Heart disease deaths</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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\(^{59}\) 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 above the national average and the trend has been flat since 2000. 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**

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>Respiratory disease deaths</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>9</td>
</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 accident death rate in our service area is higher than the national average largely due to motor vehicle accidents.  

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<tr>
<th></th>
<th>Trend</th>
<th>Prevalence versus U.S. Average</th>
<th>Severe/Preventable</th>
<th>Magnitude</th>
<th>Total Score</th>
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<tbody>
<tr>
<td>Accidental deaths</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>8</td>
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</tbody>
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• **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 but is still higher than the national average. 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.

![Cerebrovascular Deaths Graph](image)

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<tr>
<td>Low score = Low potential for health impact</td>
<td>High score = High potential for health impact</td>
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<tr>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Cerebrovascular Deaths</td>
<td>0</td>
</tr>
</tbody>
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65 America’s Health Rankings 2011, www.americashealthrankings.org
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 about the same as the national rate.

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.

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<tbody>
<tr>
<td>Alzheimer's Deaths</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

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

Diabetes is the seventh leading cause of death in Idaho. The death rate from diabetes in our service area is above the national average. While the rate of people dying from diabetes has been decreasing in our service area over the past 10 years, the number of people living with diabetes is increasing significantly as shown earlier in our CHNA. 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.\(^68\)

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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 suicide rate for our service area was 20.7 in 2010 which is 75% higher than the national average. As shown in the chart below, the suicide rate in Idaho and the nation has been trending up for the last few years beginning with the recession in 2008. A strong relationship exists between unemployment, economy, and suicide.

![Suicide Deaths](chart)

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.  

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<th>Health Factor Score</th>
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<tr>
<td>Trend: Better/Worse</td>
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<tr>
<td>Suicide</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 rate from flu and pneumonia has been decreasing in our service area but is still higher than the national average.  

  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.

  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.

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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><strong>Flu/ Pneumonia</strong></td>
</tr>
</tbody>
</table>

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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. However, the nephritis death rate has increased in both the nation and our service area 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

![Nephritis Deaths](image)

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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75 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.  

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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>
<td></td>
<td>Trend: Better/Worse</td>
<td>Prevalence versus U.S. Average</td>
</tr>
<tr>
<td>Nephritis Deaths</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

76 www.cdc.gov/Features/WorldKidneyDay/
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.

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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 our service area is down and the number of smokers in our service area is now below the national average and below (better than) the top 10\(^{th}\) percentile.\(^{79}\) The top 10\(^{th}\) percentile nationally is less than 14% of the population currently smoking.

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

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\(^{79}\) Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
**Health Factor Score**

<table>
<thead>
<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>
<td>Prevalence versus U.S.</td>
</tr>
<tr>
<td>Smoking</td>
<td>0</td>
</tr>
</tbody>
</table>

### Smoking - by Income

- % of adults who smoked cigarettes by Annual Income:
  - Less than $15,000: 10%
  - $15,000 - $24,999: 12%
  - $25,000 - $34,999: 15%
  - $35,000 - $49,999: 10%
  - $50,000 - $74,999: 5%
  - $75,000+: 0%

### Smoking - by Education

- % of adults who smoked cigarettes by Level of Education:
  - K-11th Grade: 30%
  - 12th Grade or GED: 25%
  - Some College: 15%
  - College Graduate+: 10%

### Smoking - by Ethnicity

- % of adults who smoked cigarettes by Ethnicity:
  - Non-Hispanic: 15%
  - Hispanic: 5%
• **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.  

The trend for obesity has been increasing steadily for the past 10 years both nationally and in our community. Nearly 36% of the people surveyed in our community report having a BMI $\geq 30$ which is significantly above the national average and in the 90th (worst) percentile. 25% is top 10th percentile and 35% is the 90th percentile.  

---


81 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
In our community, Hispanics and those with incomes below $25,000 annually are more likely to be obese.\textsuperscript{82}

---

**Obesity - by Income**

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>% of adults who were obese (BMI ≥ 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $15,000</td>
<td>35%</td>
</tr>
<tr>
<td>$15,000 - $24,999</td>
<td>30%</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>25%</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>20%</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>15%</td>
</tr>
<tr>
<td>$75,000+</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Obesity - by Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of adults who were obese (BMI ≥ 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic</td>
<td>25%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>50%</td>
</tr>
</tbody>
</table>

---

**Health Factor Score**

<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>Obese Adults</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
</tbody>
</table>

\textsuperscript{82} Ibid.
• 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.  

As shown in the chart below, physical inactivity in our community is about the same as the national average and above the average for Idaho. The trend is flat since 2002. The top 10\textsuperscript{th} percentile (best) is 21\%.  

Physical inactivity is significantly higher among those people with annual incomes below $75,000, those without a college degree, and among Hispanics as shown in the charts below.  

---

\textsuperscript{83} University of Wisconsin Population Health Institute. *County Health Rankings* 2012. Accessible at \url{www.countyhealthrankings.org}.

\textsuperscript{84} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System

\textsuperscript{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>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

### Charts

#### Physical Inactivity - by Income

- **District 5**

#### Physical Inactivity - by Education

- **District 5**

#### Physical Inactivity - by Ethnicity

- **District 5**

### Additional Notes

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

- **Level of Education**
  - K-11th Grade
  - 12th Grade or GED
  - Some College
  - College Graduate+

- **Ethnicity**
  - Non-Hispanic
  - Hispanic
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 Districts 5 is below the national average with the trend being flat to down over the past five years. The top 10\(^{th}\) percentile (best) is 8% nationally, so our community is above that level.\(^{87}\)

\[\begin{array}{|c|c|c|c|c|}
\hline
\text{Health Factor Scoring} & \text{Trend: Better/Worse} & \text{Prevalence versus U.S.} & \text{Severe/Preventable} & \text{Magnitude: Root Cause} & \text{Total Score} \\
\hline
\text{Excessive Drinking} & 1 & 1 & 3 & 2 & 7 \\
\hline
\end{array}\]


\(^{87}\) 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 decreased for our community and nationally. However, our crash death rate is significantly above the national average.\(^{88}\)

<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:</td>
<td>Prevalence versus U.S. Average</td>
<td>Severe/Preventable</td>
</tr>
<tr>
<td>Better/Worse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor vehicle crash death rate</td>
<td>4</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.\(^9^9\)

Our teen birth rate is increasing slightly and significantly higher (worse than) the national average. The national top 10\(^{th}\) percentile rate is 22. Our community’s teen birth rate is approaching the 90\(^{th}\) percentile which is 75.\(^{90}\)

---


\(^9^0\) Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010
Health Factor Score

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

<table>
<thead>
<tr>
<th>Health Factor</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>Teen birth rate</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>12</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 increased over the past six years both in our community and nationally. Although we are well below the national average, we are still well above the national top 10\(^{th}\) percentile rate which is 84.\(^{92}\)

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


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 for the past 10 years both nationally and in our community.\(^{\text{93}}\)

\[^{\text{93}}\text{Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System}\]
**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 5 since county and service area data was not available. As shown in the chart below, over 77% of people in District 5 did not eat the recommended amounts of fruits and vegetables. The national average was also about 77%. The trend is improving in Idaho but is relatively flat in District 5 since 2000. 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.

---

**Health Factor Scoring**

<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>Nutritional habits adults</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>9</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. 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.

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 ≥85th 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 ≥95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts.

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96 Overweight In Adolescence Gives Increased Mortality Rate, ScienceDaily (May 20, 2008)
97 American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF
### 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>Obese Teens</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>13</td>
</tr>
</tbody>
</table>

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

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 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.  

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.  

---

**Health Factor Score**

<table>
<thead>
<tr>
<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>Teen exercise</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</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 has increased since 2006 and is now slightly higher than the average for Idaho. Illicit drug use is significantly higher among males less than 34 years old, the unemployed, and those without a high school degree.

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

<table>
<thead>
<tr>
<th></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></td>
<td></td>
</tr>
<tr>
<td>Prevalence versus U.S. Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe/Preventable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnitude: Root Cause</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illicit drug use</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></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.\(^{104}\)

  The chart shows the number of adults without health care coverage has been trending up for the past ten years nationally and in our service area. The percentage of people uninsured in our service area is worse than the 90\(^{th}\) percentile nationally which is 26%.\(^{105}\)

---


\(^{105}\) 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 more than twice as likely to not have health insurance coverage as non-Hispanics.\textsuperscript{106}

\textsuperscript{106} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
Health Care Coverage - by Ethnicity

% of adults without health care coverage

Non-Hispanic

Hispanic

% of adults without health care coverage

Uninsured adults

<table>
<thead>
<tr>
<th>Ethnicity</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>Hispanic</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
• 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%.\(^{107}\)

The chart below shows the population to primary care provider ratio was slightly below (better than) the national average for our service area as a whole.

<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>Primary care physicians</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

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.

For our service area as a whole, the rate of preventable hospital stays is slightly below (better than) the national average. The national top 10\textsuperscript{th} percentile rate is 49. Gooding County’s rate is slightly above the national average. The trend is also improving over time in our service area and nationally. However, our service area rate is above the average for Idaho.\textsuperscript{108}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{preventable_hospital_stays.png}
\caption{Preventable Hospital Stays}
\end{figure}

\begin{table}
\centering
\begin{tabular}{|l|c|c|c|c|c|}
\hline
& Trend: Better/Worse & Prevalence versus U.S. Average & Severe/Preventable & Magnitude: Root Cause & Total Score \\
\hline
Preventable Hospital Stays & 1 & 1 & 4 & 2 & 8 \\
\hline
\end{tabular}
\caption{Health Factor Score}
\end{table}

\textsuperscript{108} Ibid.
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 overall 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{center}
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\textbf{Diabetes Screening} & 2006 & 2007 & 2008 & 2009 \\
\hline
Idaho & \% of diabetics who received HbA1c screening \\
\hline
United States & \\
\hline
Gooding County & \\
\hline
Jerome County & \\
\hline
Lincoln County & \\
\hline
\end{tabular}
\end{center}


\begin{center}
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Health Factor Score} & Low score = Low potential for health impact & High score = High potential for health impact \\
\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}
\end{center}


\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 been decreasing in our service area for the past several years. Overall the percent for our service area is lower than the national average. Gooding County’s percentage of 51% is below the national 90th percentile (worst) which is 53%.

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 is

---

lower than the percentage of women ages 65 to 67 receiving breast cancer screenings. This is an area of concern. 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.

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 49th in the nation for cholesterol screening. District 5 and Idaho each have a lower percent of people receiving cholesterol checks than the national average.

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112 Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
113 America’s Health Rankings 2011, www.americashealthrankings.org
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}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Health Factor Score} & \textbf{Low score = Low potential for health impact} & \textbf{High score = High potential for health impact} \\
\hline
\textbf{Trend: Better/Worse} & \textbf{Prevalence versus U.S. Average} & \textbf{Severe/Preventable} & \textbf{Magnitude: Root Cause} & \textbf{Total Score} \\
\hline
\end{tabular}
\end{table}

\textsuperscript{115} Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System
• **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. However, the percent of people not receiving colorectal screening in our service area is significantly higher (worse) than the national or Idaho average.\(^\text{116}\)

![Colorectal Screening Graph](image)

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.\(^\text{117}\)

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\(^{116}\) 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.\textsuperscript{118}

As shown in the chart below, fewer women in our community have historically been receiving early prenatal care than in Idaho or the nation. The trend in our service area for receiving early prenatal care increased slightly 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.\textsuperscript{119}

<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>Prenatal care 1st Trimester</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

\textsuperscript{118} America’s Health Rankings 2011, www.americashealthrankings.org

\textsuperscript{119} Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010
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.\textsuperscript{120}

According to the Behavioral Risk Factor Surveillance System surveys, the percentage of people not receiving preventive dental visits in our service area is slightly higher than the nation as a whole. The trend appears to have been flat over the past ten years.\textsuperscript{121}

![Preventive Dental Visits](chart)

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.\textsuperscript{122}

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

<table>
<thead>
<tr>
<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>Dental Visits</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Low score = Low potential for health impact
High score = High potential for health impact
• 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.\(^{124}\) Gooding, Jerome, and Twin Falls counties have areas listed as mental health professional shortage areas as of March 2012.\(^{125}\) 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).\(^{126}\)

<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>

\(^{124}\) Mental Health, United States, 2010 Report SAMHSA www.samhsa.gov

Health Services and Resource Administration Data Warehouse, Mental Health Care HPSAs PDF http://datawarehouse.hrsa.gov/hpsadetail.aspx#table

\(^{126}\) Mental Health, United States, 2010 Report SAMHSA 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).  

High school graduation rates for our service area are about the same as the national average. Overall the trend has been relatively flat since 2008. Service area post-secondary education is below the national 90\textsuperscript{th} percentile which is 37%.

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.

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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>Education</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>10</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.

Post-Secondary Education

- Service Area
- Idaho
- United States

Post-Secondary Education

% of adults with some post-secondary education

<table>
<thead>
<tr>
<th>Year</th>
<th>Service Area</th>
<th>Idaho</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>30%</td>
<td>35%</td>
<td>40%</td>
</tr>
<tr>
<td>2010</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
</tr>
</tbody>
</table>

*Percent of adults with some post-secondary education in Service Area, Idaho, and United States.
- **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.\(^\text{129}\)

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.\(^\text{130}\)

![Unemployment Rate Graph](image)

<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>Unemployment</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>


• 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 2003. The prevalence of children in poverty for our service area is above the national average.\(^{132}\)

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![Children in Poverty chart](chart.png)

### 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>Children in Poverty</td>
<td>3</td>
</tr>
</tbody>
</table>


**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.\(^{133}\)

The percent of people with inadequate social support in Lincoln County is below the national average; however, Gooding and Jerome County percentages are significantly higher than the national average.\(^{134}\)

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134 Ibid
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, 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 our service area.\textsuperscript{135}

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\textbf{Health Factor Score} & \textbf{Low score = Low potential for health impact} & \textbf{High score = High potential for health impact} \\
\hline
\textbf{Trend:} & \textbf{Prevalence} & \textbf{Severe/} & \textbf{Magnitude:} & \textbf{Total Score} \\
\textbf{Better/Worse} & \textbf{versus U.S.} & \textbf{Preventable} & \textbf{Root Cause} & \\
\hline
Inadequate social & 2 & 2 & 1 & 3 & 8 \\
support & & & & & \\
\hline
\end{tabular}
\end{table}

\textsuperscript{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.\(^{136}\)

  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.\(^{137}\)

  ![Homicide Rate Chart](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>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide rate / Community safety</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

\(^{136}\) Ibid.

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 90\(^{th}\) percentile (worst) is four (4) unhealthy air particulate days and the reading for our counties is at that level.

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Air Pollution Ozone Days

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

<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>Air pollution</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

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. Overall our service area has about the same percentage of restaurants that are fast food as the nation as a whole.\(^{141}\)

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\(^{141}\) 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. Gooding and Jerome counties have a lower percentage of people in poverty who live more than 10 miles from a grocery store than the nation as a whole. However, Lincoln County’s percentage is very high and well above the national 90th percentile which is 25%. This is due to the fact that Lincoln is a very rural county.\(^{142}\)

![Limited Access to Healthy Food](chart)

<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>Access to healthy foods</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

• **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.

Overall our community has a lower rate of access to recreation facilities than the national average. Lincoln and Gooding County rates are at zero. 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. Not recognizing these venues will result in an underestimation of recreational facilities in our community because we have an abundance of outdoor recreational opportunities.\(^\text{143}\)

![Access to Recreational Facilities](image)

<table>
<thead>
<tr>
<th>Health Factor Scoring</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>Access to recreational facilities</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>8</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.¹⁴⁴

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

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>5.9</td>
<td>We need find ways to make people aware of existing exercise opportunities and effectively motivate people to exercise especially children. Suggested solution: Increase exercise instruction in schools. Promote benefits of existing exercise programs and encourage more youth participation.</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>6.2</td>
<td>Our community needs programs to teach people how to shop for healthy foods and then store and cook healthy foods. Suggested solution: More instruction in schools and from hospitals on nutrition, food preparation, and exercise. Also, the food stamp program should encourage health eating.</td>
</tr>
<tr>
<td>Issue</td>
<td>Score</td>
<td>Details</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Safe-sex education programs                                  | 6.9   | We have sex education programs, but we still have high teen pregnancy and STD rates.  
Suggested solutions: Partner with schools to support abstinence education and update safe-sex promotional materials. |
| Substance abuse services and programs                       | 7.5   | We need more low-cost substance abuse and prevention programs.  
Suggested solution: Use old Magic Valley hospital facility to house all the rehabilitation programs for people on drug and alcohol programs. Work with College of Southern Idaho (CSI) to help prisoners or people in drug and alcohol programs to gain skills so they can integrate into society when they are released. |
| Tobacco cessation programs                                  | 5.5   | The only way smoking cessation works is for the person to be ready.  
Suggested solutions: Apply to the Millennium Fund for support for tobacco cessation programs. Emphasize prevention programs in schools. |
| Wellness and prevention programs                            | 7.2   | Wellness programs are in place, but people don’t know about them or use them. No publicly funded programs are available unless you break the law or are pregnant. Most people wait for a crisis before they make changes. Stress reduction programs are also needed.  
Suggested solutions: Partner with county, schools, and community organizations and use social media to promote wellness programs more effectively. Strengthening volunteer programs would help as well. Need more public programs for low income people. The programs need to be more motivational. Tattooing and piercing are causes of MRSA, AIDS, and hepatitis. |
| Weight management programs                                  | 7.5   | We have weight management programs, but obesity is still increasing.  
Suggested solution: Exercise and nutrition programs are available, but we need to get people to engage in using them – especially people in poverty. We need free, online weight management programs. |
<table>
<thead>
<tr>
<th>Potential Needs</th>
<th>Leader Score</th>
<th>Leader Comments</th>
</tr>
</thead>
</table>
| Affordable health insurance                         | 7.5          | Universal affordable insurance is the most important need. We have Medicare for seniors over age 65. However, affordable health insurance is a problem for early age seniors. The population just over the poverty-level is the most vulnerable because they don’t qualify for Medicaid or have insurance. We need to have insurance rates based on income.  
Suggested solutions: Adopt some kind of universal health insurance. |
| Affordable care for low income individuals           | 8            | We need more low cost options for low income individuals. Sometimes there are programs to help lower costs but people in need don’t know about them.                                                                                                                                                                                                                       |
|                                                     |              | Suggested solutions: We need more support for the Mustard Seed Clinic. The clinic helps support uninsured individuals keeping them out of the ER. Allow patients to volunteer their time to help pay for their services at low income health clinics. Partner with Family Health Services. Catholic charities and ministerial associations could use more support in caring of low income individuals  
We need a profound reorganization of the health system, making it more efficient and lowering costs. Medicaid can help lead this transformation because our data is public and Medicare and Medicaid represent over 50% of all health care costs. Medicaid numbers will increase another 50% by 2014 due to health care reform. |
| Availability of primary care providers               | 5.9          | We have a good ratio of primary care providers in our area, but primary care clinics need to extend their hours.                                                                                                                                                                                                                                                   |
| Affordable dental care for low income individuals    | 6.8          | There are only a few low fee dental providers in the area, and the waiting lists are long. The greatest need is among seniors and youth.                                                                                                                                                                                                                                     |
|                                                     |              | Suggested solutions: CSI has a dental program that provides services at reasonable rates and Family Health Services also provides dental care at low cost.                                                                                                                                                                                                             |
| Availability of behavioral health services (providers, suicide hotline, etc) | 8.3 | Mental health is the most important health issue we have. Our community’s suicide rates are high. There are not enough counselors who speak Spanish. Jerome needs more master’s degree certified counselors and psychiatrists, especially for low income people.  
Suggested solutions: Legislators need to put more money into mental health. Use Sources of Strength in North Dakota as a program model to cut suicide rate. Continue training police officers how to deal with suicide and mental health issues. Insurance and Medicaid rules should be adjusted so enrollees can get mental health care more easily. Partner with Health and Welfare. |
| Chronic disease management programs | 6.1 | Our service area needs better access to diabetes management programs and kidney dialysis. Also, we need to find ways to make these programs more accessible to people with low incomes. We have screening programs for cholesterol, but we need to promote them more effectively.  
Suggested solutions: Expand St. Luke’s Jerome’s disease management services and promote them with more outreach and marketing. |
| Immunization programs | 3.5 | We have immunization programs. The biggest problem is getting people to access them. South Central District Health has a lot of immunization programs.  
Suggested solutions: We need more promotion for our immunization programs to increase participation. |
| Improved health care quality | 4.5 | We have good quality health care in our community.  
Suggested solutions: Family counseling for end of life care. Provide trauma-informed care education to all health care providers, especially with regard to childhood emotional trauma. Many people’s health and emotional stability as adults are impacted by childhood trauma. |
<table>
<thead>
<tr>
<th>Integrated, coordinated care (less fragmented care)</th>
<th>7.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are getting lost between health care providers.</td>
<td></td>
</tr>
<tr>
<td>Suggested solution: Implementation of a single electronic medical record will help. People with chronic conditions often have behavioral health problems and they are the people who are the big users of our health system. We need to provide case management for these people.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More providers accept public health insurance</th>
<th>5.4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prenatal care programs</th>
<th>4.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have prenatal care programs, but they need more cultural sensitivity and promotion, as well as low cost options.</td>
<td></td>
</tr>
<tr>
<td>Suggested solutions: Adjust programs to be more culturally sensitive and promote them in culturally appropriate ways. WIC and Family Health Services have good prenatal health programs that could be promoted better. South Central District Health prenatal care programs could be promoted specifically to teens, Hispanics, and migrant farm workers.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening programs (cholesterol, diabetes, mammography, etc)</th>
<th>4.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have cholesterol and other screening programs, but we need to promote them better – affordability might be an issue for some people.</td>
<td></td>
</tr>
<tr>
<td>Suggested solutions: Promote the availability and importance of screening programs and affordable options for low income individuals. Make sure programs are culturally correct.</td>
<td></td>
</tr>
<tr>
<td>Potential Needs</td>
<td>Leader Score</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Children and family services</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled services</td>
<td>5.3</td>
</tr>
<tr>
<td>Service Type</td>
<td>Score</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Homeless services</td>
<td>6.5</td>
</tr>
<tr>
<td>Job training services</td>
<td>6.5</td>
</tr>
<tr>
<td>Senior services</td>
<td>6</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>6.2</td>
</tr>
<tr>
<td>Violence and abuse services</td>
<td>6.9</td>
</tr>
<tr>
<td>Potential Needs</td>
<td>Leader Score</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Availability of recreation and exercise facilities</td>
<td>4.7</td>
</tr>
<tr>
<td>Availability or access to healthy foods</td>
<td>5.2</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc</td>
<td>3</td>
</tr>
<tr>
<td>Transportation to and from appointments</td>
<td>7.1</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 15.4. Scores above the median are highlighted in orange in the tables below. Six (6) out of the 31 potential health needs have scores of 19.3 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 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 wellness and prevention programs for diabetes, obesity, and mental illness. Diabetes and obesity rank as high priority needs because both are trending higher and are contributing factors 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, obesity, and high cholesterol. 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>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</th>
<th>Populations Affected Most</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight management</td>
<td>Obese</td>
<td>Income &lt;$35,000, Hispanic, No high school diploma</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>Obese/overweight teens</td>
<td>Income &lt;$35,000, Hispanic</td>
<td>20.1</td>
</tr>
<tr>
<td>Wellness/prevention</td>
<td>Diabetes</td>
<td>Income &lt;$35,000, No high school diploma</td>
<td>20.2</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
<td></td>
<td>20.2</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Teen nutrition</td>
<td></td>
<td>16.2</td>
</tr>
<tr>
<td>Safe-sex education programs</td>
<td>Sexually transmitted infections</td>
<td></td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td>Teen birth rate</td>
<td></td>
<td>18.9</td>
</tr>
<tr>
<td>Community Identified Needs</td>
<td>Related Health Factors or Outcomes</td>
<td>Populations Affected Most</td>
<td>Total Score</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Substance abuse services and programs</td>
<td>Illicit drug use</td>
<td>Income &lt;$35,000, No high school diploma, Males 18-34</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Vehicle crash death rate</td>
<td></td>
<td>17.5</td>
</tr>
<tr>
<td>Wellness and Prevention</td>
<td>High cholesterol</td>
<td>Income &lt; $35,000, No high school diploma, Age 55+</td>
<td>17.2</td>
</tr>
<tr>
<td></td>
<td>Respiratory disease</td>
<td></td>
<td>16.2</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
<td></td>
<td>17.2</td>
</tr>
<tr>
<td>Exercise programs/education</td>
<td>Adult physical activity</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Teen exercise</td>
<td></td>
<td>14.9</td>
</tr>
<tr>
<td>Nutrition education</td>
<td>Adult nutrition</td>
<td>No college</td>
<td>15.2</td>
</tr>
<tr>
<td>Substance abuse services and programs</td>
<td>Alcohol</td>
<td>Ages 18-64</td>
<td>14.5</td>
</tr>
<tr>
<td>Tobacco cessation programs</td>
<td>Smoking</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>13.5</td>
</tr>
<tr>
<td>Wellness and prevention</td>
<td>Accidents</td>
<td></td>
<td>15.2</td>
</tr>
<tr>
<td></td>
<td>AIDS</td>
<td>African American, Males &lt;24</td>
<td>14.2</td>
</tr>
<tr>
<td></td>
<td>Alzheimer’s</td>
<td>Age 65 +</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>Arthritis</td>
<td>Income &lt; $35,000, Non-Hispanic, No college, Overweight, Age 65 +</td>
<td>12.2</td>
</tr>
</tbody>
</table>
### Health Behavior Need Summary Table, Continued

<table>
<thead>
<tr>
<th>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</th>
<th>Populations Affected Most</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness and prevention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td>13.2</td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td>Female</td>
<td>14.2</td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td></td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td></td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Flu/pneumonia</td>
<td></td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65+</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td></td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Nephritis</td>
<td></td>
<td>14.2</td>
<td></td>
</tr>
<tr>
<td>Non-Hodgkin’s lymphoma</td>
<td></td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td></td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Male age 60+</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Skin cancer</td>
<td></td>
<td>14.2</td>
<td></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; affordable health insurance; and increased availability of behavioral health services. 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 not improving. Availability of behavioral health services ranked as a top priority due to our health leader scores and because Idaho has a shortage of behavioral health professionals.

As shown in the table below, high priority clinical care needs are often 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>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</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>20</td>
</tr>
<tr>
<td>Affordable health Insurance</td>
<td>Uninsured adults</td>
<td>Income &lt; $50,000, Hispanic, No college</td>
<td>20.5</td>
</tr>
<tr>
<td>Availability of behavioral health services</td>
<td>Mental health service providers</td>
<td>Income &lt; $50,000</td>
<td>19.3</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Diabetes</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>19.1</td>
</tr>
<tr>
<td>More providers accept public health insurance</td>
<td>Children in poverty</td>
<td>Income &lt; $35,000</td>
<td>17.4</td>
</tr>
<tr>
<td>Screening programs</td>
<td>Mammography screening</td>
<td>Income &lt; $50,000</td>
<td>16.5</td>
</tr>
</tbody>
</table>
**Clinical Care Need Summary Table, Continued**

<table>
<thead>
<tr>
<th>Community Identified Needs</th>
<th>Related Health Factors or Outcomes</th>
<th>Populations Affected Most</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable dental care</td>
<td>Dental visits, preventive</td>
<td>Income &lt; $50,000</td>
<td>15.8</td>
</tr>
<tr>
<td>Availability of primary care providers</td>
<td>Primary care providers</td>
<td></td>
<td>14.9</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>11.1</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Income &lt; $35,000</td>
<td>12.1</td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td>Income &lt; $35,000, No college, Overweight, Age 65 +</td>
<td>14.1</td>
</tr>
<tr>
<td>Immunization programs</td>
<td>Children immunized</td>
<td></td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>Flu/pneumonia</td>
<td></td>
<td>11.5</td>
</tr>
<tr>
<td>Improved health care quality</td>
<td>Preventable hospital stays</td>
<td></td>
<td>12.5</td>
</tr>
<tr>
<td>Integrated, coordinated care (less fragmented)</td>
<td>Preventable hospital stays</td>
<td>Refugees, Hispanics, Age 65 +</td>
<td>15.2</td>
</tr>
<tr>
<td>Prenatal care programs</td>
<td>Low birth weight</td>
<td></td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td>Prenatal care 1st trimester</td>
<td>Hispanic, No high school diploma</td>
<td>15.4</td>
</tr>
<tr>
<td>Screening programs</td>
<td>Cholesterol</td>
<td>Income &lt; $35,000, No high school diploma, Age 55 +</td>
<td>14.5</td>
</tr>
<tr>
<td></td>
<td>Colorectal screening</td>
<td>Income &lt; $35,000, No college, Age 50 +</td>
<td>13.5</td>
</tr>
<tr>
<td></td>
<td>Diabetic screening</td>
<td>Income &lt; $35,000, No high school diploma</td>
<td>13.5</td>
</tr>
</tbody>
</table>

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

Children and family services is the only social and economic health needs scoring above the median. The increasing number of children living in poverty in our service area drives the need for more children and family services in our community.

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>19.3</td>
</tr>
<tr>
<td>Education support and assistance programs</td>
<td>Education</td>
<td>Age &lt; 18</td>
<td>15.9</td>
</tr>
<tr>
<td>Children and family services</td>
<td>Inadequate social support</td>
<td></td>
<td>15.3</td>
</tr>
<tr>
<td>Disabled services</td>
<td></td>
<td></td>
<td>13.3</td>
</tr>
<tr>
<td>Homeless services</td>
<td>Unemployment rate</td>
<td></td>
<td>13.5</td>
</tr>
<tr>
<td>Job training services</td>
<td>Unemployment rate</td>
<td></td>
<td>13.5</td>
</tr>
<tr>
<td>Senior services</td>
<td>Inadequate social support</td>
<td>Age 65 +</td>
<td>14</td>
</tr>
<tr>
<td>Veterans’ services</td>
<td>Inadequate social support</td>
<td></td>
<td>14.2</td>
</tr>
<tr>
<td>Violence and abuse services</td>
<td>Safety - homicide rate</td>
<td></td>
<td>12.9</td>
</tr>
</tbody>
</table>

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

In the physical environment category, transportation to and from appointments ranked above the CHNA median health need score. This need was identified during our affected population focus groups and was reinforced during our community leader interview process. Low income, senior, and rural populations are most affected by the need for transportation to and from appointments.

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>Transportation to and from appointments</td>
<td></td>
<td>Income &lt; $35,000, Rural populations, Age 65 +</td>
<td>16.1</td>
</tr>
<tr>
<td>Availability of recreation and exercise facilities</td>
<td>Recreational facilities</td>
<td>Income &lt; $50,000</td>
<td>12.7</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>13.7</td>
</tr>
<tr>
<td>Healthier air quality, water quality, etc.</td>
<td>Air pollution</td>
<td></td>
<td>11</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
Behavioral Health Facilities
Childcare
Dental Services
Government Contacts
Homeless Services
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

Jerome County Social Services
300 No. Lincoln Ave.
Jerome, ID 83338
Phone: 208-644-2711
www.jeromecountyid.us

Office on Aging
315 Falls Ave
Twin Falls, ID 83301
Phone: 208-736-2122
http://officeonaging.csi.edu/adultprotection

After School Programs/Youth Mentoring

Jerome Recreation District
2032 So. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-2413
Fax: 208-324-3380
www.jeromerecreationdistrict.com
Description: Offering a wide range of activities including various sports and leisure programs to meet the diverse needs of the community.

Pure Energy Gymnastics
141 South Lincoln Ave
Jerome, ID 83338
Phone: 208-324-0000
www.pureenergygym.com
Description: Parents, drop your kids off, for a night out.

Behavioral Health Facilities

St. Luke’s Canyon View Behavioral Health Services
St. Luke’s Magic Valley
228 Shoup Avenue West
Twin Falls, ID 83301
Phone: 208-734-6760
www.stlukesonline.org
Description: Provides treatment for adolescents, adults, and seniors. Offering intensive inpatient programs that address acute psychiatric issues in addition to medical detoxification from alcohol and drugs. We utilize individual, family, and
group counseling to address personal, family, emotional, psychiatric behavioral and addition-related problems. Outpatient services are scheduled at convenient hours. The common goal of our programs is to help people find positive solutions to resolve the challenges and crises in their lives.

**Family Health Services**  
114 Pioneer Ct  
Jerome, ID 83338  
Phone: 208-324-3471  
[www.fhsid.org](http://www.fhsid.org)  
Description: Private not-for-profit organization which provides behavioral health care to all based on their ability to pay.

**Childcare**

**April’s Angels Childcare**  
620 E Main Street  
Jerome, ID 83338  
Phone: 208-324-3436

**Bright Beginnings Childcare Center**  
124 No. Lincoln  
Jerome, ID 83338  
Phone: 208-324-3142

**First Baptist Church Nursery School**  
308 1st Ave E  
Jerome, ID 83338  
Phone: 208-324-7533

**Dental Services**

**Family Health Services**  
114 Pioneer Ct  
Jerome, ID 83338  
Phone: 208-324-3471  
[www.fhsid.org](http://www.fhsid.org)  
Description: Dedicated to providing quality, affordable dental care.
Government Contacts

City of Jerome
152 East Ave A
Jerome, ID 83338
Phone: 208-324-8189
www.ci.jerome.id.us

County of Jerome
300 N Lincoln Ave
Jerome, ID 83338
Phone: 208-644-2740
www.jeromecounty.org

Social Security Administration
1437 Fillmore St
Twin Falls, ID 83301
Phone: 208-734-3985
www.ssa.gov

Homeless Services

South Central Community Action
300 No. Lincoln Ave
Jerome, ID 83338
Phone: 208-324-8856
www.sccap.org
www.idahocommunityaction.org

Helping Hearts & Hands, Inc
426 Main Street
Gooding, ID
Phone: 208-934-5101

Hospices

St. Luke’s Home Health & Hospice
601 Pole Line Road West (H&W Building)
Twin Falls, ID 83301
Phone: 208-814-7600
www.stlukesonline.org
Hospitals

**St. Luke's Jerome**
709 No. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-4301
[www.stlukesonline.org](http://www.stlukesonline.org)

**North Canyon Medical Center**
267 North Canyon Dr.
Gooding, ID 83330
Phone: 208-934-4433
[http://northcanyonmedicalcenter.com](http://northcanyonmedicalcenter.com)

Legal Services

**Idaho Legal Aid Office**
475 Polk Street
Twin Falls, ID 83301
Phone: 208-734-7024
[www.idaholegalaid.org/office/twin_falls](http://www.idaholegalaid.org/office/twin_falls)
Description: 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 Farm Worker Law Unit provides legal services to Idaho's migrant population.

Low Income Medical Resources

**Family Health Services**
114 Pioneer Ct
Jerome, ID 83338
Phone: 208-324-3471
[www.fhsid.org](http://www.fhsid.org)
Description: Private not-for-profit organization which provides medical, dental, and behavioral health care to all, based on their ability to pay.
Idaho Department of Health & Welfare
601 Pole Line Rd
Twin Falls, ID 83301
Phone: 208-736-3024
www.healthandwelfare.idaho.gov
Description: Idaho State Department of Health and Welfare oversees Medicaid, food stamps, child welfare, mental health, and other programs.

South Central Public Health
300 N. Lincoln Ave.
Jerome, ID 83338
Phone: 208-644-2779
www.phd5.idaho.gov
Description: Provides community health programs and basic services of public health education, physical health, environmental health, and health administration.

St. Luke's Jerome
709 No. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-4301
www.stlukesonline.org

Nursing Homes

St. Luke’s Jerome
Transitional Care (Swing Bed)
709 No. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-4301
www.stlukesonline.org

Lincoln County Care Center
511 East 4th Street
Shoshone, ID
Phone: 208-969-9107
www.lincolncountycarecenter.com

Public Health Resources

South Central Public Health
300 N. Lincoln Ave.
Jerome, ID 83338
Phone: 208-644-2779
www.phd5.idaho.gov
Description: Provides community health programs and basic services of public health education, physical health, environmental health, and health administration.

Referral & Miscellaneous Services

**Accomplishments in Home Service**
844 North Washington, Suite 200
Twin Falls, ID 83301
Phone: 208-324-8409
Description: Skilled nursing care for homebound persons.

**Jerome County WIC Program**
951 East Avenue H
Jerome, ID 83338
Phone: 208-324-1323

Refugee Services

**CSI Refugee Center**
1526 Highland Ave. East
Twin Falls, ID 83301
Phone: 208-736-2166
Fax: 208-736-4711

Senior Services

**Alzheimer’s Association Helpline**
Phone: 800-272-3900

**Jerome Senior Center**
520 No. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-5642
[www.ci.jerome.id.us](http://www.ci.jerome.id.us)

**CSI Office on Aging**
315 Falls Ave.
Twin Falls, ID 83301
Phone: 208-736-2122
[www.officeonagingcsi.edu](http://www.officeonagingcsi.edu)
Description: Serves as Idaho’s Area 5 agency on aging. Helping seniors with common referrals.
Veteran Services

US Dept of Veterans Affairs Medical Care
260 2nd Ave E
Twin Falls, ID 83301
Phone: 208-732-0947

Jerome County Service Officer
Terry Gabbert
Jerome County Courthouse, Room 310
Jerome, ID 83338
Phone: 208-644-2708
Fax: 208-644-2709

tgabbert@co.jerome.id.s
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:** College of Southern Idaho  
   **Date contacted:** 5/1/2012  
   **How input was obtained:** Phone interview and questionnaire  
   **Health leader category:** III

   Populations represented/served:

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

2. **Affiliation:** College of Southern Idaho Office on Aging  
   **Date contacted:** 4/30/2012  
   **How input was obtained:** Phone interview and questionnaire  
   **Health leader category:** III
Populations represented/served:

<table>
<thead>
<tr>
<th>Yes</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disabled</td>
</tr>
<tr>
<td>Yes</td>
<td>Hispanic population</td>
</tr>
<tr>
<td></td>
<td>Homeless</td>
</tr>
<tr>
<td></td>
<td>Low income individuals and families</td>
</tr>
<tr>
<td></td>
<td>Migrant and seasonal farm workers</td>
</tr>
<tr>
<td>Yes</td>
<td>Populations with chronic conditions</td>
</tr>
<tr>
<td></td>
<td>Refugees</td>
</tr>
<tr>
<td>Yes</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>

3. **Affiliation:** Family Health Services  
   **Date contacted:** 5/1/2012  
   **How input was obtained:** Phone interview and questionnaire  
   **Health leader category:** III

   Populations represented/served:

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

4. **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
Yes Migrant and seasonal farm workers
Yes Populations with chronic conditions
Yes Refugees
Yes Senior citizens
Yes Those with behavioral health issues
Yes Veterans

5. **Affiliation:** Idaho Department of Health and Welfare, Regions 5, 6, and 7  
**Date contacted:** 4/27/2012  
**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
Yes Migrant and seasonal farm workers
Yes Populations with chronic conditions
Yes Refugees
Yes Senior citizens
Yes Those with behavioral health issues
Yes Veterans

6. **Affiliation:** Idaho Health and Welfare  
**Date contacted:** Contacted numerous times from November 2011 through January 2012 to obtain and insure appropriate collection of Vital Statistics data for our service area.  
**How input was obtained:** Phone conversations, emails  
**Health leader category:** Category II

Populations represented/served:

Yes Children
___ Disabled
___ Hispanic population
___ Homeless
___ Low income individuals and families
___ Migrant and seasonal farm workers
___ Populations with chronic conditions
7. Affiliation: Idaho Health and Welfare
Date contacted: Contacted numerous times from November 2011 through January 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

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

8. Affiliation: Jerome Recreation District
Date contacted: 5/11/12
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
Refugees
Yes  Senior citizens
___  Those with behavioral health issues
___  Veterans

9. **Affiliation**: Jerome School District  
   **Date contacted**: 5/15/12  
   **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  
___  Populations with chronic conditions  
___  Refugees  
___  Senior citizens  
Yes  Those with behavioral health issues  
___  Veterans

10. **Affiliation**: Jerome Senior Center  
    **Date contacted**: 5/29/12  
    **How input was obtained**: Phone interview and questionnaire  
    **Health leader category**: Category III  

Populations represented/served:

___  Children  
Yes  Disabled  
___  Hispanic population  
___  Homeless  
Yes  Low income individuals and families  
___  Migrant and seasonal farm workers  
___  Populations with chronic conditions  
___  Refugees  
Yes  Senior citizens  
Yes  Those with behavioral health issues  
Yes  Veterans
11. **Affiliation:** Jerome Interfaith Association  
   **Date contacted:** 5/11/12  
   **How input was obtained:** Phone interview and questionnaire  
   **Health leader category:** Category III

Populations represented/served:

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

12. **Affiliation:** Mustard Tree Clinic and St. Luke’s Magic Valley  
   **Date contacted:** 5/4/12  
   **How input was obtained:** Phone interview and questionnaire  
   **Health leader category:** Category III

Populations represented/served:

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

13. **Affiliation:** Shoshone Family Medical Center  
   **Date contacted:** 5/14/12  
   **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

14. Affiliation: South Central Public Health
Date contacted: 5/9/12
How input was obtained: Phone interview and questionnaire
Health leader category: Categories I and III

Populations represented/served:

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

* Population category added per leader’s request.

Date contacted: 5/11/12
How input was obtained: Phone interview and questionnaire
Health leader category: Category III
Populations represented/served:

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

   Date contacted: 5/15/12
   How input was obtained: Phone interview and questionnaire
   Health leader category: Category III
   Description of expertise:

   Registered nurse certified diabetes educator for St. Luke’s Jerome for ten years. Also a board member of the Diabetes Center Foundation and serves on the State Advisory Board for diabetes prevention programs. In addition, works with the local affiliate of the Diabetes Coalition.

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: 5/14/12
    How input was obtained: Phone interview and questionnaire
    Health leader category: Category I 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
- Yes  Populations with chronic conditions
-  Refugees
- Yes  Senior citizens
-  Those with behavioral health issues
-  Veterans

18. **Affiliation:** St. Jerome Catholic Church  
**Date contacted:** 5/11/12  
**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
-  Populations with chronic conditions
-  Refugees
- Yes  Senior citizens
- Yes  Those with behavioral health issues
-  Veterans

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

Populations served or represented:

-  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

Date contacted: 5/14/12 
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  
- Veterans

21. 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

22. 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

23. Affiliation: Family Medicine Residency of Idaho  
Date contacted: 6/28/12
**How input was obtained:** Phone interview & questionnaire  
**Health leader category:** Category III  
Populations represented/served:

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<td>Low income individuals and families</td>
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<tr>
<td>Migrant and seasonal farm workers</td>
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<td>Populations with chronic conditions</td>
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<td>Refugees</td>
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<tr>
<td>Senior citizens</td>
<td></td>
</tr>
<tr>
<td>Those with behavioral health issues</td>
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<tr>
<td>Veterans</td>
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**24. Affiliation:** St. Luke’s Behavioral Health  
**Date contacted:** 5/9/12  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Category III

Populations represented/served:

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<tr>
<td>Children</td>
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<td>Hispanic population</td>
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<td>Refugees</td>
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<tr>
<td>Senior citizens</td>
<td></td>
</tr>
<tr>
<td>Those with behavioral health issues</td>
<td></td>
</tr>
<tr>
<td>Veterans</td>
<td></td>
</tr>
</tbody>
</table>

**25. Affiliation:** Coordinator of the CARES (Children At Risk Evaluation Services) at St. Luke’s Magic Valley  
**Date contacted:** 5/1/2012  
**How input was obtained:** Phone interview and questionnaire  
**Health leader category:** Category 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

26. **Affiliation:** United Way of Magic Valley

**Date contacted:** 5/11/12

**How input was obtained:** Phone interview and questionnaire

**Health leader category:** III

Populations represented/served:

___  Children
___  Disabled
___  Hispanic population
___  Homeless
Yes  Low income individuals and families
___  Migrant and seasonal farm workers
___  Populations with chronic conditions
___  Refugees
Yes  Senior citizens
___  Those with behavioral health issues
___  Veterans
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>Exercise programs/education</td>
<td>5.9</td>
<td>Adult physical inactivity</td>
<td>9</td>
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<tr>
<td></td>
<td></td>
<td>Teen exercise</td>
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<td>14.9</td>
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<td>Nutrition education</td>
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<td>Adult nutrition</td>
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<td>Teen nutrition</td>
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<td>Safe-sex education programs</td>
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<td>Sexually transmitted infections</td>
<td>10</td>
<td>16.9</td>
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<td></td>
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<td>Teen birth rate</td>
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<td>18.9</td>
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<td>Substance abuse services and programs</td>
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<td>Excessive drinking</td>
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<td>Illicit drug use</td>
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<td>Vehicle crash death rate</td>
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<td>Tobacco cessation programs</td>
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<td>Smoking adult</td>
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<td>Weight management programs</td>
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<td>Obese adults</td>
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<td></td>
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<td>Obese/Overweight teenagers</td>
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<td>Wellness and prevention programs</td>
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<td>Accidents</td>
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<td>15.2</td>
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<td>AIDS</td>
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<td>Alzheimer’s</td>
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<td>Asthma</td>
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<td>Breast cancer</td>
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<td>Non-Hodgkin's lymphoma</td>
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<td>Pancreatic cancer</td>
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<td>Prostate cancer</td>
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## Clinical Care Category

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<th>Related Health Factors and Outcomes</th>
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<th>Combined Score</th>
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<td>Preventable hospital stays</td>
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<td>Integrated, coordinated care (less fragmented care)</td>
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<td>Preventable hospital stays</td>
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<td>Prenatal care 1st trimester</td>
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<td>Mammography screening</td>
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**Social and Economic Category**

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<th>Related Health Factors and Outcomes</th>
<th>Health Factor Score</th>
<th>Combined Score</th>
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<tbody>
<tr>
<td>Children and family services</td>
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<td>19.3</td>
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<td>Inadequate social support adults</td>
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<td>15.9</td>
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<td>Unemployment rate</td>
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<td>13.5</td>
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<td>Job training services</td>
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<td>Senior services</td>
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<td>Violence and abuse services</td>
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* 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

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<th>Related Health Factors and Outcomes</th>
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<th>Combined Score</th>
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<tbody>
<tr>
<td>Availability of recreation and exercise facilities</td>
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<td>Recreational facilities</td>
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<td>12.7</td>
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<td>Availability or access to healthy foods</td>
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<td>Limited access to healthy foods</td>
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<td>13.7</td>
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<tr>
<td>Healthier air quality, water quality, etc</td>
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<td>Air pollution particulate matter</td>
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<td>11</td>
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<tr>
<td></td>
<td></td>
<td>Air pollution ozone days</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Transportation to and from appointments *</td>
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<td>* See note below</td>
<td>9</td>
<td>16.1</td>
</tr>
</tbody>
</table>

* Transportation did not have an objective health factor measure associated with it. Therefore, we used a health factor value that was slightly above the middle of the possible range of scores to reflect the fact that it had the 7th highest leader score.